STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodcrest at Blakeford	11 Burton Hills Blvd Nashville, TN 37215

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on facility policy review, record review, facility document review, and interview, the facility failed to ensure staff honored residents' rights related to self-determination, which affected 1 (Resident #31) of 1 resident reviewed for dignity concerns. The findings include: An undated facility policy titled, Resident Rights And Responsibilities, revealed, The resident has the right to, which included, Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal, and Exercise his or her rights without being subjected to discrimination or reprisal. An admission Record revealed the facility admitted Resident #31 on 10/26/2023. According to the admission Record, the resident had a medical history that included a diagnosis of unspecified dementia, severe with agitation. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was short-tempered, easily annoyed for half or more of the assessment's lookback period. The MDS indicated the resident was dependent on staff for showering/bathing and personal hygiene. Resident #31's care plan included a category titled, Behavior Problem, that indicated the resident had impaired behavior related to their dementia that was evidenced by being aggressive and resistant to care with staff. The care plan included a category titled, Resistive to Care, that revealed the resident resisted care related to a knowledge deficit, denial of illness, denial of risk factors, cognitive impairment, and mental/emotional illness. Interventions initiated on 08/08/2024 directed staff to discuss the resident's objections and fears, inform the resident about the risks of non-compliance, offer the resident as many choices as possible, and accept the resident's right to refuse and show respect for the resident's decisions. A facility document titled, Notes from Meeting on 09/13/'24 [2024] at 2:30pm with officer [officer's name], indicated that on 09/06/2023, an incident occurred between a staff member and Resident #31. Per the document, the Administrator stated that it had been reported that two staff members were providing care when the resident became agitated. A typed statement dated 09/13/2024 by Certified Nursing Assistant (CNA) #17, indicated that she had worked a shift lately when CNA #18 told her that Resident #31 refused their shower. The statement indicated that CNA #17 told CNA #18 that she would help because Resident #31 had to get their showers. The statement indicated that CNA #17 and CNA #18 helped the resident into a shower chair. A handwritten staff statement dated 09/13/2024 by CNA #18 indicated that it was Resident #31's shower day, that she entered the resident's room with CNA #17, and that CNA #18 told the resident that it was their shower day and they were going to help the resident get into the shower. The document indicated that Resident #31 said, No I don't want a shower. The statement indicated that CNA #17 told the resident that they were getting a shower and pulled the covers off the resident. The statement indicated that the aides placed the resident in a shower chair, CNA #17 left the room, and CNA #18 continued with providing the shower. During a telephone interview on 03/04/2026 at 9:17 AM, CNA #17 stated that the staff member who was assigned to Resident #31 told her that the resident refused their shower. She stated that she told the other staff member that it was the resident's day to get a shower and to go ahead and provide the shower. During an interview on (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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/05/2026 at 8:49 AM, the Director of Nursing (DON) stated that if a resident refused provision of care, the staff were expected to come back later and try again. She stated that if the resident continued to refuse, staff were expected to leave the resident alone and notify the nurse of the refusal and see what the resident's preference was. She stated that it was expected that staff honor the residents' right to refuse provision of care/showers. During an interview on 03/05/2026 at 9:23 AM, the Administrator stated that staff were expected to acknowledge the residents' right to say no. She stated that staff were expected to come back to the resident another time andˆnotify the nurse or social services staff of the refusal, or the resident's family if necessary.