STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495291	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shalom Gardens Health & Rehabilitation	1600 John Rolfe Parkway Richmond, VA 23233

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on staff interviews, clinical record review, and facility documentations the facility staff failed to notify the responsible party about a fall for one resident, Resident #23 (R23) out of a survey sample of 24 residents. The findings included:Facility staff failed to notify the responsible party of R23's reported fall.On 5/4/26 at 2:10 pm an interview was conducted a registered nurse, RN1. RN1 stated that when a fall is reported the resident should be assessed and then the physician and responsible representative (RP) should be notified. She said, if a resident reports a fall, it should be treated as a fall and post assessments should be completed.On 5/6/26 at 12:48 pm, an interview was conducted with the assistant director of nursing, ADON. She stated that R23's fall occurred on 4/15/26. She further stated that post fall assessments were not completed. The ADON stated that agency staff were involved and that the staff member failed to complete the required fall assessments. She also acknowledged that the RP should have been notified but was not. Additionally, she acknowledged that the care plan was not updated following the fall. On 5/6/26, a clinical record review was conducted. RN1 had a progress note she wrote that read in part, .4/16/2026 14:06 Writer asked resident when she had fallen. She stated this morning. Writer asked resident where did she fall at? Resident stated, out there. When writer asked resident how she got up, resident stated, I don't know I dragged myself up I guess. Writer asked nurse if she had any knowledge of this. The nurse stated that the resident said she had fallen the night before and that some woman got her up. Writer went back into residents room and spoke to resident and daughter. Daughter said well she must have fallen because she said so. Reviewed a progress note that was written by a licensed practical nurse, LPN6. The progress note read in part, .4/16/2026 08:48:27 This resident [R23] reported to OT that she had a fall yesterday. This writer [LPN6] asked the resident if she fell and she stated She fell earlier in the day yesterday, when asked if anyone helped her up she said some girl and when asked about injuries the resident stated she was not hurt. V/S 133/80, 77, 18, 97.8, 99% on room air. No skin concerns noted r/t to fall or injuries noted during assessment by this writer.The clinical record had no documentation of any staff member notifying the responsible representative of the reported fall by R23 on 4/16/26 and the care plan had no recorded fall for that day or any interventions.On 5/6/26, facility documentation was reviewed. The document titled, Change in a Resident's .Condition, read in part, .The facility will promptly notify the resident, his or her physician/practitioner, resident's medical/mental condition and representative of changes in the etc.). and/or status (e.g., changes in level of care, billing/payments, resident rights. 1. The nurse a(an): will notify the resident's Attending Physician / practitioner or physician on call when there has a. accident or incident involving the resident; b. discovery of injuries of an unknown source; c. adverse reaction to medication; d. significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in e. health, need to mental, or psychosocial status in either life-threatening conditions or clinical complications) alter the resident's medical treatment significantly; f. refusal of treatment or medications two (2) or more consecutive times); g. need to transfer the resident to a hospital/treatment center; h. discharge without proper medical authority; and/or i. specific instruction to notify the physician/practitioner of changes in the resident's condition.On 5/6/26 a meeting was (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	held with the administrator, the director of nursing, and the assistant director of nursing and the above concerns were discussed.No additional information was presented prior to exit conference.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on clinical record reviews, observations, staff interviews, and facility documentation the facility staff failed to review and revise the comprehensive person centered care plans for three residents, Resident #15 (R15), Resident # 23 (R23), and Resident #24 (R24) out of a survey sample of 24 residents. The findings included:1. Facility staff failed to implement fall interventions and precautions after R15 had a fall.On 5/5/26, a clinical record review was conducted. During the review, R15's care plan was reviewed. The care plan had a concave mattress as the intervention for R15's fall on 3/9/26 and was the only intervention for that fall.On 5/5/26 at 2:00 pm, an observation was made of R15's bed and he did not have a concave mattress on his bed. It was observed that R15 had an alternating pressure mattress on his bed.On 5/6/26 at 12:48 pm, the Assistant Director of Nursing, (ADON) stated that a concave mattress was initially considered as a fall intervention; however, it was not placed on the resident's bed. The resident currently has an alternating pressure mattress in place due to skin impairment. The ADON stated the concave mattress should have been implemented following the resident's fall on 3/9/26. ADON further acknowledged the care plan should have been updated to include the fall interventions and stated the care plan would be updated at this time. 2. Facility staff failed to implement interventions for R23's fallsOn 5/5/26, a clinical record was reviewed. During the review, there was a progress note written on 3/19/26 that read in part, .resident [R23] found sitting on floor in front of wheelchair. Resident [R23] states she was reaching for her snack and slipped out of chair. Resident [R23] denies pain, denies any injuries. Resident assisted back into chair. Vitals taken, WNL [within normal limits].During the clinical record review there was a progress note dated 4/16/26 that read in part, . This resident [R23] reported to OT that she had a fall yesterday. This writer asked the resident [R23] if she fell and she stated, She fell earlier in the day yesterday, when asked if anyone helped her up she said, some girl and when asked about injuries the resident stated she was not hurt. V/S 133/80, 77, 18, 97.8, 99% on room air. No skin concerns noted r/t to fall, or injuries noted during assessment by this writer. A review of R23's care plan revealed there were no falls or fall interventions implemented following the falls that occurred on 3/19/26 or 4/16/26.On 5/6/26 at 12:48 pm, an interview was conducted with the ADON, and she acknowledged that R23's care plan was not updated with the fall or fall interventions for the falls on 3/19/26 or 4/16/26. 3. Facility staff failed to include R24's behaviors and interventions in the resident's care plan.On 5/4/26 at 1:00 pm, during a tour of the nursing units R24 was observed sitting in her room on her phone yelling and cursing about facility staff members and things she felt they had done. She was saying the staff ignored her call bell, gave her the wrong medications, serves her food in cups and the food was cold. On 5/5/26, a clinical record review was conducted. Throughout the review, progress notes documented behaviors including agitation, yelling, screaming at staff, cursing, refusal of care and medications, wanting medications explained, and being tearful at times. A review of R24's care plan revealed there were no documented behaviors or interventions related to these behaviors.On 5/6/26 at 12:48 pm, An interview with the ADON was conducted regarding R24's care plan. The ADON stated they were waiting for the nurse practitioner to evaluate the resident so diagnoses could be obtained to address the behaviors and determine appropriate care plan interventions. The ADON stated she understood the resident's behaviors were documented throughout the progress notes and acknowledged the care plan had not been updated. The ADON stated, We need her to see the in-house psychiatric provider to see if we can meet her needs. ADON acknowledged the care plan needed to be completed and revised, stating, we are trying, but it's hard to do when her behavior is not the same daily.On 5/6/26, a facility documentation review was conducted. The facility policy titled, Care Planning - Comprehensive Person-Centered, read in part, . A person-centered comprehensive care plan that includes measurable objectives and resident. To the extent the resident's medical, nursing, mental and psychosocial needs shall be developed for each participate in the care planning (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practicable, the resident/resident representative will be provided with opportunities to participate in the care planning process. 16. The Care Planning/Interdisciplinary a. When Team is responsible for the review and updating of care plans: requested by the resident/ resident representative b. When there has been a significant change in the resident's condition; C. When the desired outcome is not met; d. When goals, needs, and preferences change e. When the resident has been readmitted to the facility from a hospital stay; and f. At least quarterly and after each OBRA MDS assessment. On 5/6/26, a meeting was held with the administrator, director of nursing, and the assistant director of nursing and they were made aware of the above concerns.No additional information was provided prior to exit conference.

