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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vanayer Senior Living and Rehabilitation	460 Hannings Lane Martin, TN 38237

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on facility policy review, medical record review, facility investigation, Quality Assurance and Performance Improvement (QAPI) Committee documentation review, and interview, the facility failed to provide adequate assistance and supervision to prevent falls for 1 of 12 (Resident #1) sampled residents reviewed for accident hazards. Resident #1, who was dependent on staff for bed mobility, fell from her bed on 1/14/2025 when Certified Nursing Assistant (CNA) A rolled the resident on her side then CNA A turned her back on the resident during incontinence care. Resident #1 sustained a right distal femoral shaft fracture (break in the lower part of the thighbone, just above the knee joint), left distal femoral shaft fracture, and left proximal tibia fracture (break in the upper part of the shinbone near the knee joint) from the fall, which resulted in actual HARM to the resident. The facility was cited past noncompliance for F689, and is not required to submit a plan of correction. The findings include: 1. Review of the facility's policy titled, Fall Management System, with a revision/review date of 12/2023, revealed .It is the policy of this facility to provide an environment that remains as free of accident hazards as possible .to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs .Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of overwhelming external force .Review of the fall incident will include investigation to determine probable causal factors . 2. Review of the medical record revealed Resident #1 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses which included Fracture of Left Proximal Tibia, Fracture of Left Distal Femoral Shaft, Fracture of Right Distal Femoral Shaft, Hemiplegia and Hemiparesis following Cerebral Infarction affecting the Left Non-Dominant Side, Leukemia, Contracture of the Right and Left Hand (permanent tightening of the muscles, tendons, skin and nearby tissues that causes the joint to shorten and become very stiff), Parkinson's Disease, Vascular Dementia, and Osteoporosis. Review of the Fall Risk Evaluation dated 11/9/2024, revealed Resident #1 scored an 11 which indicated she was at high risk for falls. (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 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #1 scored an 8 on the Brief Interview for Mental Status (BIMS) assessment, which indicated moderate cognitive impairment. Resident #8 experienced limited range of motion in bilateral upper and lower extremities and was totally dependent on staff for mobility. Review of Resident #1's Care Plan dated 11/20/2024 with a revision date of 12/14/2024, revealed .ADL [activities of daily living] self-care performance deficit r/t [related to] .ambulation, bathing, bed mobility, dressing, eating, hygiene, locomotion, transfers .BED MOBILITY: Assist with bed mobility as needed . pressure reducing mattress, position for comfort .Turn/reposition every 2 hours/prn [as needed] . TRANSFERS .[Named brand] lift x [times] 2 staff for transfer bed to chair .The resident is at risk for falls r/t Unaware of safety needs, functional/cognitive deficits .The resident will be free of falls .Anticipate and meet the resident's needs . Review of the Nursing Progress Note for Resident #1 dated 1/8/2025 at 1:14 PM, revealed Temp [temperature] 99.3 observed with cough and runny nose. Received new order .for CXR [Chest xray], COVID test and Flu [influenza] test. Review of the Nursing Progress note for Resident #1 dated 1/9/2025 at 9:52 AM, revealed .flu test came back with positive results for flu A. MD [Medical Doctor/Director] made aware with new order . Review of the [Named Hospital] Laboratory Report for Resident #1 dated 1/9/2025, revealed Resident #1 tested positive for Influenza A and a new order for Tamiflu (medication to treat influenza) 75 milligrams (mg) twice daily for 5 days was received from the physician. Review of the [Named Company] Radiology Report for Resident #1 dated 1/9/2025, revealed a chest xray was obtained and no active cardiopulmonary disease was seen. Review of the Physician's Order for Resident #1 dated 1/9/2025, revealed .cefTRIAXone Sodium Injection [an antibiotic given for bacterial infections] .1 GM [gram] Inject 1 gram intramuscularly one time a day for congestion for 3 days. Review of the Nursing Progress Note for Resident #1 dated 1/13/2025 at 3:59 AM, revealed .Resident continues to receive Tamiflu .d/t [due to] positive for flu .Occasional cough still noted and generalized malaise [feeling of weakness, overall discomfort, illness, or simply not feeling well]. Review of the Nursing Progress Notes for Resident #1 revealed no documentation of the fall Resident #1 sustained on 1/14/2025 at approximately 9:15 to 9:30 AM. Review of the Nursing Progress Note for Resident #1 dated 1/14/2025 at 1:27 PM, revealed O2 [oxygen] applied to resident due to decreased SpO2 [oxygen saturation-measurement of how much oxygen the blood is carrying] .MD made aware of current condition and Xray results with new orders for bilateral knee immobilizers and Albuterol [medication to treat wheezing, difficulty breathing, and chest tightness] 2 puffs per inhaler [small handheld device that delivers medication in a spray or powder form directly to the lungs through inhalation] QID [four times a day] . Review of the Nursing Progress Note for Resident #1 dated 1/15/2025 at 4:09 PM, revealed Called and updated daughter .on patient's condition. Respiratory status is declining . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the Nursing Progress Note for Resident #1 dated 1/18/2025 at 11:54 AM, revealed .Resident with no B/P [blood pressure], heart tones or spontaneous respirations. Time of death 11:50a.m. [11:50 AM] . 3. Review of the facility investigation Incident Report dated 1/14/2025, revealed Resident [#1] .Incident Location: Resident's Room .Nursing Description: While receiving incontinent care CNA [A] rolled resident on her side and turned to grab a pad and resident slid off the bed .MD in facility and examined resident with new orders received. 2 person assist with turning and repositioning [new intervention implemented after Resident #1's fall] .Predisposing Physiological Factors .Recent illness . The report was completed by Licensed Practical Nurse (LPN) B. Review of the facility investigation FALL QUESTIONNAIRE dated 1/14/2024, revealed .[Named Resident #1] .calm, let me [CNA A] get her cleaned up .Incontinent .As I [CNA A] was changing [Resident #1] I turned to grab a pad to put under her and she slid off of the side of the bed . The document was documented by LPN B and signed by CNA A. Review of the radiology report for Resident #1 dated 1/14/2025 at 11:44 AM, and reported at 12:09 PM, revealed .KNEE .LEFT .Fracture of the distal femoral shaft with malalignment .Proximal tibia fracture with mild displacement . KNEE .RIGHT .Fracture of the distal femoral shaft with malalignment . Review of the typed investigation signed by the Administrator and dated 1/15/2025, revealed On Tuesday, January 14 [2025], at approximately 9:30 am, it was reported to this staff member that [Named Resident #1] . was being changed by [Named CNA A]. [Named CNA A] had turned [Named Resident #1] towards the window, away from her [CNA A], in order to tuck a clean pad underneath [Named Resident #1]. [Named Resident #1] has transfer rails [grab bars] on her bed and usually holds to the bar when she is turned. Prior to this time, [Named Resident #1] had been sick and was weaker than baseline. According to [Named CNA A], she turned to grab a pad to put under [Named Resident #1] and [Named Resident #1] started to slide off the side of the bed. [Named CNA A] stated she tried to get to [Named Resident #1] in time to stop the fall but was not quick enough. [Named Resident #1] fell on her bottom, hitting her knee on the floor .An Xray of both knees was obtained on 1/14/2025 at 12:08 [PM] .left leg: Acute appearing femoral and tibial fracture. Right leg: Acute appearing femoral fracture . Review of the handwritten statement for Resident #1 documented by CNA A on 1/17/2025 for the incident that happened on 1/14/2025, revealed I [CNA A] went into the room [Resident #1's room] around 9am [9:00 AM]. I gathered all of my things to assist [Named Resident #1]. As I finished cleaning her [Resident #1] up in the front I rolled her away from me, towards the window. I turned to grab a pad and sheet to put under her. As I was turned I heard her start to slide off of the side [of the bed]. I tried to get to her in time to keep her on the bed but I wasn't quick enough. She fell on her bottom hitting her knee on the ground. I ran out the door to grab a nurse to assist me. We were able to get her on her back with the help of two others and [Named Brand lift] her back into the bed, where I finished up with help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	4. During a telephone interview on 2/4/2025 at 10:36 AM, Family Member (FM) C denied Resident #1 received hospice services. FM C stated, .I had signed for her a DNR .no she was not in hospice because as I understood if she were in hospice care she would not be able to be taken to the hospital .[Resident #1] was a fighter and had made it to 94 [years old] .apparently the CNA was trying to change her and she [CNA] dropped her out of the bed and it fractured both of her femurs . FM C was asked was there only one CNA in the room. FM C stated, Yes .quite often there was two because she was immobile from the waist down and had lost a lot of her upper arm strength. FM C stated, .somewhere in there I made the decision for them not to move her to the hospital because [Named Medical Director] had said he didn't believe she would make it through surgery .the only objection, with a patient who is 94, immobile from the waist down, [had] just gone through the flu, [was given] antibiotics for chest congestion, that instead of two CNAs to change her they had one and that's how the accident happened .I'm just so unhappy about the accident because it was avoidable . her hands had contractures . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/5/2025 at 9:27 AM, CNA A read and verified her handwritten statement dated 1/17/2025. CNA A was asked if she was familiar with [Resident #1's] care. CNA A stated, A little bit .I hadn't been working with her for maybe a month or so prior to that because my hours went down because I had gone back to school .I usually work when someone calls off or they're short staffed . CNA A confirmed she worked in the facility as the shower aide, also. CNA A was asked was she scheduled as the shower aide that day [1/14/2025]. CNA A stated, I think in the schedule I was, but someone had called off, so they put me on the floor. CNA A was asked did she look at Resident #1's Kardex (system that summarizes care a resident requires for the CNA staff) or Care Plan before she went in Resident #1's room. CNA A stated, No, I didn't get a chance to. CNA confirmed she did not receive a shift report from the off-going CNA prior to beginning her shift. CNA A stated, I was [here] as a shower aide and they didn't know someone had called out, so I didn't get report before starting. CNA A acknowledged that she was not aware Resident #1 had been sick with the flu and chest congestion over the past few days prior to the fall and that information would have been important for her to know. CNA A was asked what interventions to prevent falls were in place before the accident occurred. CNA A stated, I do not know, it was never brought up to me. CNA A was asked if Resident #1 was one or two-person assist for ADLs. CNA stated, A lot of times people did her one person but I think she should have been two person [that day] .I had her before and she used to be able to hold herself up, but I didn't know she was sick and wasn't as strong as she usually was. CNA A stated, I went in there roughly 9 or 9:15ish, I had grabbed my pad, brief, rags, and gloves as I went in there, cleaned up the front side [while she was lying on her back] .rolled her toward [the] window .[CNA A confirmed she was behind Resident #1 when she rolled her over] .With her right hand [Resident #1 grabbed the grab bar on the bed] .I proceeded to clean up her back side, took the old brief out, tucked the old pad under her. I turned around to grab the new pad and the new brief and as I was turned, I heard her sliding but wasn't sure what I was hearing, so I turned around and by the time I turned she was already on the floor. CNA A stated she turned around to the overbed table to grab the brief and pad. CNA A was asked if her hands were on the resident or was she completely turned around. CNA A stated, I was completely turned around .I yelled for help and went to open the door. My nurse [named LPN B] was there in the hall . CNA A was asked did Resident #1 complain of pain. CNA A stated, She was saying Ow, Ow . CNA A stated Resident #1 was sitting on her bottom with her legs in front of her and was leaning against the wall the window was on. CNA A confirmed LPN B obtained Resident #1's vital signs while she got two other CNAs to help them get the resident up with the mechanical lift. CNA A stated, After the fall she was kind of out of it .she couldn't keep her eyes open .now that I know she was sick, she didn't look too good .looked like she was in a lot of pain and didn't feel too good. I did let the nurse know [that it] looked like she was going in and out of consciousness and didn't feel too good. CNA A stated Resident #1 was on an air mattress (alternating pressure mattress). CNA A was asked did she believe the air mattress contributed to the fall. CNA A stated, A little bit. It wasn't as firm [as the regular mattresses], it was soft, you would put your hand on it, and it would go down. CNA A stated this incident taught her to get the help she needed and trust her instincts. CNA A was asked to explain what she meant by trust her instincts. CNA A stated, When I went in there, she wasn't looking too good because she was sick, so I definitely should've gotten help. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/5/2025 at 10:39 AM, LPN B acknowledged she was familiar with Resident #1. LPN B stated, .She was total assist .she could feed herself, but you would have to watch her plate and turn it and sometimes assist [with eating] .Yes [contractures] of her hands .one hand she kept closed but the other you could have her open up and she could drink her coffee and used her spoon . LPN B was asked how the flu [positive for flu A on 1/9/2025] affected her. LPN B stated, .You could just tell she didn't feel good. LPN B was asked what were [Resident #1's] risk factors for falling. LPN B stated, She didn't get out of bed, no falls . I was kind of shocked when [Named CNA A] came and got me [after Resident #1 fell out of bed on 1/14/2025] .never dreamed [Named Resident #1] would fall. LPN B stated, She was on an air mattress and they [facility Administration] think that contributed to the fall .