| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 455444 | A. Building<br>B. Wing | 06/01/2025 |

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| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>San Antonio, TX 78240 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that included measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs that were identified in the comprehensive assessment for 1 of 11 (Resident #4) reviewed for care plans.<br><br>1.<br><br>The facility failed to ensure a care plan was developed and interventions put in place to address Resident#4 physical and verbally aggressive behaviors toward others.<br><br>This deficient practice could place residents with behaviors at risk for injury to themselves or others.<br><br>The findings included:<br><br>Record review of Resident #4's face sheet revealed Resident #4 was a [AGE] year-old female who admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a progressive disease that affects memory and other important mental functions) and Type 2 Diabetes (a chronic condition that occurs when the body cannot use insulin effectively).<br><br>Record review of Resident #4's quarterly MDS assessment, dated 03/10/2025 revealed Resident #4 had a BIMS score of 7, indicating severe cognitive impairment. Section E -Behavioral symptoms revealed Resident #4 displayed physical and verbal behavioral symptoms toward others 1 to 3 days during the 7-day look back assessment period. Resident #4 was coded to display other behavioral symptoms not directed toward others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds), 1 to 3 days during the look back period. Section E also revealed Resident #4 displayed wandering behaviors 1 to 3 days during the 7-day look back period. Section GG - Functional Abilities revealed Resident #4 was ambulatory and required partial assistance with dressing and grooming and substantial assistance with bathing.<br><br>(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 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Record review of Resident #4's comprehensive care plan revealed a care plan for impaired cognition function and impaired thought process related to Alzheimer's disease, date initiated 11/27/2024 and revised 01/24/2025. Resident #4 had a care plan that revealed Resident #4 was at risk for wandering, date initiated 11/27/2024 and revised 12/18/2024. Resident #4 had a care plan that revealed Resident #4 resided in the secure unit related to a diagnosis of dementia and risk for elopement, date initiated 11/27/2024 and revised 12/18/2024. Resident #4 had a care plan that revealed Resident #4 displayed sexually inappropriate behavior, date initiated 02/06/2025. The interventions included evaluating the resident's ability to understand her behavior, reenforcing clear limits on healthy behavior, intervening to protect other residents and reporting the behavior to the charge nurse.<br><br>Record review of Resident #4's May 2025 physician orders revealed Resident #4 had an order for Donepezil HCl oral tablet 10 mg daily for Alzheimer's Disease and Trazadone HCl oral tablet 50mg two times a day for anxiety.<br><br>Record review of facility document titled, Event Nurses' Note-Behavior, dated 02/22/2025 at 10:57 a.m., revealed Resident #4 was observed sitting on the lap of another resident and attempted to strike her. Resident #4 stated another resident was talking about her boyfriend.<br><br>Record review of a Health and Human services provider investigation report submitted to HHSC on 02/26/2025 revealed Resident #4 was witnessed attempting to hit another female resident on 2/22/2025 because Resident #4 thought the other female resident was saying bad things about her. The report revealed there were no injuries related to the incident and Resident #4 was placed on monitoring for the behavior.<br><br>During an interview with LVN B, 05/29/2025 at 11:45 a.m., LVN B stated she witnessed Resident #4 on 02/22/2025, leaning up against another female resident and yelling in the other resident's face. LVN B stated Resident #4 was redirected and placed on monitoring and did not display any additional behaviors. LVN B stated Resident #4 and the other resident were assessed and no injuries were noted.<br><br>During an interview with CNA D, 05/29/2025 at 1:12 p.m., CNA D stated she was aware of Resident #4 having an altercation with another resident on 2/22/2025 and stated Resident #4 was easily redirectable if Resident #4 would become agitated. CNA D stated she had received training on providing redirection for resident with behaviors to maintain resident safety.<br><br>During an interview with ADON M, 05/30/2025 at 11:23 a.m., ADON M stated it was the responsibility of the IDT team to update resident care plans and stated it was important for a resident's care plan to be accurate, for the continuum of care and to make sure we are all on the same page.<br><br>During an interview with ADON C, 05/30/2025 at 12:19 p.m., ADON C stated that Resident #4's behavior should have been updated on the comprehensive care plan and stated the MDS Coordinator, ADONs and DON were responsible for updating a resident care plan. ADON C stated it was important to have behaviors included in the comprehensive care plan so there is a continuity of care, and everyone has access to it and can see what the plan of care is for that resident.