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident?s advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to provide basic life support measures to include initiation of cardiopulmonary resuscitation (CPR) in accordance with the resident's wishes/advance directives for one of twenty-four residents in the survey sample (Resident #1). Resident #1, with physician orders for a full code status requiring CPR in case of cardiac/respiratory arrest, had no immediate assessment, basic life saving measures, or CPR efforts initiated, when the resident was found unresponsive and without pulse/respirations, resulting in the resident being pronounced deceased . This failure resulted in the identification of immediate jeopardy and substandard quality of care.The findings include:Resident #1, ordered with a full code resuscitation status, had no immediate assessment, CPR initiated, or other life sustaining measures initiated when the resident was found unresponsive and without pulse/respirations on [DATE], instead the resident was pronounced deceased .Resident #1 (R1) was admitted to the facility with diagnoses that included cerebral infarction (stroke) with hemiplegia, aphasia, dysphagia with gastrostomy, respiratory failure with hypoxia, diabetes, hypertension, insomnia and gastroesophageal reflux disease (GERD). The minimum data set (MDS) date [DATE] assessed R1 with severely impaired cognitive skills.R1's clinical record documented the resident was pronounced deceased on [DATE] at 12:30p.m.R1's clinical record documented a physician's order dated [DATE] for a full code resuscitation status in case of cardiac/respiratory arrest. R1's plan of care at the time of the resident's death listed the resident's resuscitation status as full code with interventions listed to follow code status as ordered by the physician and education of staff regarding the resident's resuscitation status.R1's clinical record included a nursing noted entered by licensed practical nurse (LPN) #1 on [DATE] stating a scheduled second nurse on the unit did not show for work. LPN #1 documented on [DATE], .I received the keys from the night nurse only because the scheduler said she just got off the phone with the second nurse and she would be here in 10 minutes. I started med [medication] pass with a lot of interruption it was extremely busy; I texted the scheduler around 10 am to say I don't see the 2nd nurse, she replied I'm working on getting someone in to work. After completing med pass around 12:30, DON [director of nursing] approached me to say I need to start med pass on the 2nd cart and to complete the blood sugars I went to check [Resident #1] and touched her arm to say I planned on doing and notice she was unresponsive I then called out to the CNA [certified nurse's aide] for help, then we contacted DON. (sic) LPN #1 documented no assessment of R1 for vital signs (blood pressure, pulse, respirations) and initiated no life support efforts including CPR and made no mention of the resident's code status.A nursing note was entered in R1's record by registered nurse (RN) #1 on [DATE] at 4:38 p.m. that documented, .Was alerted to come to the room. Resident was found unresponsive in the bed. Assessed resident and no spontaneous respirations observed. No palpable carotid pulse noted upon palpation. No heart sounds auscultated with stethoscope for one full minute. Extremities were cold to the touch. No signs of life observed. Pronounced deceased at 1230 [12:30 p.m.] . An addendum listed as a late entry was documented by RN #1 on [DATE] stating, .Was alerted to come to the room. Resident was found unresponsive in the bed. Assessed resident and no spontaneous respirations observed. No palpable carotid pulse noted upon palpation. No heart sounds auscultated with stethoscope for one full minute. Extremities were cold to the touch. Resident noted to be pale in color. Mouth open and eyes closed. Rigor mortis present. No other signs of life observed. Pronounced deceased at 1230 . RN #1 initiated no CPR, documented no mention of the resident's code status or any explanation of why CPR was not or had not been initiated.R1's clinical record documented a note by the then Administrator (other staff #5) stating that he notified R1's family on [DATE] at approximately 1 p.m. of the resident's death. This note documented, .Emergency Medical Technicians (EMTs) were notified and responded to the (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility to assess [R1]. Upon their arrival and assessment, they confirmed that [R1] had expired . The Administrator documented no mention of R1's code status or any rationale for why staff had not initiated CPR.The nurses involved (LPN #1, RN #1), the DON and the Administrator documented no explanation of why CPR was not initiated when R1 was found responsive and subsequently with no pulse or respirations. The clinical record provided no explanation or rationale for why basic life saving measures were not initiated. It was unclear from the documentation of who called emergency medical services regarding the resident's condition.R1's clinical record documented the resident was assessed on [DATE] by the nurse practitioner for respiratory congestion and was prescribed an antibiotic and nebulizer treatments. The nebulizer treatment was administered on [DATE] at 9:00 p.m. with the antibiotic scheduled to start on [DATE] at 9:00 a.m. R1's clinical record documented care during the prior night shift (11:00 p.m. to 7:00 a.m.) with no changes in condition noted/documented. The night shift nurse caring for R1 on [DATE] until 7:00 a.m. documented changing of the gastric tube syringe, checking gastric tube residuals, care to the gastric tube site, gastric tube flushes as ordered in addition to a pain assessment with no care concerns noted. CNA #1 that cared for R1 on [DATE] starting at 7:00 a.m., documented care/assistance had been provided for R1 during the morning prior to 11:00 a.m. CNA #1 entered in the care tracking system on [DATE] at 10:53 a.m. that assistance had been provided for R1 that included bed mobility, dressing, personal hygiene and incontinence care for a bowel movement. R1's clinical record documented no nursing care, assessments or medication administration for R1 on day shift on [DATE] that started at 7:00 a.m. There was no nursing documentation for R1 until the resident was found unresponsive around 12:30 p.m. R1's physician ordered medications and treatments scheduled for [DATE] at 9:00 a.m., were not administered. This included the following: insulin per sliding scale (based on blood sugar reading), aspirin and Plavix for stroke prevention, esomeprazole magnesium for GERD, lisinopril and carvedilol for hypertension, polyethylene glycol for constipation, baclofen for dysarthria, and the antibiotic amoxicillin and albuterol nebulizer treatment for the newly diagnosed upper respiratory congestion.The nursing schedule was reviewed and documented two