STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415044	A. Building B. Wing	12/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Friendly Home	303 Rhodes Avenue Woonsocket, RI 02895

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to maintain acceptable parameters of nutritional status, such as usual body weight, for 1 of 1 resident reviewed, who experienced actual significant weight loss of 9.06% (19.4 pounds, lbs.) in two weeks, Resident ID #120.Findings are as follows:Review of a facility policy and procedure titled Weight Loss/Gain Protocol., last revised in June of 2022, states in part, .All residents are to be weighed upon admission and at least monthly; so as to monitor for weight loss or gain for underlying causes. to intervene accordingly and timely to allow for an optimal level for well-being.a significant weight discrepancy is defined as: a weight change of 3 pounds or more in one week (if resident on weekly weights); a loss/gain of 5% or greater within one month.if the reweigh is accurate and there has been significant weight loss/gain, nursing must notify the; Physician, Dietician, DNS [Director of Nurses] and Resident representative .For any resident who tolerates less than 50% of any meal, the resident(s) will be offered a nutritional supplement (the house supplement) .The nutritional supplement is not to replace a meal per say, but rather to supplement the residents' intake so they are not more at risk for weight loss.Record review revealed the resident was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, kidney infection with an obstruction.Further record review revealed the s/he was recently hospitalized from [DATE]-[DATE] with a diagnosis of a deep vein thrombosis (DVT, a blood clot in a vein located deep within your body).Record review revealed the following physician's orders: 11/26/2025: Document intake each shift.12/4/2025: Daily weight for 6 days. If weight gain or loss of 3 lbs. notify the physician. 12/11/2025: Order to obtain a re-weight and if there is a 3 lbs. gain or loss to notify the physician. 12/16/2025: Daily weights for 6 days. Review of a care plan dated 12/1/2025 revealed that the resident is at nutritional risk related to malnutrition due to a mechanically altered diet, dysphagia and infection. Further review of the care plan revealed interventions to monitor weights and consult with a Registered Dietician (RD) as needed.Record review of the Registered Dietician assessment dated [DATE] revealed a readmission weight of 214.2 pounds (lbs.) and s/he was documented as a moderate nutritional risk with recommendations to monitor intake.Record review revealed the following weights were obtained from 12/3/2025 through 12/17/2025:12/3/2025: 214.2 lbs.12/4/2025: 212 lbs.12/5/2025: 211.8 lbs.12/6/2025: 212.4 lbs.12/7/2025: 212.6 lbs.12/8/2025: 200 lbs.12/11/2025: 201 lbs.12/13/2025: 201.2 lbs.12/15/2025: 202.2 lbs.12/16/2025: 195 lbs.12/17/2025: 194.8 lbs.Record review revealed the resident experienced a 9.06% (19.4 lbs.) severe weight loss in two weeks, from 12/3/2025 to 12/17/2025.Record review of the resident's intake revealed the following from 12/15 through 12/18/2025:12/15/2025-Breakfast: No intake documented-Lunch: No intake documented-Dinner: 1-25%12/16/2025:-Breakfast: No intake documented-Lunch: No intake documented-Dinner: No intake documented12/17/2025:-Breakfast: No intake documented-Lunch: No intake documented-Dinner: 1-25%12/18/2025:-Breakfast: 1-25%-Lunch: 1-25%,-Dinner: 1-25%Record review failed to reveal that the resident was offered a nutritional supplement when s/he tolerated less than 50% of their meal per the facility's policy.Record review failed to reveal evidence that the Registered Dietician (RD) or the physician was notified of the weight change of 3 pounds or more in one week per the facility's policy.During a surveyor interview (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 0692 Level of Harm - Actual harm Residents Affected - Few	on 12/18/2025 at 8:05 AM with the Director of Nursing Services (DNS), she revealed that the Nursing Assistants are to document meal intake for each meal and notify the nurse if the resident consumes less than 50%. She further revealed that the Dietician and the physician should be notified when a resident is refusing multiple meals and when a weight loss is greater than 3 lbs. for further recommendations.During a surveyor interview on 12/18/2025 at 8:19 AM with the RD, she revealed that she was unaware of the resident's weight loss since readmission. She further revealed that she was not aware that s/he was not eating most of his/her meals and would expect staff to offer a nutritional supplement and to notify the provider if less than 25%. Record review of a note authored by the Nurse Practitioner dated 12/18/2025 at 9:05 AM, states in part, .Unintended weight loss likely multifactorial due to acute infection, antibiotic use, decreased appetite, and missed meals. Poor oral intake, At risk for malnutrition. Start mirtazapine 7.5 mg [An antidepressant, commonly used as an appetite stimulant], start high-calorie/high-protein oral nutrition supplement. Nursing to document meal and supplement intake.Record review of a note authored by the RD dated 12/18/2025 at 9:15 AM, states in part, .Intake has been suboptimal, often refusing a bite or stating that [s/he] does not want it . New order for nutritional supplements twice a day and daily weights.During a surveyor interview on 12/18/2025 at 9:15 AM with the DNS, she was unable to provide evidence that the RD or the Physician were notified of the resident's severe weight loss, per the facility's policy. She further revealed that the facility notified the NP about the significant weight loss after it was brought to their attention by the surveyor and received new orders.

