STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525376	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Upland Hills Nursing and Rehab	800 Compassion Way Dodgeville, WI 53533

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F 0757 Level of Harm - Actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure that each resident's drug regimen must be free from unnecessary drugs for 1 or 2 residents (R28). R28 has a history of a Gastrointestinal bleed (GI bleed; bleeding that occurs in the digestive tract) and R28 did not receive adequate monitoring for bleeding while taking an anticoagulant (blood thinner) medication. A Certified Nursing Assistant (CNA) notified RN G (Registered Nurse) of R28 possibly having blood in her stool. RN G did not assess R28 when it was first reported and initiate continued monitoring for bleeding for R28. R28 continued to decline and was sent to the emergency department (ED) where she received 2 units of blood due to a GI bleed and anemia. This is evidenced by: Facility policy, titled Notification of Change of Condition, last reviewed in 07/2025, includes in part, Purpose: To inform the resident, resident's physician, and resident representative of any significant change of condition.Procedure: The following symptoms indicate a change of condition and are further categorized by need for physician response as critical, urgent, or non-urgent, but the categories may not be all inclusive. Based on the total resident assessment the staff will determine urgency of response needed. The resident representative will be notified of change of condition as soon as possible and/or as directed in the resident's plan of care.Urgent: those conditions requiring a physician to respond one hour after the first attempt to contact him/her.Includes but not limited to the following conditions: .4. Any onset of sudden bleeding.Non-Urgent: those conditions requiring a physician to respond prior to their regularly scheduled visit per nurse discretion. May be called or faxed to clinic. State of Wisconsin Nurse Practice Act states in part: . N 6.03ˆStandards of practice for registered nurses (1)ˆGeneral nursing procedures. An R.N. shall utilize the nursing process in the execution of general nursing procedures in the maintenance of health, prevention of illness or care of the ill. The nursing process consists of the steps of assessment, planning, intervention and evaluation. This standard is met through performance of each of the following steps of the nursing process:(a) Assessment. Assessment is the systematic and continual collection and analysis of data about the health status of a patient culminating in the formulation of a nursing diagnosis.(b) Planning. Planning is developing a nursing plan of care for a patient which includes goals and priorities derived from the nursing diagnosis.(c) Intervention. Intervention is the nursing action to implement the plan of care by directly administering care or by directing and supervising nursing acts delegated to L.P.N.s or UAPs.(d) Evaluation. Evaluation is the determination of a patient's progress or lack of progress toward goal achievement which may lead to modification of the nursing diagnosis . Per the Mayo Clinic, symptoms of GI bleeding can be easy to see (overt), or not so obvious, known as occult. Symptoms depend on the rate of bleeding as well as the location of the bleed. Overt bleeding might show up as: Vomiting blood, which might be red or might be dark brown and look like coffee grounds. Black, tarry stool. Rectal bleeding, usually in or with stool. With occult bleeding, you might have: Lightheadedness. Difficulty breathing. Fainting. Chest pain. Abdominal pain. R28 admitted to the facility on [DATE] with diagnoses that include paroxysmal atrial fibrillation (irregular heartbeat, with irregular heart rhythms starting and stopping on their own), aphasia following cerebral infarction (language disorder affecting the ability to communicate after a stroke), essential hypertension (high blood pressure with no identifiable medical (continued on next page)

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

