STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	385234	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Transitional Care	3445 Boone Road SE Salem, OR 97317

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 34703 Based on interview and record review, the facility failed to honor resident preference for medication administration for 1 of 1 resident (#77) reviewed for choices. This placed residents at risk for not having the opportunity to exercise her/his autonomy (self-governance) regarding choices. Findings include: Resident 77 was admitted to the facility in 9/2024 with diagnoses including stroke. A FRI (Facility Reported Incident) was received on 9/20/24. It alleged Resident 77 was administered her/his medications with a spoon, all at one time, by Staff 30 (Former CNA). Resident 77 was to receive her/his medication one pill at a time with water or applesauce. Resident 77 and Witness 7 (Friend) told Staff 30 to stop administering the medications multiple times, but she did not stop. Witness 7 went to the nurses station and found a nurse to stop Staff 30 from administering Resident 77's medications. Resident 77 and Witness 7 told Staff 14 (LPN) the resident took her/his medications one at a time with water or applesauce per her/his choice. A 9/20/24 Nursing Care Note added to special instructions per resident request: Meds: one at a time with water, cut large pills in half Instructions placed on the cover sheet for staff to follow. On 4/9/25 at 3:12 PM, Staff 32 (LPN-RCM) stated Resident 77 took her/his medication one pill at a time with water or applesauce, one at a time per her/his choice.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34703 Based on interview and record review, it was determined the facility failed to honor resident choice for 1 of 1 sampled resident (#77) reviewed for medication administration. This placed residents at risk for choking. Findings include: Resident 77 was admitted to the facility in 9/2024 with diagnoses including brain cancer and stroke. A 9/20/24 FRI was received on 9/20/24 which alleged Staff 30 (Former CNA) administered medication to Resident 77. The 4/2019 facility policy, Administering Medications indicated: -Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. -The 10/2024 Scope of Practice Nurses vs CNAs indicated when medications are left in the resident's room, (usually not allowed) notify the nurse; do not administer or assist. The FRI indicated Staff 29 (CMA) entered Resident 77's room with her/his morning medications and realized Staff 30 was providing personal care for Resident 77. Staff 29 placed the resident's medication on the bedside table and left the resident's room. Staff 30 attempted to administer the medications to Resident 77. Witness 7 (Friend) ran out of Resident 77's room to the nurses station and yelled, Staff 30 was administering medications to Resident 77 by the spoonful, but Resident 77 was only able to take medications one at a time with water. Witness 7 stated, Resident 77 was yelling no, no, no and spitting the medications back into the medication cup, but Staff 30 did not stop. On 4/9/25 at 11:21 AM, 4/10/25 at 9:39 AM, and 4/10/25 at 9:45 AM, Staff 30 was called multiple times for an interview, answered the phone, then hung up. On 4/9/25 at 3:12 PM, Staff 14 (LPN) stated Staff 29 left Resident 77's medication on the bedside table and left the resident's room while Staff 30 provided personal care for Resident 77. Staff 30 attempted to administer Resident 77's medications while the resident and Witness 7 told her to stop. On 4/10/25 at 8:29 AM, Staff 29 stated he went to Resident 77's room to administer her/his morning medication, but Staff 30 was providing personal care, so he left her/his medication at the bedside to return later to administer the medication. Staff 29 stated Witness 7 came out of Resident 77's room yelling Staff 30 administered Resident 77's medications by the spoonful, was told to stop multiple times but did not stop. On 4/10/25 at 9:04 AM, Staff 32 (RCM-LPN) heard Witness 7 yelling and headed to the nurses station, stating Staff 30 was administering Resident 77's medications, and Resident 77 and Witness 7 told her to stop multiple times but she did not stop. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 at 9:12 AM, Staff 7 (CNA) stated she went into Resident 77's room to assist Staff 30 with care for Resident 77 and observed Staff 30 administering medications to Resident 77. Resident 77 and Witness 7 were yelling for her to stop, but she did not. Staff 29 and Staff 32 came into the resident's room to assist the resident and remove Staff 30 from the resident's room. On 4/15/25 at 9:38 AM, Staff 2 (DNS) stated Staff 30 was observed administering Resident 77 her/his medications when she knew this was outside her scope of practice. Staff 2 stated if a resident is stating no, staff need to stop what they are doing. Staff 2 stated her expectation was certified staff and nurses were the only staff allowed to administer medications, not CNAs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 34703 Based on interview and record review, it was determined the facility staff failed to follow professional standards of practice for medication administration for 1 of 1 sampled resident (# 77) reviewed for medication administration.This placed residents at risk for unsafe medication administration. Findings include: Resident 77 was admitted to the facility in 9/2024 with diagnoses including brain cancer and stroke. On 9/20/24, a FRI was received on 9/20/24 which alleged Staff 30 (Former CNA) administered medication to Resident 77. The 4/2019 facility policy; Administering Medications indicated: -Only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. -The 10/2024 Scope of Practice Nurses vs CNAs indicated when medications are left in the resident's room, (usually not allowed) notify the nurse; do not administer or assist. The FRI indicated Staff 29 (CMA) entered Resident 77's room with morning medications and found Staff 30 was providing personal care for Resident 77. Staff 29 left the resident's medication on the bedside table and left the resident's room. Staff 30 attempted to administer medication to Resident 77, but Resident 77 stated no, no no and told Staff 30 to stop. Witness 7 (Friend) also told Staff 30 to stop administering medication to Resident 77, ran out of Resident 77's room to the nurses station, and yelled, Staff 30 was administering medication to Resident 77 by the spoonful. Resident 77 was able to take medications one at a time with water. Witness 7 stated, Resident 77 was yelling no, no, no and spitting the medication back into the medication cup. Witness 7 stated Staff 30 continued to administer medications until Staff 29 and Staff 32 (RCM-LPN) removed her from Resident 77's room. Resident 77 was discharged from the facility on 10/31/24. On 4/9/25 at 11:21 AM, 4/10/25 at 9:39 AM, and 4/10/25 at 9:45 AM, Staff 30 was called for an interview multiple times, answered the phone, then hung up. On 4/9/25 at 3:12 PM, Staff 32 stated Staff 29 left Resident 77's medication on the bedside table while Staff 30 provided personal care for the resident and left the resident's room to provide privacy. Staff 30 began administering the resident's medications; Resident 77 and Witness 7 told her to stop but she did not. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 at 8:29 AM, Staff 29 stated he went to Resident 77's room to administer her/his morning medication, but Staff 30 was providing personal care, so he left the resident's medication on the bedside table and left the resident's room. Staff 29 stated Witness 7 came out of the resident's room yelling Staff 30 was administering Resident 77's medication by the spoonful, and she/he told her to stop, but she did not stop. Staff 29 stated he went to Resident 77's room with Staff 32 to help the resident. Staff 29 acknowledged he should not have left medications on the resident's bedside table. On 10/4/25 at 9:04 AM, Staff 14 (LPN) stated she heard Witness 7 yelling and headed to the nurses station, stating Staff 30 was administering Resident 77's medication, and Resident 77 told Staff 30 to stop, but she did not. On 4/10/25 at 9:12 AM, Staff 7 (CNA) stated she went into Resident 77's room to assist Staff 30 with personal care for the resident and observed Staff 30 administering medication to Resident 77. Resident 77 and Witness 7 yelled for her to stop. Staff 29 and Staff 27 came into the resident's room to assist the resident and removed Staff 30 from the resident's room. On 4/10/25 at 3:33 PM, Staff 2 (DNS) stated Staff 30 acknowledged she understood administering medications to residents was a task she was not allowed to complete. Staff 2 stated CNAs should not administer medications, and her expectation is for certified, trained staff to administer medications, and definitely not a CNA.