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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 surveyor observation, clinical record review, and staff interview, the facility failed to ensure that services provided meet professional standards of quality and practices relative to 1 of 1 resident reviewed for a fall resulting in a fracture, Resident ID #32, 1 of 1 resident observed for the use of geri-sleeves (protective arm wear) during a transfer, Resident ID #111, and 1 of 1 resident reviewed for off-loading booties, Resident ID #88.Findings are as follows:1. Review of a facility reported incident submitted to the Rhode Island Department of Health on 11/24/2025 revealed that Resident ID #32 fell while ambulating to the bathroom. Additionally, it was determined that s/he fractured his/her femur (thigh bone) and was admitted to the hospital.Record review revealed Resident ID #32 was readmitted to the facility in November of 2025 with a diagnosis including, but not limited to, displaced fracture of the medial condyle of the right femur (inner part of the lower thigh bone).Review of a care plan focus area dated 9/29/2025 revealed that s/he is at risk for falls due to vertigo (dizziness) and impaired mobility.Record review of the progress notes revealed that s/he had a fall on 11/17/2025.1a. Review of a progress note dated 11/21/2025, authored by the resident's Physician, Staff F, revealed that the resident's blood pressure is low and to check orthostatic blood pressure (a type of low blood pressure that occurs when moving from a sitting to a standing position. The drop in blood pressure can result in dizziness, lightheadedness, and/or fainting. Orthostatic blood pressure measurements are recorded when an individual is lying, sitting, and standing to assess for drops in blood pressure related to positional changes).Record review failed to reveal evidence that orthostatic blood pressure monitoring was obtained on or after 11/21/2025.Record review revealed that the resident had another fall two days after the request to check orthostatic blood pressures on 11/23/2025, and was found in his/her room on the floor between the bed and bathroom. Additionally, s/he was determined to have a right femur fracture and was transported and admitted to the hospital for surgical repair of the fracture.Record review revealed that the s/he was readmitted on [DATE] following surgical repair of his/her right femur fracture.1b. Review of a document titled, Orthopaedic Surgery Discharge Instructions dated 11/25/2025 revealed that s/he was to follow up with the surgeon in 10-14 days.Record review failed to reveal evidence that a follow up appointment was made until it was brought to the facility's attention by the surveyor.During a surveyor interview on 12/17/2025 at 12:22 PM with Licensed Practical Nurse (LPN), Staff A, she acknowledged the physician's note indicating to check the resident's orthostatic blood pressure and that s/he was supposed to have a follow up appointment scheduled. She was unable to provide evidence that a follow up appointment was scheduled or that his/her orthostatic blood pressures were taken.During a surveyor interview on 12/18/2025 at 10:35 AM with the Scheduler, Staff B, she revealed that she is the person responsible for making appointments. She indicated the nursing staff will message her to make her aware of appointments that need to be scheduled. She revealed that she was unaware that the resident required a follow up appointment until staff first made her aware on 12/17/2025, after it was brought to the facility's attention by the surveyor.During a surveyor interview on 12/18/2025 at 11:20 AM with the Director of Nursing Services (DNS), she was unable to provide evidence that Resident ID #32 received services that meet professional standards of quality and practices.During a surveyor interview on 12/19/2025 at 10:40 AM with the resident's Physician, he revealed that he would expect orthostatic blood pressure monitoring to be completed within 24 hours and that his/her follow appointment would have been scheduled.2. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.Record review revealed Resident ID #88 was admitted to the facility in January of 2025 with a diagnosis including, but not limited to, need for assistance with personal care.Review of Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicating intact cognition.Review of a care plan focus area dated 12/16/2025 revealed an alteration in skin integrity due to impaired skin integrity with an intervention for bilateral off-loading foot booties as ordered.Review of a physician's order dated 12/15/2025 revealed bilateral booties to feet off in mornings and on at bedtime.Review of the December 2025 Treatment Administration Record revealed that the resident's booties were documented by the morning shift nurse as no or off, indicating that they were not applied at bedtime, as ordered, on the following dates:-12/15-12/16-12/17-12/18-12/19During a simultaneous surveyor observation and interview on 12/19/2025 at 8:58 AM with the resident, s/he was observed in bed without his/her booties in place. S/he further revealed that the staff did not apply the booties at bedtime the night prior on 12/18/2025.During an interview immediately following the above observation with LPN, Staff C, she acknowledged that the resident did not have his/her booties on.During a surveyor interview on 12/19/2025 at 9:20 AM with the Nurse Practitioner, she revealed that she would expect the staff to be following the physician's order.3. According to Mosby's 4th Edition, Fundamentals of Nursing, page 314 states, The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm the clients.Record review revealed Resident ID #111 was admitted to the facility in February of 2025 with a diagnosis including, but not limited to, atrial fibrillation (irregular hearbeat).Review of a care plan focus area dated 10/6/2025 revealed that s/he is at risk for skin breakdown with an intervention that includes to apply geri-sleeves as ordered.Review of a physician's order dated 6/20/2025 revealed to apply geri-sleeves to his/her arms and a pillow in front of his/her legs for all transfers with the stand aide transfer device.During a surveyor observation on 12/17/2025 at 11:11 AM, revealed Nursing Assistant, Staff D, transferring the resident using the stand aide transfer device without the resident wearing geri-sleeves, as ordered.During a surveyor interview immediately following the above observation with Staff D, she acknowledged the resident's geri-sleeves were not on while she was transferring the resident with the stand aide transfer device.During a surveyor interview on 12/19/2025 at approximately 10:00 AM with the DNS, she was unable to provide evidence that staff were following the physician's order.Cross reference F 842

