STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525273	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloit Health and Rehabilitation Center	1905 W Hart Rd Beloit, WI 53511

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility did not promptly notify and consult with a physician when a resident missed their medications for 1 of 1 resident's (R2) reviewed for medication administration. R2's physician was not notified when R2 did not receive antipsychotic medication over several days. This is evidenced by: The facility's policy titled Notification of Changes, dated 10/24/23, includes the following: The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, the resident's representative when there is a change requiring notification. The facility must inform the resident, consult with the resident's physician and/or notify the resident's family or legal representative when there is a change requiring such notification. The facility's policy titled Medication Error Reporting and Counseling Procedure, dated 12/12/23, includes the following: Notifying the Provider(s): The facility will inform the primary or prescribing physician(s) of the medication error in a timely manner and document notification in the medical record. This communication will help ensure that appropriate corrective measures can be taken, and future medication orders can be adjusted, if necessary. R2 admitted to the facility on [DATE] with a diagnosis of schizophrenia. R2's physician orders include the following: Seroquel oral tablet 25 mg give 1 tablet by mouth one time a day related to Schizophrenia Start date 11/21/24 8:00 AM. Seroquel oral tablet 25 mg give 1 tablet by mouth one time a day related to Schizophrenia Start date 11/21/24 12:00 PM (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel oral tablet 25 mg give 2 tablets by mouth one time a day related to Schizophrenia Start date 11/21/24 4:00 PM R2's nurse progress notes include the following: 12/21/24 at 5:29 PM Seroquel oral tablet 25 MG . none in cart on order. 12/22/24 at 5:28 PM Seroquel oral tablet 25 MG .on order 12/23/24 at 5:35 PM Seroquel oral tablet 25 MG .on order 12/24/24 at 5:24 PM Seroquel oral tablet 25 MG .on order 12/25/24 at 10:23 AM Seroquel oral tablet 25 MG .waiting for delivery 12/25/24 at 12:27 PM Seroquel oral tablet 25 MG .waiting on delivery 12/25/24 at 4:15 PM Seroquel oral tablet 25 MG .on order 12/26/24 at 4:46 PM Seroquel oral tablet 25 MG . (no documentation) 12/27/24 at 6:53 PM Seroquel oral tablet 25 MG . on order 12/29/24 at 11:16 AM Seroquel oral tablet 25 MG . (no documentation) 12/29/24 at 4:14 PM Seroquel oral tablet 25 MG .awaiting delivery of medication 12/30/24 at 8:37 PM Seroquel oral tablet 25 MG . not in cart Of note, there is no documentation of the physician being notified that R2 did not have his prescribed Seroquel for these days. On 4/29/25 at 3:10 PM, Surveyor asked LPN G (Licensed Practical Nurse) to show surveyor what medications are in the facility's contingency medication supply. LPN G showed surveyor the facility's contingency supply contained Seroquel 25 mg. LPN G stated the contingency supply is usually 8 to 10 pills of the medication. On 4/29/25 at 11:40 AM, Surveyor interviewed RN D (Registered Nurse) regarding administering medications. RN D indicated if a resident does not have a medication, the nursing staff is supposed to look in the facility's contingency medication supply and pull the medication from there to give to the resident. RN D also stated the staff is supposed to call pharmacy and ask to have the medication delivered and to notify the physician. RN D indicated this should all be documented in the resident's medical record. Surveyor asked what the facility would do if a resident did not get the medication delivered and now it was the second day, and the resident still does not have the medication. RN D indicated the facility would call the pharmacy and have the medication stat delivered which means the medication should be there within 4 hours. Surveyor asked what the process would be if a resident did not have a medication on the third day. RN D indicated she has never had it get that far before. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 11:50 AM, Surveyor interviewed LPN E regarding administering medications. LPN E indicated on day one of a resident not having medication, the facility should look in the contingency medication supply and call pharmacy to order it. LPN E indicated the physician should also be notified. On day two of a resident not having medication, LPN E stated she would notify DON B (Director of Nursing). On day three of a resident not having a medication, LPN E indicated she would ask the provider for a substitute. On day four, LPN E indicated she would call the physician and do an assessment. LPN E indicated it is unacceptable for a resident to be without medication for four days. On 4/29/25 at 2:08 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse) regarding medication administration. ADON/WN C indicated on day one of a resident not having medication, the staff should look in the contingency medication supply, call the physician and call pharmacy to have the medication stat delivered. Day two, the staff should notify the physician, call pharmacy and notify their supervisor. ADON/WN indicated there should not be a day three. On 4/29/25 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) regarding medication administration. DON B indicated if a resident does not have medication, on day one, the facility should check in the contingency medication supply, call pharmacy, and call the provider. On day two, the staff should call again. On day three, staff should call the physician, and the facility would have to call the head of pharmacy because there is a problem. On day four, the staff should do the same thing, call the pharmacy, and call the physician. DON B indicated an assessment needs to be done daily based on the missed medication. DON B indicated all of this should be documented in the resident's medical record. DON B stated missed medications is a medication error and a risk management should be completed. Surveyor notified DON B that surveyor was unable to locate any documentation of a completed assessment for the missed medication, the pharmacy being notified, or the physician being notified of the missed Seroquel for R2 for the dates of 12/21/24 through 12/30/24. DON B did not provide surveyor with any documentation regarding R2's missed Seroquel for those dates.

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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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38725 Based on interview and record review the facility did not ensure based on the comprehensive assessment of a resident, the resident received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents/choice for 1 of 2 residents (R1) reviewed for non-pressure wounds. R1 had dates his wound care was not signed out in the TAR (Treatment Administration Record). R1 returned from the hospital and did not have a full assessment completed for his non-pressure wounds. This is evidenced by: The Facilities Policy and Procedure entitled Wound Treatment Management dated 2/14/23 documents in part: .Policy Explanation and Compliance Guidelines: 1. Wound treatments will be provided in accordance with physician orders .7. Treatments will be documented on the Treatment Administration Record or in the electronic health record. 8. The effectiveness of treatments will be monitored through ongoing assessment of the wound . R1 is a long-term resident of the facility. R1 has the following diagnoses: metabolic encephalopathy, type 2 diabetes mellitus, cellulitis of RLE (right lower extremity) (infection of leg), open wound to RLE, open wound to LLE (left lower extremity), open wound to right foot, PVD (peripheral vascular disease- circulatory condition where narrowed blood vessels reduce blood flow to the limbs), and CHF (congestive heart failure- condition where the heart muscle is weakened and can't pump enough blood to meet the body's needs, leading to buildup of fluid in the lungs and other body parts). R1's TAR has the following documented: January 2025- blank box on 1/2/25. February 2025- 2/24/25 has 4 documented. According to key on TAR 4 is other/see nurse's notes. March 2025- blank box on 3/21/25. R1' Progress Notes do not include a nurses note for 2/24/25 as to why R1's wound care was not completed. R1 was hospitalized [DATE]-[DATE]. Upon R1's return to the facility on [DATE] there was not a full assessment of R1's wounds. R1's Admission/Readmission/Routine Head to Toe Evaluation dated 1/23/25 documents the following: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Skin integrity .Site #42 LLE (left lower extremity) (front) bilateral lower extremity unna boot, multiple