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, record review, and facility document and policy review, the facility failed to submit an initial report of an allegation of staff-to-resident abuse to the state survey agency within two hours for 1 (Resident #31) of 1 resident reviewed for abuse. Specifically, CNA #18 failed to report an allegation of staff-to-resident abuse that occurred on 09/06/2024 until 09/13/2024. ˆ The findings include: A facility policy titled, Abuse, Neglect, Misappropriation Protocol, revised 04/2025, revealed, 1. Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing. An admission Record revealed the facility admitted Resident #31 on 10/26/2023. According to the admission Record, the resident had a medical history that included a diagnosis of unspecified severe dementia with agitation. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/25/2024, revealed Resident #31 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was short-tempered and easily annoyed half or more of the days over the last two weeks. Resident #31's Care Plan included an undated focus area that indicated the resident was at risk for behavior problems. Interventions directed staff to intervene as necessary to ensure safety of resident and others (initiated 08/08/2024). A handwritten witness statement by Certified Nursing Assistant (CNA) #18, dated 09/13/2024, revealed when CNAs #17 and #18 went to assist Resident #31 with a shower, the resident stated they did not want a shower. The witness statement indicated CNA #17 told Resident #31 that the resident was getting a shower and began to pull the resident's clothes off. The witness statement revealed Resident #31 hit CNA #17. The witness statement revealed CNA #17 hit Resident #31 back, pointed their finger at the resident, and told the resident, You don't hit me. An undated facility investigative document titled Note for Meeting 9/13/'24 [2024] [sic] with [Name of police officer] revealed, Administrator explained that the team was notified this morning (9/13) of an allegation of abuse that had happened last Friday (9/6) between a staff member and the resident [Resident #31]. An email from the state reporting agency, dated 09/13/2024 at 10:42 AM, indicated the initial submission of an allegation of physical abuse. A facility incident report, dated 09/17/2024 at 12:53 PM, indicated a witness stated that she asked the alleged perpetrator to assist with transferring Resident #31 for a shower. The incident report indicated during the process, Resident #31 became combative and hit the alleged perpetrator. The incident report indicated the alleged perpetrator slapped Resident #31 back, pointed their finger at the resident, and stated, Don't hit me. The incident report concluded, The investigation was conducted and has been concluded as not substantiated by view of the findings. During an interview on 03/04/2024 at 9:30 AM, CNA #18 stated that she was in Resident #31's room to get the resident ready for a bath when the resident became aggressive. CNA #18 stated that she was being assisted with the transfer of Resident #31 by CNA #17. CNA #18 stated that during the transfer Resident #31 hit CNA #17, and CNA #17 hit the resident back and stated, You don't hit me. CNA #18 stated that she reported the incident to the Administrator (ADM) a couple of days later because she worked overnight and no one was around during the night to receive the report. CNA #18 stated there was a nurse present on the unit, but the nurse was friends with CNA #17, and CNA #18 did not feel like anything would be done. CNA #18 stated that Resident #31 was slapped with an open hand but was unsure as to what part of the resident's body was hit. CNA #18 stated that Resident #31 was not injured. CNA #18 stated that if abuse was identified it was supposed to be reported. CNA #18 stated that she did not remember when she should have reported the incident. During an interview on 03/04/2026 at 9:59 AM, the ADM stated that on 09/13/2024 CNA #18 reported that, while providing care, CNA #18 witnessed CNA #17 being hit by Resident #31 and then CNA #17 hitting the resident back on 09/06//2024. The ADM stated she had a conversation with CNA #18 about the timeliness of reporting, and she was not sure why CNA #18 did not report the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident immediately per the policy. During an interview on 03/05/2026 at 8:49 AM, the Director of Nursing (DON) stated that her expectation was for staff to report abuse to her or the abuse coordinator as soon as it was identified, and that was how staff were trained. During an interview on 03/05/2026 at 9:23 AM, the ADM stated the facility process was that allegations of abuse were to be reported immediately, and that pertained to all staff. The ADM stated staff were trained in abuse at the time of hire and with routine facility training. The ADM stated that CNA #18 should have reported the incident as soon as it was identified.ˆ

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, review of facility policy, and review of the American Heart Association Adult Basic Life Support Algorithm, the facility failed to have documented evidence that Emergency Medical Services (EMS or 911) was contacted or that an Automated External Defibrillator (AED) was utilized when cardiopulmonary resuscitation (CPR) was provided for 1 resident (Resident #78) of 2 residents reviewed for CPR, who had a physician's order for a full code (a medical directive indicating that if a person's heart stops or they stop breathing, healthcare providers will use all available life saving measures to revive them). The findings include: A facility policy titled, CPR - Do Not Resuscitate - DNR POST Form, revised 07/2025, revealed, Cardiopulmonary Resuscitation (CPR) shall be defined as the administering of any means or device to restore or support resuscitative functions in a resident, whether by mechanical devices, chest compressions, mouth-to-mouth resuscitation, cardiac massage, tracheal intubation, manual or mechanical ventilator or respirator, defibrillation, and/or the administration of drugs and/or chemical agents intended to restore cardiac and/or respiratory functions in a resident where cardiac or respiratory arrest has occurred or is believed to be imminent. The facility should direct staff to call 911 for resident emergencies except for residents who have a signed POST [Physician Orders for Scope of Treatment] form or other physician's order directing withholding of CPR, and residents who show American Heart Association [AHA] signs of clinical death as defined in the AHA Guidelines for CPR and Emergency Cardiovascular Care (ECC). The 2020 American Heart Association Adult Basic Life Support Algorithm for Healthcare Providers revealed, Check for responsiveness. Shout for nearby help. Activate emergency response system via mobile device (if appropriate). Get an AED and emergency equipment (or send someone to do so). Per the algorithm, if No breathing or only gasping, pulse not felt staff should Start CPR. Perform cycles of 30 compressions and 2 breaths. Use AED as soon as it is available. A Profile Face Sheet indicated the facility admitted Resident #78 on [DATE]. According to the Profile Face Sheet, Resident #78 was full code. Resident #78's Interdisciplinary Notes dated [DATE] revealed that the facility admitted the resident for rehabilitation services and 24-hour skilled nursing care following a hospitalization due to a fall at home. According to the Interdisciplinary Notes, the resident had a medical history that included diagnoses of atrial fibrillation, history of multiple cardioversions, dysphagia, chronic kidney disease, mild cognitive impairment with memory loss, hypertension, urinary tract infection (UTI), influenza, and type 2 diabetes mellitus. A 5-day Minimum Data Set (MDS) for a Medicare Part A stay with an Assessment Reference Date (ARD) of [DATE], revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. Resident #78's care plan dated [DATE] revealed Resuscitate: FULL CODE was in the top left corner on each page of the 12-page document. Resident #78's Physician's Orders for [DATE] revealed the resident had an order for a full code. Resident #78's Interdisciplinary Notes dated [DATE] at 5:15 AM revealed Registered Nurse (RN) #6 documented that she administered medication to the resident and checked the resident's vital signs at 8:20 PM (on [DATE]). Per the note, the resident was sitting in a wheelchair, watching television. The notes revealed a Certified Nursing Assistant (CNA) assisted the resident to the bathroom before going to bed at 10:00 PM and the