STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415020	A. Building B. Wing	08/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Grandview Center	100 Chambers Street Cumberland, RI 02864

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on surveyor observation and staff interview, it has been determined that the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, relative to the main kitchen.Findings are as follows:1) Record review of The Rhode Island Food Code 2022 Edition 4.601.11 reads in part, .(A) equipment food contact surfaces .shall be clean to sight .During the initial tour of the main kitchen on 8/18/2025 at 9:15 AM, in the presence of the Food Service Director (FSD), revealed an ice machine that was noted to have black wipeable matter on the white plastic cover of the ice dispenser, located inside of the ice machine.During a surveyor interview, immediately following the above observation, the FSD acknowledged the black wipeable matter on the ice dispenser and indicated that it is cleaned monthly by the facility and quarterly by an outside company.2) Review of the Rhode Island Food Code 2018 Edition 5-202.13 states in part, An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE .may not be less than 25mm [millimeter] (1 inch) .During the initial tour of the main kitchen on 8/18/2025 at 9:15 AM, in the presence of the FSD and Maintenance Director, revealed the pipe from the ice machine was noted to be resting inside the plumbing fixture (drain) in the floor, and did not have, at a minimum, a one-inch air gap, as required.During a surveyor interview, immediately following the above observation, with the Maintenance Director, he acknowledged that there was not an air gap between the pipe and the plumbing fixture of the ice machine, as required.

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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(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 - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it has been determined that the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice, relative to 1 of 1 resident reviewed for medication refusals, Resident ID #5.Findings are as follows:According to [NAME] (2023), ninth edition, Nursing Procedures, page 745, states in part, If a medication wasn't administered, document the reason why, any interventions taken, practitioner notification, and the patient's response to interventions.Record review revealed the resident was readmitted to the facility in July of 2014 with diagnoses including, but not limited to, type two diabetes mellitus, vascular dementia, hypertension (high blood pressure), gastro-esophageal reflux disease (GERD; a chronic condition where stomach acid flows back into the esophagus), and polymyalgia rheumatica (PMR; a condition characterized by muscle weakness and stiffness).Record review revealed a physician's order dated 7/22/2024 for aspirin, 81 milligrams (mg), with instructions to administer one tablet by mouth in the morning to prevent blood clots.Review of the August 2025 Medication Administration Record (MAR) revealed that on the following dates the resident refused his/her aspirin: 8/1, 8/2, 8/5, 8/6, 8/7, 8/8, 8/9, and 8/10/2025.Record review failed to reveal evidence that the provider was notified of the above documented refusals of aspirin.Record review revealed a physician's order dated 12/13/2023 for docusate sodium oral tablet, 100 mg, with instructions to administer one tablet by mouth, twice daily, for bowel management.Review of the August 2025 MAR revealed that on the following dates and times the resident refused his/her docusate sodium: 8/1 (AM and PM), 8/2 (AM), 8/5 (AM), 8/6 (AM), 8/7 (AM), 8/8 (AM), 8/9 (AM and PM), 8/10 (AM and PM), and 8/18/2025 (PM).Record review failed to reveal evidence that the provider was notified of the above documented refusals of the docusate sodium.Record review revealed a physician's order dated 6/12/2024 for Humalog injection solution (insulin), with instructions to administer, twice daily, based on a sliding scale of blood sugars, for diabetes mellitus.Review of the August 2025 MAR revealed that the resident refused to have his/her morning blood sugar obtained, in order to be able to have the appropriate dose of Humalog administered to him/her on 8/7/2025.Record review failed to reveal evidence that the provider was notified that the resident refused to have his/her blood sugar taken. Record review revealed a physician's order dated 6/28/2023 for isosorbide mononitrate, 30 mg, with instructions to administer one tablet, once daily, for heart rate, and to hold if the resident's systolic blood pressure (SBP; the top number in a blood pressure reading that indicates the force of blood pushing against the artery walls when your heart beats) is below 100.