nurses were scheduled to work on R1's unit on the day shift (7:00 a.m. to 3:00 p.m.) on [DATE]. The as-worked schedule documented LPN #1 worked the shift starting at 7:00 a.m. but the other nurse slot was listed as open with no nurse listed as working prior to R1's death at 12:30 p.m.LPN #1 and CNA #1 that worked on R1's unit on the morning of [DATE] and the DON at the time of R1's death, were not available for interview as they no longer worked for the facility.On [DATE] at 2:25 p.m., RN #1 that pronounced R1's death on [DATE] was interviewed. RN #1 stated [DATE] was her first day working as a registered nurse after just completing education/testing. RN #1 stated she was not working on R1's unit on [DATE] but worked on the adjacent unit on the same floor. RN #1 stated the nurse from unit 2 (LPN #1) came over and said she thought that R1 had passed away. RN #1 stated she went, assessed the resident and pronounced her death. When asked what R1's code status was, RN #1 stated, I don't know. She [R1] was not my patient. When asked how nurses knew the code status for residents, RN #1 stated the code status displayed on the medication record, on physician orders and the 24-hour report sheet. RN #1 stated when she arrived and assessed R1, nobody had called a code or initiated CPR. RN #1 stated she pronounced the resident's death at 12:30 p.m. RN #1 stated that the DON was there. RN #1 stated she was not sure who called 911. RN #1 stated the DON was on the phone when she was assessing the resident and that she assumed the DON was calling 911. On [DATE] at 3:50 p.m. RN #1 was interviewed again about R1's death and no CPR. RN #1 stated the administrator nor the DON, discussed the resident's death with her. RN #1 stated she remembered getting education after the event about what to do if a resident was found unresponsive.On [DATE] at 2:53 p.m., the current DON was interviewed about any assessment or care that had been provided for R1 on the morning of [DATE] prior to being found unresponsive. The DON stated she reviewed the clinical record and CNA #1 documented on [DATE] at 10:53 a.m. that care had been provided that included incontinence care, dressing and personal hygiene. The DON presented no other documentation of care or assessment of (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1 prior to being found unresponsive.On [DATE] at 4:52 p.m., the current Administrator, DON and ADON (RN #2) were interviewed about why no assessment and subsequent CPR was initiated for R1 when found unresponsive. The administrator stated none of the current administrative staff (administrator, DON, ADON) worked in the facility at the time of R1's death. The ADON stated she had reviewed the clinical record. When asked if CPR was initiated for R1 on [DATE] and if the resident had a do not resuscitate order, the ADON stated, No. The administrator, DON and ADON offered no explanation of why CPR was not initiated for R1 when the resident was a full code.On [DATE] at 8:26 a.m., the Administrator (other staff #5) at the time of R1's death was interviewed by phone. The former Administrator stated on the morning of [DATE], he was observing residents in the dining room on R1's unit. The former Administrator stated he saw the DON coming down the hall around 12:30 p.m. The former Administrator stated the DON said she was looking into rooms, performing rounds and that he accompanied the DON with the rounding. The former Administrator stated R1's room was the fourth room they observed during the walk-through. The former Administrator stated when they entered R1's room, R1 was in bed, the head of the bed up, eyes closed and that R1 looked like she had expired. The former Administrator stated the DON had a stethoscope and checked the resident and said R1 was no longer with us. The former Administrator stated the resident was cold, pale, bluish and had a stiff body. The Administrator stated he was not sure how long R1 had been in that condition. The Administrator stated he called the MDS nurse to come to assist with post-mortem care, that he left the room at that time and called to notify the family of the death. The Administrator stated emergency services were called and came but he did not recall who called them. When asked if CPR was initiated or attempted for R1, the former administrator stated, I cannot speak to that. The former Administrator stated he was not in the room when emergency services were called and no one else was in the room when he observed the resident other than the DON. The former Administrator stated R1 had been a long-term resident in the facility, and he was aware that she was a full code. The former Administrator stated that when he saw the resident and touched her, there were signs of rigor mortis and that was a reason listed in policy to not to do CPR. The former Administrator stated prior to entering the room with the DON, no staff members had informed him of the resident's death and that he had no conversation with LPN #1 or RN #1 about the death or circumstances surrounding the death. The former Administrator stated the DON did not appear shocked when they entered R1's room and found her with signs of death. The former Administrator was asked if there were concerns about why CPR had not been initiated or if the circumstances around R1's death were reviewed and/or discussed following the incident. The former Administrator stated he thought deaths were reviewed in the morning meeting. The former Administrator stated the next day was Friday ([DATE]) and he left the facility for an appointment at 11:30 a.m. and returned later in the afternoon. The former Administrator stated [DATE] was his last day working as Administrator of the facility and he was not sure what if any actions were taken in response to the death. The former Administrator offered no explanation of why R1 was not assessed when found unresponsive by LPN #1 or why staff had not started CPR when the resident had no pulse/respirations. The former Administrator stated that finding a resident with rigor mortis was in the policy as a reason not to perform CPR but did not indicate that was what occurred with R1's death. The former Administrator voiced that he was unaware of the resident's death until he entered the room with the DON, that the DON assessed the resident with a stethoscope in his presence and that he had no conversation with the RN that pronounced the resident's death (RN #1) or LPN #1 that first found the resident unresponsive. The facility presented certificates listing that LPN #1, RN #1 and the former DON (other staff #4) had been trained to perform CPR at the time of R1's death.The facility presented an in-service education sheet dated [DATE] addressed to all nurses and CNAs regarding the topic titled Code Blue. This education documented instructions that if a patient was found unresponsive, dial *88, call code blue and name room number, to start CPR if the patient was a full code until