STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	415057	A. Building B. Wing	11/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elderwood of Scallop Shell at Wakefield	55 Scallop Shell Way South Kingstown, RI 02883

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on record review and staff interview, the facility failed to ensure adequate supervision and timely intervention for Resident ID #9, a resident with documented dysphagia (swallowing difficulties), to prevent accident hazards related to choking. Despite multiple documented episodes of the resident coughing and choking during meal and medication consumption between October 23, 2025, and October 27, 2025, the facility staff failed to implement any immediate, necessary interventions or notify the medical provider of the significant change in condition as required by policy and the resident's care plan. This failure resulted in a severe choking event on October 28, 2025, where the resident was found to be cyanotic (blue in the face) and required staff intervention to manually remove food, placing the resident in Immediate Jeopardy of serious injury, aspiration pneumonia, or death.Findings are as follows:Review of a policy titled Physician Notification of Emergency or Change of Condition, last modified on 5/30/2019, states in part, On an ongoing basis, the Resident Care Manager, Licensed Nurse or Shift Supervisor will evaluate the Resident's status and respond to any changes in the Resident's condition to ensure immediate access to the appropriate necessary services. The Resident Care Manager/designee will notify the Primary Physician and all disciplines, as appropriate of the Resident's emergency or change of condition. The Resident's Physician will provide instructions to the care staff when emergency treatment is determined to be necessary for a resident due to illness, injury or change of condition or behavior. The resident's safety and comfort will be protected at all times.a change of condition is defined as a change in the Resident's mental, physical, emotional or medical status.Record review revealed Resident ID #9 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, Parkinson's Disease and dysphagia (difficulty swallowing).Record review revealed a physician's order dated 9/19/2025 for a no added salt (NAS) diet with regular texture and regular liquid consistency, with whole sandwiches allowed.Record review of a care plan last revised on 7/17/2025 revealed, the resident has mild oral pharyngeal dysphagia (a condition characterized by difficulty swallowing, primarily affecting the mouth and throat) and cannot drink through a straw with a goal which states I will exhibit no signs of aspiration [inhaling an object or fluid into the airways which can lead to coughing, difficulty breathing, discomfort, and/or choking] or difficulty swallowing before my next review date. Further review of the care plan revealed to report any changes to the medical provider.Record review revealed the following progress notes:- 10/23/2025: the resident was coughing during meals- 10/24/2025: the resident has been having coughing episodes during meals and speech therapy was notified- 10/26/2025: the resident had an episode of choking on his/her food during dinner- 10/27/2025: the resident had an episode of choking during the medication pass but was able to swallow pills eventually- 10/28/2025: the resident was found to have a blue face, actively choking, requiring the use of back slaps. The food was removed from the mouth with a finger sweep, the provider was notified, and new orders were obtained which included, to obtain a chest x-ray to evaluate for possible aspiration, obtain vital signs for 24 hours, and the resident's diet was downgraded to a pureed diet (soft pudding like consistency). S/he complained of shortness of breath with crackles noted at bilateral (affecting both sides) lung bases. Record review failed to reveal (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	evidence the provider was notified of the resident's increased coughing and choking with meals and/or medications on 10/23, 10/24, 10/26 and 10/27/2025. Further review failed to reveal evidence that an intervention was implemented in the resident's care plan to prevent the choking incident that occurred on 10/28/2025.Review of a document titled Referral to Therapy, dated 10/26/2025, revealed a list of symptoms that would warrant a therapy referral. Under the section labeled Signs of Aspiration, the symptoms Choking and Frequent Coughing were marked on 10/26/2025 as reasons for the referral. Further review revealed that speech therapy evaluated the resident on 10/28/2025.During surveyor interviews on 11/18/2025 at 12:08 PM and 12:30 PM, with Unit Manager, Staff D, she revealed that the resident often has episodes of choking while eating but is able to clear the contents him/herself. When questioned again by the surveyor if it was coughing or choking, Staff D responded choking. She acknowledged the resident had coughing