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview with the MDS Coordinator, 05/30/2025 at 2:53 p.m., stated she had received training on the accuracy of resident care plans and stated the IDT team was responsible for updating resident care plans The MDS Coordinator stated if a resident was displaying verbal or physical behaviors, the care plan should be updated to reflect the behavior. The MDS Coordinator stated it was important to for a resident care plan to be accurate, so everyone knows what interventions are in place for each resident because the interventions are all different and residents require different interventions.<br><br>During an interview with the Administrator N, 05/31/2025 at 1:45 p.m., Administrator N stated resident behaviors should be included in the comprehensive care plan and each department was responsible for updating care plans. Administrator N stated it was important for a resident's care plan to accurately reflect a resident's behavior, to make sure the resident is receiving the care that he/she needs. Administrator N stated staff had received training on the accuracy of resident care plans and stated a resident care plan that does not include resident behaviors could affect the resident due to, the staff that is caring for that resident might not know what is going on with that resident and it would affect the resident in that way.<br><br>Record review of a facility document titled, Comprehensive Care Planning (Nursing Policy & Procedure Manual GP MC 03-18.0), revealed each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. It also revealed, Through the care panning process, facility staff will work with the resident and his/her representative, if applicable, to understand and meet the resident's preferences, choices, and goals during their stay at the facility. The facility will establish, document, and implement the care and services to be provided to each resident to assist in attaining or maintaining his or her highest practicable quality of lie. Care planning drives the type of care and services that a resident receives. |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure 1 of 2 physicians (Physician R) signed and dated resident physician orders for physicians reviewed for physician visits.<br><br>The facility failed to have Physician R electronically sign physician orders. The Medical Records Director was instructed by Administrator O to electronically sign Physician R orders in the EMR using Physician R's username and password.<br><br>This failure could place residents assigned to Physician R at risk for not receiving appropriate physician ordered care.<br><br>Findings included:<br><br>Record review of a facility document titled, Investigation Summary, provided by Administrator N, revealed Administrator N had a meeting with the Medical Records Director on 05/05/2025 regarding an audit of the EMR conducted by the Regional Medical Records Director that revealed unsigned physician orders. Administrator N stated the Medical Records Director said she had been instructed by Administrator O, to sign Physician R's physician orders in the EMR. The document revealed Administrator N instructed the Medical Records Director to immediately stop that practice and Administrator N reported the practice to the regional staff. The document stated an audit was conducted by the Corporate Compliance Nurse to ensure no orders had originated from anyone other than Physician R and in-services were conducted, on 05/08/2025, with the DON, ADONs, Wound Care Nurse, Medical Records Director, Administrator and Physician R on physician instructions for signing orders electronically in the EMR . On 05/14/2025 the Corporate Compliance Nurse conducted an in-service with Physician R to ensure he understood and knew how to electronically sign orders and a password change request was submitted for Physician R. The corporate office changed the process for obtaining and changing passwords for physicians to ensure only Physician R had access to the assigned passwords.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with Administrator N, on 05/30/2025 at 10:01 a.m., Administrator N stated the Regional Medical Records Director conducted an audit of physician orders on 04/30/2025 and the audit revealed that the facility had over 103 physician orders that were pending signature by Physician R in the EMR. Administrator N stated she met with the Medical Records Director on 05/05/2025 to discuss the audit findings and find out what the process was for physicians to sign orders in the EMR. Administrator N stated the Medical Records Director first stated Physician R was on vacation and when Administrator N questioned the process further, the Medical Records Director told Administrator N that she had been instructed by Administrator O to electronically sign Physician R orders for Physician R. Administrator N stated the Medical Records Director told her that Administrator O asked her to start signing the orders for Physician R years ago after DON P left the facility. The Medical Records Director stated DON P was signing the orders and when DON P left it was assigned to ADON M by the Administrator but ADON M said she had too much to do so it was assigned to the Medical Records Director. Administrator N stated she instructed the Medical Records Director to stop signing orders for Physician R and the Medical Records Director stated she would only sign off on the orders when Physician R was in the facility rounding and that it did not feel right to sign the orders but she was afraid she would lose her job if she did not do it. Administrator N stated the Medical Records Director provided her with a copy of an email that was given to her by Administrator O that had Physician R's username and password on the document and stated the email was dated 2021. Administrator