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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>515134 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>04/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowbrook Acres |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>2149 Greenbrier Street<br>Charleston, WV 25311 |  |

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

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| <p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>42120</p> <p>Based on observation, and staff interview the facility failed to treat each resident with respect and dignity regarding meal service. This was a random opportunity for discovery. Resident identifier: # 211. Facility census: 54.</p> <p>Findings included:</p> <p>a) Resident #211</p> <p>During an observation of meal services on 04/08/25 at 12:08 PM revealed Resident #211's sitting in the dining room at a table with 2 other residents and a visitor that was eating their lunch. Resident #211 watched as everyone around consumed their lunch.</p> <p>Continued observation revealed seven more tables were served, prior to surveyor intervention.</p> <p>During an interview on 04/08/25 at 12:20 PM the Director of Nursing (DON) verified that Resident #211 should have been served when the other residents at the table received their meal.</p> |

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0552</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that residents are fully informed and understand their health status, care and treatments.</p> <p>42120</p> <p>Based on record review, and staff interview, facility failed to ensure residents and/or their medical representatives were given the right to be informed of participate in the decision to initiate a psychotropic medication. This was true for one (1) of five (5) reviewed for unnecessary medications. Resident identifier #23. Facility census: 54.</p> <p>Finding included:</p> <p>a) Resident #23</p> <p>A review for Unnecessary Medication for Resident #23 on 04/14/25 found, Physician order for:</p> <p>Zoloft oral tablet 50 MG (Sertraline HCl) Give one (1) tablet by mouth one time a day related to anxiety disorder.</p> <p>Continued review found no consent form for Zoloft in the medical record.</p> <p>During an interview on 04/14/25 at 4:15 PM the Director of Nursing (DON) stated that there was no signed consent form for Zoloft for Resident #23</p> |

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| <p>F 0582</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.</p> <p>52482</p> <p>Based on record review and staff interview, the facility failed to provide evidence that the required Notification of Medicare Non-Coverage (NOMNC) notice was issued in a timely fashion for one (1) of three (3) residents reviewed for beneficiary protection notification. This failure had the potential to place the resident at risk of not being informed of their rights prior to the end of Medicare Part A covered services. Resident identifier: #4 . Facility census: 54.</p> <p>Findings included:</p> <p>a) Resident #4</p> <p>On 04/10/25 at 11:30 AM, a review was completed regarding the beneficiary protection notification liability notice given for the following resident who was discharged home following the last covered day of Medicare Part A services:</p> <p>-Resident #4's last covered day of Part A Services was on 01/08/25.</p> <p>-Resident #4 was discharged to home on 01/08/25; however, the NOMNC was only issued 24 hours prior on 01/07/25 .</p> <p>The Form Instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 state: The NOMNC must be delivered at least two (2) calendar days before Medicare covered services end . The instructions also state: A NOMNC must be delivered even if the beneficiary agrees with the termination of services.</p> <p>The Business Office Manager (BOM) Employee #39 confirmed the Beneficiary Protection Notification Review was outside of the notification date range of only 24 hours as opposed to required minimal 48 hours notice.</p> |   |  |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Develop and implement policies and procedures to prevent abuse, neglect, and theft.</p> <p>42120</p> <p>Based on observation, staff interviews, electronic medical record and policy review the facility failed to ensure they implemented their policy regarding the training of nurse aide staff following a substantiation of allegations of neglect. This is true of one (1) of six (6) residents reviewed for abuse and neglect. Resident identifier: #161. Facility census: 54.</p> <p>Findings included:</p> <p>a) Resident #161</p> <p>A record review found an allegation from 05/07/24 where Nurse Aide NA #94 and NA #114 did not follow the plan of care and did not use the lift during a transfer causing a skin tear to Resident # 161's arm.</p> <p>A medical record review revealed the following care plan:</p> <p>Focus:</p> <p>(Name) has a ADL self-care performance deficit related to Dementia, blindness and limited functional mobility as well as generalized muscle weakness.</p> <p>Goal:</p> <p>Resident will maintain the current level of function in ADLs through the review date</p> <p>Interventions:</p> <p>Transfers: require two (2) staff assistance using a full body Hoyer lift and placing him in a Rock and Go Chair.</p> <p>A reportable was completed with action notes:</p> <p>NA's involved will be re-educated/disciplined. All other NA's will be re-educated.</p> <p>Continued review found NA's #94 and #114 were re-educated. No other documentation could be provided for education with all other NA's.</p> <p>During an interview the Administrator verified that all NA's were not re-educated.</p> <p>Subsequent record review found that an allegation from 05/21/24 where Nurse Aide NA #8 and NA #91 did not follow the plan of care and did not use the lift during a transfer causing pain into Resident #161s leg.</p> <p>A reportable was completed with action notes:</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0607</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>NA's involved will be re-educated / disciplined. All other NA's will be re-educated.</p> <p>Continued review found NA's #8 and #91 were re-educated. No other documentation could be provided for education with all other NA's.</p> <p>Record review of the facility's policy titled, Abuse, neglect, and exploration, showed:</p> <p>Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than two (2) hours after the allegation is made if it does result in serious bodily injury.</p> <p>Report allegations to appropriate state and local authorities involving neglect, exploitation or mistreatment (including injuries of unknown source), suspected criminal activity, and misappropriation of patient property not later than (24) hours after the allegation is made if it does not result in serious bodily injury.</p> <p>Taking all necessary actions as a result if the investigation, which may include, but not limited to, the following:</p> <p>Analyzing the occurrence to determine abuse, neglect, misappropriation of resident property or exportation occurred, and what changes are needed to prevent further occurrences.</p> <p>Define how care provision will be changed and /or improved to protect residents receiving services.</p> <p>Training of staff on changes made and demonstration of competency after training is implemented.</p> <p>The expected date for implementation; and Identification of staff responsible for monitoring and implementation of the plan.</p> <p>During an interview the Administrator verified that all NA's were not re-educated.</p> |   |  |