CNA checked the resident again at 12:00 AM. The notes revealed at 2:00 AM on [DATE], the CNA found Resident #78 unresponsive and notified RN #6. The note revealed that RN #6 rushed to the room and assessed Resident #78. Per the note, the resident had no heart sounds, pulse, or respirations. The Interdisciplinary Notes revealed that staff initiated CPR, and fellow nursing staff assisted; however, the resident continued to have no pulses. According to the notes, despite staff' continued efforts, Resident #78 was pronounced deceased at 2:45 AM on [DATE]. There was no documented evidence that the facility contactedˆEMS/911 or used an AED during the resuscitation attempts. An electronic mail (e-mail) (continued on next page)

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication between the state agency and the fire department medical records department dated [DATE] at 2:40 PM revealed that in reference to Resident #78 on [DATE], the fire department responded, We do not have any reports under that name for that date. During an interview on [DATE] at 1:52 PM, CNA #4 reported that she was assigned to care for Resident #78 when the resident passed away. She stated when she saw the resident, the way the resident was lying was different and the resident's mouth was opened, and she called RN #6 to check the resident. Per CNA #4, RN #6 checked the resident's vital signs and could not detect a pulse. CNA #4 stated that RN #6 started CPR and asked RN #14 to call 911. CNA #4 stated RN #14 left to call 911, but she did not witness the RN making the call and could not remember whether EMS came to the facility because she resumed care of other residents. Telephone attempts to interview RN #6 on [DATE] at 3:03 PM and 6:01 PM were unsuccessful. Telephone attempts to interview RN #14 on [DATE] at 11:11 AM and 2:25 PM were unsuccessful. On [DATE] at 11:04 AM, Licensed Practical Nurse LPN 10 stated that if a resident who had no vital signs of life was a full code, the licensed nurse must initiate CPR, call 911, and get an AED. Per LPN #10, staff should continue CPR until EMS arrived. During an interview on [DATE] at 12:06 PM, the Director of Nursing (DON) stated that when a resident had an order for full code and was found not breathing, staff should initiate CPR, get the AED, call EMS, and continue CPR until EMS arrived. The DON stated that staff found Resident #78 unresponsive at 2:00 AM and RN #6 pronounced the resident deceased at 2:45 AM. The DON stated that at the time of the incident, the state was experiencing inclement weather. The DON stated staff verbally told her that they called EMS; however, she stated she had no evidence to verify that EMS was contacted. Per the DON, the facility contacted 911 dispatch, who told facility staff that they did not keep records from two years ago. A follow-up interview with the DON on [DATE] at 4:08 PM, revealed staff were educated on AED use as a part of CPR training and the facility had two AEDs. The DON stated she did not have a log for the AED for 2024 and did not know whether staff used an AED for Resident #78. Per the DON, the expectation was for staff to document the use of an AED and 911 notification. During an interview on [DATE] at 9:03 AM, the facility Health Care Consultant stated that per staff, on the morning of Resident #78's death, staff called EMS, but they did not show up due to bad weather. She stated the staff felt like the resident was clinically deceased prior to starting CPR. On [DATE] at 4:41 PM, Nurse Practitioner (NP)ˆ#7ˆindicatedˆthat when aˆresidentˆwas full code,ˆtheˆfacility practice was to initiate CPR and contact 911, use the AED, and continue CPR until EMS arrived.ˆ During an interview on [DATE] at 11:54 AM, Medical Director (MD) #22 stated that a nurse should initiate CPR and contact EMS. He stated that if EMS could not make it due to a weather situation, they may be able to provide guidance by telephone. MD #22 further stated that if it was clear the resident was deceased and not responding to CPR, EMS did not need to come, and an RN was permitted to pronounce death in accordance with state practice standards. During an interview on [DATE] at 4:28 PM, the Administrator stated she expected staff to follow the facility's policy regarding CPR and to properly document in the resident's medical record all care and services that were provided to the resident.