[Resident #1 had] No falls in the time I've been here [2 years in June or July 2025] . LPN B was asked what caused the accident. LPN B stated, .what [Named CNA A] said is all I know. She said she turned her [Resident #1] away from her [CNA A] towards the window and reached to grab the pad .and she [Resident #1] just tumbles over .She had a hematoma on her right knee. [Named Medical Director] was in the facility, and I wanted him to see it. I had put ice on it [right knee] and he said we needed to xray [her] bilateral lower extremities .he said he thought she had a fracture, so we got xrays and she had 2 fractures [Resident #1 had 3 fractures per xrays]. LPN B stated, She was sitting in the floor with her back against the window [wall the window was on] and her legs were kind of to the side [LPN B sat in the floor and demonstrated how she found Resident #1, sitting on her bottom with her legs bent at the knees, out to the right of the resident, and angled towards her bottom]. LPN B was asked was it safe for CNA A to turn Resident #1 on her side then turn her back and leave the resident on her side. LPN B stated, .I wouldn't have done that myself. During a telephone interview on 2/6/2025 at 3:32 PM, the Family Nurse Practitioner (FNP) stated Resident #1 was on her caseload and she saw her once a month and as needed. The FNP was asked was she aware of the resident's fall from bed on 1/14/2025. The FNP stated, Yes, I was aware of the fall, [I was] actually rounding in the facility. Actually [Named Medical Director] and I went in there together. He looked her [Resident #1] over .She was laying in bed, did not appear to be in any pain, [we] asked her several times if she was hurting, and she said no .could tell by looking at her legs she probably had fractures. The FNP stated she was not aware how the fall happened, but she thought it was during patient care. The FNP was asked in her professional opinion did she believe it was safe for a staff member to turn her (Resident #1) on her side and turn their back to retrieve items from the over bed table. The FNP stated, You and I both know the answer to that. It could have been a safety concern, obviously . The FNP was asked in her professional opinion did she believe the fall where Resident #1 sustained a left femur fracture, left tibia fracture, and a right femur fracture on 1/14/2025 may have contributed to her death 4 days later (1/18/2025). The FNP stated, That's too hard to say, she already had flu and had respiratory illness .with fracture of long bones there's always a risk of death. She was in very poor health and very fragile . During an interview on 2/7/2024 at 10:40 AM, the Staffing Coordinator was asked how she taught CNA students to recognize when two staff members were needed for resident care. The Staffing Coordinator stated, [I] teach them if the patient cannot physically hold on to the side rail, to make sure they have two people .prior to this incident when you rolled her [Resident #1] she would hold on .with her wrist and hand . around the grab bar kind of like hugging it. The Staffing Coordinator was asked if Resident #1 was in a weakened state physically from the flu. The Staffing Coordinator stated, Yes, I think she was. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/10/2025 at 3:44 PM, the Director of Nursing (DON) stated, On some days she [Resident #1] could feed herself, some days she couldn't, [staff] would always pop in to make sure she didn't need extra help. She was incontinent of bowel and bladder. The DON stated she was made aware of Resident #1's fall on 1/15/2025, because she was not working on 1/14/2025 when the fall occurred. The DON was asked was it safe for CNA A to leave Resident #1 on her side and turn her back to retrieve a clean brief and pad. The DON stated, It's hard for me to say because I wasn't in there to see if she [CNA A] made sure she [Resident #1] was safe. The DON was asked did she believe it was safe for CNA A to completely turn her back on the resident. The DON stated, No, I do not. During an interview on 2/11/2025 at 11:08 AM, the Administrator stated she went to Resident #1's room immediately after her fall, .[I] observed her on the bed .looked at her mattress .She has a transfer rail .she would typically hold to it but she had been weak and sick, she had the flu and she didn't do that this time evidently [hold to the transfer rail/grab bar]. The Administrator was asked with Resident #1 being weak and sick, should two people have been used to provide care for the resident. The Administrator stated, It depends, this girl [CNA A] had done her before [provided care alone] like I said, she wasn't labeled as two-person . The Administrator was asked was Resident #1 harmed when CNA A left her on her side, turned her back to retrieve supplies, and she fell out of bed. The Administrator stated, Yeah, she fell out of bed and was harmed for sure. The Administrator was asked what the QAPI Committee identified as the root cause of the fall. The Administrator stated, I named 4 factors that contributed .determined because of these 4 things the safest practice would be to have a 2nd staff member on the other side of the alternating mattress [5 Whys but they only identified 4 Whys] . 