emergency services arrived. This sheet had signatures of forty-seven nursing staff members (RNs, LPNs, CNAs).The facility's policy titled (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Cardiopulmonary resuscitation (CPR) (undated) documented, The facility will provide emergency basic life support immediately when needed, including cardiopulmonary resuscitation (CPR), to any resident requiring such care, prior to the arrival of emergency medical personnel, in accordance with physician orders, such as a DON, and the resident's advance directives . This policy defined basic life support as, .a level of medical care which is used for victims of life-threatening illnesses or injuries until they can be given full medical care at a hospital, and may include recognition of sudden cardiac arrest, activation of the emergency response system, early cardiopulmonary resuscitation . The policy listed under procedures/guidance, .Staff will initiate CPRT when cardiac or pulmonary arrest occurs, unless .A valid DO Not Resuscitate (DNR) order is in place .There is an obvious clinical sign of irreversible death (e.g., rigor mortis, dependent lividity, decapitation, transection, or decomposition); or .Initiating CPR could cause injury or peril to the rescuer . The facility's policy titled Death of A Resident - Documenting (undated) documented, .Appropriate documentation shall be made in the clinical record concerning the death of a resident .All information pertaining to a resident's death (i.e., date, time of death, the name and title of the individual pronouncing the resident dead, etc.) will be recorded on the nurses' note .All records will be completed and maintained in the resident's medical record in accordance with federal/state law .Facility staff failed to immediately assess R1's vital signs when the resident was found unresponsive on [DATE] at around 12:30 p.m. LPN #1 documented she left the resident to notify staff of the resident's condition instead of assessing and initiating potentially life-saving CPR. RN #1 that came from another unit and assessed and pronounced the resident's death, stated she was not aware of the resident's code status because R1 was not her patient. The interview with the former administrator working in the facility when R1 died, provided conflicting information and timing to the events documented and/or stated by LPN #1 and RN #1. It was unclear to the survey team why the DON assessed R1 when seen with the administrator when the resident's death was pronounced by RN #1 at 12:30 p.m. It was unclear who called 911 emergency services for R1 or when and interviews with RN #1 and the former administrator offered no explanation of why R1 was not immediately assessed and CPR started as required. No staff members, including the DON or RN #1, documented that CPR was not initiated due to rigor mortis.On [DATE] at 10:45 a.m., after consulting with the state agency supervision, immediate jeopardy was identified regarding facility staff's failure to initiate CPR for R1 who had a physician order for CPR. The administrator, DON, ADON and regional nurse consultant were notified at this time of the immediate jeopardy, and a plan of removal was requested. The facility's plan of immediacy removal was presented and included the following.Resident #1 expired on [DATE]All residents currently residing at the facility have the potential to be affected by this practice. All residents' code status preferences verified and updated accordingly.Licensed nursing staff in-serviced on policy regarding Death of a resident and Cardiopulmonary Resuscitation. Any staff not present on [DATE] will be required to receive mandatory education prior to the start of their next shift. No staff will be allowed to return to work after [DATE] until this mandatory education has been completed. New hire orientation will include this education/training as part of the new hire process and all agency staff will be required to complete training/education prior to starting work in the facility.A 100% audit was completed on code status of admission and re-admission for resident preferences for advanced directives.The medical director was notified of the situation on [DATE].The facility conducted an Ad Hoc QAPI meeting to accept the immediate jeopardy removal plan on [DATE].Date of compliance [DATE] at 6:00 p.m.On [DATE], the survey team reviewed the facility policies for death of a resident and cardiopulmonary resuscitation. The audits of resident's code status conducted by the facility were reviewed and a sample of residents was reviewed to ensure accuracy and documentation within the clinical record of code status per residents' wishes. The survey team conducted staff interviews with licensed nurses and certified nursing aides on each of the units and confirmed education had been completed and staff were knowledgeable about the CPR and resident death policies. Staff records were reviewed and verified nursing staff had current CPR certification. After verification of the plan of immediate (continued on next page)

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Shalom Gardens Health & Rehabilitation	1600 John Rolfe Parkway Richmond, VA 23233

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	jeopardy removal and consultation with state agency supervisory staff, the immediate jeopardy was removed on [DATE] at 12:00 p.m. at which time the facility administration was notified. Following the removal of the immediate jeopardy status, this deficiency was cited at level 3, isolated (harm).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for medications/treatments for one of twenty-four residents in the sample (Resident #1) and failed to document ongoing assessments of a wound for one of twenty-four residents in the sample (Resident #3).The findings include:1. Resident #1 was not administered medications/treatments as ordered by the physician. Resident #1 (R1) was admitted to the facility with diagnoses that included cerebral infarction (stroke) with hemiplegia, aphasia, dysphagia with gastrostomy, respiratory failure with hypoxia, diabetes, hypertension, insomnia and gastroesophageal reflux disease (GERD). The minimum data set (MDS) date 6/3/25 assessed R1 with severely impaired cognitive skills.R1's clinical record documented on 8/14/25 the resident had current physician orders for the following medications/treatments that were scheduled for administration at 9:00 a.m.Lispro insulin per sliding scale (based upon blood sugar reading) for treatment of diabetes; aspirin 81 mg (milligrams) for stroke prevention, Plavix 75 mg for stroke prevention, esomeprazole magnesium 40 mg for GERD, lisinopril 10 mg for hypertension, carvedilol 12.5 mg for hypertension, polyethylene glycol 17 grams for constipation, baclofen 5 mg for dysarthria, albuterol sulfate 0.83% 3 milliliters nebulizer for respiratory congestion, amoxicillin 875-125 mg for respiratory congestion and zinc oxide to