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| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>42120</p> <p>Based on record review, and staff interview. The facility failed to assist dependent residents with activities of daily living (ADL's) in accordance with the residents assessed needs for care. This was true for one (1) of one (1) residents reviewed for ADL care. Resident identifier:164. Facility census: 54.</p> <p>Findings included:</p> <p>a) Resident #164</p> <p>A record review revealed Resident #164 was covered in feces on 11/17/24 and reported to the facility by her son.</p> <p>Statement from Nurse Aide #113 revealed Resident #164 was covered in dried feces from head to toe.</p> <p>Statements from Registered Nurse #87 confirmed that dried feces was all over the resident and the bed.</p> <p>Continued record review found the incident was reported to appropriate state and local authorities for neglect. The allegations were found substantiated by the facility and the NA assigned to Resident #164 was suspended and resigned at that time.</p> <p>An interview with the Director of Nursing on 04/14/25 at approximately 2:10 PM confirmed that Resident #164 did not get ADL care timely.</p> |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>42120</p> <p>Based on observation and interviews, the facility failed to ensure the resident environment over which it had control was as free from accident hazards as possible. This was a random opportunity for discovery of a resident smoking in non-designated areas, a medication cart and janitor closet unlocked and unattended. Resident identifier: #5. Facility census: 54.</p> <p>Findings included:</p> <p>a) An observation on 04/08/25 at 12:20 PM of an unlocked janitors closet on the B hall.</p> <p>A second observation on 04/08/25 at 1:00 PM of the unlocked janitors closet on the B hall found:</p> <ul style="list-style-type: none"> <li>-Clorox Clean-up</li> <li>-Sani-Clean 2 spray</li> <li>-Odor Neutral</li> <li>-Clorox bleach germicidal wipes</li> <li>-Glass Cleaner</li> <li>-DNA bath cleaner</li> <li>-Clorox urine cleaner</li> <li>-Sun burst neutral cleaner</li> </ul> <p>An interview on 04/08/25 at 1:08 PM with the Maintenance Assistant revealed the closet should always be locked and the lock was broken. He stated he was unsure how long the lock had been broken.</p> <p>An observation on 04/09/25 at 9:55 AM found the Medication Cart on the B Hall was unlocked and unattended.</p> <p>An interview with Licensed Practical Nurse (LPN #33) on 04/09/25 at 10:00 AM revealed that the medication cart should not be unlocked when unattended.</p> <p>45173</p> <p>c) Resident #5</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>On 04/08/25 at 6:47 PM, a review of the list of resident smokers was completed. The review found one (1) resident listed as a smoker. Resident #5 smoked a vape (electronic cigarette). The resident was allowed to smoke at designated times and places with a staff member. The designated times were 9:00 AM, 11:00 AM, and 1:30 PM. The designated area was in the outer gazebo at the side of the building. A smoking assessment was completed on 03/24/25. The smoking assessment stated, Smoking safety note: Electronic cigarette to be used with staff supervision during scheduled smoke breaks. Electronic cigarette to be stored in med (medication) cart and charged by nurse as needed.</p> <p>On 04/09/25 at 9:05 AM, the resident was being pushed in a wheelchair by a staff member; and, before the resident exited the door of the lobby, the resident began smoking the vape. Nurse Aide (NA) # 91 was the staff member pushing the resident's wheelchair. An interview was held with NA #91 at 9:30 AM. NA #91 was asked, Does the resident usually use the vape prior to exiting the building? NA #91 stated, Not normally, but I did tell her not to smoke it before we got out of the building NA #91 was then asked, Does the resident usually hold the vape prior to exiting the building? NA #91 stated, She normally doesn't smoke until we are outside the building.</p> <p>On 04/09/25 at 9:40 AM, the Administrator confirmed the resident should not be vaping before she got outside to the designated smoking area. The Administrator stated, Maybe the staff member should hold on to the vape until they get to the designated spot.</p> <p>On 04/09/25 at 10:00 AM, a review of the facility policy was completed. Under the heading of Policy Explanation and Compliance Guidelines: Number 7 stated, Any resident who is exempt from the Smoke Free Facility policy, in accordance with his/her right to self-determination and participation, will be allowed to smoke in designated smoking areas (weather-permitting), at designated times, and in accordance with his/her care plan.</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>45171</p> <p>Based on observation, record review and staff interview it was determined the facility failed to ensure proper reconciliation of the narcotic medication logbook was performed. Facility census: #54</p> <p>Findings include:</p> <p>a) A Hall</p> <p>On 04/09/25 at 8:24 AM during the medication administration observation process, it was noted that the narcotic medication logbook reconciliation was not completed properly for each daily shift change.</p> <p>The current narcotic medication logbook on hand begins on 02/18/25 through 04/09/25.</p> <p>The following dates were not reconciled as required as explained by the Administrator.</p> <p>02/21/25 no entry for 7 PM - 7 AM shift</p> <p>02/22/25 no entry for 7 AM - 7 PM shift</p> <p>02/23/25 no entry for 7 PM - 7 AM shift</p> <p>02/28/25 no entry for 7 PM - 7 AM shift</p> <p>03/01/25 no entry for 7 AM - 7 PM shift</p> <p>03/01/25 no entry for 7 PM - 7 AM shift</p> <p>03/06/25 no Nurse signature for going off duty for 3 PM shift</p> <p>03/08/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>03/09/25 no entry for 7 PM - 7 AM shift</p> <p>03/12/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>03/17/25 no Nurse signature for going off duty for 1:30 PM shift change</p> <p>03/18/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>03/19/25 no Nurse signature for going off duty for 3 PM shift change</p> <p>03/20/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>(continued on next page)</p> |   |  |