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26991 Based on observation, interview, and record review it was determined the facility failed to ensure residents' pressure injuries were monitored and care plans were updated for 2 of 3 sampled residents (#s 52 and 77) reviewed for pressure ulcers and choices. This placed residents at risk for worsening pressure injuries. Findings include: 1. Resident 52 was readmitted to the facility on [DATE] with a diagnosis of blood loss anemia. Resident 52's care plan for skin impairment initiated 3/7/25 and last revised on 3/10/25 revealed she/he was at risk for pressure ulcers due to weakness. Interventions included weekly skin assessments and new skin impairments were to be reported to the nurse. Resident 52's 3/18/25 admission MDS revealed Resident 52 was admitted to the facility with no pressure ulcers but had maroon discoloration to her/his great toes. Staff were to monitor her/his skin weekly. Resident 52's 3/30/25 Admission Nursing Database revealed Resident 52 did not have skin impairment. Resident 52's Progress Notes dated 3/31/25 by Staff 13 (RN) revealed a second skin check was completed and Resident 52 was assessed to have redness to the tips of both great toes. Resident 52's clinical record had no additional assessments related to the redness to the tips of the great toes related to size and if the impairment was blancheable (Pushing on a red area of the skin impedes circulation, when the pressure is removed, the areas is white and should return to the original color). Resident 52's 4/2025 TAR revealed staff applied compression socks in the morning and removed the socks at bedtime from 4/1/25 though 4/8/25. On 4/7/25 at 3:30 PM, during a phone interview, Witness 6 (Spouse) stated Resident 52 had pressure areas to the tips of her/his toes from he/his compression socks. Witness 6 stated she/he tried to loosen the toes of Resident 52's compression socks to prevent pressure. On 4/8/25 at 3:31 PM with Staff 16 (RNCM/Assistant DNS) Resident 52 was observed to have dark red/brown areas to the tops of both great toes. Staff 16 stated Resident 52's clinical record indicated she/he did not have skin impairment on 4/2/25. A 4/9/25 Weekly Skin Audit revealed a skin irregularity was previously identified. DTIs (Deep tissue injury-purple or maroon localized area of discolored intact skin due to damage of underlying soft tissue from pressure and/or shear). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/9/25 at 3:14 PM an interview occurred with Staff 16 and Staff 2 (DNS). Staff 2 stated if a skin issue was identified she was to be notified then she reassessed the skin injury and determined the type of care and monitoring the injury required. Staff 2 stated if a skin injury was a pressure ulcer it should be monitored and measured weekly. Staff 2 stated she was not aware Resident 52 had skin impairment to her/his great toes. On 4/9/25 at 3:26 PM Staff 13 (RN) stated on 3/31/25 when she assessed Resident 52, she/he had red areas to her/his great toes. Staff 13 stated she did not measure the red areas and did not reassess the areas after 3/31/25. Staff 13 stated the redness may have been from the compression socks. Staff 20 (LPN) stated he believed he checked the red areas to Resident 52's toes, the areas were blancheable, and Resident 52 expressed pain when the toes were touched. 34703 2. Resident 77 was admitted to the facility in 9/2024 with diagnoses including brain cancer and stroke. The facility's Accident and Incidents-Investigation and Reporting policy dated 7/2017 indicated the nurse supervisor, charge nurse, and/or the department director or supervisor shall promptly initiate and document an investigation of an accident or incident. The 9/12/24 Nursing Admission Evaluation revealed Resident 77 had intact skin, bruising around an IV (Intravenous line), and a small scab on her/his right shin. There was no evidence which indicated Resident 77 had redness to her/his coccyx (tailbone) or to her/his buttocks. The 9/16/24 Admission MDS indicated: Resident 77 was incontinent of bladder and bowel, at risk for skin breakdown, and needed assistance with bed mobility. The resident had no pressure injuries and was cognitively intact. Staff would proceed to the care plan for ongoing assessment for prevention of skin breakdown. Staff would monitor and document the location, size, and treatment of any skin injury. Staff would report abnormalities, failure to heal, signs and symptoms of infection, maceration (softening of skin due to moisture), etc., to the MD (Medical Doctor). Staff would report any new skin impairment to the LN (Licensed Nurse) immediately. The 9/17/24 Skin and Wound Evaluation indicated Resident 77 developed a facility-acquired Stage 2 (partial-thickness skin loss) pressure wound to the sacrum (triangular bone at the base of the spine), medial, and middle areas. The wound measured 77.9 cm by 8.9 cm by 11.3 cm. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/10/25 at 10:38 AM, Staff 2 (DNS) acknowledged the resident's wound was most likely present upon admission but was not identified until 9/17/24. Staff 2 stated the resident had a DTI (deep tissue injury) from the coccyx to the medial gluteal cleft (the crease between the buttocks), a Stage 2 pressure ulcer to the right buttocks, and redness to the surrounding areas. Staff 2 acknowledged the wound assessment was not accurate, the care plan was not revised related to the wounds, and no incident report was completed. Staff 2 stated her expectation was if a new wound was identified, the nurses should call the physician, start an investigation, document accurately, and update the care plan.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 26991 Based on interview and record review it was determined the facility failed to ensure a heat pack was safely applied for 1 of 1 sampled resident (#76) reviewed for accidents. Resident 76 sustained burns. Findings include: On 11/23/24 the Past Noncompliance was corrected when the facility initiated an investigation, identified the root cause of the incident, and provided CNA and nurse in-service training on the use of heat packs. The training included: 1. A nurse was to approve a heat pack prior to use for each resident, 2. A barrier was to be applied between the heat source and the resident's skin, and 3. A heat pack was only to be left on for a maximum of 20 minutes. Resident 76 was admitted to the facility in 10/2024 with a diagnosis of kidney disease. Resident 76's 11/3/24 admission MDS revealed she/he was cognitively intact, required partial assistance with upper body dressing, and did not have skin impairment. Resident 76's 11/2024 TAR did not have interventions for a heat pack. Resident 76's Progress Notes revealed the following: -11/23/24: Resident 76 was provided a heat pack on 11/22/24 and she/he did not know there was a limit on how long to apply the heat pack. Resident 76 was not able to verbalize how long the heat pack was left on her/his skin. The resident's skin was assessed to have small uncapped blisters to the shoulder and arm. Resident 76's skin was red and the blisters were noted to be superficial. A 11/23/24 Burn investigation revealed on 11/23/24 Resident 26 presented with superficial blisters on the left shoulder and underarm. Resident 26 reported the blisters were from a heat pack. The investigation revealed a CNA obtained the heat pack without communicating with a nurse prior to providing the heat pack to Resident 76. The heat pack was an insta-hot pack which was activated when pressure was applied. The CNA did not apply the heat pack but handed it to Resident 76. A barrier was not provided to the resident. On 4/8/25 at 2:26 PM Staff 18 (CNA) stated in 11/2024 she recalled providing Resident 76 a heat pack and Resident 76 applied the heat pack her/himself. Staff 18 stated she did not recall additional details. On 4/9/25 at 10:42 AM a telephone call was placed to Resident 76. The phone number was no longer in service. On 4/9/25 at 11:42 AM Staff 2 (DNS) stated Resident 76 had standing orders for a heat pack but the orders were not transcribed onto the TAR. An unidentified CNA provided the heat pack, the resident applied the heat pack, but staff did not ensure the heat pack was removed timely. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 4/10/25 at 9:14 AM Staff 14 (LPN) stated Resident 76 had chronic skin conditions. On 11/22/24 Resident 76 requested a heat pack at the end of a CNA's shift. An unidentified CNA provided a heat pack to the resident and left the facility. Resident 76 kept the heat pack on for a long time, exact amount of time was unknown. The next morning, Resident 76 reported she/he had itching to her/his arm and shoulder region and when Staff 14 assessed the area, she observed clear blisters and uncapped blisters. It looked like the top of her/his skin came off. Staff 14 stated Resident 14 did not report increased pain.