

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Maplewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  100 Cherrywood Place Jackson, TN 38305	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38441</b></p> <p>Based on policy review, facility daily staffing review, medical record review, hospital record review, and interview, the facility failed to ensure residents were free of neglect as evidenced by the facility's failure to provide sufficient licensed nursing staff to perform assessments and administer morning medications as ordered for 6 of 6 (Resident #1,#2, #3, #4, #5, and #6) sampled residents reviewed. The facility's failure resulted in Immediate Jeopardy (IJ) when Resident #1 experienced a change of condition, and a nurse was not available on the 100 Hall to assess Resident #1. Resident #1's spouse called 911. Resident #1 was evaluated in the Emergency Department (ED) and admitted to the hospital. Resident #2 did not receive the morning blood glucose check, scheduled Insulin or Metformin, as ordered by the physician on 2/23/2025, and at 7:46 PM, Resident #2's blood glucose level reached 402 milligrams per deciliter (mg/dl).</p> <p>Immediate Jeopardy (IJ) is a situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.</p> <p>A partial-extended survey was conducted 2/28/2025 through 3/3/2025.</p> <p>The Administrator and the Director of Nursing (DON) were notified of the Immediate Jeopardy (IJ) for F-600 on 2/24/2025 at 6:30 PM, in the Administrator's office.</p> <p>The facility was cited Immediate Jeopardy at F-600 at a scope and severity of J which is substandard quality of care.</p> <p>An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F600 was received on 2/28/2025, and the Removal Plan was validated onsite by the surveyor on 3/3/2025 through policy review, medical record review, observation, review of education records, and staff interviews.</p> <p>The IJ began on 2/23/2025 through 2/26/2025 for F-600, the IJ was removed on 2/27/2025.</p> <p>The facility's noncompliance at F-600 continues at a scope and severity of D for monitoring of the effectiveness of the corrective actions.</p> <p>The facility is required to submit a Plan of Correction.</p> <p>(continued on next page)</p>		

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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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The findings include:</p> <p>1. Review of the facility's undated policy titled, Abuse, Neglect, and Exploitation, revealed .It is the policy of this facility to provide protections for the health, welfare, and rights of each resident by developing and implementing policies and procedures to prohibit and prevent .neglect .Neglect means failure of the facility, its employees, or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress .</p> <p>Review of the facility's undated policy titled, Medication Administration, revealed .Medications are administered by licensed nurses .as ordered by the physician .</p> <p>Review of the facility's undated policy titled, Blood Glucose Monitoring, revealed .The facility will perform blood glucose monitoring as per physician's orders .</p> <p>2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], with diagnoses of Type 1 Diabetes, Heart Failure, and Acquired absence of left leg. Resident #1 was admitted to the facility from an acute care hospital after a left leg amputation.</p> <p>Review of the physician's orders dated 2/22/2025, included Apixaban (anticoagulation medication used to thin the blood to prevent blood clots and stroke) 2 milligrams (mg) by mouth 2 times a day.</p> <p>Review of the Order Summary Report for February 2025, revealed .2/22/2025 .Apixaban .5mg by mouth two times a day for blood .</p> <p>Review of the Medication Administration Record (MAR) dated 2/23/2025, revealed Resident #1 did not receive the 8:00 AM Apixaban medication as scheduled.</p> <p>Review of the progress notes dated 2/23/2025, revealed there was no documentation Resident #1 was transferred to the hospital by Emergency Medical Services (EMS).</p> <p>Review of the hospital medical record dated 2/23/2025, revealed .2/23/2025 at 14:23 [2:23 PM] .[Resident #1] presented to the Emergency Department [ED]. Patient was brought here from [Named Nursing Home] . he was not getting his medications .there was no nurse available to give them to him .review of systems . positive for fatigue .weakness .Blood Pressure 115/49 Review of the hospital lab results dated 2/23/2025 revealed blood glucose [blood sugar] level 276 mg/dl .2/23/2025 at 1841 [6:41 PM] CM [Case Management] Director received a message asking if an APS [Adult Protective Services] or Ombudsman referral needed to be made on the patient due to neglect at [Named Nursing Home] due to patient not receiving his morning meds [medications] and they didn't have a nurse .CM Director called [Named Nursing Home] Administrator to find out what was going on .