STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495272	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to notify the physician and/or responsible party when medications were not administered for one of 11 residents in the survey sample, Resident #4. The findings include: For Resident #4,(R4), the facility staff failed to notify the physician when medications were not administered per the physician orders. The nurse's note dated, 1/4/25 at 2:00 a.m. documented, Patient is readmitted . R4's physician orders dated 1/4/25, documented, Sucralfate Oral Tablet; Give 2 gram via PEG - tube two times a day for ulcer. Vancomycin HCL (hydrochloride) 250 MG (milligrams); Give 125 mg via PEG-tube two times a day for infection. The above physicians' orders for R4 were documented on the January 2025 MAR (medication administration record), that indicates both medications and doses scheduled for 9:00 a.m. and 5:00 p.m., A 22 was documented. A 22 indicates, Drug/Treatment Not Administered. The nurse's note dated 1/4/25 at 12:34 p.m. documented, Ordered from pharmacy. The nurse's note dated 1/4/25 at 12:55 p.m. documented, medication ordered from pharmacy. Review of the contents of their emergency medication back up system, documented in part, Inventory on Hand: Vancomycin 125 mg cap (capsule). Sucralfate 1 GM (gram) tablet. An interview was conducted with LPN (licensed practical nurse) #1 on 1/22/25 at 11:32 a.m. LPN #1 stated, If a nurse cannot find the medication on the medication cart, the facility has a backup pharmacy system. If it's in there, then you get it from there and if not available, you call the doctor and follow their instructions. When asked if they document anything in the clinical record that it couldn't be given, LPN #1 stated, Yes, the nurse should document a progress note of why it wasn't given, calling the doctor, and you have to call the responsible party also. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, Unavailable Medications, documented in part, 2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility's automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. Obtain a new order and discontinue prior order, or ii. Obtain a hold order for the unavailable medication. ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/23/25 at 1:08 p.m. No further information was provided prior to exit. References: (1) Vancomycin is used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. Vancomycin is in a class of medications called glycopeptide antibiotics. It works by killing bacteria in the intestines. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a604038.html. (2) Sucralfate is used to treat and prevent the return of duodenal ulcers (ulcers located in first part of the small intestine). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681049.html.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to protect one of 11 residents from sexual abuse, Resident #1. The findings include: a. For Resident #1(R1), the facility staff failed to protect her from sexual abuse from Resident #8. On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 12/6/24, R1 scored a zero out of 15 on the BIMS (brief interview for mental status) score, indicating R1 was severely impaired for making daily decisions. In Section GG - Functional Status, the resident was coded as being able to walk independently at least 150 feet. R1 progress note dated, 1/10/25 at 7:45 p.m. documented, While standing in the common area passing medications, writer overheard CNA (certified nursing assistant) (CNA #2) holler down the hall and call for CNA (CNA #1) to come here. (CNA #2) stated to (CNA #1), 'You will be my witness, I caught (name of R8) eating (name of R1)'s vagina.' Writer immediately stopped passing medications and proceeded down the corridor to find out what was happening. Upon arrival into (R8's) room, (R1) was noted to be undressed from the waist down with her brief off and a towel wrapped around her groin area. (R8) was observed coming out of the bathroom. Resident (R1) was immediately removed from (R8)'s room. Unit manager was immediately notified of the situation. RP (responsible party), MD (medical doctor) and Hospice made aware of the event. Police report was made. Patient sent to the ER (emergency room) for possible sexual assault. The psychiatric nurse practitioner note dated, 1/13/25 at 3:41 a.m. (LATE ENTRY) documented in part, Chief Complaint Comments: Behavioral mood disorder, Sexual Encounter with another Patient .Interval History: Patient seen today for behavioral mood disorder, Sexual Encounter with another patient and medication management follow up. Per staff report, (R8) was observed by one of the CNA's eating (R1)'s vagina. Nurse reported (R1) was in the Male patient's room, she was noted to be undressed from the waist down with her brief off and a towel wrapped around her groin area, while male patient was observed coming out from the bathroom. both patients were immediately separated, and (R1) was removed from the male patient room. During interaction with patient, she was unable to explain or recognized that any of the above sexual behaviors due to cognitive impairment. No active anxiety or depress mood observed or reported. The comprehensive care plan dated, 9/30/24, documented in part, Focus: I have a behavior problem r/t (related to) agitation - resident has a history of seeking out male attention. Interventions: Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet resident's needs. Assist the resident to develop more appropriate methods of coping and interacting. Encourage resident to express feelings appropriately. Focus: I have a psychosocial well-being problem r/t anxiety, depression. Resident to resident relationship. Interventions: 1/10/25 -When conflict arises, remove me to a calm safe environment and allow me to vent/share feelings. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. Resident #8 (R8) - On the most recent MDS assessment, a quarterly assessment, with an assessment reference date of 10/28/24, R8 scored a 7 out of 15 on the BIMS score, indicating the resident was severely impaired for making daily decisions. In Section GG - Functional Status, R8, was coded as being able to walk independently at least 150 feet. He was also coded as requiring set up assistance to being independent for his activities of daily living. A BIMS score completed on 1/22/25, the resident scored a 10 out of 15, indicating the resident was moderately impaired for making daily decisions. The nurse's note dated, 1/10/25 at 7:51 p.m. documented, While standing in the common area passing medications, writer overheard CNA (certified nursing assistant) (CNA #2) holler down the hall and call for CNA (CNA #1) to come here. (CNA #2) stated to (CNA #1), 'You will be my witness, I caught (name of R8) eating (name of R1)'s vagina.' Writer immediately stopped passing medications and proceeded down the corridor ot find out what was happening. Upon arrival into (R8's) room, (R1) was noted to be undressed from the waist down with her brief off and a towel wrapped around her groin area. (R8) was observed coming out of the bathroom. Resident (R1) was immediately removed from (R8)'s room. Unit manager was immediately notified of the situation. RP (responsible party), MD (medical doctor) and Hospice made aware of the event. Police report was made. Patient sent to the ER (emergency room) for possible sexual assault. The comprehensive care plan dated, Focus: I have a behavioral problem related to sexual ideation. Interventions: 1:1 (one to one) supervision. Administer medications as ordered. Monitor/document for side effects and effectiveness. Anticipate and meet resident's needs. Intervene as necessary to protect the rights and safety of others. Approach/speak in a calm manner, divert attention. Remove from situation and take to alternative location as needed. The psychiatric nurse practitioner note dated, 1/13/25 at 7:44 a.m. LATE ENTRY, documented in part, Patient seen today for depression mood disorder, psychosis, sexual encounter with a patient, mood disorder and medication follow up. Staff reports of patient observed having sexual behavior with a female patient in his room. Per staff report, (R8) was observed by one of the CNA's eating a female patient vagina. Nurse reported, saw female patient in (R8)'s room, she was noted to be undressed from the waist down with her brief off and a towel wrapped around her groin area, while (R8) was observed coming out from the bathroom. Both patients were immediately separated, and female patient was removed from the male patient room. Patient was placed on 1:1 staff supervision. During interaction with patient bedside, patient cooperative, alert to self, current pretendent, DOB (date of birth), and current location. Patient denies above sexual behaviors. No active anxiety or depressed mood observed or reported. No change in patient sleep and appetite patterns. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility synopsis of the event, dated, 1/10/25, documented, Both residents were found in a bedroom and (R1) was noted to be naked. No injuries noted to either resident. Investigation has been initiated. The synopsis dated 1/17/25, documented, This is the final FRI (facility reported incident) regarding a resident-to-resident sexual allegation between (name of R8) and (name of R1). (R8) is a 75 -year-old male with a medical history not limited to: Dementia, Anxiety, and COPD (chronic obstructive pulmonary disease) and a BIMS of 0. (R1) ear-old hospice resident with a medical history of but not limited to: Dementia, Cerebrovascular Disease and Psychosis. (R1) has a BIMS of 0. After reviewing staff statements, medical records, medical assessments and documentation, (R1) was seen walking in the hallway 10 minutes before she was seen sitting on (R8)'s bed with her brief off and (R8) in the same room fully clothed. The complete skin assessment of (R1) did not show any skin altercations/impairments. (R1) was sent to hospital with no further deviations in skin or any other recommendations. Responsible parties for both residents and authorities were informed of this incident. Neither resident has any recollection of the incident. Social services, the medical director, and psychiatry continue to follow both residents. Care plans have been revised and will be updated as needed. Both residents remain at baseline, continue to tolerate meals, activities and medications well with no psychosocial disturbances. A request was made for the Virginia State Police Sex Offenders screening completed on R8's admission to the facility. On 1/22/25 at 8:39 a.m. a copy of a screening completed 1/21/25 was presented. The resident did not have any offenses on the report. When asked where is the Sex Offender screening report completed upon admission, OSM (other staff member) #1, the director of admissions, stated there is no evidence one was run at the time of admission but the other employee that did this at that time stated she had done it. An interview was conducted with CNA #1 on 1/22/25 at 3:15 p.m. CNA #1 stated she heard (name of CNA #2) at the doorway of (R8)'s room calling for help. She went there and (R1) was sitting on the side of the bed. She was naked from the waist down. Pants, brief and shoes were on the floor. (R8) was just walking towards us, he went into the bathroom, He was fully clothed. She wrapped a towel around (R1) and walked her out of the room to another female resident room. Then the nurse came in to examine (R1). CNA #1 stated That R8 is independent for his care, he does his own bathing, brushes his own teeth, even shaves himself and makes his own bed. He knows the staff names and some of the resident's names. R8 stays to himself, only comes out of his rooms for meals. When asked if she's