buttocks for skin protection.R1's medication administration record documented these medications/treatments were not administered on 8/14/25 at 9:00 a.m. as scheduled.R1's clinical record included a nursing note entered by licensed practical nurse (LPN) #1 on 8/14/25 stating a scheduled second nurse on the unit did not show for work. LPN #1 documented on 8/14/25, .I received the keys from the night nurse only because the scheduler said she just got off the phone with he second nurse and she would be here in 10 minutes. I started my med [medication] pass with a lot of interruption it was extremely busy, I texted the scheduler around 10 am to say I don't see the 2nd nurse, she replied I'm working on getting someone in to work. After completing med pass around 12:30, DON [director of nursing] approached me to say I need to start med pass on the 2nd cart and to complete the blood sugars . (sic)On 5/4/26 at 2:53 p.m., the current DON was interviewed about the medications/treatments not provided for R1 on 8/14/25 at 9:00 a.m. as ordered/scheduled. The DON stated the certified nurse's aide (CNA #1) provided care for R1 on the morning of 8/14/25 but presented no documentation the resident's medications or treatments were administered. On 5/5/26 at 9:00 a.m., the current administrator, DON and assistant director of nursing (ADON - RN #2) were interviewed about staffing on R1's unit on 8/14/25. The ADON stated the schedule indicated a nurse position on the morning on 8/14/25 was open and not filled. The ADON stated she was not working in the facility at that time but currently two nurses were required on R1's unit to provide needed care/services that included medication administration. The ADON stated if a nurse was not available, nurse managers, infection preventionist, ADON or the DON were expected to work so that required care was provided. The ADON stated she was not sure if or why someone was not assigned to administer medications for R1 on the morning of 8/14/25. This finding was reviewed with the administrator, DON, ADON and regional nurse consultant during a meeting on 5/5/26 at 4:30 p.m. with no further information provided prior to the end of the survey. 2. Facility staff failed to document thorough assessments of trauma wounds for Resident #3.Resident #3 (R3) was admitted to the facility with diagnoses that included gunshot wounds to both thighs, hyperlipidemia, cognitive communication deficit, dysphagia and respiratory failure with hypoxia. The minimum data set (MDS) dated [DATE] assessed R3 as cognitively intact.R3's clinical record documented an admission nursing assessment dated [DATE] that listed the resident had gunshot wounds to the front of both thighs. A nursing note dated 8/21/25 at 7:51 p.m. documented diagnosis of gunshot wounds to bilateral extremities. The admission assessment and nursing note documented no assessment of the gunshot wounds describing the appearance, size, characteristics/presence of drainage, odor if any or (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition of surrounding skin.R3's clinical record documented physician orders dated 8/22/25 for treatment for the gunshot wounds with daily dressing changes that included cleansing with normal saline, application of Iodoform packing and covering with gauze and ABD pad/tape. R3's medication administration record documented the wound care and dressing changes were provided daily as ordered from 8/22/25 until the resident's discharge on [DATE].Daily skilled nursing notes including weekly skin assessments documented the resident had thigh wounds but did not include descriptive assessment of the wounds. Dressing changes were performed daily as ordered but notes did not document a descriptive assessment of the wounds' status. A physician and/or nurse practitioner assessed R3 on 8/25/25, 8/28/25, 9/1/25, 9/3/25, 9/8/25, 9/9/25 and 9/10/25. The providers documented the wound dressings as intact but listed no descriptive assessment of the wounds. R3 went out of the facility for a surgical follow up visit regarding the gunshot wounds on 8/25/25. Nursing notes documented the surgical consultant requested no changes in treatment but documented no descriptive status of the wounds. A registered nurse assessed R3 on 9/9/25 and documented erythema and edema of the left thigh wound with serosanguineous drainage noted and no edema/drainage of the right thigh wound. This change in wound status was reported to the on-call provider with orders implemented in response to the change in condition. On 5/6/26 at 8:45 a.m., the director of nursing (DON) was interviewed about any wound assessments for R3's thigh wounds. The DON reviewed the clinical record and stated skin assessments were documented, that the resident was seen by the consultant surgeon on 8/25/25 with orders to continue treatments and that nurses monitored the wounds during daily dressing changes. The DON presented no documented descriptive assessments of R3's wounds.On 5/6/26 at 1:08 p.m., the nurse practitioner (other staff #6) that cared for R3 was interviewed. The NP stated dressing changes were performed as ordered. The NP stated R3 was assessed by a consultant surgeon as follow up care for the wounds. The NP stated she was not sure if nursing documented assessments when dressings were changed and that changes in condition or wound status were reported and addressed.The facility's policy titled Wound Care (effective 7/2024) documented the policy purpose was to monitor wounds for signs and symptoms of infection or other complications. This policy documented that wounds would be assessed on admission and at each dressing change with nursing noting the wound appearance (size, color, condition), odor if any, amount of drainage, type of dressing and any concerns if noted and that the nurse would chart their observations on admission and at each dressing change and notify the physician of any changes in condition.This finding was reviewed with the administrator, DON, assistant director of nursing and regional nurse consultant during a meeting on 5/5/26 at 4:30 p.m. with no further information presented prior to the end of the survey.