and/or choking documented in his/her progress notes on 10/23, 10/24, 10/26 and 10/27/2025. She revealed that she was unable to find evidence that the provider was notified of the coughing on 10/23 and 10/24/2025 or the choking on 10/26 and 10/27/2025. Additionally, she was unable to provide evidence that an intervention was implemented following the coughing and choking episodes on 10/23, 10/24,10/26 and 10/27/2025 to prevent the choking episode on 10/28/2025.During a surveyor interview on 11/18/2025 at 1:02 PM, NP, Staff E, she stated that she works with NP, Staff C. She revealed that she was present after the choking incident on 10/28/2025 and accompanied the speech therapist to assess the resident. The speech therapist screened the resident and subsequently changed the resident's diet to pureed. Staff E revealed that she would expect staff to notify a provider if a resident exhibited increased coughing or choking episodes and that she would expect interventions to be implemented to prevent choking.During a surveyor interview on 11/18/2025 at 1:08 PM with the Administrator and the Interim Director of Nursing Services (DNS), they revealed that they would expect staff to notify the provider if the resident was having increased coughing/choking. Additionally, they revealed they would expect the staff to implement interventions to keep the resident's safe.During a surveyor interview on 11/19/2025 at 8:11 AM, Registered Nurse, Staff F, he acknowledged that he documented in the resident's progress notes that the resident was observed choking on 10/26 and 10/27/2025. He stated that on 10/26/2025 he heard the resident coughing, went to assess the situation and observed the resident having difficulty swallowing food, accompanied by coughing and dry heaving. Staff F also imitated the sound of someone gasping for air due to a throat obstruction to describe the resident's presentation and stated that the resident was unable to speak during the episode. He further revealed, on 10/27/2025 the resident presented in the same manner while attempting to swallow medication. When asked whether he notified the provider about the resident's difficulty swallowing, coughing, or choking, Staff F responded, no. When asked if he removed the resident's meal tray and replaced it with a softer, easier-to-swallow option on 10/26/2025, he again responded, no, I didn't think of that. Lastly, when questioned whether he moved the resident to a supervised location to finish meals or for subsequent meals, he responded, no.During a surveyor interview on 11/19/2025 at 7:53 AM with the Administrator, the Interim DNS, and the Speech Therapist, that were unable to provide evidence an intervention was implemented on 10/23, 10/24, 10/26, and 10/27/2025 for the coughing/choking episodes. The Speech Therapist revealed that he received the referral to therapy on Monday 10/27/2025 but did not screen the resident on that Monday because the screen did not indicate the resident was choking, as the handwritten note read coughing during meals, although choking was marked off as a concern on the form. Lastly, they revealed that they were unable to provide evidence that a provider was notified on 10/23, 10/24, 10/26, and 10/27/2025, per the policy and care plan.As a result of this failure on 10/23, 10/24, 10/26, and 10/27/2025, the resident was found on 10/28/2025 blue in color, actively choking, requiring the staff to provide a back slap and a finger sweep, to remove food from the resident's mouth. This failure had the potential to cause more than serious harm, serious impairment, serious injury, or death.Refer to F 726

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, record review, and staff interview, the facility failed to ensure that appropriate treatment and services were provided to one resident (Resident ID #70) who was reviewed for fluid management. This failure included missing two physician-ordered doses of Lasix (a medication used to treat excess fluid trapped in the body's tissue) and failing to obtain daily weights as ordered by the physician. As a direct result of these failures, the resident experienced clinical deterioration, including increased shortness of breath and an elevated respiratory rate (30 breaths per minute), requiring an immediate transfer to the hospital for evaluation of potential congestive heart failure exacerbation.Findings are as follows:Review of a policy titled Electronic Physicians Orders (Create, Confirm, Processing orders) last modified 8/28/2024, states in part, .Routine orders- Electronic prescriptions/orders will be obtained in the following manner: Verbally.written in the paper chart or entered into the EMR [Electronic Medical Record] by the medical provider.The Licensed Nurse.who has obtained the order from the MD/PA/NP [Medical Doctor/Physician Assistant/Nurse Practitioner] transcribing the medical order in to the EMR will ensure the correct date, time, ordering prescriber, medication name, order category, communication method, route of