5. Review of the QAPI Committee documentation revealed the following: A typed summary of the incident and corrective action steps taken dated 1/15/2025, revealed the following: a. Resident #1's alternating pressure mattress was examined and determined to be in the proper working order with normal pressure indicated. Of significance the pressure mattress was noted to give downward when the edge of the mattress was weighted which could allow a weak resident to slide downward when weight was applied to the edge of the mattress. CNA instructor/Staffing Coordinator was consulted regarding instructions for CNA students when turning a resident for occupied bed care, such as changing linens. b. Resident #1's transfer rails were properly installed and sturdy. c. All alternating pressure mattresses in the facility were assessed on the afternoon of 1/14/2025 and it was determined that bedbound residents on alternating pressure mattresses who lacked core body control were also at risk. d. The 5 Whys were used to determine the root cause of the fall. e. An in-service was initiated on 1/15/2025 for all nursing staff. f. An Ad Hoc QAPI Clinical meeting was conducted on 1/15/2025. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	a. Nurse Administration and charge nurses will perform knowledge checks and random observations, each rotation (shift) weekly for 4 weeks and then bi-monthly for 2 months. b. Nurse Managers and Administrator will perform air mattress audits to ensure proper functioning, weekly for 4 weeks, and then bi-monthly for 2 months. c. Findings will be reported to the QAPI committee for the 1st QAPI quarter, 2025. d. If substantial compliance is not met, staff will be re-educated and facility audits will continue, until substantial compliance is met. Review of the facility's investigation and corrective action plan revealed the facility returned to substantial compliance on 1/31/2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445423	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER Vanayer Senior Living and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 460 Hannings Lane Martin, TN 38237	

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37532 Based on policy review, medical record review, observation, and interview, the facility failed to ensure medications were stored appropriately when an unsecured medication was observed in 1 of 38 resident rooms (Resident #4's room) which could have potentially affected the 4 identified wandering residents (Resident #11, #12, #13, and #14) in the facility. The findings include: Review of the facility's policy titled, Medication Storage, dated 1/2025, revealed .It is the policy of this facility to ensure the proper and safe storage of drugs and biologicals .Drugs and/or biologicals should not be left unsecured/unattended . Review of the medical record revealed Resident #4 was admitted to the facility on [DATE], with diagnoses of Chronic Ischemic Heart Disease, Anemia, Cardiomegaly, Bipolar Disorder, Major Depressive Disorder, Allergic Rhinitis, Generalized Anxiety Disorder, and Polyosteoarthritis. Review of the quarterly Minimum Data Set (MDS) dated [DATE], revealed Resident #4 scored a 15 on the Brief Interview for Mental Status (BIMS) assessment indicating Resident #4 was cognitively intact. No behaviors were documented during the 7-day lookback period. Review of the Care Plan dated 10/9/2024 with a revision date of 12/28/2024, revealed Resident #4 was not care planned to self-administer medications. Review of the Physician's Order for Resident #1 dated 1/10/2025, revealed .Breo Ellipta 100-25 MCG [microgram]/ACT [Actuation-a mouthpiece to allow the patient/resident to operate the inhaler and directs the medicine into the lungs] Aerosol Powder .INHALE ONE PUFF INTO THE LUNGS EVERY DAY. RINSE MOUTH AFTER USE AND SPIT OUT . Observation and interview in Resident #1's room on 2/7/2025 9:02 AM, revealed a Breo Ellipta 100 mcg/25 mcg inhaler (a small handheld device that delivers medication in a spray or powder form directly to the lungs through inhalation) on the foot of Resident #4's bed. When asked if she kept the inhaler in her room, Resident #4 stated, No, the nurse left it for me to use .She gave it to me and will come to get it on her way back. If not, I'll take it to her. During an interview on 2/10/2025 at 11:42 AM, the Director of Nursing (DON) was asked should medications be left unattended in the residents' rooms. The DON stated, No, ma'am. The DON confirmed Resident #4 had not been assessed by the Interdisciplinary Team (IDT) to self-administer the Breo-Ellipta inhaler. The DON was asked if self-administration of medications was on the resident's care plan. The DON stated, I'm pretty sure it's not . During an interview on 2/10/2025 at 3:44 PM, the DON confirmed Resident #4's care plan did not include self-administration of medications.