open areas. Site #41 RLE (right lower extremity) Bilateral lower extremity unna boot, multiple open areas. Is worse looking than left leg. Bilateral feet 3+ pitting edema . On 4/30/25 at 11:40 AM, Surveyor interviewed RN D (Registered Nurse) regarding signing out treatments on the TAR. RN D indicated if the TAR is blank, the treatment was not completed. RN D indicated if there is a number 4 on the TAR, that means there should be a progress note made in the resident's chart on why the treatment was not completed. On 4/30/25 at 11:50 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) regarding signing out treatments on the TAR. LPN E indicated if the TAR is blank, the treatment was not completed. LPN E indicated a number 4 on the TAR means there should be a progress note regarding the treatment. On 4/30/25 at 12:00 PM, Surveyor interviewed RN F regarding signing out treatments on the TAR. RN F indicated if it is not documented then it was not done and a number 4 on the TAR would indicate there is a progress note related to the treatment. On 4/30/25 at 2:08 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse) regarding signing out treatments on the TAR. ADON/WN C indicated a 4 would mean there is a progress note about the treatment and if the TAR is blank, it means the treatment was not completed. ADON/WN C indicated treatments should be completed and signed out. On 4/30/25 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) regarding signing out treatments on the TAR. DON B indicated if a nurse charts a 4 on the TAR, then the nurse would make a progress note about the treatment. DON B indicated if the TAR is blank, then the treatment was not completed. DON B indicated all treatments should be completed or a note made for why it was not completed. DON B stated she expects treatments to completed. On 4/30/25 at 3:51 PM, Surveyor interviewed ADON/WN C. Surveyor asked ADON/WN C if there should have been a full assessment of R1's wounds to BLE's (bilateral lower extremities) upon return from the hospital on 1/23/25, ADON/WN C stated, yes there should have been. On 4/30/25 at 5:10 PM, Surveyor interviewed DON B. Surveyor asked DON B if she would have expected there to have been a full assessment of R1's wound to BLE's upon return from the hospital, DON B stated yes.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49436 Based on interview and record review, the facility did not ensure each resident received care, consistent with professional standards of practice, to prevent pressure injuries (PI) for 1 of 3 residents (R2) reviewed for pressure injuries. The facility did not complete wound care as ordered for R2. This is evidenced by: The facility's policy titled Wound Treatment Management, dated 2/14/23, includes: To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Treatments will be documented on the Treatment Administration Record or in the electronic health record. R2 admitted to the facility on [DATE] and discharged on [DATE]. R2's Treatment Administration Record (TAR) for December 2024 includes the following: Sacrum wound; Cleanse with Vashe wound cleanser (a solution used for cleaning wounds) or equivalent, apply skin prep to peri-wound, apply hydrofera blue classic (a type of wound dressing that provides antibacterial protection) to wound bed, cover with ABD (absorbent gauze pad) and secure with mediflex tape (a type of tape to secure dressings) daily. Start date 12/5/24. Discontinued dated 12/18/24. R2's TAR indicates 12/15/24 and 12/16/24 are blank. Sacrum wound; Cleanse with Vashe wound cleanser (a solution used for cleaning wounds) or equivalent, apply skin prep to peri-wound, apply hydrofera blue classic (a type of wound dressing that provides antibacterial protection) to wound bed, cover with foam dressing twice daily. Start 12/19/24 Discontinued 1/8/25. R2's TAR indicates 12/19/24 and 12/25/24 are blank. R2's TAR indicates there is no documentation of the wound care being completed a second time from 12/19/24 through 12/31/24. B/L (bilateral, both) ischial tuberosities (the part of the pelvis that supports your weight when you're seated): Cleanse with Vashe wound cleanser or equivalent, apply skin prep to peri-wound, lightly pack with hydrofera blue classic, cover with hydralock (super absorbent dressing) 4 x 4, then abd pad, and secure with medi-flex tape once daily. Use betadine swabs to macerated wound edges every day and evening shift for wound care. Start Date 12/11/24 1500 (3:00 PM). Discontinued 12/18/24 1513 (3:13 PM). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's TAR indicates 12/15/24 and 12/16/24 are blank. R2's TAR indicates 12/14/25 is blank. B/L (bilateral, both) ischial tuberosities (the part of the pelvis that supports your weight when you're seated): Cleanse with Vashe wound cleanser or equivalent, apply skin prep to peri-wound, lightly pack with hydrofera blue classic, cover with hydralock (super absorbent dressing) 4 x 4, secure with foam dressings. Use betadine swabs to macerated wound edges every day and evening shift for wound care. Start dated 12/19/24 0700 (7:00 AM). Discontinued 1/8/25 1216 (12:16 PM). R2's TAR indicates 12/19/24 and 12/25/24 day shifts are blank. R2's TAR indicates 12/22/24 and 12/25/24 evening shifts are blank. R2's TAR for January 2025 includes the following: B/L ischial tuberosities: Cleanse with Vashe wound cleanser or equivalent, apply skin prep to peri-wound, lightly pack with hydrofera blue classic, cover with hydralock 4 x 4 secure with foam dressing Use betadine swabs to macerated wound edges every day and evening shift for wound care Start 12/19/24 Discontinue 1/8/25. R2's TAR indicates 1/5/25 is blank for day shift. R2's TAR indicates 1/2/25 is blank for evening shift. Cleanse B/L ischial tuberosity wounds and sacrum with vashe or equivalent wound cleanser, protect peri wound with skin prep, lightly pack with Ca alginate and cover with Hydralock dressing then ABD, Secure with mepilex tape once daily and as needed if dressing soiled or loose every day shift for wound care Start date 1/23/25. Discontinued 3/25/25. R2's TAR indicates 1/28/25 and 1/30/25 are blank. Sacrum wound; Cleanse with Vashe wound cleanser (a solution used for cleaning wounds) or equivalent, apply skin prep to peri-wound, apply hydrofera blue classic (a type of wound dressing that provides antibacterial protection) to wound bed, cover with foam dressing twice daily. Start 12/19/24 Discontinued 1/8/25. R2's TAR indicates 1/5/25 is blank. R2's TAR indicates there is no documentation of the wound care being completed a second time from 1/1/25 through 1/7/25. Sacrum: Cleanse with vashe or equivalent wound cleanser, protect peri wound with skin prep and apply foam dressing daily and as needed every day shift for wound care Start 1/20/25. Discontinue 1/15/25. R2's TAR indicates 1/12/25 through 1/15/25 is blank. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/30/25 at 11:40 AM, Surveyor interviewed RN D (Registered Nurse) regarding signing out treatments on the Treatment Administration Record (TAR). RN D indicated if the TAR is blank, the treatment was not completed. RN D indicated if there is a number 4 on the TAR, that means there should be a progress note made in the resident's chart on why the treatment was not completed. On 4/30/25 at 11:50 AM, Surveyor interviewed LPN E (Licensed Practical Nurse) regarding signing out treatments on the TAR. LPN E indicated if the TAR is blank, the treatment was not completed. LPN E indicated a number 4 on the TAR means there should be a progress note regarding the treatment. On 4/30/25 at 12:00 PM, Surveyor interviewed RN F (Registered Nurse) regarding signing out treatments on the TAR. RN F indicated if it is not documented then it was not done and a number 4 on the TAR would indicate there is a progress note related to the treatment. On 4/30/25 at 2:08 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse) regarding signing out treatments on the TAR. ADON/WN C indicated a 4 would mean there is a progress note about the treatment and if the TAR is blank, it means the treatment was not completed. ADON/WN C indicated treatments should be completed and signed out. On 4/30/25 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) regarding signing out treatments on the TAR. DON B indicated if a nurse charts a 4 on the TAR, then the nurse would make a progress note about the treatment. DON B indicated if the TAR is blank, then the treatment was not completed. DON B indicated all treatments should be completed or a note made for why it was not completed. DON B stated she expects treatments to completed. Of note, R2's treatment to his sacrum was not documented as completed 26 times between December 2024 and January 2025. R2's treatment to his bilateral tuberosity wounds was not documented as completed 11 times between December 2024 and January 2025.

