STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	375460	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montereau, Inc.	6800 South Granite Avenue Tulsa, OK 74136

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** On [DATE], a past non-compliance Immediate Jeopardy (IJ) situation was determined to exist related to the facility's failure to assess, monitor, and intervene for a resident with a history of skin breakdown. The facility failed to accurately identify the status of a resident at high risk for skin breakdown, failed to accurately and timely document the resident's skin condition, failed to accurately care plan, provide, and monitor the success or failure of interventions for the resident's deteriorating skin condition, and failed to communicate the resident's deteriorating skin condition to other disciplines of the resident's care team. Based on record review and interview, the facility failed to assess, monitor, and intervene for 1 (#1) of 7 sampled residents who had pressure ulcers/wounds or were at high risk for the development of pressure ulcers/wounds. The facility's Census and Condition, dated [DATE], showed five residents with pressure ulcers and 41 resident receiving preventative skin care. Findings: The rehabilitation hospital's Discharge summary, dated [DATE], showed a wound assessment with pictures was performed. The wound assessment documented a stage II sheering was present on the right buttocks and the right heel wound was resolved. The Montereau clinical admission assessment, dated [DATE], showed moisture associated skin damage to the resident's right gluteus was present on admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The Functional Abilities and Goals - admission form, dated [DATE], [DATE], and [DATE], showed the resident required partial to moderate assistance with bed mobility, transfers, and ambulation. The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. There were no other documented skin concerns/conditions. The skin check, dated [DATE], created on [DATE], showed the resident had moisture associated skin damage to the right gluteus. The skin check showed the moisture associated skin damage was present on admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The baseline care plan, dated [DATE], did not address skin issues/concerns. The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The Brief Interview for Mental Status Evaluation, dated [DATE], showed the resident was cognitively intact in daily decision making. The admission MDS assessment, dated [DATE], showed the resident had a stroke affecting the right side of the body; was cognitively intact with a BIMS score of 13; displayed no behaviors such as refusal of care; required partial/moderate to substantial/maximal assistance with most activities of daily living; had no pressure ulcers but was at risk for pressure ulcers and had moisture associated skin damage. The admission assessment documented the facility utilized a pressure reducing device for chair/bed and applied ointments/medications to areas other than the resident's feet. There was no documentation of a deep tissue injury, wounds, or other skin issues. The shower sheet, dated [DATE], showed the resident refused their shower. The shower sheet did not address if the resident had skin issues/concerns. The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The Braden scale used to determine the risk of developing pressure ulcers, dated [DATE] (created [DATE]), showed a score of 20 which indicated the resident was at low risk for developing a pressure ulcer. The physical therapy treatment encounter note, dated [DATE], showed the resident had decreased motivation and participation in therapy. The note also showed a CNA reported to the therapist the resident had decreased oral intake and an increased need for assistance with transfers. The shower sheet, dated [DATE], showed the resident received a shower and had no skin issues/concerns on visual inspection. The skin check, dated [DATE] (created on [DATE]), showed the resident had moisture associated skin damage to the right gluteus. The skin check showed the moisture associated skin damage was present on admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The shower sheet, dated [DATE], documented the Resident #1 refused their shower. The shower sheet did not address if the Resident #1 had skin issues/concerns. The multidisciplinary care conference, dated [DATE], did not address the resident's skin condition. The physician's progress note, dated [DATE], showed the resident's chief complaint was sacral pain, debility, and weakness. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The Braden scale, dated [DATE] [but created [DATE]], showed a score of 20 which indicated the resident was at low risk for developing a pressure ulcer. The shower sheet, dated [DATE], documented the Resident #1 refused their shower. The shower sheet did not address if Resident #1 had skin issues/concerns. The skin check, dated [DATE], (created on [DATE]), showed the resident had moisture associated skin damage to the right gluteus. The skin check showed the moisture associated skin damage was present on admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The physical therapy treatment encounter notes, dated [DATE], showed the resident initially refused therapy due to sacral wound pain. The note read in part, PTA [physical therapy assistant] added w/c [wheelchair] cushion to decrease risk of further skin breakdown. The treatment record, dated February 2025, showed the first ordered dressing (leptospermum honey dressing) was applied on [DATE]. The physical therapy treatment encounter notes, dated [DATE], showed the resident refused therapy due to buttock pain from wound. The note also reported the resident was not eating. The shower sheet, dated [DATE], documented the resident refused their shower. The shower sheet did not address if the resident had skin issues/concerns. A physician's order, dated [DATE], showed the resident was placed on enhanced barrier precautions due to the resident the existence of a pressure ulcer. The physician's progress note, dated [DATE], showed the resident complained of sacral pain, debility, and weakness. The progress note showed the resident reported some sacral pain when seated in their wheelchair for extended periods. The progress note showed the resident's sensation was mildly decreased in their lower extremities with right hemiparesis. The Braden scale, dated [DATE] [but created [DATE]], showed a score of 18 which indicated the resident was at a mild risk for developing a pressure ulcer. The shower sheet, dated [DATE], showed the Resident #1 refused their shower. The shower sheet did not address if Resident #1 had skin issues/concerns. The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The skin check, dated [DATE] (created on [DATE]), showed the resident had moisture associated skin damage to the right gluteus. The skin check showed the moisture associated skin damage was present on admission. There was no other documented skin concerns/conditions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The care plan, dated [DATE], showed the resident was at risk for skin breakdown related to their occasional incontinence and had moisture associated skin damage to the buttock. The goal was to develop clean and intact skin by the review date. The interventions included educating the resident / family / caregivers of causative factors and measures to prevent skin injury; to follow facility protocols for treatment of injury; to keep the resident's skin clean and dry; to use lotion on the resident's dry skin; and to monitor / document the location, size and treatment of skin injury; to report abnormalities, failure to heal, and/or signs and symptoms of skin / wound infection such as maceration of the skin to the physician. The care plan did not address the resident's pressure ulcer. The Weekly Wound Tracking Worksheet, dated [DATE] through [DATE], showed the resident had wounds on their sacrum, right heel, and left foot. The skilled nursing note, dated [DATE], read in part, skin warm & dry, skin color WNL [within normal limits] and turgor is normal. Skin Issue #001: Skin issue has been evaluated. Location: Right gluteus. Issue type: Moisture associated skin damage (MASD). Wound was present on admission. Measurements not documented as part of this assessment. Reason measurements not documented as part of this assessment: na. Skin note: WNL. The physician's progress note, dated [DATE], showed the resident had a sacral wound. The progress note, showed nursing staff were to clean the site with normal saline, apply leptospermum honey (a medicated gel used for the treatment of wounds), and cover with a border foam dressing. The physician's progress note, dated [DATE] showed the resident complained of sacral pain. The wound care physician's progress note, dated [DATE], showed an unstageable pressure ulcer to the sacrum due to full thickness necrosis with serosanguinous exudate; 50% thick adherent devitalized necrotic tissue, 30% slough, 10% granulation tissue, and 10% viable dermis was present. The wound care physician's progress note showed the wound was present for greater than 30 days and was noted to be present on admission per staff. The wound measured 4.2 x 3.5 x 0.1cm (centimeter) and was mechanically debrided (to cut away the nonviable tissues) to a depth of 0.5cm. The wound progress was exacerbated due to an unclear cause. The resident's objective of the wound care was to maintain healing. A daily dressing was ordered. The dressing consisted of leptospermum honey and calcium alginate applied daily and covered with a gauze island bordered dressing. The wound physician's progress note also showed the presence of a stage 1 pressure wound on the resident's right heel and a non-pressure wound on the left foot. The progress note showed to apply skin prep (an ointment) twice daily to each site. The wound care physician progress note showed the physician recommended the addition of a protein supplementation per facility formulary and protocol, noting the resident's preferred flavor was chocolate. The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The skin check, dated [DATE] [but created on [DATE]], showed the resident had moisture associated skin damage to the right gluteus. The skin check showed the moisture associated skin damage was present on admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The Long-Term Care Evaluation form, dated [DATE], showed the resident's buttock was red and they had a stage IV pressure ulcer / injury to the sacrum they documented was present since admission. The evaluation form showed the resident had a stage I right heel pressure ulcer / injury was present on