administration, frequent, schedule, indication for use or diagnosis.are listed.Record review revealed Resident ID #70 was admitted to the facility in October of 2025 with diagnoses including, but not limited to, acute on chronic diastolic congestive heart failure (a condition where the heart is unable to pump blood effectively, leading to fluid buildup in the lungs causing difficulty breathing and other parts of the body such as the arms and legs) and chronic obstructive pulmonary disease (a lung condition caused by damage to the lungs).During a surveyor observation on 11/18/2025 at 10:01 AM, the resident was noted to have edema to his/her upper and lower extremities.1. Record review revealed a care plan, last revised 11/17/2025, states in part, I have an alteration in respiratory status. with interventions that include, but not limited to, administer medications per MD/NP order.Review of a handwritten physician order revealed an order dated 11/14/2025 for Lasix 20 milligrams (mg), every afternoon for 4 days.Further review revealed an additional order dated 11/17/2025 for Lasix 20 mg, every evening on 11/18/2025 and 11/19/2025.Record review revealed a progress note authored by NP, Staff C, on 11/17/2025 which states in part, .Patient noted with 4 pounds weight gain yesterday. Overall edema to lower extremities has improved. Patient has been receiving an extra 20 mg of Lasix on Friday [11/14/2025], Saturday [11/15/2025], Sunday [11/16/2025], and Monday [11/17/2025]. Will extend extra 20 mg of Lasix for Tuesday [11/18/2025] and Wednesday [11/19/2025]. Left arm edema is improved. This indicates the resident was to receive a total of 6 days of additional Lasix.Record review revealed the resident weight on the following dates:-10/26/2025: 155.2 pounds (lbs)-11/9/2025: 164.4 lbs-11/11/2025: 166 lbs-11/16/2025: 168.4 lbs-11/18/2025: 171.0 lbsRecord review of the November 2025 Medication Administration Record revealed that the resident received only 4 additional days of Lasix on 11/15/2025, 11/16/2025, 11/17/2025, and 11/18/2025 and not the 6 days of as Lasix ordered. The 11/14/2025 and 11/19/2025 doses were not signed off as administered.During a surveyor interview on 11/20/2025 at 11:25 AM, with Unit Manager, Staff D, she acknowledged that the resident did not receive the 6 days of Lasix as ordered and did not receive a dose last night, 11/19/2025. Additionally, she revealed that the resident is currently having a hard time breathing and his/her respiratory rate is elevated requiring immediate interventions.During surveyor interviews on 11/20/2025 at 11:41 AM and 12:37 PM, with NP, Staff C, she revealed that she would have expected the Lasix order to have been administered for a total of 6 days. Additionally, she revealed that the resident was noted to have pursed lip breathing (a type or breathing observed when someone has difficulty breathing), the resident's respiratory rate was 30 breaths per minute (normal respirations is 12 to 20), and that the resident will be transferred to the hospital.1b. Record review revealed a care plan, last revised 11/17/2025, states in part, I have a potential for alteration in (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	nutrition.11/17/25-weight trending up.daily weights. with interventions to include, but not limited to, Monitor and record weights and Update MD/NP/PA on resident status, as needed. Record review revealed a progress note dated 11/16/2025 which revealed, the resident has had an increased weight gain over the past 3 weeks, with a total weight of 13.2 pounds in the 3 weeks since admission. Additionally, the resident had a 2.4-pound weight gain in 4 days and has shortness of breath on exertion and is utilizing oxygen at 3 liters. The on-call provider was notified, and an order was obtained for daily weights.Record review revealed a physician's order dated 11/17/2025 for daily weights.Review of the Medication Administration Record and weight log for November of 2025, failed to reveal evidence that a weight was obtained on 11/17/2025 and 11/19/2025During surveyor interviews on 11/20/2025 at 11:41 AM and 12:37 PM, with NP, Staff C, she revealed that she would have expected the daily weights to have been obtained, or a reason documented as to why they were not.During a surveyor interview on 11/20/2025 at 11:45 AM, with the Interim Director of Nursing Services, she acknowledged that the resident only received an additional 4 doses of Lasix and not the 6 doses, as ordered. Additionally, she acknowledged that the resident was not weighted daily per the physician's order and would have expected the daily weights to have been obtained, as ordered. Further, she acknowledged that the resident was currently having increased shortness of breath and was being sent to the hospital for evaluation. Review of the hospital Discharge summary dated [DATE], revealed that although the patient was favored to have chronic obstructive pulmonary disease exacerbation, a congestive heart failure exacerbation cannot be ruled out.