heard R8 say anything sexual in nature to a resident, CNA #1 stated that, he's told her that He's a good-looking guy and all the girls like him. She has never seen him say anything to a resident or acted sexually towards any other resident. Witness statement of CNA #2 dated 1/10/25 doceumented. I walked in (R8)'s room to prep for care and heard (R8) on the B side, he had the curtain pulled. I heard (R1) stuttering, so I pulled the curtain back and seen her laying on her back with no pants or brief or shoes on (they were at R8's) feet. She was trying to sit up and (R8) was holding her legs around his neck with his face in her vagina and his head going in a back-and-forth motion. I yelled for (CNA #1) and a nurse and he (R8) got up and ran into the bathroom locking the door. When the nurse got to the room, he came out and still had cream on his upper lip. There was a dirty towel in the trash as well and when we took (R1) out the room, he washed his face and drank mouthwash. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with CNA #2 on 1/22/25 at 3:59 p.m. She reviewed her statement and stated that is what happened that day. CNA #2 stated R8 stated he didn't do anything. She further stated she had heard R8 telling another resident that just left the facility that it's easy to get away with things when they think you are crazy. CNA #2 stated that R1 is sometimes difficult to do incontinence care on as she will state, 'No, No, No' when you try to take her clothes off. An interview was conducted with LPN (licensed practical nurse) #3 on 1/22/25 at 4:28 p.m. LPN #3 stated that her note above speaks for itself and is accurate of the details of that evening. LPN #3 stated she doesn't see (R8) as demented. He is oriented times four (person, place, time and situation). He shaves himself; he was a barber. He stated to her at the time, what are you talking about, you can't prove anything. Observations were made of R1 and R8 throughout the survey. R1 was noted to be in the day room of the Grove unit. She was interacting with staff, eating her meals or napping in her chair. R8 was observed on the first floor, being on a 1:1 supervision with a CNA by his side. ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/23/25 at 1:08 p.m. The facility presented a Plan of Correction, dated 1/13/25. Problems: Females and Males with BIMS indicating cognitive impairment engaging in sexual behavior from oral, fondling/touching, disrobing of clothing, entering the room of another resident room without knowledge of the staff. Immediate Response: The residents were immediately separated, skin and pain assessment completed. No evidence of female resident's redness, trauma, bleeding/discharge. Trauma informed screens conducted. Psych services to follow. MD/RP review. How to Identify other resident that might be impacted: All residents have the potential to be affected. An audit by the DON (director of nursing) or designee to identify residents that wander in other rooms and shows signs of sexual behaviors will be monitored when out of room and redirect from other rooms with care plan updated, MD/RP and Medical Director aware of sexual and/or wandering behaviors specific to type of incidents with residents' interventions. What measures were put in place to prevent reoccurrence: Education by the DCS (director of clinical services) or designee on the process and procedure for residents who wander in other resident room and/or exhibiting sexual behaviors to protect the resident prevent entering other resident's room with risk for sexual behaviors. Monitoring of the identified residents when out of room and redirect from other rooms, activities to prevent/distract from sexual behaviors, TV, radio on non-sexual content, redirector sexual conversations, during socialization, dining activity, when possible pair with same gender to prevent the identified male and/or female residents from touching or sexual behavior, purposeful rounding to verify resident have not wandered in other room, no sexual behaviors, immediately separate, report to nurse, Administrator and DON are aware. Date of Compliance: 1/20/25. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	All of the credible evidence was reviewed. The facility was found to be in compliance. No further information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for three of 11 residents in the survey sample, Residents #7, #4, and #3. The findings include: 1. For Resident #7, the facility staff failed to implement the comprehensive care plan to give treatments as ordered. The comprehensive care plan dated, 12/26/24, documented in part, Focus: I have impaired skin integrity. The Interventions documented in part, Administer treatments as ordered and monitor for effectiveness. The physician order dated, 12/27/24, documented, [NAME] Prep (3) L (left) heel DTI every shift. [NAME] Prep R (right) heel DTI every shift. The January 2025 TAR (treatment administration record) documented the above orders. For both the left and right heel, there were blanks on the TAR on the following dates for the evening shift: 1/3/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/12/25, 1/13/25, 1/14/25, 1/15/25, 1/16/25. The physician order dated, 1/16/25, documented, Betadine L heel DTI every shift. Betadine R heel DTI every shift. The January 2025 TAR documented the above order. For both the left and right heel, there were blanks on the TAR on the following dates for the evening shift: 1/17/25 and 1/20/25. An interview was conducted with LPN (licensed practical nurse) #1, on 1/22/25 at 11:32 a.m. LPN #1 stated the purpose of the care plan is to know how to care for the resident and it should be followed. The facility policy, Care Plans, Comprehensive Person-Centered, documented in part, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/22/25 at 4:41 p.m. No further information was provided prior to