admission. The evaluation form showed the resident had a left plantar foot trauma injury present on admission. There were no other documented skin concerns/conditions. The skilled nurse's note, dated [DATE], showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The shower sheet, dated [DATE], showed the resident refused their shower. The shower sheet did not address if the resident had skin issues/concerns. The wound care physician's progress note, dated [DATE], showed a stage IV pressure ulcer (full-thickness tissue loss with exposed bone, tendon, or muscle) to the sacrum with sero-sanguinous exudate and 90% thick adherent devitalized necrotic tissue and 10% viable dermis. The wound care physician's progress note read in part that the wound was present for greater than 37 days and was noted to be present on admission per staff. The wound measured 4.2 x 3.7 x 0.1cm and was mechanically debrided to a depth of 1.7cm. A daily dressing was ordered. The dressing consisted of leptospermum honey and calcium alginate applied to the wound and covered with a gauze island bordered dressing daily for 23 days. The skilled nurse's note, dated [DATE] at 3:35 p.m., showed the resident had moisture associated skin damage to their right gluteus which was present on/since admission. There was no documentation of a deep tissue injury, wounds, or other skin issues. The wound weekly observation tool, dated [DATE] at 9:45 p.m., showed the sacral wound was a suspected deep tissue injury, present on admission, which worsened into a stage IV pressure ulcer with necrotic tissue and serosanguinous drainage present. The current treatment read in part, may use Santyl is [sic] available, Medihoney/calcium alginate/ island border dressing daily protein supplement. The skilled nurse's note, dated [DATE] at 9:45 p.m., showed the resident had a stage IV pressure ulcer / injury to the sacrum they documented was present since admission. The evaluation form showed the resident had a stage I right heel pressure ulcer / injury they documented was present on admission. The evaluation form showed the resident had a left plantar foot trauma injury they documented was also present on admission. There were no other documented skin concerns/conditions. The Weekly Wound Tracking Worksheet, dated [DATE] through [DATE], showed the resident had wounds on their sacrum and right heel. The sacral wound was 100% necrotic tissue with moderate serosanguinous exudate and measured 5x3.4x0.1cm. The right heel, stage I, measured 6x3cm. The skilled nurse's note, dated [DATE], showed the resident had a stage IV pressure ulcer / injury to the sacrum they documented was present since admission. The evaluation form showed the resident had a stage I right heel pressure ulcer / injury they documented was present on admission. The evaluation form showed the resident had a left plantar foot trauma injury they documented was also present on admission. There were no other documented skin concerns/conditions. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The shower sheet, dated [DATE], showed the resident refused their shower. The shower sheet did not address if the resident had skin issues/concerns. The shower sheet, dated [DATE], showed the resident received their shower and had a right arm skin tear, and a bedsore upon visual inspection. The wound care physician's progress note, dated [DATE], showed a stage IV pressure ulcer to the sacrum with serosanguinous exudate and 100% thick adherent devitalized necrotic tissue. The wound care physician's progress note read in part that the wound was present for greater than 44 days and was noted to be present on admission per staff. The wound measured 5.0 x 3.4 x 0.1cm and was mechanically debrided to a depth of 0.3cm. The wound progress was exacerbated due to the resident not eating much per the resident's spouse, and the resident's preference to lay supine (on their back). The resident's objective of the wound care was to maintain healing. A daily dressing was ordered. The dressing consisted of leptospermum honey and calcium alginate applied to the wound and covered with a gauze island bordered dressing daily for 16 days. The wound care physician progress note showed the physician recommended a low air loss mattress for the resident, noting the resident preferred to lay supine. The wound weekly observation tool, dated [DATE], showed the sacral wound as a suspected deep tissue injury, present on admission, which worsened into a stage IV pressure ulcer with necrotic tissue and serosanguinous drainage present. The current treatment read in part, Medihoney, calcium alginate gauze island with bdr [border] daily. The wound observation tool showed the wound did not have an odor. The treatment record, dated [DATE], showed the daily sacral wound dressing was dressed on [DATE], [DATE], [DATE], [DATE], [DATE] and [DATE]. The Weekly Wound Tracking Worksheet, dated [DATE] through [DATE], showed the resident had wounds on their sacrum, right heel, and right forearm. The tracking worksheet documented the addition of a low air loss mattress to the pressure ulcer interventions. A physician's order, dated [DATE], showed to cleanse the wound to the sacrum with wound cleanser, apply Santyl, and cover with a gauze island dressing with border daily. The wound care physician's progress note, dated [DATE], showed a stage IV pressure ulcer to the sacrum with