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F 0757 Level of Harm - Actual harm Residents Affected - Few	cause), acute cystitis without hematuria (bladder inflammation symptoms without blood in the urine), hyperlipidemia (high cholesterol), and long term (current) use of anticoagulants (medications that prevent or reduce blood clot formation). R28's most recent Minimum Data Set (MDS) with Assessment Reference Date (ARD) of 12/10/25 indicates R28's cognition is moderately impaired with a Brief Interview for Mental Status (BIMS) score of 10 out of 15. R28's hospitalist discharge summary notes, dated 11/11/25, summarize her hospital stay from 11/3/25 to 11/11/25, prior to being admitted to the facility. The summary notes include the following, in part: Final diagnoses: .2. Paroxysmal atrial fibrillation previously not on anticoagulation due to history of GI bleeding, now on Eliquis (an anticoagulant medication).Hospital Course: .Paroxysmal atrial fibrillation.Discussed with Neurology: resumed apixaban (Eliquis) on 11/8. Prior history of GI bleed appeared minor. Will stop aspirin at that time. R28's Preadmission Nursing Assessment was completed on 11/10/25 and GI bleed was noted in her medical history. R28's physician orders upon admission to the facility included the following, in part: Eliquis oral tablet 5 mg (Apixaban) Give 1 tablet by mouth two times a day for Afib (atrial fibrillation). Start date: 11/11/25. Surveyor reviewed R28's care plan and medication/treatment administration record (MAR/TAR) and did not note any precautionary instructions for staff related to R28 being on an anticoagulant.(It is important to note that for other residents taking anticoagulants, the facility has the following information addressed in the care plan: Monitor/document/report PRN (as needed) adverse reactions of anticoagulant therapy: blood tinged or red blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB (shortness of breath), loss of appetite, sudden changes in mental status, significant or sudden changes in v/s (vital signs).) R28's nurses' note on 12/20/25 at 10:31 AM by RN G indicates: Orders - Administration Note: Monitor temp and urinary symptoms every shift while on antibiotics for UTI. Chart a progress note. Current sx (symptoms): increased confusion and c/o (complaint of) back pain.Continues on monitoring d/t (due to) UTI (urinary tract infection). PO abx tx (oral antibiotic therapy) completed. Up and about per baseline. Reports feeling ?alright.' A&Ox3. Denies sx UTI. Denies back pain this AM.VSS. Afebrile @ 97.4 (degrees).R28's nurses' note on 12/21/25 at 8:01 PM by RN G indicates: Continues to be confused.Stated it was 1955. Did not know what day of the week it was despite us just discussing that it was Sunday. Has had intermittent reports of back pain and weak feeling today. DX (diagnosed) with UTI this week and completed 3 day dose of Bactrim which was completed yesterday. Urine remains medium yellow and clear without sx of sediment or blood. Continues to state she has burning with toileting. Reminded she has a catheter.Appetite good. Up and abpout [sic] in room with walker and 1A per baseline. R28's nurses' note on 12/22/25 at 11:00 AM by RN E indicates: .clinic updated of continued symptoms of confusion and back pain, concern for continuing antibiotic treatment. Any additional monitoring was reviewed. R28's blood pressure was recorded on 12/16/25 at 10:10 AM (121/47), 12/23/25 at 11:52 AM (132/72), 12/26/25 at 12:15 PM (108/58), and was then monitored each shift beginning on 12/28/25, as ordered. R28's nurses' note on 12/27/25 at 4:15 PM by RN G (Registered Nurse): Rec'd (received) call from CNA (certified nursing assistant) stating resident had ?bloody stool'. When asked of [sic] the sample was still in the toilet replied, ?No. I flushed the toilet but the wipes I used are still in the garbage.' 1:1. Reminded CNA that if any further bloody stools are noted they should not be flushed and writer should be notified immediately. Wipes noted to have deep brown stool with some area [sic] having light red discoloration. No evidence of blood noted on wipes. Resident denies GI upset. Will monitor. (of note: RN G did not conduct a GI (gastrointestinal) assessment on R28.)The following was added to R28's care plan on 12/27/25:-Need: The resident has an alteration in gastro-intestinal status possible blood in stools.-Approaches/Support Actions: If needed obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and update MD if needed and follow up as indicated.