N stated the Medical Records Director stated no one else was aware that she was signing the orders in the EMR and that she did not report the situation to anyone. Administrator N stated the Medical Records Director said she was not aware of Administrator O ever using Physician R username and password. Administrator N stated she reached out to Administrator O to see if Administrator O had an agreement with Physician R or if Physician R did not have access the EMR and the only response she received was, have nursing reach out to [physician name]. Administrator N stated she was not comfortable with that, so Administrator N reached out to the Area Director of Operations and reported her concern. Administrator N stated the Corporate Compliance Nurse immediately sent an in-service for the managers to receive about signing orders and then the Corporate Compliance Nurse came to the facility to start an audit of the orders and interview the Medical Records Director on 05/06/2025 to validate there were no discrepancies with the orders and to see if Administrator O or the Medical Records Director ever originated any orders. Administrator N stated no order discrepancies were identified and no orders were originated or created by Administrator O or the Medical Records Director. Administrator N stated the Corporate Compliance Nurse spoke to Physician R and Physician R stated he signed his orders that he received on paper and reviewed orders on resident charts. Physician R also stated he was not aware his username and password were being used to sign orders in the EMR. Administrator N stated Physician R username and password was reset and only Physician R had access to that information. Administrator N stated the Medical Records Director and Administrator O were terminated from the company after the company investigation. Administrator N stated it was important that only Physician R sign physician orders because the orders are from Physician R, and he is the licensed professional and he is the only one that can sign the order. Administrator N stated, Physician R gave the orders, he knew the orders he was giving. [Medical Record Director name] was just clicking off on it to sign them as reviewed in the EMR. I do not believe there was any harm to residents, but you do not share your passwords with anyone.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with the Regional Medical Records Director, on 05/20/2025 at 10:47 a.m., the Regional Medical Records Director stated she conducted audits of resident records quarterly and her last audit was completed on 04/30/2025. The Regional Medical Records Director stated the Medical Records Director was responsible for reviewing physician orders pending signature in the EMR, contacting physicians to sign the orders, and stated physicians should review and sign the orders in the EMR at least every 60 days. The Regional Medical Records Director stated a physician would sign resident orders by entering their username and password to enter the EMR, review the orders and then enter their password to sign the orders. The Regional Medical Records Director stated no other discipline had access to review and sign physician orders except for Physician R using Physician R username and password. The Regional Medical Records Director stated [physician name] did not enter orders into the EMR and stated [physician name] would verbally give orders to the nurses, the nurses would enter the orders and then the orders would be carried out. The Regional Medical Records Director stated she was not aware the Medical Records Director was signing the orders in the EMR on behalf of Physician R and stated the Medical Records Director never reported that she had been instructed to complete this task to clear the orders in the EMR. The Regional Medical Records Director stated it was important to have Physician R sign the orders in the EMR to verify that Physician R was agreeing to the orders that the resident had and the care that was being provided.<br><br>During an interview with ADON M, on 05/30/2025 at 11:23 a.m., ADON M stated the process for obtaining physician orders was for Physician R to give orders verbally to the charge nurse who then enters the order into the EMR for the nurses and staff to follow. ADON M stated if a physician were to enter an order in the EMR, the order would be identified as prescriber written and when a nurse entered the order it was identified as verbal or telephone order. ADON M stated Physician R did not enter his own orders into the EMR but stated Physician R should be signing the orders in the EMR. ADON M stated she was provided Physician R's username and password by Administrator O in 2021 and asked to give the information to Physician R and show Physician R how to sign orders in the EMR. ADON M stated she would round with Physician R when he came into the facility to see residents several days a week and would keep a binder of documents that required Physician R signature which included pharmacy recommendations, therapy certifications, Medicare certifications and discharge orders and Physician R would sign all the forms in the binder when he would visit weekly. ADON M stated she was never asked by Administrator O to sign physician orders in the EMR and stated she never used Physician R's username or password to sign physician orders. ADON M stated she was not aware of the Medical Records Director signing physician orders and stated the Medical Records Director never told ADON M that Administrator O had instructed her to do so.