exit. References: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/. (3) [NAME](e) Prep pads - Fast-drying skin protectant is vapor permeable and delivers protection from friction and incontinence. This information was obtained from the following website: https://www.medline.com/product/SurePrep-Skin-Protectant-Wipe/Z05-PF00058?question=sure%20prep%20pads& (4) Betadine is an antiseptic solution used to disinfect open wounds or cuts and to prepare the skin for surgery. It is used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns. Betadine kills viruses, bacteria, and fungi on the skin by damaging important proteins that the germs need to survive. Betadine is also useful to heal second and third-degree burns. This information was obtained from the following website: https://www.drugs.com/mtm/betadine.html. 2. For Resident #4, the facility staff failed to implement the comprehensive care plan for administering medications per the physician orders. The comprehensive care plan dated, 1/9/25, documented in part, Focus: I have altered cardiovascular status. The care plan further documented, Interventions: Give all cardiac meds (medications) as ordered. The comprehensive care plan dated, 1/9/25, documented, Focus: I am on seizure medication r/t (related to) POLYNEUROPATHY. Interventions: Give medications as ordered. The comprehensive care plan dated, 1/9/25, documented in part, Focus: I am on pain medication therapy. Interventions: Administer medications as ordered and monitor for effectiveness. The physician order dated, 1/9/25, documented, Midodrine HCL (hydrochloride) Tablet 10 MG (milligrams); Give 1 table via PEG-tube three times a day related to hypotension (low blood pressure); HOLD FOR SBP (systolic blood pressure) GREATER THAN 130. The January 2025 MAR (medication administration record) documented the above order. On 1/13/25 at 1:00 p.m. the blood pressure was documented as 167/90. On 1/13/25 at 5:00 p.m. the blood pressure was documented as 145/78. On 1/16/25 at 5:00 p.m., the blood pressure was documented as 133/86. On all three occasions, the medication was administered even though the blood pressure was outside the physician prescribed parameters. Review of the nurse's notes failed to evidence any documentation related to giving the medication even though the blood pressure was outside the prescribed parameters. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician order dated, 1/9/25, documented, Gabapentin Oral Solution; Give 5 ml (milliliters) via PEG-tube three times a day related to polyneuropathy due to other toxic agents. The January 2025 MAR documented the above order. On 1/18/25 at 5:00 p.m. and 1/19/25 at 9:00 a.m., a 5 was documented. A 5 documents, Hold. The nurse's note dated, 1/18/25 at 8:58 p.m. documented, Medication on order. MD (medical doctor) notified. The nurse's note dated 1/19/25 at 11:53 a.m. failed to evidence documentation of why the medication was not given. Review of the narcotic count sheet for the Gabapentin, revealed documented 450 ml of the medication was delivered on 1/10/25. If the nurse gave 5 ml as ordered, there should be 90 doses of the medication in the medication cart. There were 350 ml available on 1/18/25 to be administered. The physician order dated, 1/14/25, documented, Oxycodone HCL Oral Tablet 10 MG; Give 10 mg via PEG-tube three times a day for Chronic pain. The January 2025 MAR documented the above order. On 1/14/25 at 5:00 p.m. and 1/15/25 at 9:00 a.m. a 22 was documented. A 22 indicates, Drug/Treatment Not Administered. The nurse's note dated, 1/14/25 at 6:58 p.m. documented Pharmacy state they didn't get script, though writer faxed several hours ago. Refaxed. The Narcotic Sheet for Oxycodone 5 mg tablet documented on 1/14/25, there were 74 tablets available for administration. An interview was conducted with LPN (licensed practical nurse) #1, on 1/22/25 at 11:32 a.m. LPN #1 stated the purpose of the care plan is to know how to care for the resident and it should be followed. ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/22/25 at 4:41 p.m. No further information was provided prior to exit. References: (1) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html. (2) Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694007.html. (continued on next page)

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Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3) Oxycodone immediate-release tablets, capsules, and oral solution are used to relieve severe, acute pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) in people who are expected to need an opioid pain medication and who cannot be treated with other pain medications. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html. 3. For Resident #3, the facility staff failed to implement the comprehensive care plan for administering medications and treatments as ordered. The comprehensive care plan dated, 10/22/24, documented in part, Focus: The resident has a pressure ulcer or has the potential for pressure ulcer development r/t disease process, history of pressure ulcers, immobility, admitted with sacral wound stage 4. Interventions: Administer treatments as ordered. The comprehensive care plan dated, 10/22/24, documented in part, Focus: I have Gastro-esophageal reflux disease (GERD) related to hyperacidity. The care plan documented in part, Interventions: Give medications as ordered. The comprehensive care plan dated, 11/19/25, documented in part, Focus: I am on antibiotic therapy r/t (related to) osteomyelitis. The care plan documented in part, Interventions: Administer medications as ordered. The physician orders dated 1/5/25, documented, Cleanse left distal upper back every day shift; cleanse left distal upper back with NS (normal saline) apply Silvasorb (1), cover with bordered gauze change daily. Left upper back every day shift; cleanse area to left upper back with NS, apply Silvasorb secure with