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her isosorbide mononitrate: 8/4, 8/5, 8/7, 8/8, 8/9, 8/11, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, and 8/20/2025.Record review failed to reveal evidence that the provider was notified of the above documented refusals of the isosorbide mononitrate.Record review revealed a physician's order dated 12/20/2022 for Lasix, 20 mg, with instructions to administer one tablet daily for edema (swelling).Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Lasix: 8/4, 8/5, 8/7, 8/8, 8/9, 8/11, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, 8/20/2025.Record review failed to reveal evidence that the provider was notified of the above documented Lasix refusals.Record review revealed a physician's order dated 7/1/2025 for lisinopril tablet, 2.5 mg, once daily, for a history of hypertension.Review of the August 2025 MAR revealed the following dates the resident refused his/her lisinopril: 8/1, 8/2, 8/5, 8/6, 8/7, 8/8, 8/9 and 8/10/2025.Record review failed to reveal evidence that the provider was notified of the above documented lisinopril refusals.Record review revealed a physician's order dated 10/9/2023 for Lopressor tablet, 12.5 mg, with instructions to administered twice daily for hypertension, and to hold if the resident's SBP is below 100 or his/her heart rate is below 60.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Lopressor: 8/1 (AM), 8/2 (AM), 8/5 (AM), 8/7 (AM), 8/9 (AM and PM), 8/10 (AM and PM), and 8/18/2025 (PM).Record review failed to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reveal evidence that the provider was notified of the above documented Lopressor refusals.Record review revealed a physician's order dated 7/22/2014 for magnesium oxide tablet, 400 mg, with instructions to administer one tablet, twice daily, for magnesium supplement.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her magnesium oxide: 8/1 (AM and PM), 8/2 (AM), 8/5 (AM), 8/6 (AM), 8/7 (AM), 8/8 (AM), 8/9 (AM and PM), 8/10 (AM and PM), and 8/18/2025 (PM).Record review failed to reveal evidence that the provider was notified of the above documented magnesium oxide refusals.Record review revealed a physician's order dated 11/12/2024 for Metamucil oral powder, with instructions to give 1 teaspoon by mouth, once daily, every other day, to bulk up stool.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Metamucil: 8/1, 8/5, 8/7, and 8/9/2025.Record review failed to reveal evidence that the provider was notified of the above documented Metamucil refusals.Record review revealed a physician's order dated 7/22/2014 for Prednisone tablet, 2.5 mg, with instructions to administer one tablet, by mouth in the morning, for PMR.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Prednisone: 8/1, 8/2, 8/5, 8/6, 8/7, 8/8, 8/9, and 8/10/2025.Record review failed to reveal evidence that the provider was notified of the above documented Prednisone refusals.Record review revealed a physician's order dated 10/3/2019 for Prilosec capsule delayed release, 20 mg, with instructions to administer once daily for GERD.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Prilosec: 8/4, 8/5, 8/7, 8/8, 8/9, 8/11, 8/13, 8/14, 8/15, 8/16, 8/17, 8/18, 8/19, and 8/20/2025.Record review failed to reveal evidence that the provider was notified of the above documented Prilosec refusals.Record review revealed a physician's order dated 12/13/2023 for Senna oral tablet, 8.6 mg, with instructions to administer two tablets, twice daily, for bowel management.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Senna: 8/1 (AM and PM), 8/2 (AM), 8/5 (AM), 8/6 (AM), 8/7 (AM), 8/8 (AM), 8/9 (AM and PM), 8/10 (AM and PM) and 8/18/2025.Record review failed to reveal evidence that the provider was notified of the above documented Senna refusals.Record review revealed a physician's order dated 12/15/2024 for Travoprost solution 0.004%, with instructions to administer one drop in his/her right eye, every evening, for glaucoma (a disease that can cause vision loss and blindness).Review of the August 2025 MAR revealed the resident refused his/her Travoprost on 8/9/2025.Record review failed to reveal evidence that the provider was notified of the above documented Travoprost refusal.Record review revealed a physician's order dated 8/2/2024 for Tylenol 8-hour Arthritis Pain oral tablet extended release (ER), with instructions to administer 650 mg, every 8 hours, for arthritis pain.Review of the August 2025 MAR revealed that on the following dates the resident refused his/her Tylenol: 8/1 (2:00 PM and 10:00 PM), 8/2 (2:00 PM), 