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff interviews, clinical record reviews, and facility documentation the facility staff failed to assess the resident following a reported fall for one resident, Resident #23 out of a survey sample of 24 residents. The findings included:The facility staff failed to complete post fall assessments on R23 reported fall.5/4/26 at 2:10 pm an interview was conducted a registered nurse, RN1. RN1 stated that when a fall is reported the resident should be assessed and then the physician and responsible representative (RP) should be notified. She said, if a resident reports a fall, it should be treated as a fall and post assessments should be completed.On 5/6/26 at 12:48 pm, an interview was conducted with the assistant director of nursing, ADON. She stated that R23's fall occurred on 4/15/26. She further stated that post fall assessments were not completed. The ADON stated that agency staff were involved and that the staff member failed to complete the required fall assessments. On 5/6/26, a clinical record review was conducted. RN1 had a progress note she wrote that read in part, .4/16/2026 14:06 Writer asked resident when she had fallen. She stated this morning. Writer asked resident where did she fall at? Resident stated, out there. When writer asked resident how she got up, resident stated, I don't know I dragged myself up I guess. Writer asked nurse if she had any knowledge of this. The nurse stated that the resident said she had fallen the night before and that some woman got her up. Writer went back into residents room and spoke to resident and daughter. Daughter said well she must have fallen because she said so. Reviewed a progress note that was written by a licensed practical nurse, LPN6. The progress note read in part, .4/16/2026 08:48:27 This resident [R23] reported to OT that she had a fall yesterday. This writer [LPN6] asked the resident if she fell and she stated She fell earlier in the day yesterday, when asked if anyone helped her up she said some girl and when asked about injuries the resident stated she was not hurt. V/S 133/80, 77, 18, 97.8, 99% on room air. No skin concerns noted r/t to fall or injuries noted during assessment by this writer.During the review of the clinical record, there was no documentation of post- fall assessments for R23 following the fall on 4/16/26. There were no documented vital signs, neurological checks, or skin assessments completed after the initial progress note of the reported fall.On 5/6/26, a review of facility documentation was conducted. The facility document titled, Fall and Fall management, read in part, Fall refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred (refer to Resident Assessment Instrument User's Manual. Version 3.0, Resident-Centered Approaches to Managing Falls and Fall Risk - 1. The staff, with the input of the attending physician/practitioner, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once). This was the policy provided when policy for fall protocol and procedure was requested.On 5/6/26, a meeting was held with the administrator, the director of nursing, and the assistant director of nursing and the above concerns were discussed.No additional information was provided prior to exit conference.

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to provide sufficient nursing staff for assessment/monitoring of one of twenty-four residents in the survey sample (Resident #1). With no nurse assigned, Resident #1 had no assessment or administration of medications/treatments on the morning [DATE]. Resident #1 was found unresponsive on [DATE] at 12:30 p.m. without pulse or respirations and was pronounced deceased without initiation of required CPR (cardio-pulmonary resuscitation). This resulted in the identification of immediate jeopardy.The findings include:Staffing schedules documented no nurse assigned to care for Resident #1 on [DATE] during the day shift (7:00 a.m. to 3:00 p.m.). Resident #1 had no documented nursing assessments or medications administered on the morning [DATE], was found at 12:30 p.m. unresponsive and subsequently without pulse or respirations and was pronounced deceased without initiation of required CPR. A nurse scheduled to report shortly after 7:00 a.m. did not report for duty and no other nurse was assigned to care for the resident.Resident #1 (R1) was admitted to the facility with diagnoses that included cerebral infarction (stroke) with hemiplegia, aphasia, dysphagia with gastrostomy, respiratory failure with hypoxia, diabetes, hypertension, insomnia and gastroesophageal reflux disease (GERD). The minimum data set (MDS) date [DATE] assessed R1 with severely impaired cognitive skills.R1's clinical record included a nursing noted entered by licensed practical nurse (LPN) #1 on [DATE] stating a scheduled second nurse on the unit did not show for work. LPN #1 documented on [DATE], .I received the keys from the night nurse only because the scheduler said she just got off the phone with the second nurse and she would be here in 10 minutes. I started my med [medication] pass with a lot of interruption it was extremely busy, I texted the scheduler around 10 am to say I don't see the 2nd nurse, she replied I'm working on getting someone in to work. After completing med pass around 12:30, DON [director of nursing] approached me to say I need to start med pass on the 2nd cart and to complete the blood sugars I went to check [Resident #1] and touched her arm to say I planned on doing and notice she was unresponsive I then called out to the CNA [certified nurse's aide] for help, then we contacted DON. (sic) LPN #1 documented no assessment of R1 for vital signs (blood pressure, pulse, respirations) and initiated no life support efforts including CPR and made no mention of the resident's code status.A nursing note entered in R1's record by registered nurse (RN) #1 on [DATE] at 4:38 p.m. documented, .Was alerted to come to the room. Resident was found unresponsive in the bed. Assessed resident and no spontaneous respirations observed. No palpable carotid pulse noted upon palpation. No heart sounds auscultated with stethoscope for one full minute. Extremities were cold to the touch. No signs of life observed. Pronounced deceased at 1230 [12:30 p.m.] . An addendum listed as a late entry was documented by RN #1 on [DATE] stating, .Was alerted to come to the room. Resident was found unresponsive in the bed. Assessed resident and no spontaneous respirations observed. No palpable carotid pulse noted upon palpation. No heart sounds auscultated with stethoscope for one full minute. Extremities were cold to the touch. Resident noted to be pale in color. Mouth open and eyes closed. Rigor mortis present. No other signs of life observed. Pronounced deceased at 1230 . R1's clinical record documented a note by the then Administrator (other staff #5) stating that he notified R1's family on [DATE] at approximately 1 p.m. of the resident's death. This note documented, .Emergency Medical Technicians (EMTs) were notified and responded to the facility to assess [R1]. Upon their arrival and assessment, they confirmed that [R1] had expired . R1's clinical record documented a physician's order dated [DATE] for a full code resuscitation status in case of cardiac/respiratory arrest. The nursing schedule was reviewed and showed two nurses were scheduled to work on R1's unit on the day shift (7:00 a.m. to 3:00 p.m.) on [DATE]. The as-worked schedule documented LPN #1 worked the shift starting at 7:00 a.m. but the second nurse for the unit was marked as open with no nurse listed (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	as working this slot prior to R1's death at 12:30 p.m.R1's clinical record documented the resident was assessed