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| <p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>03/27/25 no Nurse signature for going off duty for 1 PM shift change</p> <p>03/28/25 no entry for 7 PM - 7 AM shift</p> <p>03/31/25 no Nurse signature for going off duty for 7 AM - 7 PM shift</p> <p>04/02/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>04/04/25 no entry for 7 PM - 7 AM shift</p> <p>04/07/25 no Nurse signature for going off duty for 7 AM - 7 PM shift</p> <p>The above missing entries were confirmed on 04/09/25 at 10 AM with the Administrator who agreed the reconciliation process had failed on these dates.</p> <p>b) B Hall</p> <p>On 04/09/25 at 8:24 AM during the medication administration observation process, it was noted that the narcotic medication logbook reconciliation was not completed properly for each daily shift change.</p> <p>The current narcotic medication logbook on hand begins on 02/18/25 through 04/09/25.</p> <p>The following dates were not reconciled as required as explained by the Administrator.</p> <p>02/21/25 no entry for 7 AM - 7 PM shift</p> <p>02/21/25 no entry for 7 PM - 7 AM shift</p> <p>02/27/25 no Nurse signature for coming on duty for 7 AM - 7 PM shift</p> <p>02/28/25 no entry for 7 PM - 7 AM shift</p> <p>03/09/25 no entry for 7 AM - 7 PM shift</p> <p>03/14/25 no Nurse signature for coming on duty for 7 AM - 7 PM shift</p> <p>03/16/25 no entry for 7 AM - 7 PM shift</p> <p>03/16/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>03/17/25 no Nurse signature for going off duty for 7 PM - 7 AM shift</p> <p>03/20/25 no Nurse signature for coming on duty for 7 AM - 7 PM shift</p> <p>03/20/25 no entry for 7 PM - 7 AM shift</p> <p>03/21/25 no entry for 7 AM - 7 PM shift</p> <p>(continued on next page)</p> |