moderate serous exudate and 100% thick adherent devitalized necrotic tissue. The wound care physician's progress note read in part that the wound was present for greater than 51 days and was noted to be present on admission per staff. The wound measured 6.0 x 5.0 x 0.5cm and was mechanically debrided to a depth of 0.9cm. The wound progress was exacerbated due to the generalized decline of the resident, their nutritional compromise, and the resident's preference to lay supine. The resident's healing potential was shown as poor, and the objective of the wound care was changed to palliative. A twice daily dressing was ordered. The wound care physician progress note showed the physician recommended a low air loss mattress for the resident, noting the resident preferred to lay supine. The skin check, dated [DATE], showed the resident had a stage IV pressure ulcer to the sacrum. The skin check showed the stage IV pressure ulcer was present on admission. There were other documented skin concerns to the right heel and right upper arm. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The death certificate, dated [DATE], documented Resident #1 expired on [DATE]. The immediate cause of death was due to a Streptococcus viridans bacteremia infected sacral decubitus ulcer and severe sepsis. The hospital Discharge summary, dated [DATE], showed the resident was admitted to the hospital on [DATE]. The emergency room note read in part, The patient presents today with worsening sacral decubitus ulcer. On examination does appear infected is very malodorous. Unstageable .CT [computerized tomography] the pelvis shows sacral coccygeal decubitus ulcer with dissecting soft tissue gas along the right gluteus maximus [NAME] [sic - muscles] base may be related to tunneling of the decubitus ulcer versus necrotizing and infection. Also sacrococcygeal osteomyelitis was seen and there was no drainable fluid collection seen. The discharge summary showed the resident was admitted with severe sepsis secondary to an infected decubitus ulcer with acute metabolic encephalopathy, an infected sacral decubitus ulcer, sacrococcygeal osteomyelitis, and acute metabolic encephalopathy. The discharge summary showed the resident expired on [DATE] with final diagnoses of severe sepsis secondary to infect decubitus ulcer acute metabolic encephalopathy; Streptococcus viridans, Clostridium and Bacteroides bacteremia; infected sacral decubitus ulcer; sacrococcygeal osteomyelitis; cardiomyopathy; metabolic acidosis; dysphagia; hypernatremia; symptomatic anemia; acute metabolic encephalopathy; neurocognitive disorder without behavioral disturbances; type 2 diabetes mellitus with hyperglycemia; history of stroke; hypernatremia; and hypokalemia. The hospital discharge summary read in part, [AGE] year-old presented for evaluation of worsening decubitus wound and altered mental status. Patient was admitted and was found to have severe sepsis secondary to sacral decubitus ulcer and sacrococcygeal osteomyelitis. Surgery team were consulted and patient underwent surgical debridement. ID team were consulted and assisted in management. Patient was initiated on IV antibiotics. Patient continued to deteriorate during the course of the hospitalization with poor appetite, high risk for aspiration and worsening mentation. After extensive discussion with the patient's family they wished [Resident #1] to be DNR. Patient's clinical condition continued to deteriorate and [the resident] passed away on [DATE] On [DATE] at 4:11 p.m., RN (registered nurse) #1 stated they admitted Resident #1. The RN stated another nurse performed the admission assessment and documented the resident had moisture associated skin damage and a small open area on the right buttock, which was covered with a dressing. RN #1 stated they were unable to find measurements in the EMR (electronic medical record) of the small open area identified on the admission assessment. RN #1 stated the measurements would be documented on the facility wound log. The RN stated the facility was without a wound nurse when Resident #1 was admitted . RN #1 stated during that time, they followed the wound physician on their rounds and filled in the wound log with the information they received from the wound physician. The RN stated during that time, the floor nurses were responsible for performing wound care and communicating any changes to the family, physician, and nursing administration. RN #1 stated the floor nurses were responsible for performing weekly skin checks which automatically showed on the nurses' computer screen as they came due. The RN stated the current wound care nurse also performed some of the weekly skin checks for residents assessed as high risk for skin breakdown. The RN stated the skin check, dated [DATE], showed Resident #1 had moisture associated skin damage on the right gluteus. RN #1 stated the skin check did not identify there was a dressing present on Resident #1. The RN stated there were no treatment orders related to skin or wound care until the pressure ulcer was identified. RN #1 stated the resident's pressure ulcer was identified on [DATE]. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 4:50 p.m., LPN (licensed practical nurse) #1 identified themselves as the new wound nurse. The LPN stated they started work in [DATE] and had three to four weeks of orientation during which they followed RN #1 and/or the wound care physician. LPN #1 stated they were working with administration to build a system where LPN #1 would assess high risk residents and have another nurse or the assigned floor nurse for the area perform the rest of the skin assessments. The LPN stated they rounded to each nurses' station daily and asked if there were any new issues. The LPN stated the nurses informed them of any skin concerns verbally or through email. LPN #1 reviewed the clinical record for Resident #1 and stated there was no ordered treatment for the moisture associated skin damage and no ordered treatment for wounds for Resident #1 until the pressure ulcer was identified on [DATE]. On [DATE] at 5:30 p.m., the DON (director of nursing) stated they started in February 2025. The DON stated the nurses were to notify the physician and family of any changes in condition. The DON stated any physician's orders they received were to be documented and followed. The DON stated the facility monitored this through the resident's care plan, during care plan meetings, and during weekly meetings with therapy, the lead nurses, the ADON, MDS nurse, dietary department, the wound nurse, and the DON. The DON stated the administrator attended the weekly meeting at times as well. The DON stated during the weekly meeting, they reviewed information from the nurses' notes, resident labs, the care plan meetings, and the wound nurses' notes. The DON reviewed the clinical record for Resident #1. The DON stated there was an order for a leptospermum honey dressing and a protein supplement ordered on [DATE]. The DON was asked if there were treatment orders for skin care and/or wound dressing on admission. The DON remained silent. The DON was asked if the resident's care plan addressed any skin concerns. The DON stated the diabetic care plan showed to check all of the body for breaks in skin and the resident's moisture associated skin damage was care planned. The DON stated the resident's admission MDS showed the resident had moisture associated skin damage and interventions which included a pressure reducing device for the chair/bed and the application of ointments/medications other than to feet. The DON stated there was no documentation Resident #1 had a deep tissue injury or an unstageable pressure ulcer on admission. The DON stated there was no documentation that ointments were applied to the resident's skin to manage/address the moisture associated skin damage or to manage/address wound prevention. The DON stated the wound physician's documentation of the location of the pressure ulcer did not match the location of the moisture associated skin damage or dressing identified the admission assessment. The DON stated the wound physician ordered a daily dressing of leptospermum honey and calcium alginate covered with an island border dressing on [DATE]. The DON stated the nurse practitioner for Resident #1 wrote the same order in their progress note dated [DATE]. The DON stated the treatment sheet documented the order was for a daily dressing change but was scheduled in the EMR to perform the dressing only three times a week: on Tuesday, Thursday, and Sunday. The DON stated they did not see a note or order to clarify why the schedule for dressing change did not match the wound physician's ordered frequency for wound care/dressing. The DON reviewed the weekly Braden scale and skin checks for Resident #1. The DON stated the Braden scale and skin checks were documented as late entries and were not done until [DATE] and [DATE], respectively. The DON stated the late entries meant information on the Braden scale and skin checks were not available for the QA team to review in their weekly meetings. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The DON stated the facility identified there was a problem with skin assessments and developed a QA plan. The DON stated they in-serviced the nursing staff to keep skin clean/dry, to monitor residents for early signs of skin changes, and to communicate those changes to their charge nurse, wound nurse, and lead nurses. The DON stated they developed a process to monitor their wound tracking/interventions and communicated the information to the MDS nurse to add to the residents' care plan. The DON stated facility nursing staff performed a skin sweep where they assessed the skin of all their residents to rule out the possibility of undocumented skin issues/concerns and ensure the facility was in regulatory compliance. The DON stated the facility recently hired more nursing staff, including a new wound nurse, and an additional ADON (assistant director of nursing). The DON stated ADON #2 was hired to monitor QA which included reviewing resident charts to ensure accurate and complete documentation. The DON stated they added new policies/procedures for skin/wound assessments, interventions, and treatment orders; better defined the lead nurse responsibilities, and who was responsible for monitoring to ensure weekly skin documentation was done with interventions in place for any skin issues/concerns. The DON stated prior to hiring ADON #2, ADON #1 was responsible for reviewing the clinical records but had other duties as well. The DON stated they were ultimately responsible for ensuring the nursing staff performed their duties based on the physician's orders, the resident's plan of care, nursing standards of practice, and the facility policies.