[Named Administrator] stated they had a nurse call in .Final [ED] Diagnosis: Generalized Weakness, Coronary Artery Disease, Chronic Kidney Disease, and Type 2 Diabetes .</p> <p>During an interview on 2/24/2025 at 11:05 AM, the Administrator confirmed Resident #1 was transferred to the hospital on 2/23/2025 at approximately 1:30 PM, Resident #1 did not receive his morning medications and there was not a nurse on the 100 Hall to assess Resident #1 for a change in condition prior to being transferred to the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>3. Review of the medical record revealed Resident #2 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes, Dementia, and Polyneuropathy.</p> <p>Review of the physician's orders dated 2/21/2025, revealed Glargine (long-acting insulin used to lower blood glucose level in diabetic patients) 25 units subcutaneously (beneath the skin) 2 times a day and Metformin 500 mg 2 times a day.</p> <p>Review of the MAR dated 2/23/2025, revealed .Glargine 25 units subcutaneously two times a day for Diabetes .0800 [8:00 AM] .Metformin .500mg .by mouth two times a day [at] 0800 [8:00 AM] and 1600 [4:00 PM] .</p> <p>Review of the Medication Audit Report dated 2/23/2025, revealed Metformin 500 mg was scheduled to be administered at 8:00 AM. The Metformin was administered at 2:44 PM. Novolin R (Regular-short acting) sliding scale Insulin was scheduled to be administered at 11:00 AM. The Novolin R insulin was administered at 2:47 PM.</p> <p>There was no documentation Resident #2 received a blood glucose check, and the scheduled Glargine insulin or Metformin on 2/23/205 at 8:00 AM as ordered by the physician.</p> <p>Review of the Blood Sugar Summary for Resident #2 revealed the following:</p> <p>On 2/23/2025 at 8:00 AM, there was no blood sugar documented.</p> <p>On 2/23/2025 at 11:00 AM, there was no blood sugar documented.</p> <p>On 2/23/2025 at 2:47 PM, Resident #2's blood sugar was 313 mg/dl and 8 units of Novolin R insulin was administered.</p> <p>On 2/23/2025 at 5:32 PM, Resident #2's blood sugar was 332mg/dl and 8 units of Novolin R insulin was administered.</p> <p>On 2/23/2025 at 7:46 PM, Resident #2 blood sugar was 402 mg/dl.</p> <p>During interview on 2/24/2025 at 3:32 PM, the DON confirmed Resident #2 did not receive morning blood glucose checks, insulin or Metformin as scheduled on 2/23/2025. The DON confirmed Resident #2 experienced elevated blood glucose levels in the afternoon, and it continued to rise to 402 mg/dl. The DON confirmed elevated blood glucose levels could lead to serious complications for diabetic residents.</p> <p>4. Review of the medical record revealed Resident #3 was admitted to the facility on [DATE], with diagnoses of Abscess of buttock, Methicillin Resistant Staphylococcus Aureus Infection, Type 2 Diabetes, and Seizure disorder.</p> <p>Review of the admission physician orders for Resident #3 revealed the following dated orders:</p> <p>1/28/2025 Keppra (seizure medication) 500mg 1 tablet two times a day for seizures.</p> <p>1/29/2025 Insulin Lispro (fast acting insulin to treat diabetes) sliding scale for blood glucose:</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>201-250 = administer 2 units sc.</p> <p>251-300= administer 4 units sc.</p> <p>301- 350= administer 8 units sc.</p> <p>401-500= administer 10 units sc.</p> <p>2/22/2025 Clindamycin (antibiotic) 300 mg three times a day by mouth for infection control.</p> <p>2/22/2025 Mupirocin external ointment 2% (treatment/prevention of skin infections) apply two times a day for infection control.</p> <p>Review of the Medication Administration Audit Report dated 2/23/2025 revealed Resident #3 did not receive the following medications as scheduled:</p> <p>Kepra 500 mg scheduled for 8:00 AM was not administered until 3:33 PM.</p> <p>Clindamycin scheduled for 8:00 AM, 12:00 PM, and 8:00 PM, was not administered until 4:05 PM.</p> <p>Mupirocin ointment scheduled for 8:00 AM was not administered until 2:01 PM.</p> <p>Insulin Lispro sliding scale scheduled for 11:00 AM was not administered until 2:00 PM.</p> <p>5. Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses of Type 2 Diabetes, Chronic Kidney Disease, Chronic Heart Failure, and Atrial Fibrillation (irregular heart rhythm).