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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. 49436 Based on interview, and record review, the facility did not ensure each resident received adequate supervision to prevent accidents for 1 of 1 resident's (R2) reviewed for smoking/vaping. The facility failed to re-assess and update R2's care plan for safety after being observed vaping in the facility. This is evidenced by: The facility's policy titled Resident Smoking, dated 7/10/25, includes the following: It is the guideline of this facility to provide a safe and healthy environment for residents, visitors, and employees, including safety as related to smoking. Safety protections apply to smoking and non-smoking residents. Smoking is prohibited in all areas except the designated smoking area. Electronic cigarettes (e-cigarettes/vape/vapor pen) can catch on fire and/or explode if not handled and stored safely. Safety measures for the use of electronic cigarettes by residents will include but are not limited to: Use of e-cigarettes in designated smoking areas only. A safe smoking assessment will be completed on all residents using e-cigarettes. Any resident who is deemed safe to smoke .will be allowed to smoke in designated smoking areas . A Risk vs. Benefit Evaluation may be conducted by facility staff if a resident is exercising rights that may cause risk or harm to themselves. A resident does not have the right to put others at risk within or on grounds of the facility and the right to smoke may be revoked immediately. If a resident or family does not abide by the smoking policy or care plan .the plan of care may be revised to include additional safety measures and may include a Smoking Contract. R2's Smoking evaluation dated 12/30/24 includes the following: Does resident need facility to store lighter and cigarettes? No Plan of care is used to assure resident is safe while smoking? Yes Is the resident a supervised or unsupervised smoke? Unsupervised R2's comprehensive care plan printed on 4/29/25 includes the following: Focus: The resident is a smoker. Interventions: Instruct resident about the facility policy on smoking: locations, times, safety concerns. The resident can smoke unsupervised. The resident's smoking supplies are stored on his person. R2's nurse progress notes include the following: 1/11/25 1:20 PM . pt (R2) up in w/c vaping . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Of note, this was in the facility when R2 was speaking to the nurse about wound treatments. 1/13/25 1:54 PM .when this writer entered room and noted pt (R2) vaping, this writer attempted to educate pt that he is not to be vaping in room. Pt shrugged his shoulders with a smile on his face and then took a long drag on the vape. Of note, R2 did not have a new smoking assessment completed and did not have his care plan updated after the 2 incidents of non-compliance when vaping in the facility. On 4/30/25 at 3:00 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse) regarding R2's vaping. Surveyor asked ADONWN C if R2 should have had a new smoking assessment, care plan review, or IDT (Intradisciplinary Team) meeting/progress note regarding his non-compliance with the facility's smoking policy. ADON/WN C indicated something should have been done but was not. On 4/30/25 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) regarding R2's vaping. DON B indicated vaping was treated the same as smoking and all vaping should be done outside in the designated smoking areas. DON B indicated a new smoking assessment should have been completed and R2 should have turned in his vape supplies but did not.

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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** 49436 Based on interview and record review the facility did not ensure residents are free of any significant medication errors for 1 of 1 resident's (R2) reviewed for medications. The facility did not ensure R2 was provided his Seroquel (Antipsychotic medications) for several days. This is evidenced by: The facility policy titled Medication Error Reporting and Counseling Procedure, dated 12/12/23, includes the following: Medication errors .should be reviewed for the potential of a negative outcome. When a medication error occurs, the licensed nurse/employee needs to be able to report the error .to Nursing Management. The facility should consider reporting the error to their contracted pharmacy provider for any desired information or needed follow-up. A prompt assessment of the resident(s) involved to be completed to determine harm or the potential risks to the resident. Three general guidelines in determining whether a medication error is significant or not: resident condition, drug category and frequency of error. The facility will inform the primary or prescribing physician(s) of the medication error in a timely manner and document notification in the medical record. This communication will help ensure that appropriate corrective measures can be taken, and future medication orders can be adjusted, if necessary. R2 admitted to the facility on [DATE] with a diagnosis of schizophrenia. R2's physician orders include the following: Seroquel oral tablet 25 mg give 1 tablet by mouth one time a day related to Schizophrenia Start date 11/21/24 8:00 AM. Seroquel oral tablet 25 mg give 1 tablet by mouth one time a day related to Schizophrenia Start date 11/21/24 12:00 PM Seroquel oral tablet 25 mg give 2 tablets by mouth one time a day related to Schizophrenia Start date 11/21/24 4:00 PM R2's nurse progress notes include the following: 12/21/24 at 5:29 PM Seroquel oral tablet 25 MG . none in cart on order. 