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 35855 Based on interview and record review, it was determined the facility failed to provide adequate catheter care for 1 of 2 sampled residents (#226) reviewed for catheter care. This placed residents at risk for unmet catheter needs. The facility's External Catheter Policy, dated 2001, revealed: To verify a physician's order existed for the procedure, review the resident's care plan to assess any special needs, and assemble the equipment and supplies. Resident 226 was admitted to the facility in 4/2025 with a diagnosis including kidney failure. A 4/3/25 Hospital History and Physical Notes indicated Resident 226 had an external urinary catheter placed on 3/31/25. A 4/6/24 SBAR (Situation, Background, Assessment, and Recommendation) Note indicated Resident 226 continued to void dark urine, denied any urinary issue, and her/his catheter was changed. Resident 226's care plan lacked documentation of a catheter, and no physician-ordered treatment for a catheter was found on the TAR. On 4/10/25 at 1:05 PM, Resident 226 stated her/his catheter was removed on 4/9/25. On 4/11/25 at 10:59 AM, Staff 9 (Agency LPN) stated he changed Resident 226's catheter on 4/6/25 because the original catheter, brought from the hospital, had dislodged. Staff 9 obtained and replaced it with a new catheter of the same size, and acknowledged he did not review the physician's order beforehand. Staff 9 stated he documented the catheter change in notes, not on the TAR. On 4/15/25 at 7:25 AM Staff 22 (Administrator in Training) stated she expected physician orders for Resident 226's catheter care to be on the TAR and catheter information included in the care plan.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 35855 Based on interview and record review, it was determined the facility failed to ensure annual performance reviews for CNA staff were completed for 5 of 5 sampled CNA staff (#s 3, 4, 5, 6, and 7) reviewed for staffing. This placed residents at risk due to lack of competent staff. Findings include: A review of personnel profile records revealed the following. -Staff 3 (hired on 2/19/15): performance review dated 3/20/20. -Staff 4 (hired on 1/13/15): performance review dated 2/2/18. -Staff 5 (hired on 3/23/15): performance review dated 3/11/21. -Staff 6 (hired on 12/5/18): performance review dated 3/25/20. -Staff 7 (hired on 2/19/20): No performance review provided. In a 4/15/25 interview at 7:18 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 22 (Administrator in Training), Staff 2 stated she expected annual performance reviews to be completed in a timely manner.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34703 Based on interview and record review it was determined the facility failed to provide timely pharmaceutical services for 2 of 10 sampled residents (#61 and 62) reviewed for medications and pain management. This placed residents at risk for lack of treatment. Findings include: 1. Resident 61 was admitted to the facility in 3/2025 with diagnoses including cancer. The 4/2025 MAR directed staff to start Nystatin Mouth/Throat Suspension (antifungal liquid for the mouth and throat) on 3/31/25 five times a day for thrush (yeast infection). A Progress Note dated 4/6/25 showed Nystatin Mouth/Throat Suspension was ordered, but staff could not find the medication. A Progress Note dated 4/7/25 showed Nystatin Mouth/Throat Suspension was not available, and staff were waiting for delivery from the pharmacy. A Progress Note dated 4/13/25 showed the medication was not available in the cubex (emergency medication dispensary), and staff were waiting for delivery. A Progress Note dated 4/13/25 showed Nystatin Mouth/Throat Suspension was unavailable. LN (Licensed Nurse) called the pharmacy, and the pharmacy thought the medication should have a stop date, so they only sent a small amount. According to LN, there was no stop date. This was reordered on 4/7/25, and they still had not received more. LN stated it should arrive that night. On 4/13/25 at 9:44 AM, Staff 31 (CMA) confirmed on 4/6/25, 4/7/25, and 4/13/25 she could not locate the Nystatin Mouth/Throat Suspension for the medication cart or in the cubex. Staff 31 stated the usual procedure when a medication could not be found was to notify the nurse and verify if it had already been ordered from the pharmacy. The medication should be ordered three days before running out. On 4/11/25 at 2:37 PM, Staff 2 (DNS) indicated the pharmacist stated Resident 61's Nystatin Mouth/Throat Suspension was ordered on 4/7/25 and was delivered to the facility on [DATE]. On 4/15/25 at 7:31 AM Staff 2 (DNS) stated she expected staff to call the pharmacy if a resident's medication was not available. 35855 2. Resident 62 was admitted to the facility in 3/2025 with diagnoses including hypertension (high blood pressure) and heart disease. (continued on next page)