</p> <p>Review of the physician orders for Resident #4 revealed the following dated orders:</p> <p>1/30/2025 Amiodarone HCL (medication used to treat life-threatening heart rhythm problem) 200mg by mouth one time a day.</p> <p>1/30/2025 Insulin Lispro sliding scale insulin sc before meals and at bedtime.</p> <p>1/29/2025 Midodrine 10 mg by mouth three times a day for blood pressure.</p> <p>Review of the Medication Administration Audit Report dated 2/23/2025 revealed Resident #4 did not receive the following medications as scheduled:</p> <p>Amiodarone 200 mg scheduled for 8:00 AM, was not administered until 2:55 PM.</p> <p>Insulin Lispro sliding scheduled for 11:30 AM was not administered.</p> <p>Midodrine 10 mg scheduled for 8:00 AM and 12:00 PM, the documentation revealed both scheduled doses were administered at 3:58 PM.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/24/2025 at 9:23 AM, EMS Paramedic E stated, . I received the 911 call around 1:30 PM to go out to [Named facility]. [Named Resident #1]'s wife stated he had not received any meds today because there was not a nurse working on the 100 Hall. EMS Paramedic E stated, .[Resident #1]'s spouse was concerned because the resident was sweating and seemed sick .[Resident #1]'s spouse couldn't find a nurse on the hall to assess [Resident #1]. The resident's spouse called 911. When we got there [at the facility] there wasn't a nurse [on the 100 hall] to get report from . EMS Paramedic E stated Resident #1 was transported by EMS to the Emergency Department and admitted to the hospital.</p> <p>During an interview on 2/24/2025 at 9:55 AM, LPN B stated she was on-call for the facility on 2/23/2025. LPN B was asked to explain what being on-call meant. LPN B stated, The on-call nurse is responsible for coming to work if a scheduled nurse can't work. LPN B was asked what time she was contacted by the facility to report to work to replace the 100 hall nurse (LPN A). LPN B stated, .I got a phone call around 12:30 [PM] from the Staffing Coordinator. I was grocery shopping at the time, so I went home, changed clothes and came to work. LPN B was asked what time she arrived to work on the 100 hall. LPN B stated, .I got here [at the facility] around 1:45 PM .[Named LPN C] and [Named LPN F] were just beginning to check vital signs and start passing meds on the 100 hall .</p> <p>LPN B arrived 6.75 hours after the day shift began, to replace LPN A, and was assigned to the 100 hall.</p> <p>During an interview on 2/24/2025 at 10:08 AM, LPN C stated, I came in [to work] at 7:00 AM, I was told by [Named LPN D] there wasn't a nurse on the 100 hall, the nurse [LPN A] scheduled to work didn't show up, but that [Named LPN B] would be coming in soon. So I took the med [medication] cart keys (to the 100 hall med cart) and went back to my hall [300 hall]. I had a resident [on the 300 hall] that was transitioning [dying] so I was busy with that resident. Around 11:30 AM, I sent a text message to the DON [Director of Nursing] and told her the nurse scheduled to work on the 100 hall didn't show up today and the DON told me we needed to tag team the 100 hall to give medications to the residents. LPN C was asked what time he went to the 100 hall to administer medications. LPN C stated, It was around 1:30 PM. [Named LPN F] helped me, we started checking vital signs and giving medicines to the residents on the 100 hall .</p> <p>LPN C and LPN F began administering medications and checking vital signs on the 100 hall at 1:30 PM (6.5 hours after the 7:00 AM- 7:00 PM shift began).</p> <p>During an interview on 2/24/2025 at 10:30 AM, LPN D stated she worked the night shift (7:00 PM-7:00 AM) on 2/22/2025 on the 200 Hall. LPN D stated, .The nurse [LPN A] scheduled to work [2/23/2025 on the 7:00 AM- 7:00 PM shift] the 100 hall, didn't show up for work. I tried to call [named Staffing Coordinator]. I text the DON around 7:20 AM and told her the day [100 hall] nurse did not show up. I never spoke with [LPN B], the nurse on-call .</p> <p>During an interview on 2/24/2025 at 10:47 AM, the DON was asked if she was told the 100 hall nurse did not show up to work on 2/23/2025 for the 7:00 AM shift. The DON confirmed (LPN D) contacted her on 2/23/2025 around 7:20 AM and reported the 100 hall nurse [LPN A] had not reported to work. The DON was asked what was done to replace the 100 hall nurse. The DON stated, .I told [named LPN D] to reach out to the [named Staffing Coordinator]. The DON confirmed she did not follow up with the staffing coordinator or the on-call nurse (LPN B) to ensure the 100 hall had nursing coverage.