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on clinical record review and staff interview the facility failed to provide care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices relative to assessment and implementation of the bowel protocol for 8 of 8 residents reviewed who required such services, Resident ID #s 2, 9, 12, 32, 66, 73, 95, and 99. Findings are as follows:Review of a facility provided policy titled, Bowel Protocol states in part, It is the policy of the facility to manage each resident's bowel function in order to promote regular, voluntary, controlled bowel evacuation of normal consistency .Further review of the policy revealed the following protocol:On Day 4 or 72 hours without bowel movement:- 7 AM - 3 PM offer prune juice as ordered.- 3 PM -11PM offer Milk of Magnesia (MOM) as ordered, if no bowel movement.- 11 PM - 7 AM offer Dulcolax Suppository as orderedOn Day 5 without a bowel movement:- 7 AM - 3 PM offer fleet enema as ordered.1. Record review revealed that Resident ID #2 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, dementia.Review of the bowel movement record revealed that s/he had no bowel movement from 12/6/2025 through 12/12/2025, 7 days and again 12/14/2025 through 12/19/2025, 6 days.Review of the physician's orders revealed the following:-120 milliliters (mL) of prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400 milligram (mg)/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 Medication Administration Record (MAR) revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/9/2025 or 12/17/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/10/2025 or 12/18/2025.2. Record review revealed that Resident ID #9 was admitted to the facility in March of 2025 with a diagnosis including, but not limited to, constipation.Review of the bowel movement record revealed that s/he had no bowel movement from 12/15/2025 through 12/19/2025, 5 days.Review of the physician's orders revealed the following:-120 milliliters (mL) of prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400 milligram (mg)/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 MAR revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/18/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/19/2025.3. Record review revealed that Resident ID #12 was admitted to the facility in July of 2022 with a diagnosis including, but not limited to, constipation.Review of the bowel movement record revealed that s/he had no bowel movement from 12/15/2025 through 12/19/2025, 5 days.Review of the physician's orders revealed the following:-120 milliliters (mL) of prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400 milligram (mg)/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 MAR revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/18/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/19/2025.4. Record review revealed that Resident ID #32 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, need for assistance with personal care.Review of the bowel movement record revealed that s/he had no bowel movement from 12/14/2025 through 12/19/2025, 6 days.Review of the physician's orders revealed the following: - 120 prune juice give once a day as needed for constipation - Milk of Magnesia suspension; 400mg/5 mL, administer 30 ml (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If no BM on day 4, per request, per nursing discretion - Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion - Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 MAR revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/17/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/18/2025.5. Record review revealed that Resident ID #66 was admitted to the facility in October of 2018 with a diagnosis including, but not limited to, constipation.Review of the bowel movement record revealed that s/he had no bowel movement from 12/14/2025 through 12/19/2025, 6 days.Review of the physician's orders revealed the following:-120 prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400mg/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 MAR revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/17/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/18/2025.6. Record review revealed that Resident ID #73 was admitted to the facility in August of 2025 with a diagnosis including, but not limited to, need for assistance with personal care.Review of the bowel movement record revealed that s/he had no bowel movement from 12/6/2025 through 12/10/2025, 5 days and 12/12/2025 through 12/19/2025, 8 days.Review of the physician's orders revealed the following:-120 prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400mg/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 MAR revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/9/2025 and 12/15/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/10/2025 and 12/16/2025.7. Record review revealed that Resident ID #95 was admitted to the facility in December of 2023 with a diagnosis including, but not limited to, encounter for surgical aftercare following surgery on the nervous system, cranioplasty (a surgical operation on the repairing of cranial defects caused by previous injuries or operations).Review of the bowel movement record revealed that s/he had no bowel movement from 12/6/2025 through 12/12/2025, 7 days and 12/14/2025 through 12/19/2025, 6 days.Review of the physician's orders revealed the following:-120 prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400mg/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the December 2025 MAR revealed that the resident did not receive the prune juice, MOM, or Dulcolax suppository on 12/9/2025 and 12/17/2025, Day 4 without a documented bowel movement. Additionally, the resident did not receive a fleet enema on 12/10/2025 and 12/18/2025.8. Record review revealed that Resident ID #99 was admitted to the facility in December of 2025 with a diagnosis including, but not limited to, constipation.Review of the bowel movement record revealed that s/he had no bowel movement from 11/2/2025 through 12/8/2025, 37 days and 12/13/2025 through 12/19/2025, 7 days.Review of the physician's orders revealed the following:-120 prune juice give once a day as needed for constipation-Milk of Magnesia suspension; 400mg/5 mL, administer 30 ml If no BM on day 4, per request, per nursing discretion-Dulcolax suppository 10 mg administer once a day on day 4 after no BM from MOM, per request, per nurses' discretion-Fleet Enema administer on day 5 after no BM from MOM, per request, per nurses' discretionReview of the November and December 2025 MAR revealed that the resident did not receive the prune juice, MOM, Dulcolax suppository, or a fleet enema although the resident was not documented for having a bowel movement (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for 37 days and 7 days.During a surveyor interview on 12/19/2025 at 9:44 AM with the Director of Nursing Services (DNS) she acknowledged that the bowel protocol was not followed for the above residents. The DNS was unable to provide evidence that the facility provided care in accordance with professional standards of practice relative to initiating the bowel protocol.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care or services that was trauma informed and/or culturally competent. Based on clinical record review and staff interview, the facility failed to ensure that residents who are trauma survivors, receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents experiences, and preferences, in order to eliminate, or mitigate triggers that may cause re-traumatization of the resident for 1 of 1 resident reviewed with a history of trauma, Resident ID #11.Findings are as follows:Review of an undated facility policy titled, Trauma Informed Care revealed in part, .A trauma assessment will be done on each resident by the social worker as part of the admission social history. When it is not practical or possible to interview the resident, information will be obtained from family members.when they are able and authorized to provide such information.The particular type and extent of the trauma (as best can be determined) will be incorporated when planning culturally competent, resident centered care with the purpose of avoiding re-traumatization.Record review revealed that Resident ID #11 was readmitted to the facility in October of 2024, with a diagnosis including, but not limited to, major depressive disorder severe with psychotic features.Review of a Trauma Informed Care screen dated 10/8/2024 revealed Yes was answered, indicating that the resident had experienced the following events: Natural disaster (s)(i.e. flood, tornado, hurricane, earthquake, blizzarded.Physical assault (s) i.e., hitting, pushing, pulling.Verbal Assault (s) (i.e. yelling, swearing, name calling, slur words used, threats of physical/sexual assault.Financial struggle (s) (e.g. homelessness, loss of a job with major impact, bankruptcy.Loss of (a) family member(s),friend(s), mentor(s). It was documented on the form that the resident had experienced physical and verbal abuse, lived through hurricanes, was homeless and lost a sibling. Further the screen revealed that the resident is still bothered by the events.Review of the comprehensive care plan for the resident failed to include trauma informed care and interventions to eliminate or mitigate triggers that may cause re-traumatization of the resident.During surveyor interviews on 12/18/2025 at 2:02 PM and 12/19/2025 at 9:11 AM, with the Social Worker, she acknowledged that the initial screen documents trauma and that it is not reflected in his/her care plan.During a surveyor interview on 12/19/2025 at 9:44 AM, with the Director of Nursing Services, she was unable to provide evidence of a trauma informed care plan was in place for the resident.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on clinical record review and staff interview, the facility failed to ensure that the irregularities identified by the Clinical Consultant Pharmacist during the Admission/readmission pharmacist Medication Regimen Review (MRR) were acted upon for 1 of 1 resident reviewed for antibiotics, Resident ID #6.Findings are as follows:Review of a facility policy titled, Medication Administration Safety Program (MASP) - Monthly Drug Regimen Review, states in part, .Any irregularities are to be documented.and reported to the resident's attending physician, the facility medical director and the director of nursing timely.The attending physician is to document in the medical record that the irregularity was reviewed, and what if any actions were taken to address it.If there is no change in the identified medication, the attending physician is to document their rationale (for not taking action) in the medical record.Record review revealed the resident was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, peripheral vascular disease and osteomyelitis (bone infection) of the right ankle and foot.Record review revealed a physician's order dated 8/22/2025 for doxycycline hyclate (antibiotic) tablet, 100 milligrams, administer 1 tablet twice a day.Record review of the pharmacist's MRR, dated 8/25/2025, revealed that the continuity of care form (a document from the hospital listing discharge medications) listed the ordered doxycycline as a once-a-day medication and the facility entered the doxycycline as a twice a day medication and to clarify the order with the provider.Record review failed to reveal evidence that the admission/readmission MRR, with a noted irregularity, was reviewed and acted upon by the resident's provider.During a surveyor interview on 12/18/2025 at 1:56 PM with the Director of Nursing Services, she was unable to provide evidence that the pharmacy consultation reports were reviewed by the provider and acted upon, as required.