foam bordered gauze change daily. Sacral Wound: clean with Dakin's solution (2), apply Santyl (3) and Dakin's moist gauze, cover with superabsorbent dressing and bordered foam every day shift. The January 2025 TAR (treatment administration record) documented the above orders. There were blanks in the day shift for 1/20/25. The nurse's note dated, 1/4/25 at 2:00 a.m. documented, Patient is readmitted . The physician orders dated 1/4/25, documented, Sucralfate Oral Tablet (5); Give 2 gram via PEG - tube two times a day for ulcer. Vancomycin HCL (hydrochloride) (4) 250 MG (milligrams); Give 125 mg via PEG-tube two times a day for infection. The January 2025 MAR (medication administration record) documented the above orders. For both medications for both doses scheduled for 9:00 a.m. and 5:00 p.m., a 22 was documented. A 22 indicates, Drug/Treatment Not Administered. The nurse's note dated 1/4/25 at 12:34 p.m. documented, Ordered from pharmacy. The nurse's note dated 1/4/25 at 12:55 p.m. documented, medication ordered from pharmacy. Review of the contents of their emergency medication back up system, documented in part, Inventory on Hand: Vancomycin 125 mg cap (capsule). Sucralfate 1 GM (gram) tablet. An interview was conducted with LPN (licensed practical nurse) #1, on 1/22/25 at 11:32 a.m. LPN #1 stated the purpose of the care plan is to know how to care for the resident and it should be followed. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/23/25 at 1:08 p.m. References: (1) Silvasorb is a silver-based product that is used to treat minor cuts, scrapes, burns, skin irritation, ulcers, and wounds. It may cause allergic reactions, skin infections, or overdose symptoms. This information was obtained from the following website: https://www.drugs.com/cdi/silvasorb.html (2) Dakins Full Strength Solution is used to treat or prevent infections caused by cuts or abrasions, skin ulcers, pressure ulcers, diabetic foot ulcers, or surgery. This information was obtained from the following website: https://www.drugs.com/mtm/dakins-full-strength-solution.html. (3) Santyl (for the skin) is used to treat severe burns or skin ulcers in adults. Santyl helps remove dead skin tissue and aid in wound healing. This information was obtained from the following website: https://www.drugs.com/mtm/santyl.html. (4) Vancomycin is used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. Vancomycin is in a class of medications called glycopeptide antibiotics. It works by killing bacteria in the intestines. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a604038.html. (5) Sucralfate is used to treat and prevent the return of duodenal ulcers (ulcers located in first part of the small intestine). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681049.html.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to administer medications and/or treatments per the physician order for two of 11 residents in the survey sample, Residents #3 and #4. The findings include: 1.a. For Resident #3(R3), the facility staff failed to administer physician ordered treatments to an abdominal surgical wound, a right great toe callus, and right lateral foot callus. The physician orders dated, 1/8/25, documented, Cleanse abdominal surgical wound with wound wash; apply skin prep (1) daily one time a day for wound care. Apply skin prep to right great toe q (every) shift, every shift for wound care. Apply skin prep to the right lateral foot every shift for wound care. The TAR (treatment administration record) documented the above orders. On 1/20/25 for the day shift, there was no documentation that the treatement was adminstered. On 1/22/25 at 11:32 a.m., an interview was conducted with LPN (licensed practical nurse) #1, When asked how do nurses' evidence that they've completed a physician prescribed treatment, LPN #1 stated The nurse signs it off on the TAR. The facility policy, Wound Treatment, documented in part, Documentation: The following information should be recorded in the resident 's medical record: 1. The date and time the wound care was given. 2. The type of wound care given. On 1/23/25 at 1:08 p.m. #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: (1) Skin Prep Protective Barriers are liquid silicone-based products to create a film layer to shield delicate and vulnerable skin. This information was obtained from the following website: ttps://www.vitalitymedical.com/skin-prep-protective-barriers-films.html. 1.b. For Resident #3 (R3), the facility staff failed to administer Vancomycin (1) and Sucralfate (2) per the physician orders. The nurse's note dated, 1/4/25 at 2:00 a.m. documented, Patient is readmitted . (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The physician orders dated 1/4/25, documented, Sucralfate Oral Tablet; Give 2 gram via PEG - tube two times a day for ulcer. Vancomycin HCL (hydrochloride) 250 MG (milligrams); Give 125 mg via PEG-tube two times a day for infection. The January 2025 MAR (medication administration record) documented the above orders. For both medications for both doses scheduled for 9:00 a.m. and 5:00 p.m., a 22 was documented. A 22 indicates, Drug/Treatment Not Administered. The nurse's note dated 1/4/25 at 12:34 p.m. documented, Ordered from pharmacy. The nurse's note dated 1/4/25 at 12:55 p.m. documented, medication ordered from pharmacy. Review of the contents of their emergency medication back up system, documented in part, Inventory on Hand: Vancomycin 125 mg cap (capsule). Sucralfate 1 GM (gram) tablet. The comprehensive care plan dated, 10/22/24, documented in part, Focus: I have Gastro-esophageal reflux disease (GERD) related to hyperacidity. The care plan documented in part, Interventions: Give medications as ordered. The comprehensive care plan dated, 11/19/25, documented in part, Focus: I am on antibiotic therapy r/t (related to) osteomyelitis. The care plan documented in part, Interventions: Administer medications as ordered. An interview was conducted with LPN (licensed practical nurse) #1 on 1/22/25 at 11:32 a.m. LPN #1 stated that if a nurse cannot find the medication on the medication cart, the facility has a backup pharmacy system. If it's in there, then you get it from there. If not available, you call the doctor and follow their instructions. When asked if they document anything in the clinical record that it couldn't be given, LPN #1 stated, yes, the nurse should document a progress note of why it wasn't given, calling the doctor and you have to call the responsible party also. The facility policy, Unavailable Medications, documented in part, 2. In the event that a medication ordered for a resident is noted to be unavailable near or at the time it is to be dispensed, nursing staff shall: a. Contact the pharmacy regarding the unavailable medication. b. Attempt to obtain the medication from the facility ' s automated medication dispensing system or emergency kit. c. Notify the physician of the unavailable medication, explain the circumstances, report the date of expected availability, and provide the alternative medication(s) recommended by pharmacy. i. Obtain a new order and discontinue prior order, or ii. Obtain a hold order for the unavailable medication. ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/23/25 at 1:08 p.m. No further information was provided prior to exit. References: (1) Vancomycin is used to treat colitis (inflammation of the intestine caused by certain bacteria) that may occur after antibiotic treatment. Vancomycin is in a class of medications called glycopeptide antibiotics. It works by killing bacteria in the intestines. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a604038.html. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) Sucralfate is used to treat and prevent the return of duodenal ulcers (ulcers located in first part of the small intestine). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681049.html. 2.a. For Resident #4 (R4), the facility staff failed to administer medications Midodrine (1) per the physician orders. The physician order dated, 1/9/25, documented, Midodrine HCL (hydrochloride) Tablet 10 MG (milligrams); Give 1 table via PEG-tube three times a day related to hypotension (low blood pressure); HOLD FOR SBP (systolic blood pressure) GREATER THAN 130. The January 2025 MAR (medication administration record) documented the above order. On 1/13/25 at 1:00 p.m. the blood pressure was documented as 167/90. On 1/13/25 at 5:00 p.m. the blood pressure was documented as 145/78. On 1/16/25 at 5:00 p.m., the blood pressure was documented as 133/86. On all three occasions, the medication was administered even though the blood pressure was outside the physician prescribed parameters. Review of the nurse's notes failed to evidence any documentation related to giving the medication even though the blood pressure was outside the prescribed parameters. The comprehensive care plan dated, 1/9/25, documented in part, Focus: I have altered cardiovascular status. The care plan further documented, Interventions: Give all cardiac meds (medications) as ordered. An interview was conducted with RN (registered nurse) #1, on 1/23/25 at 10:38 a.m. RN #1 stated if a medication has parameters in which to give the medication, you take the vital signs, example, blood pressure. If the reading is within the parameters, then you administer the medication. The facility policy, Administering Medications documented in part, 4. Medications are administered in accordance with prescriber orders, including any required time frame. 2.b. For R4, the facility staff failed to administer Gabapentin (2) per the physician order. The physician order dated, 1/9/25, documented, Gabapentin Oral Solution; Give 5 ml (milliliters) via PEG-tube three times a day related to polyneuropathy due to other toxic agents. The January 2025 MAR documented the above order. On 1/18/25 at 5:00 p.m. and 1/19/25 at 9:00 a.m., a 5 was documented. A 5 documents, Hold. The nurse's note dated, 1/18/25 at 8:58 p.m. documented, Medication on order. MD (medical doctor) notified. The nurse's note dated 1/19/25 at 11:53 a.m. failed to evidence documentation of why the medication was not given. Review of the narcotic count sheet for the Gabapentin, revealed documented 450 ml of the medication was delivered on 1/10/25. If the nurse gave 5 ml as ordered, there should be 90 doses of the medication in the medication cart. There were 350 ml available on 1/18/25 to be administered. The comprehensive care plan dated, 1/9/25, documented, Focus: I am on seizure medication r/t (related to) POLYNEUROPATHY. Interventions: Give medications as ordered. (continued on next page)

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Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with LPN (licensed practical nurse) #1 on 1/22/25 at 11:32 a.m. LPN #1 stated that if a nurse cannot find the medication on the medication cart, the facility has a backup pharmacy system. If it's in there, then you get it from there. If not available, you call the doctor and follow their instructions. When asked if they document anything in the clinical record that it couldn't be given, LPN #1 stated, yes, the nurse should document a progress note of why it wasn't given, calling the doctor and you have to call the responsible party also. 2.c. For R4, the facility staff failed to administered Oxycodone (3) per the physician order. The physician order dated, 1/14/25, documented, Oxycodone HCL Oral Tablet 10 MG; Give 10 mg via PEG-tube three times a day for Chronic pain. The January 2025 MAR documented the above order. On 1/14/25 at 5:00 p.m. and 1/15/25 at 9:00 a.m. a 22 was documented. A 22 indicates, Drug/Treatment Not Administered. The nurse's note dated, 1/14/25 at 6:58 p.m. documented Pharmacy state they didn't get script, though writer faxed several