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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 0726 Level of Harm - Actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and staff interview, the facility failed to ensure that Registered Nurse, Staff F, was competent to provide nursing services related to acute changes in condition, which resulted in actual harm to Resident ID #9. Despite having been competency-trained and observing the resident choking on food and medication on 10/26 and 10/27/2025, Registered RN, Staff F failed to follow policy and the resident's care plan by neglecting to immediately implement an intervention (such as removing the meal or providing a softer diet option) and failing to notify the resident's provider. This immediate failure to act and notify on a serious change in condition led to the resident experiencing a severe, life-threatening choking episode on 10/28/2025, requiring emergency physical intervention and resulting in signs of aspiration pneumonia, which mandated a diet change and further medical workup.Findings are as follows:Review of a policy titled, Physician Notification of Emergency or Change of Condition, last modified on 5/30/2019, states in part, On an ongoing basis, the Resident Care Manager, Licensed Nurse or Shift Supervisor will evaluate the Resident's status and respond to any changes in the Resident's condition to ensure immediate access to the appropriate necessary services. The Resident Care Manager/designee will notify the Primary Physician and all disciplines, as appropriate of the Resident's emergency or change of condition. The Resident's Physician will provide instructions to the care staff when emergency treatment is determined to be necessary for a resident due to illness, injury or change of condition or behavior. The resident's safety and comfort will be protected at all times.a change of condition is defined as a change in the Resident's mental, physical, emotional or medical status.Record review revealed Rn, Staff F was hired on 4/24/2025. Further review revealed he completed a competency titled, Observing and Reporting Changes in Condition on 5/6/2025. Record review revealed Resident ID #9 was admitted to the facility in April of 2025 with diagnoses including, but not limited to, Parkinson Disease and dysphagia (difficulty swallowing).Record review of a care plan last revised on 7/17/2025, revealed, the resident has mild oral pharyngeal dysphagia (a condition characterized by difficulty swallowing, primarily affecting the mouth and throat) with a goal which states I will exhibit no signs of aspiration [inhaling an object or fluid into the airways which can lead to coughing, difficulty breathing, discomfort, and/or choking] or difficulty swallowing before my next review date. Further review of the care plan revealed to report any changes to the medical provider.Review of the progress notes revealed the following authored by Staff F:- 10/26/2025: the resident had an episode of choking on his/her food during dinner-10/27/2025: the resident had an episode of choking during the medication pass but was able to swallow pills eventuallyAdditional review of the progress notes revealed a note dated 10/28/2025, which revealed the resident was found to have a blue face, actively choking, requiring the use of back slaps. The food was removed from the mouth with a finger sweep, the provider was notified, and new orders were obtained which included, to obtain a chest x-ray to evaluate for possible aspiration, obtain vital signs for 24 hours, and the resident's diet was downgraded to a pureed diet (soft pudding like consistency). S/he complained of shortness of breath with crackles noted at bilateral (affecting both sides) lung bases. Record review failed to reveal evidence Staff F notified the resident's provider of his/her episodes of choking with meals and/or medications on 10/26 and 10/27/2025. Further review failed to reveal evidence that an intervention was implemented by Staff F in the resident's care to prevent the choking incident on 10/28/2025.During a surveyor interview on 11/18/2025 at 1:02 PM, Nurse Practitioner (NP), Staff E, she stated that she works with NP, Staff C. She revealed that she was present after the choking incident on 10/28/2025 and accompanied the speech therapist to assess the resident. The speech therapist screened the resident and subsequently changed the resident's diet to pureed. Staff E revealed that she would expect staff to notify a provider if a resident exhibited increased coughing or choking episodes and that she would expect interventions to be implemented to prevent choking.During a surveyor interview on (continued on next page)