12/22/24 at 5:28 PM Seroquel oral tablet 25 MG .on order 12/23/24 at 5:35 PM Seroquel oral tablet 25 MG .on order 12/24/24 at 5:24 PM Seroquel oral tablet 25 MG .on order (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525273	A. Building B. Wing	04/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beloit Health and Rehabilitation Center	1905 W Hart Rd Beloit, WI 53511

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/25/24 at 10:23 AM Seroquel oral tablet 25 MG .waiting for delivery 12/25/24 at 12:27 PM Seroquel oral tablet 25 MG .waiting on delivery 12/25/24 at 4:15 PM Seroquel oral tablet 25 MG .on order 12/26/24 at 4:46 PM Seroquel oral tablet 25 MG . (no documentation) 12/27/24 at 6:53 PM Seroquel oral tablet 25 MG . on order 12/29/24 at 11:16 AM Seroquel oral tablet 25 MG . (no documentation) 12/29/24 at 4:14 PM Seroquel oral tablet 25 MG .awaiting delivery of medication 12/30/24 at 8:37 PM Seroquel oral tablet 25 MG . not in cart On 4/29/25 at 3:10 PM, Surveyor asked LPN G (Licensed Practical Nurse) to show surveyor what medications are in the facility's contingency medication supply. LPN G showed surveyor the facility's contingency supply contained Seroquel 25 mg. LPN G stated the contingency supply is usually 8 to 10 pills of the medication. On 4/29/25 at 11:40 AM, Surveyor interviewed RN D (Registered Nurse) regarding administering medications. RN D indicated if a resident does not have a medication, the nursing staff is supposed to look in the facility's contingency medication supply and pull the medication from there to give to the resident. RN D also stated the staff is supposed to call pharmacy and ask to have the medication delivered and to notify the physician. RN D indicated this should all be documented in the resident's medical record. Surveyor asked what the facility would do if a resident did not get the medication delivered and now it was the second day, and the resident still does not have the medication. RN D indicated the facility would call the pharmacy and have the medication stat delivered which means the medication should be there within 4 hours. Surveyor asked what the process would be if a resident did not have a medication on the third day. RN D indicated she has never had it get that far before. On 4/29/25 at 11:50 AM, Surveyor interviewed LPN E regarding administering medications. LPN E indicated on day one of a resident not having medication, the facility should look in the contingency medication supply and call pharmacy to order it. LPN E indicated the physician should also be notified. On day two of a resident not having medication, LPN E stated she would notify DON B (Director of Nursing). On day three of a resident not having a medication, LPN E indicated she would ask the provider for a substitute. On day four, LPN E indicated she would call the physician and do an assessment. LPN E indicated it is unacceptable for a resident to be without medication for four days. On 4/29/25 at 2:08 PM, Surveyor interviewed ADON/WN C (Assistant Director of Nursing/Wound Nurse) regarding medication administration. ADON/WN C indicated on day one of a resident not having medication, the staff should look in the contingency medication supply, call the physician and call pharmacy to have the medication stat delivered. Day two, the staff should notify the physician, call pharmacy and notify their supervisor. ADON/WN C indicated there should not be a day three. (continued on next page)

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	525273	A. Building B. Wing	04/30/2025

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/29/25 at 2:25 PM, Surveyor interviewed DON B (Director of Nursing) regarding medication administration. DON B indicated if a resident does not have medication, on day one, the facility should check in the contingency medication supply, call pharmacy, and call the provider. On day two, the staff should call again. On day three, staff should call the physician, and the facility would have to call the head of pharmacy because there is a problem. On day four, the staff should do the same thing, call the pharmacy, and call the physician. DON B indicated an assessment needs to be done daily based on the missed medication. DON B indicated all of this should be documented in the resident's medical record. DON B stated missed medications is a medication error and a risk management should be completed. Surveyor notified DON B that surveyor was unable to locate any documentation of a completed assessment for the missed medication, the pharmacy being notified, or the physician being notified of the missed Seroquel for R2 for the dates of 12/21/24 through 12/30/24. DON B did not provide surveyor with any documentation regarding R2's missed Seroquel for those dates.