hours ago. Refaxed. The Narcotic Sheet for Oxycodone 5 mg tablet documented on 1/14/25, there were 74 tablets available for administration. The comprehensive care plan dated, 1/9/25, documented in part, Focus: I am on pain medication therapy. Interventions: Administer medications as ordered and monitor for effectiveness. An interview was conducted with RN #1 on 1/23/25 at 10:38 a.m. RN #1 stated that if there are 5 mg tablets of Oxycodone in the narcotic drawer, then the nurse administers two tablets until the 10 mg dose arrives. ASM (administrative staff member) #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/22/25 at 4:41 p.m. No further information was provided prior to exit. References: (1) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html. (2) Gabapentin capsules, tablets, and oral solution are used along with other medications to help control certain types of seizures in people who have epilepsy. Gabapentin capsules, tablets, and oral solution are also used to relieve the pain of postherpetic neuralgia. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a694007.html. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(3) Oxycodone immediate-release tablets, capsules, and oral solution are used to relieve severe, acute pain (pain that begins suddenly, has a specific cause, and is expected to go away when the cause of the pain is healed) in people who are expected to need an opioid pain medication and who cannot be treated with other pain medications. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27660 Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to provide care and services for the treatment of pressure injuries (1) for three of 11 residents in the survey sample, Residents #7, #9, and #3. The findings include: 1. For Resident #7 (R7), the facility staff failed to apply physician prescribed Betadine and [NAME] Prep to treat DTI (deep tissue injury) (2) on both heels. The physician order dated, 12/27/24, documented, [NAME] Prep (3) L (left) heel DTI every shift. [NAME] Prep R (right) heel DTI every shift. The January 2025 TAR (treatment administration record) documented the above orders. For both the left and right heel, there was no documentation on the TAR for the following dates for the evening shift: 1/3/25, 1/7/25, 1/8/25, 1/9/25, 1/10/25, 1/12/25, 1/13/25, 1/14/25, 1/15/25, 1/16/25. The physician order dated, 1/16/25, documented, Betadine L heel DTI every shift. Betadine R heel DTI every shift. The January 2025 TAR documented the above order. For both the left and right heel, there was no documentation on the TAR for the following dates for the evening shift: 1/17/25 and 1/20/25. The comprehensive care plan dated, 12/26/24, documented in part, Focus: I have impaired skin integrity. The Interventions documented in part, Administer treatments as ordered and monitor for effectiveness. An interview was conducted ASM (administrative staff member) #7, the wound care nurse practitioner, on 1/22/25 at 10:34 a.m. ASM #7 stated That if a resident doesn't get their treatments as ordered it can generally have a negative effect on the healing process. She could not say if the missed treatments negatively affected R7's healing of his wounds. On 1/22/25 at 11:32 a.m., An interview was conducted with LPN (licensed practical nurse) #1. When asked how nurse evidence that they've completed a physician prescribed treatment, LPN #1 stated The nurse signs it off on the TAR. The facility policy, Wound Treatment, documented in part, Documentation: The following information should be recorded in the resident ' s medical record: 1. The date and time the wound care was given. 2. The type of wound care given. On 1/22/25 at 4:41 p.m., ASM #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	References (1) A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/ (2) Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood-filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. This information was obtained from the following website: http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/. (3) [NAME](e) Prep pads - Fast-drying skin protectant is vapor permeable and delivers protection from friction and incontinence. This information was obtained from the following website: https://www.medline.com/product/SurePrep-Skin-Protectant-Wipe/Z05-PF00058?question=sure%20prep%20pads& (4) Betadine is an antiseptic solution used to disinfect open wounds or cuts and to prepare the skin for surgery. It is used on the skin to treat or prevent skin infection in minor cuts, scrapes, or burns. Betadine kills viruses, bacteria, and fungi on the skin by damaging important proteins that the germs need to survive. Betadine is also useful to heal second and third-degree burns. This information was obtained from the following website: https://www.drugs.com/mtm/betadine.html. 2. For Resident #9 (R9) the facility staff failed to change gloves during the wound care observation. The physician order dated, 1/14/25, documented, Right buttock MASD (moisture assocated dermatitis) wound, cleanse with soap and water, apply Calcium Alginate Ag and cover with border gauze every day shift for wound. On 1/22/25 at 10:56 a.m., An observation was made of LPN #2 performing the wound care treatment for R9. LPN #2 entered the room with a gown, face mask and gloves on. She proceeded to reposition the resident in bed, assisting them to turn. Used the bed remote to raise the various parts of the bed and height of bed. Moved the resident's catheter bag to the other side of the bed. She then removed the resident's brief and proceeded to remove the resident's dressing. LPN #2 took a washcloth to the sink and applied warm water and soap. Returned to the bedside and proceeded to clean the wound. She then changed her gloves prior to applying the prescribed treatment. On 1/22/25 at 11:14 p.m., An interview was conducted with LPN #2 When asked if she should have changed her gloves after removing the dressing and before cleaning the dressing with soap and water, LPN #2 stated, Yes. (continued on next page)