-Update Nursing and do not flush discolored stools. The following orders were entered for R28 on 12/27/25: Monitor for bloody stools. If noted update MD & obtain order for guaiac. Three times a day until 12/30/2025. R28's nurses' note on 12/28/25 at 3:00 (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	PM by RN G: Called into bathroom by CNA. Resident sitting in toilet. A&OX2-3 (alert and oriented) per baseline. Awake. Able to talk and answer questions appropriately. Diaphoretic (sweating) and feels weak. ?I feel like I might pass out'. Pale in color. CNA states resident has been sitting on the toilet for 20 minutes trying to go to the bathroom. Cool cloth applied to forehead. Assisted resident to standing position with 2A (two-person assist). Tolerated wiping, cleaning, and pulling up pants with one sitting break. Transferred into bed. Diaphoresis had stopped by the time resident was in bed. Abd (abdomen) soft, nontender, nondistended. BSAX4 (bowel sounds active in all four abdominal quadrants). Denies nausea or abd (abdominal) disc (discomfort). CNA's have been reporting ?bloody stools' for several weeks but nursing staff unable to view stool. Has medium soft formed stool while on the toilet. Stool was tarry in nature. Brick red/brown in color. Slight foul odor noted. No coffee ground appearance. No bright red visible clots or blood. Hat obtained and placed in bathroom to attempt a sample with next occurrence. Resident reports feeling better. 1:1. Informed that lightheaded feeling and diaphoresis was probably related to sitting on the toilet too long trying to have BM (bowel movement). Enc (encouraged) to limit to 10 minutes or less in future. Discussed blood appearance in stool. Informed that writer would be contacting on call MD to inform them and obtain order for guaiac (test to detect hidden blood in stool). Informed that she may have a GI bleed. Informed that her condition does not seem to be emergent at this time but needs to be addressed with PCP (primary care provider) in am. Resident shook her head in agreeance and stated ?you know best' and smiled. Will attempt to update POA (power of attorney) when more information is obtained. Monitoring set up to assess VS and condition q (every) shift. R28's nurses' note on 12/28/25 at 3:10 PM by RN G: Rec'd call back from [on-call doctor]. Informed of resident's recent vasovagal episode on the toilet. Also informed of reports of bloody stools over the past 1-2 weeks. Witnessed today by writer and noted to be formed soft. Tarry brick red/brown color without evidence of coffee ground substance, bright red blood, or clots. Informed that resident is feeling better and resting in bed. VSS (vital signs stable). Rec'd order to obtain stool for guaiac sample. Informed MD that staff will monitor VS every shift and update PCP in am unless condition worsens. The following orders were entered for R28:12/28/25: Per.on call MD .Obtain guaiac stool sample. Three times a day.12/28/25: Monitor VS and condition every shift. Questionable GI bleed. Three times a day until 12/31/25.12/28/25: Update PCP in clinic Monday 12/29/25 in regard to bloody stool. On 1/27/25 at 12:25 PM, Surveyor spoke with RN G via telephone and asked about her note indicating CNAs had been reporting R28's bloody stool prior to her hospitalization. RN G indicated she only works weekends at the facility. RN G indicated she had worked the weekend of December 20th and 21st and a CNA reported to her that she thought R28 had blood in her stool but had flushed it. RN G indicated she wanted to look at it herself to know for sure. She looked at the toilet but noted no blood. RN G indicated she did not chart this information but kept an eye on R28 throughout the weekend and passed the information along to the next nurse. RN G indicated a week later, on Saturday afternoon (12/27), a different CNA reported that R28 was having bloody stool. The CNA flushed the stool but left wipes in the garbage. RN G looked at the wipes and indicated they did not appear to be truly red - they were mostly brown with a red discoloration / red tone to them, like eating lasagna. RN G indicated it did not look like blood on the wipes. RN G indicated that R28 did not feel good on the toilet on Sunday (12/28), and the incident happened with her almost passing out.Surveyor asked why RN G had not charted anything about the bloody stool after being told about it the first time. RN G indicated she did not chart anything because she hadn't seen the stool. RN G indicated R28 was feeling perfectly fine, wasn't having any stomach issues, and nothing else was wrong. RN G said, I wanted to visualize it. RN G indicated the CNA who had initially approached her