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F 0726 Level of Harm - Actual harm Residents Affected - Few	11/19/2025 at 8:11 AM, Registered Nurse, Staff F, he acknowledged that he documented in the resident's progress notes that the resident was observed choking on 10/26 and 10/27/2025. He stated that on 10/26/2025 he heard the resident coughing, went to assess the situation and observed the resident having difficulty swallowing food, accompanied by coughing and dry heaving. Staff F also imitated the sound of someone gasping for air due to a throat obstruction to describe the resident's presentation and stated that the resident was unable to speak during the episode. He further revealed, on 10/27/2025 the resident presented in the same manner while attempting to swallow medication. When asked whether he notified the provider about the resident's difficulty swallowing, coughing, or choking, Staff F responded, no. When asked if he removed the resident's meal tray and replaced it with a softer, easier-to-swallow option on 10/26/2025, he again responded, no, I didn't think of that. Lastly, when questioned whether he moved the resident to a supervised location to finish meals or for subsequent meals, he responded, no.During a surveyor interview with the Administrator, the Interim Director of Nursing Services, and the Speech Therapist, on 11/19/2025 at 7:53 AM, they were unable to provide evidence of an intervention implemented by Staff F on 10/26 and 10/27/2025, or that a provider was notified by Staff F, of the resident's choking incidents, as per the policy and care plan.Refer to F 689

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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 record review and staff interview, it has been determined that the facility failed to ensure that each resident's drug regimen is free from unnecessary medications for 2 of 2 residents reviewed for blood pressure medications with parameters, Resident ID #s 4 and 83 and for 1 of 1 resident reviewed for pain, Resident ID #79. Findings are as follows:1a. Review of a policy titled, Medication Administration Methods, dated 1/25/2024, states in part, .The nurse will take the pulse or blood pressure when a medication requires such. He/She will then record the results on the Medication Administration Record/ EMAR prior to medication administration.Record review revealed Resident ID #4 was readmitted to the facility in October of 2025 with diagnoses including, but not limited to, hypotension (low blood pressure) and heart failure.Record review revealed a physician's order dated 10/27/2025 for Metoprolol Succinate (a blood pressure medication) tablet extended release 25 milligrams (mg), to administer 1 tablet by mouth in the morning and hold if the heart rate is less than 60 beats per minute or if the systolic blood pressure (SBP, the top number in a blood pressure reading that refers to the amount of pressure experienced by the arteries while the heart is beating) is less than 100.Record review of the November 2025 Medication Administration Record (MAR) revealed, 13 out of 19 days the Metoprolol was administered without a heart rate reading being documented.Further record review revealed a physician's order dated 11/1/2025 for Losartan Potassium (a blood pressure medication) oral tablet 25 mg, give 1 tablet by mouth and hold for a SBP of less than 110.Review of the November 2025 MAR revealed the Losartan was administered on the following dates with a SBP of less than 110:- 11/1, 100/63- 11/4, 106/62- 11/5, 101/63- 11/7, 107/63- 11/9, 105/62- 11/10, 106/60- 11/11, 103/65- 11/15, 108/62- 11/16, 109/72During a surveyor interview on 11/20/2025 at 10:43 AM with Unit Manager (UM), Staff D, she acknowledged that the heart rate for administration of the Metoprolol was not documented. Additionally, she acknowledged that the Losartan was administered outside of the ordered parameters.During a surveyor interview on 11/20/2025 at 10:50 AM with the Interim Director of Nursing Services (DNS), she revealed that she would expect the staff to follow the physician's order including following the parameters to hold the medication.1b. Record review revealed Resident ID #83 was admitted to the facility in November of 2025 with diagnoses including, but not limited to, heart failure and dementia.Record review revealed a physician's order dated 11/11/2025 for Metoprolol Succinate extended release 100 mg, give 1 tablet by mouth and hold for a SBP less than 110 or a heart rate of less than 60 beats per minute.Review of the November 2025 MAR revealed that the Metoprolol was administered on 11/13/2025 with a blood