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on clinical record review and staff interview, the facility failed to ensure that the resident's drug regimen is free from unnecessary drugs for 1 of 3 residents reviewed for antibiotics, Resident ID #6.Findings are as follows:Record review revealed the resident was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, peripheral vascular disease and osteomyelitis (bone infection) of the right ankle and foot.Review of a Discharge Summary from an acute care hospital dated 8/22/2025, revealed an order for doxycycline hyclate (antibiotic) tablet, 100 milligrams (mg), administer 1 tablet once a day for 6 days, indicating a total number of 6 doses.Record review revealed a physician's order dated 8/22/2025 for doxycycline hyclate tablet, 100 mgs, administer 1 tablet twice a day, for a total of 12 doses.Review of the Medication Administration Record for August of 2025 revealed the resident received 13 doses of the doxycycline hyclate 100 mgs and not the 6 doses as per the discharge summary.Additional review revealed a Pharmacist's Medication Regimen Review, dated 8/25/2025, that the discharge summary listed the ordered doxycycline as a once-a-day medication and the facility entered the doxycycline as a twice a day medication and to clarify the order with the provider.Record review failed to reveal evidence that the resident's provider had ordered for the resident to receive his/her doxycycline hyclate twice a day and not the once a day as ordered. Additionally, the record failed to reveal evidence that the order was clarified after the pharmacy brought the irregularities to the facility's attention.During a surveyor interview on 12/18/2025 at 1:56 PM with the Director of Nursing Services, she acknowledged that the resident received the doxycycline hyclate for 13 doses, an additional 7 doses more than what the discharge summary indicated. Cross reference F-756 and F-881

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on clinical record review and staff interview, the facility failed to ensure that all residents are free from significant medication errors for 1 of 3 residents reviewed for antibiotics relative to not receiving the ordered dosage, Resident ID #33, and 2 of 2 residents reviewed who did not receive ordered dosages of anticoagulants, Resident ID #s 46 and 84. Findings are as follows:Review of an undated policy titled, Medication Administration Safety Program (MASP) - Physician Notification states in part, It is the policy of this facility to ensure that the physician is notified when medications as ordered are not administered, regardless of circumstance.When a regularly scheduled dose of medication is not administered due to resident refusal, unavailability, resident condition or absence from the facility, the physician should be notified.1. Record review revealed that Resident ID #33 was readmitted to the facility in December of 2025 with diagnoses including, but not limited to, sepsis and dementia.Record review revealed a physician's order for Cephalexin (antibiotic) 500 milligrams (mg) every 6 hours for 5 days due to cellulitis (skin infection) of his/her arm, indicating Resident ID #33 should have received 20 doses.Review of the December 2025 Medication Administration Record (MAR) revealed that Resident ID #33 received 17 doses of Cephalexin instead of the 20 doses that were ordered.During a surveyor interview on 12/18/2025 at 10:19 AM with the Director of Nursing Services (DNS) and the Regional Infection Preventionist, they acknowledged that Resident ID #33 did not receive the ordered dosage of antibiotics.Record review revealed that the physician was not notified about the missed doses of antibiotics until after it was brought to the facility's attention by the surveyor.2. Record review revealed that Resident ID #46 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, dementia and schizophrenia.Record review revealed a physician's order for Eliquis (anticoagulant; a medication prescribed to thin the blood to prevent the formation of blood clots) 2.5 mg twice daily.Review of the November and December 2025 MAR revealed that Resident ID #46 did not receive his/her ordered dose of Eliquis on 11/25, 11/26, 12/6 and 12/17/2025 due to refusal.Record review failed to reveal evidence that the Physician was made aware of the resident's refusal of Eliquis.During a surveyor interview on 12/19/2025 at 10:55 AM with Physician, Staff F, he revealed that he was unaware the resident refused his/her Eliquis and would expect the resident to get his/her medication as ordered.During a surveyor interview on 12/19/2025 at 11:11 AM with the DNS she acknowledged that Resident ID #46 did not receive his/her ordered dosage of Eliquis on the above noted dates.3. Record review revealed that Resident ID #84 was admitted to the facility in March of 2025 with diagnoses including, but not limited to, heart failure and atrial fibrillation (abnormal heart rhythm).Record review revealed a physician's order dated 9/10/2025 through 10/7/2025 for Warfarin (anticoagulant) 2 mg to be administered on Sunday, Tuesday, Wednesday, Saturday and Friday in the evening.Further record review revealed a physician's order to obtain labs on 10/8/2025 to determine continued dosing of Warfarin.Review of the Coagulation Lab dated 10/8/2025 revealed the results were reported to the Doctor with new orders to continue with Warfarin 2 mg on Sunday, Tuesday, Wednesday, Saturday and Friday in the evening.Review of the October 2025 MAR revealed Resident ID #84 did not receive the ordered dosage of Warfarin on 10/8/2025.Record review revealed a physician's order dated 10/27/2025 through 11/9/2025 for Warfarin 1.5 mg every evening.Further record review revealed a physician's order to obtain labs on 11/10/2025 to determine continued dosing of Warfarin.Review of the Coagulation Lab dated 11/10/2025 revealed the results