on [DATE] by the nurse practitioner for respiratory congestion and was prescribed an antibiotic and nebulizer treatments. The nebulizer treatment was administered on [DATE] at 9:00 p.m. with the antibiotic scheduled to start on [DATE] at 9:00 a.m. R1's clinical record documented care during the prior night shift (11:00 p.m. to 7:00 a.m.) with no changes in condition noted/documented. The night shift nurse caring for R1 on [DATE] until 7:00 a.m. documented changing of the gastric tube syringe, checking gastric tube residuals, care to the gastric tube site, gastric tube flushes as ordered in addition to a pain assessment with no care concerns noted. R1's clinical record documented no nursing care, assessments or medication administration for R1 on day shift on [DATE] that started at 7:00 a.m. There was no nursing documentation for R1 until the resident was found unresponsive around 12:30 p.m. R1's physician ordered medications and treatments scheduled for [DATE] at 9:00 a.m. were not administered. This included the following: insulin per sliding scale (based on blood sugar reading), aspirin and Plavix for stroke prevention, esomeprazole magnesium for GERD, lisinopril and carvedilol for hypertension, polyethylene glycol for constipation, baclofen for dysarthria, and the antibiotic amoxicillin and albuterol nebulizer treatment for the newly diagnosed upper respiratory congestion.LPN #1 that worked on R1's unit on the morning of [DATE] and the DON at the time of R1's death, were not available for interview as they no longer worked for the facility.On [DATE] at 2:25 p.m., RN #1 that pronounced R1's death on [DATE] was interviewed. RN #1 stated [DATE] was her first day working as a registered nurse after just completing education/testing. RN #1 stated she was not working on R1's unit on [DATE] but worked on the adjacent unit on the same floor. RN #1 stated the nurse (LPN #1) from unit 2 came over and said she thought that R1 had passed away. RN #1 stated she went, assessed the resident and pronounced her death at 12:30 p.m. RN #1 stated that the DON was there and on the phone when she assessed/pronounced the resident. On [DATE] at 2:53 p.m., the current DON was interviewed about any assessment or care that had been provided for R1 on the morning of [DATE] prior to being found unresponsive. The DON stated she reviewed the clinical record and CNA #1 documented on [DATE] at 10:53 a.m. that care had been provided during the shift that included incontinence care, dressing and personal hygiene. The DON presented no documentation of nursing care, assessment or medicines administered for R1 prior to being found unresponsive.On [DATE] at 4:52 p.m., the current Administrator was interviewed about lack of staff on R1's unit on the morning of [DATE]. The Administrator stated none of the current administrative staff (administrator, DON, ADON - assistant director of nursing) worked in the facility at the time of R1's death. A review of the staffing schedule was requested. On [DATE] at 9:00 a.m., the current administrator, DON and ADON (RN #2) were interviewed about staffing on the day of R1's death. The ADON presented the as-worked schedule for [DATE] that documented LPN #1 worked on R1's unit starting at 7:00 a.m. and that another nurse slot was open for that unit with no nurse listed. The ADON stated the schedule indicated a nurse position that morning was open and not filled. The ADON stated she was not working in the facility at that time but currently two nurses were required on R1's unit to provide needed care/services. The ADON stated if a nurse was not available, nurse managers, infection preventionist, ADON or DON were expected to work so that required care was provided. The ADON stated she did not know if or why someone was not assigned to cover the medication cart and provide resident care/assessment for R1 on the morning of [DATE]. The scheduler at the time of R1's death was not available for interview as she no longer worked at the facility.The facility's policy titled Staffing (dated [DATE]) documented, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care pans and the facility assessment .Staffing numbers and the skill requirements of direct care staff are determined by the needs of the residents based on each resident's plan of care .Facility staff failed to provide sufficient nursing staff for care/services to R1 on the morning of [DATE]. LPN #1 documented reporting to the scheduler that no nurse had shown up to administer medications from the other cart on the unit. Schedules (continued on next page)

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F 0725 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	documented another nurse was scheduled for R1's unit on the [DATE] day shift, but the opening was not filled. R1 had no medications or treatment administered as ordered on the morning of [DATE] and no record of nurse monitoring the resident until the resident was found unresponsive. There was no evidence that nurse managers assigned anyone to provide care for R1 on the day shift on [DATE] until around 12:30 p.m. when the resident was found unresponsive and subsequently without pulse or respirations. R1 was pronounced dead on [DATE] at 12:30 p.m.On [DATE] at 10:45 a.m., after consulting with the state agency supervisory staff, immediate jeopardy was identified regarding facility staff's failure to provide sufficient nursing staff for provision of required care/services for R1. The administrator, DON, ADON and regional nurse consultant were notified at this time of the immediate jeopardy, a copy of the immediate jeopardy template was provided, and a plan of removal was requested. The facility's plan of immediacy removal was presented and included the following.Staffing vacancies were noted on [DATE]. Resident #1 no longer resides at the facility.All residents of the facility have the potential to be affected by this practice. The last 30 days of staffing schedules were audited for sufficient nursing staff for assessment/monitoring of the resident.Licensed nursing staff, administrative nursing and staffing coordinator will be re-educated on the Staffing policy regarding sufficient staffing to meet residents' needs. As part of the nursing on-call 24/7 process the designated nurse will fill in for staff vacancies as indicated.A 100% audit was completed of the last 30 days of staffing schedules for sufficient staff for assessment/monitoring of the residents.The medical director was notified of the situation on [DATE].The facility conducted an Ad Hoc QAPI meeting to accept the immediate jeopardy removal plan on [DATE].Date of compliance [DATE] at 6:00 p.m.On [DATE], the survey team reviewed the facility's nursing on-call schedule to ensure there was someone scheduled 24/7. The facility's staffing for the past 30 days was reviewed. The survey team conducted staff interviews with nurses and unit managers on each unit and verified staff were aware of what to do if a nurse did not arrive for their scheduled shift, were aware of the on-call schedule and how to reach the on-call person. Education was documented as provided as listed in the plan of removal. The facility policy regarding Staffing was reviewed.After verification of the facility's immediate jeopardy removal plan and following consultation with state agency supervisory staff, the immediate jeopardy was removed at [DATE] at 11:40am at which time the facility administration was notified. Following the removal of the immediate jeopardy stats, this deficiency was cited at a scope and severity level 3, isolated (harm).