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>During an interview on 2/24/2025 at 10: 49 AM, the Staffing Coordinator stated [named Registered Nurse F] called me at 12:34 PM, and said the day nurse [100 hall] didn't show up, I reached out to [named LPN B] to come in. [LPN B] said she was at the grocery store and would come in. The Staffing Coordinator was asked if anyone tried to reach her at shift change. The staffing coordinator stated, No, the first time I was called was at 12:34 PM, and I called [LPN B] right away .</p> <p>During an interview on 2/25/2025 at 4:18 PM, Resident #1's spouse stated, 'On Sunday [2/23/2025] around 11:30 [AM] I went to see him [Resident #1], he was really sweaty and didn't look good. I thought he might have a fever or a low blood sugar. I asked the girl [unknown name] at the nurse's station if the nurse could check on him. The girl sitting at the desk said, 'He don't [doesn't] have a nurse.' I said, 'What do you mean he doesn't have a nurse.' I just called the ambulance .[Resident #1] is still in the hospital today [2/25/2025] .</p> <p>An acceptable Removal Plan, which removed the immediacy of the Jeopardy for F600 was received on 2/28/2025, and the Removal Plan was validated onsite by the surveyor on 3/3/2025 through policy review, medical record review, observation, review of education records, and staff interviews.</p> <p>The 300 hall Charge Nurse verified the 100 hall medication count and keys at 7:28 AM on 2/23/2025 from the 7:00 PM - 7:00 AM 100 hall charge nurse after being informed that assigned nurse would be arriving soon. This 300 Hall Charge Nurse then returned to 300 hall to continue medication administration on hall 300.</p> <p>From approximately 8:15 AM to 10:15 AM on 2/23/2025, the treatment nurse was noted providing treatments on the 100 hall for various residents, to include Resident #2.</p> <p>Following completion of care for other unforeseen acute resident conditions and 300 hall medication administration, the 300 hall Charge Nurse alerted the Director of Nursing that the scheduled nurse that was believed to be arriving late for the 100 hall, had not arrived. The Registered Nurse charge nurse from hall 200 attempted to notify the staffing coordinator/scheduler at approximately 12:12 PM on 2/23/2025.</p> <p>The 300 Hall Charge Nurse began medication administration for the 100 hall until the Nurse Manager on call arrived at 1:49 PM on 2/23/2025.</p> <p>On 2/23/2025 at approximately 12:40 PM, the Nursing Home Administrator was made aware that the scheduled 100 hall 7:00 AM -7:00 PM shift charge nurse had not arrived to scheduled shift. The Director of Nursing notified the Regional Director of Clinical Services at approximately 1:40 PM.</p> <p>At approximately 2:00 PM and 3:40 PM on 2/23/2025, a governing body meeting was held with attendance including the Director of Nursing, Administrator, Regional Director of Clinical Services (RDCS), Chief Operating Officer, and [NAME] President (VP) of Clinical Services to discuss findings, root cause, plan of correction, education, and development and implementation of a Performance and Improvement Plan. The Root Cause was determined to be the Charge Nurse failure to report to duty, gap in employee communication, and unforeseen patient acuity that coincided with the 300 Hall nurse's medication pass leading to the delay.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Education was provided on 2/23/2025 to the RDCS, Administrator, and Director of Nursing by the VP of Clinical Services and the Chief Operating Officer regarding On-Call Procedures, which included but were not limited to the specific details of rotating the Administrator, Director of Nursing, or Assistant Director of Nursing as designated, verifying the facility following each 7:00 AM to 7:00 PM shift change to ensure adequate and appropriate staff to administer resident medications and to monitor/assess residents needs and conditions, Communication, Procedure for delayed/missed medication, Assessments and Notifications, Reinstructed regarding Abuse Prohibition and Neglect, Staffing Procedures and adjustments which included but were not limited to specific details of shift relief has not arrived by their scheduled shift time, the off going nurse will promptly contact the Nurse Manager on call. The Nurse Manager on call will coordinate charge nurse coverage with the staffing scheduler. The off going nurse will remain at the facility to complete medication administration and to ensure resident care is continued until the Nurse Manager on call or oncoming nurse has arrived to relieve the off going charge nurse, and procedure of notifying the physician following assessing all potentially affected residents for further direction of action related to delayed or missed medication administration, and ongoing monitoring plan to prevent recurrence.