were reported to the Physician with new orders to continue with Warfarin 1.5 mg every evening.Review of the November 2025 MAR revealed Resident ID #84 did not receive the ordered dosage of Warfarin on 11/10/2025.Record review revealed a physician's order dated 11/24/2025 through 12/7/2025 for Warfarin 1.5 mg every evening.Further record review revealed a physician's order to obtain labs on 12/8/2025 to determine continued dosing of Warfarin.Review of the Coagulation Lab dated 12/8/2025 revealed the results were reported to the Physician with new orders to continue with Warfarin 1.5 mg every evening.Review of the December (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025 MAR revealed that Resident ID #84 did not receive the ordered dosage of Warfarin on 12/8/2025.During a surveyor interview on 12/18/2025 at 11:30 AM with the DNS she acknowledged that Resident ID #84 was not administered Warfarin on 10/8, 11/10 and 12/8/2025 as ordered. Additionally, the DNS was unable to provide evidence that Resident ID #s 33, 46 and 84 were kept free from significant medication errors.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on clinical record review and staff interview, the facility failed to promptly notify the ordering physician or a provider of laboratory results for 1 of 1 resident reviewed for Coumadin (an anticoagulant; a medication prescribed to thin the blood to prevent the formation of blood clots), Resident ID #84.Findings are as follows:Review of a facility policy titled, Notification of Clinicians last reviewed 1/4/2023, states in part, .The results of laboratory, radiology and other diagnostic tests will be reviewed by the unit nurse on the same day that they are received by the facility.Record review revealed the resident was admitted to the facility in March of 2025 with a diagnosis including, but not limited to, new onset of unspecified atrial fibrillation (a common type of irregular heart rhythm that may cause blood clots to form in the heart).Record review revealed the resident receives Coumadin for anticoagulation therapy.Review of a care plan focus area dated 3/19/2025 revealed that s/he receives anticoagulation therapy due to atrial fibrillation with an intervention that includes to monitor his/her prothrombin time (PT; a test that measures how quickly the blood clots and is essential for monitoring the effectiveness of anticoagulants such as Coumadin) and his/her internationalized normalized ratio (INR; another measure of how long it takes blood to clot).Record review revealed that s/he had her PT/INR bloodwork drawn on 10/8/2025 at 6:20 AM.Review of the 10/8/2025 lab document's view history revealed that the lab results were not initially reviewed until 10/9/2025 at 11:40 AM, the following day.Additional record review revealed that s/he had her PT/INR bloodwork drawn on 11/10/2025 at 6:12 AM.Review of the 11/10/2025 lab document's view history revealed that the lab results were not initially reviewed until 11/11/2025 at 4:35 PM, the following day.During a surveyor interview on 12/18/2025 at 10:01 AM with Licensed Practical Nurse, Staff A, she revealed that the PT/INR usually results between 2:00 PM and 3:00 PM the same day the bloodwork is drawn. She further revealed that she will review the bloodwork to see if the results are available between 2:00 - 3:00 PM to ensure the results are reported the provider and that the resident receives his/her Coumadin that same evening.During a surveyor interview on 12/18/2025 at approximately 11:30 AM with the Director of Nursing Services, she acknowledged the resident's PT/INR bloodwork from 10/8/2025 and 11/10/2025 were not initially reviewed until the following day and would expect staff to review them the same day.During a surveyor interview on 12/19/2025 at 10:33 AM with the resident's Physician, Staff G, he revealed that he would expect the PT/INR bloodwork to be reviewed the same day and reported immediately.Cross reference F 760

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to ensure that resident records are complete and accurately documented, relative to 1 of 3 residents reviewed for indwelling foley catheter (a flexible tube that is inserted into the bladder to drain urine) usage, 1 of 1 resident for Geri sleeves (a protective sleeve applied to the upper extremities) and right knee sleeve (protective sleeve for the right knee) being documented as applied and 1 of 2 residents reviewed for offloading booties usage, Resident ID #s 9, 88 and 111.Findings are as follows:1.Record review revealed Resident ID #9 was admitted to the facility in March of 2025 with diagnoses, including but not limited to, Flaccid neuropathic bladder (a condition where the bladder's muscles are unable to contract effectively, leading to urinary retention).Record review revealed that the Resident ID #9 has an indwelling foley catheter.Record review revealed a physician's order dated 3/14/2025, to change the foley drainage bag to a leg bag every morning.Surveyor observation on the following dates and times failed to reveal evidence that the indwelling foley catheter drainage bag was changed to a leg bag as ordered: - 12/16/2025 at 11:24 AM - 12/17/2025 at 10:54 AM - 12/17/2025 at 3:41 PMRecord review of the December 2025 Treatment Administration Record (TAR) revealed that the leg bag was documented on the above-mentioned dates as applied.During a surveyor interview on 12/18/2025 at 2:55 PM with Licensed Practical Nurse (LPN) Staff A, she acknowledged the resident foley drainage bag was not changed to the leg bag as ordered. Additionally, she acknowledged that it was documented as applied when it was not.2. Record review revealed Resident ID #88 was admitted to the facility in January of 2025 with diagnoses, including but not limited to, orthopedic aftercare (a time following orthopedic surgery).Review of a Minimum Data Set assessment dated [DATE] revealed a Brief Interview for Mental Status score of 14 out of 15 indicating intact cognition.Review of a care plan focus area dated 12/16/2025 revealed an alteration in skin integrity due to impaired skin integrity with an intervention for bilateral off-loading