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, clinical record review and facility documentation the facility staff failed to ensure that residents were free from significant medication errors for one resident (Resident 104-R104) in a survey sample of seven residents. The findings included:For R104 the facility staff failed to ensure residents were free from significant medication errors by not giving available medication as ordered. R104 was admitted to the facility on [DATE] with diagnoses that included but were not limited to Parkinson's Disease, epilepsy, coronary artery disease, neuropathy, anxiety disorder, major depressive disorder, dementia and dysphagia. R104's most recent MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/22/26 coded R104 as having a BIMS (Brief Interview of Mental Status) score of 10 out of a possible 15, indicating moderate cognitive impairment. Section GG of the MDS coded the resident as Dependent on staff for all aspects of care, turning repositioning, mobility in wheelchair, sit to stand, turn and pivot, as well as all aspects of ADL (Activities of Daily Living) care. On 6/23/26 a review of the clinical record revealed that R104 had the following orders: Carbidopa-Levodopa Oral Tablet 25-100 Mg Give 2 tablet by mouth three times a day related to Parkinson's Disease -Start Date-10/26/2023 8 pm (Medication is for the treatment of Parkinsons Disease) Gabapentin Oral Capsule 100 MG Give 1 capsule by mouth one time a day related to mononeuropathy -Start Date-03/31/2026 9 am (This medication is used to control neuropathic pain) Gabapentin Oral Capsule 100 MG Give 2 capsules by mouth one time a day related to mononeuropathy capsules -Start Date-03/30/2026 7pm A review of the MAR (Medication Administration Record) revealed Gabapentin was not given on 6/19/26 at 9:00 am and 7:00 pm A review of the Progress Notes revealed the following entries: A review of the nurses notes revealed the following: 6/19/26 11:26 am Gabapentin Oral Capsule 100 MG Give 1 capsule by mouth one time a day related to mononeuropathy (9:00 AM) Not available NP made aware with NNO [No New Orders]. NP [Nurse Practitioner] to reorder. 6/19/26 6:10 pm - Gabapentin Oral Capsule 100 MG Give 2 capsule by mouth one time a day related to mononeuropathy (7:00 PM) on order. A review of the MAR (Medication Administration Record) revealed that on 6/22/26 R104 was not given 2 doses of Carbidopa / Levodopa (the 8:00 am and 12:00 pm doses were coded as nine see nurses note). A review of the Progress Notes revealed the following: 6/22/26 Carbidopa-Levodopa Oral Tablet 25-100 MG Give 2 tablet by mouth three times a day related to PARKINSON'S DISEASE reordered A review of the Omni-cell (electronic medication dispenser aka stat box) contents revealed that gabapentin 100 mg and 300 mg, as well as Carbidopa-Levodopa 25-100 mg were available for use. On 6/24/26 at approximately 11 am an interview was conducted with the Director of Nursing (DON) who stated that it is the facility's expectation that nurses first check the omni-cell when they do not have medication on the cart. On 6/24/26 during the end of day meeting the Administrator was made aware of the concerns and no further information was provided.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, and facility documentation the facility staff failed to ensure medications were securely stored, as evidenced by and unattended and unlocked medication cart on one unit, (Unit One) out of four units. The findings included:The facility staff failed to keep medications secured on one nursing unit.On 5/4/26 at 2:30 pm, an observation was made of a medication cart left unattended on the nursing unit one. The medication cart was positioned sideways in the middle of the hallway, unlocked, with no nurse present at or within sight of the cart. As a surveyor walked by a resident's room, a nurse was observed with her back toward the door and unable to see the medication cart. There were residents and staff in the hallway near the unattended medication cart.An interview was conducted with the licensed practical nurse, LPN5. LPN5 stated that she did not know who moved the cart into the middle of the hallway and stated she usually keeps it at the doorway of the resident's room.On 5/4/26 at 2:45 pm, a second observation was made of the same medication cart, on the same unit and the same nurse (LPN5) had left the cart unattended. The medication cart was sitting at the nurse's station unlocked, and the nurse was not present at the cart The cart was unattended while the nurse walked around from one of the hallways. There were residents and staff in the hallway near the unattended medication cart.An interview was conducted with LPN5 concerning the medication cart being unlocked. She stated it was her first day at the facility and acknowledged that the cart should have been locked.On 5/5/26 at 4:11 pm, an observation was made of an unlocked medication cart on unit one. There were no staff members present on the floor to secure the medication cart. There was residents and staff in the hallway near the unattended medication cart.An interview was conducted with a registered nurse, RN4. She stated that a resident had activated her call bell, so she went down the hall to speak with the resident. RN5 acknowledged that the medication cart should have been locked when she was away from the cart.On 5/5/26, a review of facility documentation was conducted. The policy titled, [facility company name redacted] Medication Administration, read in part, .Policy Purpose: This policy establishes the guidelines for the safe and effective administration of medications at Hill Valley Healthcare. All medications administered within the facility are subject to these guidelines. Facility-specific nursing policies may override the procedures outlined here when applicable. Procedures I. Security 1. Medication storage areas, including carts, medication rooms, and central supply, must remain locked at all times unless they are in use and directly supervised by the medication nurse or aide.On 5/5/25, an end of day meeting was held with the administrator, director of nursing, assistant director of nursing, and regional of clinical services. The above concerns were discussed.No additional information was presented prior to exit conference.