8/4 (6:00 AM), 8/5 (6:00 AM and 2:00 PM), 8/6 (2:00 PM), 8/7 (6:00 AM and 2:00 PM), 8/8 (6:00 AM and 2:00 PM), 8/9 (2:00 PM), 8/10 (10:00 PM), 8/11 (6:00 AM), 8/13 (6:00 AM), 8/14 (6:00 AM), 8/15 (6:00 AM), 8/16 (6:00 AM), 8/17 (6:00 AM) 8/18 (6:00 AM and 10:00 PM), 8/19 (6:00 AM), and 8/20/2025 (6:00 AM).Record review failed to reveal evidence that the provider was notified of the above documented Tylenol refusals.During a surveyor interview on 8/20/2025 at 11:20 AM, with Certified Medication Technician (CMT), Staff A, she revealed that when a resident refuses medication, she informs the nurse of the refusal, who will then speak with the resident. She acknowledged that Resident ID #5 refuses his/her medications.During a surveyor interview on 8/20/2025 at 11:24 AM, with Registered Nurse, Staff B, she revealed that the CMT will alert the nurse when a resident refuses a medication. She further revealed that the nurse should notify the resident's physician of the medication refusal and indicated that the physician notification should be documented in a progress note or attached to a MAR note. Further, she revealed that if a resident refuses medications often, the physician will review the medications to see if any medications can be discontinued or altered.During a surveyor interview on 8/20/2025 at 12:43 PM, with the Director of Nursing Services (DNS), she revealed that if a resident refuses any medications, the physician should be notified, and the notification should be documented in a progress note. She (continued on next page)

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	415020	A. Building B. Wing	08/21/2025

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	further revealed that if a resident frequently refuses medications, a discussion will occur with the resident's physician regarding discontinuing the medications, if able. Lastly, she revealed that she was not aware of the above-mentioned medication refusals in August 2025 for Resident ID #5.During a surveyor interview on 8/20/2025 at 12:59 PM, with Nurse Practitioner, Staff C, he revealed that he was aware of some previous medication refusals, indicating the resident had been sick and was refusing his/her medications. He revealed that the resident has gone up and down with medication refusals but indicated that he thought s/he began taking his/her medications again and was not aware of the extent of his/her medication refusals.Record review revealed a progress note dated 8/20/2025 at 6:20 PM, and authored by the DNS, after this concern was brought to the facility's attention by the surveyor, which states, A call was placed to [Staff C], regarding the resident's refusal of medication. He stated that he had previously discussed with the Power of Attorney that the resident's intake would fluctuate due to [his/her] declining health, but he was unaware of the extent of [his/her] medication refusal. Upon review of the medication records, it was observed that the resident's refusal has decreased since August 10-11. This observation led him to consider that [his/her] antibiotics may have caused gastric distress, and that [his/her] current relief might enable [him/her] to take [his/her] medications. He does not wish to discontinue [his/her] medications at this time but requests certain adjustments. All 6 AM medications have been changed to 9 AM, as [s/he] consistently refuses pills at the earlier time. These medications include Tylenol 650 mg ER (now Tylenol 650 mg PO [by mouth] BID [twice daily]), Lasix 20 mg, Isosorbide, and Prilosec, all of which have been rescheduled to 9 AM.During a surveyor interview on 8/21/2025 at 11:35 AM, with the DNS, Staff C, and the Regional Clinical Nurse, they revealed that Staff C comes into the facility twice weekly to see residents, but were unable to provide evidence that Staff C or another provider were notified of the resident's frequent medication refusals in August of 2025.Review of a progress note authored by Physician, Staff D, dated 8/21/2025 at 2:32 PM, entered into the resident's medical record, after the completion of the recertification survey, revealed he was aware of the resident's medications refusals.