foot booties as ordered.Record review of a physician's order dated 12/15/2025 revealed the resident is to wear the booties to bilateral feet every night and off in the morning.Surveyor observation on the following dates and times failed to revealed evidence that the resident was provided the booties to bilateral feet as ordered. - 12/17/2025 at 8:36 AM - 12/18/2025 at 8:22 AM - 12/19/2025 at 8:58 AMDuring a surveyor interview on 12/19/2025 at 8:58 AM, with the resident following the observation, s/he revealed that the booties were not being applied at night.Record review of the December 2025 TAR revealed that the bilateral feet booties were documented on the above-mentioned dates as provided to the resident.During a surveyor interview on 12/19/2025 at approximately 9:00 AM with LPN, Staff C, she acknowledged that the resident bilateral feet booties were not applied as ordered. Additionally, she revealed that they were documented as being provided to the resident.3. Record review revealed Resident ID #111 was admitted to the facility in February of 2025 with a diagnosis, including but not limited to, repeated falls.Record review revealed a physician's order dated 6/20/2025 to apply Geri-sleeves to arms for all transfers. Additional review of a physician's order revealed the resident is to wear a right knee sleeve every morning and removed at bedtime.Surveyor observation on the following dates and times failed to reveal evidence that the resident was provided the Geri-sleeves as ordered or right knee sleeve as ordered:- 12/17/2025 at 10:29 AM- 12/17/2025 at 12:09 PM -12/17/2025 at 2:54 PM- 12/18/2025 at 10:20 AM - 12/18/2025 at 11:18 AMDuring a surveyor interview on 12/18/2025 at approximately 12:00 PM with LPN, Staff E, she acknowledged that the resident was not wearing the Geri-sleeve, or the right knee sleeve as ordered. Additionally, she acknowledged that the Geri sleeves and right knee sleeves were documented as applied although they was not.During a surveyor interview with the Director of Nursing Services on 12/19/2025 at approximately 1:15 PM, she was unable to explain why the residents' records were incomplete and inaccurate.

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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 clinical record review and staff interview, 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 2 of 3 residents reviewed for antibiotic use, Resident ID #s 6 and 33.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 an undated policy titled Antibiotic Stewardship Program, states in part, .The antibiotic stewardship program is directed toward the correct use of antibiotic- the five D's -right diagnosis, the right medication, the right dose, the right duration, and the right deceleration.1. Record review revealed Resident ID #6 was readmitted to the facility in April of 2025 with diagnoses including, but not limited to, peripheral vascular disease and osteomyelitis (bone infection) of the right ankle and foot.Review of a discharge continuity of care form from an acute care hospital dated 8/22/2025, revealed an order for doxycycline hyclate (antibiotic) tablet, 100 milligrams (mg), administer 1 tablet once a day for 6 days, indicating a total number of 6 doses.Record review for Resident ID #6 revealed a physician's order dated 8/22/2025 for doxycycline hyclate tablet, 100 mg, administer 1 tablet twice a day, for a total of 12 doses.Review of the Medication Administration Record (MAR) for August of 2025 revealed the resident received 13 doses of the doxycycline hyclate 100 mgs and not the 6 doses as per the discharge summary.Additional review revealed a pharmacist's Medication Regimen Review, dated 8/25/2025, revealed that the discharge summary listed the ordered doxycycline as a once-a-day medication and the facility entered the doxycycline as a twice a day medication, with recommendations to clarify the order with the provider.Review of the Antibiotic Timeout, completed on 8/27/2025, revealed that Resident ID #6 was prescribed doxycycline hyclate. Further review of the antibiotic timeout failed to reveal evidence that the five D's - right diagnosis, the right medication, the right dose, the right duration, and the right deceleration was observed, as the above-mentioned discrepancy was not identified.2. Record review revealed that Resident ID #33 was readmitted to the facility in December of 2025 with diagnoses including, but not limited to, sepsis and dementia.Record review revealed a physician's order for Cephalexin (antibiotic) 500 milligrams every 6 hours for 5 days due to cellulitis of his/her arm, indicating Resident ID #33 should have received 20 doses.Review of the December 2025 MAR revealed that Resident ID #33 received 17 doses of Cephalexin instead of the 20 doses that were ordered.Review of the Antibiotic Timeout, completed on 12/16/2025, revealed that Resident ID #33 was prescribed cephalexin. Further review of the antibiotic timeout failed to reveal evidence that the five D's -right diagnosis, the right medication, the right dose, the right duration, and the right deceleration was observed per the policy or CDC as the resident did not receive the 20 doses as ordered.Record review revealed that the physician was not notified about the missed doses of antibiotics until after it was brought to the facility's attention by the surveyor.During a surveyor interview on 12/18/2025 at 1:37 PM with the Director of Nursing Services (DNS) and the Regional Infection Preventionist they acknowledged that the antibiotic timeouts mention above do not include the 5 D's per the facility policy or the above-mentioned guidance per the CDC.Cross reference F-756, F-757, and F-760