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F 0684 Level of Harm - Minimal harm or potential for 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 facility policy review, record review, facility document review, and interview, the facility failed to activate a resident's physician orders for blood glucose monitoring and sliding scale insulin that were listed in the medication administration software queue, which caused staff to not monitor blood glucose levels or provide insulin according to the order. The deficiencies affected 1 (Resident # 78) of 2 residents reviewed for diabetes management. The facility implemented corrective actions to correct the identified deficient practice from [DATE] to [DATE], to include a change in electronic health record software, staff training, and ongoing audits; thus, past noncompliance was cited. The findings include: An undated facility policy titled, Insulin Administration indicated its Purpose was, To provide guidelines for the safe administration of insulin to residents with diabetes. The policy revealed Preparation included, 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure it corresponds with the order on the medication sheet and the physician's order. The policy further indicated, Steps in the Procedure (Insulin Injections via Syringe) included, 2. Check blood glucose per physician order or facility protocol, 8. Check the order for the amount of insulin, and 12. Double check the order for the amount of insulin. The policy revealed, Documentation included, 1. The resident's blood glucose result, as ordered; and 2. The dose and concentration of the insulin injection. A Profile Face Sheet indicated the facility admitted Resident #78 on [DATE]. A 5-day Minimum Data Set (MDS) for a Medicare Part A stay, with an Assessment Reference Date (ARD) of [DATE], revealed Resident #78 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated Resident #78 had an active diagnosis of type 2 diabetes. Per the MDS, Resident #78 received insulin injections. Resident #78's care plan initiated included a category initiated of Diabetes. Interventions initiated [DATE] directed staff to check the resident's blood sugar levels via fingerstick per physician orders and to administer medications per physician orders. Resident #78's Interdisciplinary Notes dated [DATE] revealed that the facility admitted the resident for rehabilitation services and 24-hour skilled nursing care following a hospitalization due to a fall at home. According to the Interdisciplinary Notes, the resident had a medical history that included diagnoses of chronic kidney disease and type 2 diabetes mellitus. Resident #78's Physician's Orders, included an order, dated [DATE], to check the resident's blood sugar before meals and at bedtime, to be completed four times a day. The Physician Orders included an order, dated [DATE], for insulin aspart (a fast-acting insulin) 100 unit/milliliter (mL) (3 mL) insulin pen four times a day to be administered based on a sliding scale. The order had a stop date of [DATE]. The Physician Orders included an order, dated [DATE], for insulin aspart 100 unit/mL (3 mL) insulin pen four times a day to be administered based on a sliding scale. Resident #78's Interdisciplinary Notes included a note, dated [DATE] at 2:43 PM, that revealed that the resident's family member expressed concern that Resident #78's blood sugar levels had not been checked for the past couple of days, and they were concerned the resident was not on a short acting insulin. Resident #78's Medication Record for 01/2024 revealed that staff did not document the resident's blood sugar level or administration of insulin aspart on the following dates and times: - [DATE]- 5:00 PM, 8:00 PM - [DATE]- 7:00 AM, 11:00 AM, 5:00 PM, 8:00 PM - [DATE]- 7:00 AM, 11:00 AM, 5:00 PM, 8:00 PM A facility Medication Error Report, completed on [DATE], indicated that Nurse Practitioner (NP) #7 updated the resident's sliding scale insulin order on [DATE]; however, the update was not signed and remained in the unsigned order queue. The report indicated that as a result, the insulin aspart order was not active on the medication administration record (MAR), preventing nursing staff from seeing the updated order, and Resident #78 missed doses of insulin aspart, which occurred twice on [DATE], four times on [DATE], and four times on [DATE]. A typed statement from Physician #22, dated [DATE], indicated that Resident #78 had an extensive past medical history, including uncontrolled type 2 diabetes mellitus, chronic kidney disease (CKD) (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stage III, and hyperlipidemia. The statement indicated that Resident #78 received insulin based on a sliding scale on Friday, [DATE] but did not receive any insulin based on the sliding scale on [DATE] or [DATE]. The statement indicated that Resident #78's blood glucose reached a maximum level of 343 mg/dL on [DATE]. The statement indicated that on [DATE], Resident #78's glucose levels had improved, and the sliding scale insulin order was replaced and resumed on [DATE]. During an interview on [DATE] at 4:41 PM, NP #7 stated that she was unable to recall the events related to the resident's insulin due to the lapse of time. NP #7 stated that the Director of Nursing (DON) showed her a copy of the order indicating that she had discontinued it, and she acknowledged that it was an