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with the Medical Records Director, on 05/30/2025 at 1:50 p.m., the Medical Records Director stated she had worked in her position at the facility for 6 years. The Medical Records Director stated about 2 years into her role she was asked by Administrator O in front of ADON M to sign the overdue physician orders for Physician R in the EMR that had been identified on an audit by the Regional Medical Records Director. The Medical Records Director stated Administrator O provided her a piece of paper that contained Physician R's username and password. The Medical Records Director stated her understanding was ADON M had been signing the orders electronically, but ADON M stated she was too busy to sign the orders electronically. The Medical Records Director stated she agreed to sign the orders since other people had been doing it and stated she only signed orders for Physician R. The Medical Records Director stated she would log into the EMR with Physician R's username and password about two times a month, go to the pending order review tab, click on resident name, put check marks on the open orders that needed signatures, enter Physician R's password and that would sign the order and remove the order from the list. The Medical Records Director stated Administrator O told her that Physician R would not sign the orders but did not tell her why. The Medical Records Director stated she had a binder of forms and information for Physician R to sign when he would come in several times a week and Physician R would sign those documents but stated Physician R orders were not printed from the EMR for physician signature. The Medical Records Director stated she went to a regional company meeting about a year after she started signing the orders and realized through the training that Physician R should be signing the orders electronically. The Medical Records Director stated she told DON P and Administrator O that they needed to talk to Physician R about signing his own orders and stated she added a document to his binder that included instructions on how to electronically sign physician orders but was told, [physician name] won't sign those by Administrator O. The Medical Records Director stated she talked to Administrator O about it before Administrator N started at the facility on 03/17/2025 and Administrator O told the Medical Records Director to continue signing the orders under Administrator N. The Medical Records Director stated after Administrator O left her role and Administrator N started, the Medical Records Director stopped signing the orders in the EMR and that was why they were identified as overdue on the audit. The Medical Records Director stated she did not report the concern to Administrator N until Administrator N asked her about the overdue physician orders after the audit was conducted. The Medical Records Director stated she did not report the concern to anyone else for fear of losing her job, but stated she did have access to an anonymous compliance hotline for her company and was aware she could have notified HHSC. The Medical Records Director stated she never created or originated any physician orders and stated she had not heard of anyone else using Physician R's credentials to create new orders.<br><br>During an interview with the MDS Coordinator, on 05/30/2025 at 2:53 p.m., the MDS Coordinator stated Physician R was in the facility several days and week and reviewed resident charts, rounded on residents, and attended facility meetings like QAPI, care plan meetings and clinical meetings. The MDS Coordinator stated Physician R would sign Medicare recertifications and other documents when he would be in the facility and was unaware that Physician R was not signing Physician R orders in the EMR. The MDS Coordinator stated she was never provided physician username or passwords to the EMR and was not aware that another staff member was using Physician R's credentials.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with the Area Director of Operations, on 05/30/2025 at 3:15 p.m., the Area Director of Operations stated she was notified by Administrator N that an audit of physician orders revealed multiple orders were unsigned by Physician R. Administrator N asked the Medical Records Director about why the orders were overdue to be signed and the Medical Records Director revealed that she had been instructed by Administrator O to electronically sign the orders on behalf of Physician R. The Medical Records Director said that she would go in the EMR and click off on the order to clear it from the pending signature list and she would use Physician R's username and password to complete this task. The Area Director of Operations stated orders are received from Physician R and entered into the EMR by the floor nurses, the orders are active, and Physician R would sign the orders in the EMR, as soon as possible. The Area Director of Operations stated Physician R was regularly active at the facility and involved with resident care and when Physician R came to the facility, he would review the resident's charts and their orders in the chart. The Area Director of Operations stated the facility did have a compliance hotline number for staff to report concerns and stated staff were able to report allegations or concerns anonymously and no concerns related to a facility staff member signing physician orders was reported.<br><br>During an interview with the Regional Medical Records Director, on 05/30/2025 at 3:57 p.m., the Regional Medical Records Director stated medical records employee receive training on how to run reports and identify when physician orders need to be signed and stated a medical records username and password log in would not give the Medical Records Director an option to sign physician orders.