pressure of 103/64.During a surveyor interview on 11/20/2025 at 11:50 AM, with the Interim DNS, she revealed that she would expect the staff to follow the physician's order including following the parameters to hold the medication.2. Record review revealed Resident ID #79 was admitted to the facility in November of 2025 with a diagnosis including, but not limited to, chronic pain.Record review revealed a physician's order dated 11/11/2025 for Hydrocodone-Acetaminophen (a medication prescribed to trat pain) 10-325 mg, administer 1 tablet by mouth every 6 hours as needed for pain.Additional record review revealed a physician's order dated 11/12/2025 for Acetaminophen oral tablet 500 mg, administer 2 tablets every 8 hours as needed for pain. Further review of the order revealed special instructions to ensure that the Acetaminophen dosage with both the as needed Hydrocodone-Acetaminophen and the as needed Acetaminophen dose, does not exceed the max dosage of 3000 mg in 24 hours.Review of the November 2025 MAR revealed that on 11/16/2025 Resident ID #79 received 4 doses of as needed Hydrocodone-Acetaminophen 10-325 mg and 2 doses of as needed Acetaminophen 1000 mg to total 3300 mg of Acetaminophen in 24 hours.During a surveyor interview on 11/19/2025 at 1:10 PM with UM, Staff D, she acknowledged that on 11/16/2025 the resident received more than the maximum dosage of Acetaminophen.During a surveyor interview on 11/19/2025 at 1:16 PM with the Interim DNS, she revealed that she would have expected the staff to follow the physician's orders. Additionally, she was unable to provide evidence that Resident ID #s 4, 79, and 83 were kept free from unnecessary medications.

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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 0582 Level of Harm - Potential for minimal harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, it has been determined that the facility failed to properly provide notice to residents and/or representatives informing them of when changes in coverage are made to items and services covered by Medicare and/or the state Medicaid plan, relative to the Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) of Non-coverage Form for 3 of 3 residents discharged from Medicare Part A Services that remained in the facility, Resident ID #s 17, 22, and 30.Findings are as follows:Review of the Center for Medicare and Medicaid Services (CMS) Form, CMS 100-55, titled Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage, states in part:Medicare requires SNFs [Skilled Nursing Facilities] to issue the SNFABN to Original Medicare, also called fee-for-service (FFS) beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is:- not medically reasonable and necessary.- or considered custodial.The SNFABN provides information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility. SNFs must use the SNFABN when applicable for SNF Prospective Payment System services (Medicare Part A) .Review of a policy titled, Room and Care Medicare Part A Billing, last revised 5/23/2022, states in part, .Issuance of SNF Advanced Beneficiary Notice Form (SNF ABN).Completion of this notice provides estimated costs of SNF services to be received but will not be covered by Traditional Medicare after the last day of Medicare A coverage. (This must be completed prior to change of liability upon competition of Traditional Part A benefits).NOTE.The SNF ABN 1005 must be delivered prior to the change of financial liability but does not hold the same two (2) day requirement. Best practice is to issue both notices simultaneously.A) Record review revealed Resident ID #17's last covered day of Medicare Part A Services was on 5/30/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form.B) Record review revealed Resident ID #22's last covered day of Medicare Part A Services was on 10/24/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form.C) Record review revealed Resident ID #30's last covered day of Medicare Part A Services was on 10/22/2025. Further record review failed to reveal evidence that the resident and/or resident representative was issued the SNFABN form.During a surveyor interview on 11/19/2025 at 10:52 AM with Minimum Data Set (MDS) Nurses, Staff A and MDS Nurse, Staff B, they acknowledged that Resident ID #s 17, 22, and 30, nor their representatives, were not issued a SNFABN form and acknowledged that they should have been.During a surveyor interview on 11/19/2025 at 11:04 AM, with the Administrator and the Interim Director of Nursing Services, they were unable to provide evidence that the facility provided the SNFABN notice for Resident ID #s 17, 22, and 30, as required.