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	385234	A. Building B. Wing	04/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salem Transitional Care	3445 Boone Road SE Salem, OR 97317

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 3/2025 and 4/2025 MARs directed one time a day administration of isosorbide mononitrate (prevents chest pain and dilates blood vessels) for hypertension. Resident 62 received five doses from 3/19/25 through 3/23/25, five doses from 3/27/25 through 3/31/25, and four doses from 4/1/25 through 4/4/25. On 4/5/25, the MAR referred to electronic medication administration record (eMAR) notes. The MAR indicated medication administration on 4/6/25 and 4/7/25, but on 4/8/25, it referred to the eMAR notes. A 4/5/25 eMAR Order Note directed the administration of isosorbide mononitrate once daily and noted the medication card was not available within the facility. A 4/8/25 eMAR Order Note directed the administration of isosorbide mononitrate once daily and noted the medication was unavailable; the pharmacy was contacted, and the facility awaited delivery. On 4/11/25 at 9:10 AM, Staff 10 (CMA) confirmed on 4/5/25 she was unable to locate the isosorbide mononitrate in the medication cart or elsewhere in the facility. Staff 10 stated her usual procedure when a medication could not be found was to notify the nurse and verify if it had already been ordered from the pharmacy. Staff 10 could not remember if it had been ordered from the pharmacy. On 4/11/25 at 9:19 AM, Witness 4 (Pharmacist) stated Resident 62's isosorbide mononitrate was ordered on 3/18/25 with a 14-day supply, another order was received on 4/8/25, and the medication was sent out the same day. On 4/15/25 at 7:31 AM Staff 2 (DNS) stated she expected the staff to call the pharmacy if a resident's medication was not available.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 26991 Based on interview and record review it was determined the facility failed to ensure a resident was administered ibuprofen (NSAIDS/nonsteroidal anti-inflammatory drug) as prescribed for 1 of 2 sampled residents (#52) reviewed for hospitalization . This contributed to Resident 52's intestinal bleed and hospitalization . Findings include: Resident 52 was admitted to the facility in 3/2025 with a diagnosis of obesity. Resident 52's Progress Notes revealed on 3/14/25 staff communicated with Resident 52's physician, reported her/his family was at the facility, and family was concerned about Resident 52's increased tremors and shaking. Staff indicated Resident 52 reported she/he was cold, but did not have a fever, or other signs and symptoms of infection. Per epocrates.com (online pharmacy resource: ibuprofen Black Box Warnings (content published with prescribing information if the Food and Drug Administration released proposed language for a new or updated boxed warning) indicated NSAIDs increase risk of serious and potentially fatal GI (Gastrointestinal-digestive system) adverse events including bleeding, ulcer, and stomach or intestine perforation; GI events may occur at any time during use and without warning; elderly patients and patients with a history of peptic ulcer disease or GI bleeding at greater risk for serious GI events. A 3/14/25 SBAR (situation, background, assessment, and recommendation) provider response form revealed: Staff 14 (Physician) would assess Resident 52 and provided orders including: 1. Give one gram Tylenol (pain medication) now and continue every eight hours scheduled. 