error. NP #7 stated that her intention was to edit the sliding scale order, not discontinue it; however, the electronic medical record software required a provider to unsign an order to bring it back for editing. NP #7 stated that in doing so, she failed to reactivate the insulin aspart order. During an interview on [DATE] at 11:19 AM, the DON stated that the nursing staff failed to identify that the insulin aspart order was missing and remained in the queue waiting to be reactivated after NP #7 erroneously unsigned the order for Resident #78. During an interview on [DATE] at 4:28 PM, the Administrator stated that her expectation was for staff to follow company policy. She further stated that for missing insulin doses where a plan of correction had been implemented, the expectation was for the DON or a designee to verify that all active orders were active and visible for the nurses. PAST NON-COMPLIANCE VERIFICATION A facility document titled, Deficient Practice of Medication Orders, dated [DATE], indicated that the electronic medical record software used by the facility had a feature in which all physician and nurse practitioner orders entered in the system were delayed from appearing on the nursing MAR until a nurse reviewed and signed the provider's order. The document indicated that the process could result in a delay in the orders becoming visible to nursing staff. Per the document, the issue had not occurred before the incident involving Resident #78. The facility implemented the following corrective actions: 1) What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. [Resident #78] Expired [DATE] 0230 AM. Request [Physician #22] to review chart for possible cause of death d/t [due to] sliding scale insulin orders not being done over the weekend. [Resident #78's] scheduled Insulin was given as ordered. [The electronic medical record software used by the facility] has a feature that all MD/NP [medical doctor/nurse practitioner] orders entered into system are delayed until nurse reviews and signs the MD orders causing a delay in seeing orders on the nursing MAR. This review was completed on [DATE]. MD Review Attached. A delay occurred in nursing staff confirming orders starting on the evening of [DATE], [DATE] and [DATE]. Nurses working on Rehab [Rehabilitation] to home failed to sign unsigned orders. On [DATE] the DON called [the software company the facility used for their electronic medical records] to change this delay of orders appearing on the MAR but was unable to fix the system. Administrator discussed with Executive staff for approval of replacement of eHR [electronic health record] system. Approval of changing to a new system was approved by the Executive staff. Beginning on [DATE] a process was developed for unsigned orders to be checked daily M-F [Monday through Friday] each week to ensure that unsigned orders are signed that would allow orders to appear on the MAR. If orders are written on weekend the DON or designee on call would be called to sign any new orders. Implemented a Huddle at the beginning of each shift to ensure RNs [registered nurses], LPNs [licensed practical nurses], and CNAs [certified nursing assistants] are aware of any change in the care needs of their assigned resident. Copy of Huddle Sheet Attached. DON instructed staffing coordinator to coordinate with the Pharmacy Consulting to conduct Insulin in-service. Staffing Coordinator and Pharmacy Consultant will conduct an In-service on Insulin administration within a week. Staffing Coordinator began in-service on [DATE] and completed this in-service on [DATE]. Pharmacy Consultant conducted an additional in-?person in-service on [DATE]. Any staff who fail to comply with the points of the in?services will be further educated and/or progressively discipline will begin as indicated. On [DATE] the Health Care Consultant and DON reviewed [Resident #78's] medical record for identifying any standard of (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care Issues. 2) How the facility will identify other residents having the potential to be affected by the same deficient practice. Effective [DATE] the DON and designee reviewed all Resident's Physician orders and MARs for unsigned orders. Any orders not signed were signed Immediately and If necessary called MD/NP for follow-up. 3) What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur. The Administrator will recommend some Software program that other facilities use to the Executive Committee within 2 weeks that could eliminate the issues with unsigned order not printing on MAR timely. Monitoring sheets developed for the DON and/or designed to initial when orders have been checked and signed each day. Monitoring Sheet Attached. 4) How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. [id est; that is], what quality assurance program will be put into place. At the QAPI [Quality Assurance and Performance Improvement] meetings the results of the monitoring by the DON and the designee will be reviewed, however any concerns identified will be addressed as discovered, including any needed education and/or progressive discipline. Beginning [DATE] DON will report monitoring outcomes of in-services on unsigned orders and change of software system at the quarterly QAPI Committee meetings. The survey team verified the above corrective actions had been implemented by the facility; thus, past noncompliance was cited.