was newer and she wasn't sure she knew what she was talking about. RN G indicated the CNA never reapproached her about R28's stool looking bloody. RN G worked 12 hour shifts that weekend. The PM CNAs never said that anything was abnormal either and she was there all weekend.Surveyor asked RN G if she knew R28 had a history of GI bleeds. RN G indicated she never knew R28 had a history of GI bleeds but knew she was on Eliquis and had a history of reflux. RN G indicated she did (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	not see any other signs of bleeding or bruising at the time.RN G indicated she could have put a hat in the toilet or tried to get a sample. RN G said she certainly should have started monitoring earlier, but indicated she has been a nurse for 27 years and her gut feeling was that R28 was feeling okay. RN G indicated if something would have been wrong, she would have followed up but wanted to see what happened throughout the weekend. RN G indicated her perspective probably wouldn't have changed if she had known about R28's history of GI bleeds, but it would have been in the back of her mind to keep an eye on things. (of note per RN G's note and interview, R28 was indicated as having blood in her stool prior to this date. R28 did not have ongoing assessments conducted regarding her GI status or monitoring for bleeding until 12/27 after RN G was informed by a 2nd CNA that blood was noted in R28's stool.) R28's nurses' note on 12/28/25 at 6:29 PM indicates: Resident noted left esophageal pain under left ribs no pain with palpation repositioned laying in same position several hours skin pink warm resident noted to be tired, no further stools at this time. The following order was entered for R28 on 12/29/25: Please draw a CBC. One time only for 1 day. On 12/29/25 at 9:27 AM: CBC (complete blood count lab) drawn from R AC (inner elbow area on right arm). R28's nurses' note on 12/29/25 at 1:05 PM RN F wrote: At about 12:00 when entering room resident was attempting to get up from recliner. She stated she had to go to the bathroom. CNA in room. Resident was too weak to stand up and already had a BM in pants. Resident became unresponsive at the time. Had a vasovagal response. Sat resident back in her recliner. Sternal rubbed resident. Within a minute she became more responsive. Vital signs were 107/51, HR (heart rate)-86, O2 sat (oxygen saturation) 96% on room air and temp (temperature) 97.4. Resident unaware of what happened. Hoyered (mechanically lifted) resident to bed with 2 people. Collected stool sample. Stool dark red and tarry. Called.POA and updated him about situation and he gave the ok to if MD wanted her transferred to ER. Called [DO H (Doctor of Osteopathic Medicine - R28's primary care provider)] office and spoke with her RN and updated her regarding situation and the CBC results. She spoke with [DO H] and got the order to transfer her to ER.POA called and updated about the transfer to ER. EMS (emergency medical services) called regarding need for transport. Writer called ER and gave report.EMS here to transport resident and appropriate paperwork with them. EMS left with resident at 1240. R28's nurses' note on 12/29/25 at 12:10 PM RN F wrote: Called.POA and updated him about situation and he gave the ok to if MD wanted her transferred to ER (Emergency Room). R28's nurses' note on 12/29/25 at 1:07 PM RN F wrote: Called and updated [POA] that [DO H] wanted her to go to ER and we are going to transfer her via EMS. Verbal consent for a bed hold . R28's nurses' note on 12/29/25 at 5:07 PM indicates: Call from Med surg with update. resident admitted . plan is to monitor, recheck hemoglobin tomorrow morning and if lab result is under 7 will give blood transfusion. at this time family does not wish to scope resident.R28's hospital discharge summary notes, dated 12/31/25, summarize her hospital stay from 12/29/25 to 12/31/25, before being readmitted to the facility. The summary notes include the following, in part: Discharge diagnoses: GI bleed, acute blood loss anemia (rapid drop in red blood cells after losing blood), paroxysmal atrial fibrillation, hypertension, hyperlipidemia.Hospital Summary: .presented to the emergency room after a syncopal episode at her nursing home setting. She is [sic] apparently being helped up from a sitting position when she lost consciousness. Hemoglobin was down and was found to be 7.5 Staff also reported to family that she has had