</p> <p>On 2/23/2025 at 2:47 PM, Resident #2's blood glucose level was assessed at 313 mg/dl by the 300 Hall Charge Nurse with 8 units of Novolin R per sliding scale administered per physician order; at 5:32 PM, Resident #2's blood glucose level was assessed by the on call Nurse Manager at 332 mg/dl with 8 units of Novolin R administered per sliding scale</p> <p>Resident #2 noted with physician order stating metFORMIN HCL [hydrochloride] ER [extended release] Oral Tablet Extended Release 24 Hour 500 MG (Metformin HCL) Give 500 mg by mouth two times a day for DM. On 2/23/2025, the 300 hall Charge Nurse administered the Metformin 500 mg dose to Resident #2 at 2:44 PM. Metformin 500 mg was also administered to Resident #2 by on call Nurse Manager for next scheduled dose following Physician notification of delayed and missed morning medication administrations at 5:28 PM. The Charge Nurse administered 25 units of Insulin Glargine as ordered at 7:46 PM on 2/23/2025 with a blood glucose of 402 mg/dl.</p> <p>All 100 hall residents, to include Resident #2, were evaluated for delayed medications by the Director of Nursing and Licensed Practical Nurse. All applicable Residents blood glucose levels, to include Resident #2, were assessed per accucheck on 2/23/2025 upon arrival of Director of Nursing to facility between 2:00 PM and 3:00 PM with physician notification completed.</p> <p>The Medical Director was notified by the DON on 2/23/2025, for notification of all delayed medications and missed accuchecks and insulin administration with current blood glucose levels obtained. The Physician was notified of all medications showing missed administration with verbal agreement provided to administer all medications at this time; notified of all missed accuchecks and insulin administrations with current blood glucose levels with no further orders. The Medical Director was included in adhoc [for this situation] Quality Assurance and Performance Improvement (QAPI) meeting on 2/23/25 with attendance including Administrator, Director of Nursing, and Regional Director of Clinical Services for discussion of notification of resident assessment findings, to include Resident #2, reviewed and approved Performance Plan developed.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445412	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/03/2025
NAME OF PROVIDER OR SUPPLIER  Maplewood Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE  100 Cherrywood Place Jackson, TN 38305	
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)		
<p>F 0600</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>2/23/2025 All on duty Licensed Nurses were educated by the Director of Nursing and Regional Director of Clinical Services regarding On-call procedures, communication, timely medication administration, re-instructed regarding abuse prohibition and neglect, and staffing procedures which details included but not limited to the facility procedure/protocol of notifying the Nurse Manager on call if a clinical staff member does not report to their scheduled shift in order for coverage to be coordinated. All off duty, to include PRN (as needed) or Agency, licensed nurses will receive this education prior to the beginning of their next shift.</p> <p>The Director of Nursing and Regional Director of Clinical Services completed a Medication Administration audit for all residents on 2/23/2025.</p> <p>On 2/24/2025 at 7:15 pm, a Governing Body meeting was held with the Administrator, Director of Nursing, Regional Director of Clinical Services, and VP of Clinical Services to discuss the notification of immediate jeopardy. Reviewed all findings from 2/23/2025 and developed Performance Improvement with agreement to continue with action and plan developed.</p> <p>Adhoc QAPI meeting held on 2/26/2025 with the Medical Director to share Removal and in agreement with Plan of Correction and Monitoring in place effective 2/23/2025.</p> <p>The Director of Nursing and/or Assistant Director of Nursing will audit medication administration competition. Monitoring will occur twice daily x (times) 7 days, then twice daily during business days x 3 weeks, then weekly thereafter during morning clinical meeting. If substantial compliance is not met, re-education will be initiated, and audits will be reinitiated.</p> <p>The Director of Nursing will report the findings to the monthly QAPI Committee meeting.</p> <p>Removal plan was discussed and approved by Medical Director 2/25/25, 2/26/25, and 2/28/25.</p> <p>The Administrator will ensure the removal plan is completed.</p>		