<br><br>During an interview with the Corporate Compliance Nurse, on 05/31/2025 at 11:09 a.m., the Corporate Compliance Nurse stated they process for obtaining physician orders was a physician would give new orders to a nurse, the nurse enter the order in the EMR, and the order is carried out. Physician R would review and sign the orders in the EMR. The Corporate Compliance Nurse stated when the Regional Medical Records Director completed an audit at the end of April 2025, the audit identified physician orders overdue for physician signatures and when the Medical Records Director was questioned about the concern by Administrator N, The Medical Records Director disclosed that Administrator O had instructed her to sign the orders for Physician R to get into compliance. The Corporate Compliance Nurse stated she went to the facility on [DATE] and conducted and in-service on how to educate Physician R to sign orders and completed an audit of every resident which included reviewing every physician order to ensure there were no duplicated orders or order discrepancies and none were identified. The investigation included interviewing staff who stated orders were only given to the nurses by Physician R and the nurses were the only staff entering physician orders into the EMR. The Corporate Compliance Nurse stated she met with Physician R at the facility on 05/07/2025 and assisted him with obtaining a new password that only Physician R had access to and showed him how to electronically sign his physician orders in the EMR. Prior to this training, The Corporate Compliance Nurse stated Physician R would have received training when he got credentialed because Physician R would have to be familiar with signing into the EMR. The Corporate Compliance Nurse said Physician R stated he was unaware anyone was using his username and password and that he signed paperwork when he would come to the facility several times a week. The Medical Records Director stated Physician R was signing recertifications, therapy authorizations transfer/discharge orders and pharmacy recommendations, not the orders in the EMR. The Corporate Clinical Nurse stated Physician R reviewed resident orders when he would come to the facility to see residents and had remote access to review resident charts. The Corporate Clinical Nurse stated the purpose of Physician R signature on orders in the EMR was for Physician R to complete a review and show agreement with the orders and that they are valid orders and if a physician were not signing the orders it could lead to a resident having an inaccurate order.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | During an interview with Physician R, on 05/31/2025 at 1:02 p.m., Physician R stated he had worked at the facility as the Medical Director and resident physician for many years. Physician R stated he was contacted by someone from the corporate office last month and was instructed on signing physician orders electronically and stated he had been signing all his orders electronically since his meeting with a corporate representative. Physician R stated prior to this meeting, he would be handed a folder full of paperwork that he would sign each time he visited the facility, and he thought the paperwork included orders. Physician R stated he did not sign orders or input orders in the EMR and would give verbal orders to the nurses to enter the EMR. Physician R stated he was at the facility several days a week and would review resident charts during visits which included resident orders and would include orders in his progress notes that he completed in the EMR. Physician R stated he also had remote access to the EMR and would review resident orders before he gave any new orders or changed orders for a resident. Physician R stated he was not aware of anyone using his username and password to sign orders in the EMR and stated that's a real problem that someone had access to his account and signed his physician orders.<br><br>During an interview with Administrator O, 05/31/2025 at 2:11 p.m. Administrator O stated she worked at the facility for 6 years as the Administrator and stated nursing, who Administrator O described as just nursing, it would have had to have been the DON or ADON, requested a copy of Physician R's EMR credentials a few years ago. Administrator O stated she was under the impression they requested the information so they could provide it to Physician R. Administrator O stated she did not remember providing Physician R's log in information to the Medical Records Director and stated she never instructed the Medical Records Director to use Physician R EMR log in access to sign physician orders. Administrator O stated the facility had used the EMR prior to her starting in the position 6 years ago and stated she never questioned how Physician R orders were getting signed, because everyone is responsible for their own duties in the building, so I did not question it.<br><br>Record review of a document titled, Witness Statement, signed by The Medical Records Director on 05/12/2025, that read, yrs ago I was instructed by my immediate supervisors to electronically sign physician orders. Before me, the DON and ADON were doing them. I was given physician's credential to complete task by [Administrator O name] before she left, I went to her with the uncomfortable feeling about doing this. She told just to continue to do it under my new supervisor. I only signed the orders.