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on record review and staff interview, it has been determined that the facility failed to establish an Infection Prevention and Control Program (IPCP) that must include, at a minimum, an antibiotic stewardship program which includes antibiotic use protocols and a system to monitor antibiotic use to ensure that residents who require an antibiotic, are prescribed the appropriate antibiotic, for 3 of 4 residents reviewed for antibiotic use, Resident ID #s 20, 22, and 36. Findings are as follows:According to the Centers for Disease Control and Prevention (CDC) document titled, The Core Elements of Antibiotic Stewardship for Nursing Homes states in part, Perform antibiotic 'time outs .Nursing homes should have a process in place for a review of antibiotics by the clinical team two to three days after antibiotics are initiated to answer these key questions: Does this resident have a bacterial infection that will respond to antibiotics? If so, is the resident on the most appropriate antibiotic(s), dose, and route of administration? Can the spectrum of the antibiotic be narrowed or the duration of therapy shortened (i.e., de-escalation)? Would the resident benefit from additional infectious disease/ antibiotic expertise to ensure optimal treatment of the suspected or confirmed infection . Review of a facility policy titled, Antibiotic Stewardship last revised on 12/16/2024 states in part, .Nursing will monitor the initiation of antibiotics on patients and conduct an antibiotic time out within 48-72 of antibiotic therapy to monitor response to the antibiotic and review laboratory results. Nursing will consult with the practitioner to determine if the antibiotic is to continue or if adjustments need to be made based on the findings.1. Record review revealed that Resident ID #20 was readmitted to the facility in July of 2024 with diagnoses including, but not limited to, osteomyelitis (a bone infection) and cellulitis (a bacterial infection).Record review revealed a physician's order for Cefazolin (an antibiotic) three times a day from 8/12/2025 through 8/25/2025.Record review revealed an assessment titled, Antibiotic Time Out was scheduled to be completed on 8/15/2025.Further record review failed to reveal evidence that the Antibiotic Time Out was completed.2. Record review revealed Resident ID #22 was readmitted to the facility in March of 2025 with a diagnosis including, but not limited to, osteomyelitis.Record review revealed a physician's order for Bactrim DS (an antibiotic) two times daily from 8/1/2025 through 8/11/2025.Record review revealed an assessment titled, Antibiotic Time Out was scheduled to be completed on 8/5/2025.Further record review failed to reveal evidence that the Antibiotic Time Out was completed.3. Record review revealed Resident ID #36 was admitted to the facility in August of 2023 with a diagnosis including, but not limited to, osteoarthritis.Record review revealed a physician's order for Amoxicillin (an antibiotic) two times daily from 8/14/2025 through 8/25/2025.Record review failed to reveal an antibiotic time out was completed for use of the antibiotic.During a surveyor interview on 8/20/2025 at 10:04 AM with the Infection Preventionist, she acknowledged that Resident ID #s 20, 22, and 36 did not have antibiotic timeouts completed, per the regulation or the facility policy.

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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. Based on record review, surveyor observation, and staff interview it has been determined that the facility failed to ensure that a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing, for 1 of 2 residents observed for wound care, Resident ID #55.Findings are as follows:Review of a facility policy titled, Wound Dressings: Aseptic last revised 2/24/2025 states in part, .Evaluate comfort level/presence of pain and treat as indicated.discard soiled dressing.cleanse or irrigate wound and peri wound gently, as ordered.Record review revealed that the resident was readmitted to the facility in May of 2023 with diagnoses including, but not limited to, a stage IV pressure ulcer (the most severe form of a pressure injury. It's characterized by a deep, open wound that extends through the skin, underlying tissue, muscle, and bone) and type II diabetes.Review of a Wound Evaluation and Summary dated 8/18/2025 revealed the resident has a stage IV pressure ulcer to his/her left lateral foot measuring 4 centimeters (cm) X 8.4 cm X 0.1 cm.Review of a care plan dated 6/30/2025 revealed an intervention to monitor for pain and medicate as needed/as ordered.Record review revealed a physician's order dated 7/25/2025 to cleanse the wound bed with Vashe wash (a wound cleanser), apply Bactroban (an antibiotic) cream to wound bed, cover with an ABD (an absorbent dressing) pad and kerlix every day.During a surveyor observation on 8/19/2025 at 8:50 AM with Licensed Practical Nurse (LPN), Staff E and Registered Nurse (RN), Staff F of the resident's wound care, the resident was observed to be screaming and swearing out in pain. Throughout the entire dressing change neither nurse stopped to assess the resident's pain or attempted to treat the