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	495272	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canterbury Rehabilitation and Healthcare Center	1776 Cambridge Drive Richmond, VA 23238

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy, Wound Treatment, documented in part, Position resident to provide access to affected area. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites, as needed. 8. Perform hand hygiene and put on clean gloves. 9. Remove soiled dressing and discard into designated container. 10. Remove gloves and perform hand hygiene. 11. Put on clean gloves. On 1/22/25 at 4:41 p.m., ASM #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit. 3. For Resident #3 (R30), the facility staff failed to evidence the administration of treatments for pressure injuries. The physician orders dated 1/5/25, documented, Cleanse left distal upper back every day shift; cleanse left distal upper back with NS (normal saline) apply Silvasorb (1), cover with bordered gauze change daily. Left upper back every day shift; cleanse area to left upper back with NS, apply Silvasorb secure with foam bordered gauze change daily. Sacral Wound: clean with Dakin's solution (2), apply Santyl (3) and Dakin's moist gauze, cover with superabsorbent dressing and bordered foam every day shift. The January 2025 TAR (treatment administration record) documented the above orders. There was no documentation for the day shift for 1/20/25. The comprehensive care plan dated, 10/22/24, documented in part, Focus: The resident has a pressure ulcer or has the potential for pressure ulcer development r/t disease process, history of pressure ulcers, immobility, admitted with sacral wound stage 4. Interventions: Administer treatments as ordered. An interview was conducted with LPN (licensed practical nurse) #1 on 1/22/25 at 11:32 a.m. When asked how nurse evidence that they've completed a physician prescribed treatment, LPN #1 stated the nurse signs it off on the TAR. ASM #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings on 1/23/25 at 1:08 p.m. No further information was provided prior to exit. References: (1) Silvasorb is a silver-based product that is used to treat minor cuts, scrapes, burns, skin irritation, ulcers, and wounds. It may cause allergic reactions, skin infections, or overdose symptoms. This information was obtained from the following website: https://www.drugs.com/cdi/silvasorb.html (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(2) Dakins Full Strength Solution is used to treat or prevent infections caused by cuts or abrasions, skin ulcers, pressure ulcers, diabetic foot ulcers, or surgery. This information was obtained from the following website: https://www.drugs.com/mtm/dakins-full-strength-solution.html. (3) Santyl (for the skin) is used to treat severe burns or skin ulcers in adults. Santyl helps remove dead skin tissue and aid in wound healing. This information was obtained from the following website: https://www.drugs.com/mtm/santyl.html.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 27660 Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to maintain a complete and accurate clinical record for one of 11 residents in the survey sample, Resident #4. The findings include: For Resident #4, the facility staff failed to document the notification of the nurse practitioner of when a medication was held. The physician order dated, 1/9/25, documented, Metoprolol Tartrate Tablet (1) 25 MG (milligrams); Give 1 tablet via PEG-tube two times a day related to essential hypertension. The January 2025 MAR documented the above order. On 1/21/25 at the scheduled 5:00 p.m. dose a 5 was documented. A 5 indicates, Hold. The nurse's notes dated 1/21/25 at 8:13 p.m. documented, Patient received Midodrine (2). BP (blood pressure) 115/67. HR (heart rate) 97. There was no notification to the doctor or responsible party as to why the medication was held. There were no documented parameters for this mediation order. On 1/22/25 at 11:32 a.m., An interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated That if a nurse cannot find the medication on the medication cart, the facility has a backup pharmacy system. If it's in there, then you get it from there. If not available, you call the doctor and follow their instructions. When asked if they document anything in the clinical record that it couldn't be given, LPN #1 stated, Yes, 'The nurse should document a progress note of why it wasn't given, calling the doctor and you have to call the responsible party also. On 1/23/25 at 11:22, An interview was conducted with ASM (administrative staff member) #8, the nurse practitioner, a.m. ASM #8 stated that the nurse did text her on 1/21/25 to tell her she had held the Metoprolol. The facility policy, Charting and Documentation, documented in part, 7. Documentation of procedures and treatments will include care-specific details, including .f. notification of family, physician or other staff, if indicated. On 1/23/25 at 1:08 p.m., ASM #1, the administrator, ASM #1, the administrator, ASM #2, the director of nursing, ASM #3, the vice president of operations, ASM #4, the regional director of operations, ASM #5, the vice president of clinical services and ASM #6, the regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit. References: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(1) Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to treat chronic (long-term) angina (chest pain). Metoprolol is also used to improve survival after a heart attack. Metoprolol also is used in combination with other medications to treat heart failure. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682864.html. (2) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a616030.html.