2. Ibuprofen 600 mg by mouth now then 600 mg by mouth every eight hours PRN chills/fever. Resident 52's 3/2025 MAR revealed Ibuprofen was incorrectly transcribed as scheduled and not entered as a PRN order. As a result Resident 52's Ibuprofen was scheduled to be administered three times a day at 4:00 AM, 12:00 PM and 8:00 PM. The resident was administered Ibuprofen from 3/14/25 at 8:00 PM through 3/17/24 at 12:00 PM, a total of nine scheduled doses. Resident 52's 3/18/25 Lab/X-Ray Note revealed from a 3/17/24 blood draw her/his hemoglobin (red blood cells which carry oxygen) was 10.4 (normal is 14-18) and hematicrit (percent of red blood cells in a person's total blood volume) was 32.4% (normal is 40-54%). Resident 52's Progress Notes revealed on 3/18/25 Resident 52 had a large, dark red liquid bowel movement in her/his brief. The nurse observed clots in the bowel movement and blood was coming from Resident 52's rectum. Resident 52's Nurse Practitioner assessed her/him and Resident 52 was transported to the hospital for evaluation and treatment. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 3/18/25 Medication Error investigation revealed Staff 14 identified Resident 52 was administered scheduled ibuprofen when the ibuprofen was ordered PRN. Prior to the identification of the medication error, Resident 52 had a large amount of blood in her/his brief and was transported to the local hospital. It was unclear at the time of transfer if the medication error contributed to the hospitalization . A pharmacy consultant reviewed Resident 52's record and the review indicated Resident 52 had normal kidney function, and risk factors included age, and a low hemoglobin while hospitalized . The pharmacist believed the ibuprofen affected the upper GI (esophagus/stomach and duodenum) stomach more than lower GI (middle part of the small intestines to the anus). Resident 52's 3/31/25 hospital Progress Notes revealed Resident 52 was admitted to the hospital on 3/18/25 with rectal bleeding. Resident 52 had studies performed which showed no active bleeding, a clean based duodenal ulcer (first part of the small interesting immediately beyond the stomach) and diverticula (small pouches that bulge outward through weak spots of the colon) without active bleeding. Resident 52's assessment indicated acute blood loss anemia, suspected diverticular bleed, duodenal ulcer, and colon polyp (abnormal tissue growth). On 4/9/25 at 11:26 AM Staff 14 stated Resident 52 had severe rigors (intense involuntary muscle contractions and shaking) and she ordered ibuprofen PRN to assist with the resident's pain from the rigors. Resident 52's family wanted Resident 52 to be comfortable and wanted her/him to be treated in the facility. Staff 14 stated it was not good for this population, (elderly) to take ibuprofen, and generally she did not prescribe ibuprofen, but Resident 52 was so uncomfortable she wanted the ibuprofen to be available PRN. Staff 14 stated Resident 52 was likely bleeding prior to the start of the ibuprofen and the ibuprofen made the situation worse. When resident 52 was admitted to the hospital the site of the bleeding was never identified. If a resident was bleeding and ibuprofen was administered, it could make it worse. On 4/9/25 at 11:27 AM Staff 2 and stated she did the investigation and when the physician sent in the electronic orders, a nurse entered ibuprofen as scheduled and not PRN. Staff 26 (Regional Director of Quality Assurance) stated the pharmacist reported he could not say for sure what caused the bleed. On 4/15/25 at 12:35 PM Staff 2 indicated multiple orders for Resident 52 were submitted by the physician on 3/14/25. When a nurse entered the orders, ibuprofen was entered as scheduled and not PRN. A second nurse reviewed the orders and did not identify the error.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 35855 Based on interview and record review, it was determined the facility failed to have a system to ensure CNA staff received 12 hours of in-service training annually for 4 of 5 randomly selected staff members (#s 4, 5, 6, and 7) reviewed for in-service training. This placed residents at risk for care provided by incompetent staff. Findings include: A review of the facility's staff training records revealed the following: -Staff 4 (CNA), hired 1/13/15, had 1.5 hours of documented training (1/13/24-1/13/25). -Staff 5 (CNA), hired 3/23/15, had 2.25 hours of documented training (3/23/24-3/23/25). -Staff 6 (CNA), hired 12/5/18, had no documented training hours (12/5/23-12/5/24). -Staff 7 (CNA), hired 2/19/20, had 8.62 hours of documented training (2/19/24-2/19/25). In a 4/15/25 interview at 7:18 AM with Staff 1 (Administrator), Staff 2 (DNS), and Staff 22 (Administrator in Training), Staff 2 stated CNA staff were expected to complete the required 12 hours of training annually.