resident's pain. During the observation Staff E stated that she would give the resident pain medication when she was finished with the wound care and the resident responded, Just.give it to me now. Additionally, Staff E was observed to remove a soiled ABD pad and calcium alginate (a wound treatment) was noted to be in the wound bed from the previous dressing change. Staff E applied vashe wash to the soiled calcium alginate and then began applying Bactroban to the exposed wound bed, failing to remove the calcium alginate. Continued observation revealed Staff F, who had exited the room, returned and noted the soiled calcium alginate remained in the wound as Staff E was applying the Bactroban. Staff F then removed the soiled Calcium Alginate while Staff E continued to apply the Bactroban to the wound bed. Neither Staff E nor Staff F cleansed the wound bed once the soiled Calcium Alginate had been removed.During a surveyor interview directly following the above observation with Staff E and F they acknowledged that Resident ID #55 was yelling and swearing in pain throughout the dressing change and that they did not stop to attempt to medicate him/her. Additionally, they acknowledged that they did not cleanse the wound bed once the soiled calcium alginate was removed.During a surveyor interview on 8/19/2025 at 9:34 AM with the Director of Nursing Services (DNS), she revealed she would expect the staff to stop a wound dressing to assess and treat a resident for pain if needed. Additionally, she would expect the staff to cleanse the wound bed after the removal of a soiled dressing. The DNS was unable to provide evidence that the resident was provided treatment and services, consistent with professional standards of practice.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and staff interview, it has been determined that the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 1 resident reviewed for Lovenox (an anticoagulant; a blood thinning medication), Resident ID #19.Findings are as follows:Review of a facility policy titled, Medication Administration General Guidelines dated January 2025, states in part, .Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record [MAR] .Record review revealed the resident was readmitted to the facility in August of 2025 with diagnoses including, but not limited to, the long term use of anticoagulants and stroke.Review of a physician's order dated 8/11/2025 revealed to administer Coumadin (a blood thinning medication) 6 milligrams (mg) once daily for valve replacement with a goal of achieving an international normalized ratio (INR; a blood test that measures how long it takes your blood to clot) of 2.5-3.5.Review of a physician's order dated 8/11/2025 revealed to inject Enoxaparin Sodium (Lovenox) 80 mg at 8:00 AM and 8:00 PM related to a stroke. Additionally, the order indicated to discontinue the Lovenox after two days of achieving a therapeutic INR of 2.5-3.5.Further review of the Lovenox order revealed it was discontinued on 8/14/2025 at 1:29 PM.Record review revealed the resident's INR level was within or above the therapeutic range on the following dates and times:-8/12/2025 at 9:22 AM: 3.0-8/13/2025 at 10:06 AM: 3.6Review of the August 2025 MAR revealed that the resident was administered Lovenox when the order should have been discontinued on the following dates and times:-8/13 at 8:00 PM-8/14 at 8:00 AMFurther review of the August 2025 MAR revealed that Registered Nurse, Staff F, administered the Lovenox to the resident on 8/14/2025 at 8:00 AM.During a surveyor interview on 8/21/2025 at 9:28 AM with Staff F, she revealed that the resident was to have his/her Lovenox discontinued once s/he had two consecutive days of his/her INR level at therapeutic levels. She acknowledged administering the Lovenox to the resident on 8/14/2025 and revealed that she does not recall checking the resident's INR level, as the order indicates, prior to administering the Lovenox to the resident. Further, she acknowledged that she should not have administered the resident Lovenox on 8/14/2025 based on his/her INR level and the physician's order.During a surveyor interview on 8/21/2025 at 9:44 AM with the resident's provider, Staff G, she revealed that she would have expected the Lovenox order to have been discontinued once the second therapeutic INR level result was received on 8/13/2025. During a surveyor interview on 8/21/2025 at approximately 9:45 AM with the Director of Nursing Services, she acknowledged that the Lovenox order should have been discontinued prior to 8/14/2025 at 1:29 PM, and that the resident received 2 unnecessary doses of Lovenox one on the evening of 8/13/2025 and one on the morning of 8/14/2025.