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| <p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to ensure two (2) monthly pharmacy reviews were reviewed by the facility physician for Resident #35. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications. Resident identifier: #35. Facility Census: 57.</p> <p>Findings Include:</p> <p>a) Resident #35</p> <p>On 04/09/25 at 1:03 PM, a record review was completed for Resident #35. The review found two (2) monthly pharmacy reviews, 03/2024 and 01/2025, were not signed by the facility physician. The pharmacy reviews had no indication if the facility physician agreed or disagreed with the pharmacy recommendations.</p> <p>On 04/14/25 at 10:32 AM, the Administrator confirmed neither of the two (2) pharmacy reviews were signed by the facility physician.</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>515134   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>04/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowbrook Acres  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2149 Greenbrier Street<br>Charleston, WV 25311 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>42120</p> <p>Based on record review, and staff interview, facility failed to ensure residents was free from unnecessary medications in regard to psychotropic medication. This was true for one (1) of five (5) reviewed for unnecessary medications. Resident identifier #23. Facility census: 54.</p> <p>Finding included:</p> <p>a) Resident #23</p> <p>A review for Unnecessary Medication for Resident #23 on 04/14/25 found, Physician order for:</p> <p>Zoloft oral tablet 50MG (Sertraline HCl) Give one (1) tablet by mouth one time a day related to anxiety disorder.</p> <p>Continued review found no consent form for Zoloft in the medical record.</p> <p>During an interview on 04/14/25 at 4:15 PM the Director of Nursing (DON) stated that there was no signed consent form for Zoloft for Resident #23</p> |   |  |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION      | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>515134 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>04/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowbrook Acres |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2149 Greenbrier Street<br>Charleston, WV 25311 |  |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
|---|--|
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>42120</p> <p>Based on observation and staff interview the facility failed to store plate lids in accordance with professional standards for food service safety related to storage. This could have affected all residents that received their nutrition from the kitchen. Facility Census: 54</p> <p>Findings included:</p> <p>a) Kitchen</p> <p>During the initial kitchen tour on 04/08/25 at 9:48 AM, an observation revealed a rack of plate lids stored up against the dirty open utility-room door. There was a mop sink, dirty mops, rags, and chemicals stored in the utility room.</p> <p>During an interview with the Dietary Manager (DM) on 04/08/25 at 9:49 AM, DM stated that they probably should not be stored there with the door open.</p> |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>515134   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing  | (X3) DATE SURVEY COMPLETED<br><br>04/14/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Meadowbrook Acres  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>2149 Greenbrier Street<br>Charleston, WV 25311 |  |
| 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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |   |  |
| <p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>45173</p> <p>Based on record review and staff interview, the facility failed to ensure an accurate and complete record for Resident #35. This was true for one (1) of five (5) residents reviewed under the care area of unnecessary medications. Resident identifier: #35. Facility Census: 57.</p> <p>Findings Included:</p> <p>a) Resident #35</p> <p>On 04/09/25 at 10:00 AM, a record review was completed for Resident #35. The review found two (2) medications without diagnoses.</p> <p>The medication is as follows:</p> <p>--Eye Scrubs External Pad apply to eyes topically every day, which started on 11/07/24.</p> <p>--Metoprolol Tartrate 25mg (milligram) by mouth twice daily, which started on 03/08/25.</p> <p>On 04/09/25 at 4:00 PM, the Administrator and the Director of Nursing (DON) confirmed the medication did not have diagnoses.</p> |   |  |