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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. Based on surveyor observation, clinical record review, and staff interview, the facility failed to provide appropriate treatment and services for residents with a foley catheter (a flexible plastic tube inserted into your bladder) for 1 of 3 residents reviewed, Resident ID #9.Findings are as follows:Record review revealed that the resident was admitted to the facility in March of 2025 with a diagnosis including, but not limited to, flaccid neuropathic bladder (a condition that results in the inability to effectively empty the bladder due to nerve damage).According to Lippincott Nursing Procedures, 9th Edition, pages 432-33 states in part, Catheter care .Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of CAUTI [A catheter-associated urinary tract infection caused by germs entering the urinary tract through a catheter].Review of a care plan focus area dated 3/14/2025 revealed a focus area for a foley catheter with an intervention to maintain the foley below bladder level.During multiple surveyor observations, the resident was observed seated in his/her recliner with his/her foley catheter tubing extending upwards over the arm rest of the recliner and into the drainage bag, and not below bladder level, on the following dates and times:-12/16/2025 at 11:24 AM-12/17/2025 at 10:54 AM and 3:41 PM-12/18/2025 at 2:55 PMDuring a surveyor interview immediately following the above observation on 12/18/2025 with Licensed Practical Nurse, Staff A, she acknowledged the resident's foley catheter tubing extended upwards over his/her recliner's armrest, and was not below bladder level, and revealed that it should be.During a surveyor interview on 12/18/2025 at 3:15 PM with the Director of Nursing Services, she revealed that she would expect staff to maintain the foley catheter tubing below the resident's bladder level.Cross reference F 842

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, clinical record review and staff interview, the facility failed to ensure that each resident receives and is provided the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, or psychosocial well-being, for 1 of 1 resident admitted with a diagnosis of schizophrenia, Resident ID #46.Findings are as follows:Record review revealed the resident was admitted to the facility in November of 2025 with diagnoses including, but not limited to, dementia with behavioral disturbances and schizophrenia (a mental illness that affect how people think and behave).Review of the resident's care plan revealed a focus area initiated on 11/26/2025, for the use of psychotropic medications related to his/her diagnosis of schizophrenia and yelling out nonsensical dialogue. Interventions include, but are not limited to, administer anti-psychotic medication as ordered and monitor its side effects.Review of a Minimum Data Set assessment dated [DATE] section E for behavioral symptoms revealed that the resident significantly intrudes on the privacy or activity of other residents.Record review of a physician's order dated 11/20/2025 revealed Fluphenazine (a medication used to treat psychotic disorders such as schizophrenia) 5 milligrams (MG) to be administered every 8 hours as needed for severe agitation related to the diagnosis of Schizophrenia.Review of the Medication Administration Record (MAR) for the months of November and December 2025 revealed the above-mentioned medication was administered once for a behavior issue on 11/26/2025 at 10:17 PM. Additionally, the MAR indicated the medication administration follow-up as effective. Further review of the MAR revealed the medication was discontinued on 12/2/2025.Review of the nursing progress note dated 11/26/2025 revealed that the resident was yelling out most of the night, calling imaginary people. Additional review of the progress note revealed that the as needed (PRN) Fluphenazine was administered to the resident with a positive result. During surveyor observations on the following dates and times revealed the resident to be behavioral: 12/16/2025 at 10:30 AM, the resident was observed in a recliner in the common area, yelling out loud incoherent words. At this time other residents were observed to be upset by this behavior and were observed yelling back at him/her, asking him/her to keep quiet. 12/16/2025 at 12:03 PM, the resident was observed being taken to the main dining room for lunch along with other residents. Approximately 5 minutes later Licensed Practical Nurse (LPN) Staff E was observed rushing to the main dining room remove the resident to prevent him/her from disturbing the other residents when [s/he] yells out. 12/16/2025 at 1:10 PM, the resident was observed in the common area yelling out. 12/17/2025 at 10:26 AM, the resident was yelling out jumbled words. 12/17/2025 at 1:36 PM, the resident was observed in the recliner yelling, appeared to be calling someone in incoherent words which apparently was upsetting other residents who were present. 12/17/2025 at 2:50 PM, the resident was observed yelling out in the hallway.Record review failed to reveal evidence of a professional Psychiatric consultation for the resident despite his/her diagnosis of schizophrenia.During a surveyor interview on 12/17/2025 at 2:29 PM with LPN Staff C, she acknowledged the resident's yelling is frequent then stated that it is his/her baseline. Additionally, the nurse was unable to provide evidence of a Psychiatric consultation for the resident.During a surveyor interview on 12/18/2025 at 8:50 AM with Staff E, she revealed that the resident came from another facility. Additionally, Staff E revealed the resident yells out all day however, s/he does not have a PRN medication to provide him/her because the last one was discontinued on 12/2/2025. Further, Staff E indicated that the yelling out upsets other residents who yell back at the resident. During a surveyor interview on 12/18/2025 at 9:06 AM with the Director of Nursing Services, she revealed the resident has a diagnosis of Schizophrenia and Dementia but has no current PRN medication. Additionally, she indicated that the PRN Fluphenazine was discontinued on 12/2/2025 for not being utilized in the 14 days period. Further, she acknowledged the facility has (continued on next page)

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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 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not requested a psychiatric consult for the resident even though s/he needs one as well as the PRN medication related to the behaviors.