<br><br>Record review of a photocopy of a document, dated 02/07/2022 at 5:23 p.m. from The Medical Records Director email. The photocopy was a picture of an email to Administrator O from an administrative assistant clinical office for [company name]. The email was dated 09/23/2021 and contained the name of three physicians, and EMR usernames and passwords.<br><br>Record review of a document titled, Orders to Review, dated 4/29/2025, revealed 82 resident names pending order reviews and listed the next order review date as overdue.<br><br>Record review of a document titled Ad Hoc QAPI, dated 05/14/2025 revealed eleven employee signatures including Administrator N, DON P, ADON C, DOR and MDS Coordinator.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 455444 | A. Building<br>B. Wing | 06/01/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Mesa Vista Inn Health Center | 5756 N Knoll Dr<br>San Antonio, TX 78240 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of a document titled, Monitoring, revealed the facility would monitor physician orders monthly to ensure that they are completely timely x 3 months and PRN unless modified by the QAPI committee. The document contained a question, were monthly physician orders completed timely? And the document had five boxes across the page that contained a space for a date and yes or no under a question. Three boxes were completed with the date of 05/12/2025, 05/13/2025 and 05/19/2025 and all were circled, yes.<br><br>Record review of a document titled, In-Service Training Attendance Roster, revealed the topic of the in-service was Physician Instruction for Electronically signing orders. The date of the in-service was 05/12/2025 and the instructor was the Area Director of Operations. The in-service revealed six employee names that included Administrator N, DON, ADON M, ADON C and The Medical Records Director. The in-service attachment included a form for physician instruction for electronically signing orders in the EMR and included, two. At the log in screen enter your username and password.<br><br>Record review of a document titled, In-Service Training Attendance Roster, revealed the topic of the in-service was, Hotline call reporting/reporting suspected fraudulent activity, password privacy, abuse/neglect policy. The date of the in-service was 05/13/2025 - 05/16/2025 and the instructors were Administrator N and the DON P. and contained sixty-seven signatures.<br><br>Record review of a document titled, In-Service Training Attendance Roster, revealed the topic of the in-service was, Hotline call reporting/reporting suspected fraudulent activity, password privacy, abuse/neglect policy. The date of the in-service was 05/13/2025 - 05/16/2025 and the instructor was the Dietary Supervisor and contained eleven signatures.<br><br>Record review of a document titled, In-Service Training Attendance Roster, revealed the topic of the in-service was, Hotline call reporting/reporting suspected fraudulent activity, password privacy, abuse/neglect policy. The date of the in-service was 05/13/2025 - 05/16/2025 and the instructor was the Housekeeping Supervisor and contained ten signatures.<br><br>Record review of a document titled, In-Service Training Attendance Roster, revealed the topic of the in-service was, Hotline call reporting/reporting suspected fraudulent activity, password privacy, abuse/neglect policy. The date of the in-service was 05/13/2025 - 05/16/2025 and the instructor was the DOR and contained twelve signatures.<br><br>Record review of a facility resident list report, dated 05/30/2025, revealed Physician R was assigned 108 of 111 facility residents.<br><br>Record review of a facility documented titled Medical Director Agreement revealed it was entered into agreement with the facility and Physician R on 05/01/2019. The agreement contains and Exhibit A that included a description of duties and responsibilities of the Medical Director and included (a) ensure that all facility records pertaining to the care of the residents are in compliance with all applicable state and federal regulations and standards.<br><br>(continued on next page) |

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| F 0711<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Record review of an undated facility document titled, [Company Name] Rules of Behavior for General Users, revealed the Purpose as The Rules of Behavior for General Users provides the rules that govern the appropriate use of [Company name] (hereinafter [company name]) data and information technology (IT) resources (hereinafter assets). [Company name}'s assets must be protected from unauthorized access, disclosure, or medication based on confidentially, integrity, and availability requirements. The document revealed the scope applied to anyone who was granted authorized access to [company name] assets. Under the section titled, Access, the document revealed I understand that I am given access only to the assets that are required to perform my official duties. I will not attempt to access assets I am not authorized to access. I will not attempt to circumvent access controls. Under the section titled, Passwords, the document revealed, I will not share my username and password. I will immediately change my password whenever its compromise is known or suspected to have occurred. Under the section titled, Incident Reporting, the document revealed, I will immediately report all lost or stolen [company name] assets; known or suspected security incidents; known or suspected policy violations; suspicious activity to my manager and the help desk. |