bloody stools dating back at least several weeks. She was hospitalized nearly 2 months ago for a stroke and was changed from aspirin to Eliquis at that time due to paroxysmal atrial fibrillation. She was sent to the emergency room for further evaluation. Stool was found to be heme positive (containing blood). She was otherwise medically stable. Goals of care were discussed with the activated power of attorney for healthcare . They were hoping she could be managed conservatively without invasive procedures excetra [sic] but would be willing for blood transfusions and more supportive type care if necessary.She (R28) was aware of the spell earlier but is not able to add additional information. Hospital Course: 1.) GI bleed/Acute blood loss anemia: patient has a past history of GI bleeding, this was likely exacerbated by the addition of Eliquis last month. Eliquis is discontinued. No more (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	episodes of blood in stool or black stools. S/p (following) 2 units of PRBC (packed red blood cells) transfusion. Hb (hemoglobin) remained stable. Repeat Hb this morning is around 8.8.(Of note: According to the Mayo Clinic, Hemoglobin is a protein in your red blood cells. Your red blood cells carry oxygen throughout your body.When your hemoglobin level is low, it means your body isn't getting enough oxygen, making you feel very tired and weak. A normal hemoglobin level is between 12.3 gm/dL and 15.3 gm/dL for women. A severely low hemoglobin level is below 12 gm/dL (https://my.clevelandclinic.org/health/symptoms/17705-low-hemoglobin).) R28's nurses' note on 12/31/25 at 1:51 PM states: Resident re-admitted to the NRC (nursing and rehab center) about 1245. On 1/26/25 at 1:45 PM, Surveyor interviewed CNA D. CNA D indicated she has worked at the facility for 4 or 5 months and works on the hallway where R28 resides often. CNA D indicated she was working with R28 on the day she went to the hospital for the GI bleed in December. CNA D indicated R28 had been having bloody stools for about a week before she went to the hospital. Surveyor asked if CNA D had told the nurses about this. CNA D indicated she told RN E about R28's bloody stool a few days before she went to the hospital. CNA indicated RN E had looked at the stool and said she would check to see what R28 ate for lunch that day. CNA did not chart this information anywhere and did not hear that any other CNAs had observed bloody stool. The next time CNA D observed bloody stool, she told RN G but flushed it before RN G could look at it. RN G told CNA D to leave it in the toilet next time it happened. CNA D was working with RN F when R28 was incontinent of bloody stool and RN F looked at it before R28 went to the hospital.On 1/26/25 at 2:27 PM, Surveyor spoke with RN E via telephone and asked if she had been informed that R28 was having bloody stools prior to being admitted to the hospital for the GI bleed. RN E indicated she was never personally told by any CNA that R28 was having blood in her stool prior to being admitted to the hospital. RN E indicated if this had occurred, the protocol would be to update the doctor to see if she should be evaluated in the ER. On 1/26/25 at 3:39 PM, Surveyor interviewed IP C (Infection Preventionist). Surveyor asked IP C if she had been informed that R28 was having bloody stools prior to being admitted to the hospital for the GI bleed. IP C indicated CNAs occasionally give her updates on residents, but she was never told anything about R28 having blood in her stool. On 1/27/25 at 11:23 AM, Surveyor interviewed RN F and asked if she had been informed that R28 was having bloody stools prior to being admitted to the hospital for the GI bleed. RN F indicated she was never told by the CNAs about the bleeding. She eventually heard that the bleeding had been going on for a week or two but was not sure who had said it or if anything was being done about it. When RN F was informed of the bloody stool, she started monitoring R28 and indicated that she held R28's Eliquis. RN F indicated after the monitoring, it was determined that R28 had a GI bleed and that is when she went to the hospital. On 1/27/25 at 11:27 AM, Surveyor interviewed DON B (Director of Nursing) and asked if any care planning had been done for the anticoagulant (Eliquis) R28 was on when she was admitted to the facility. DON B reviewed R28's care plan but did not see anything on it pertaining to anticoagulants. DON B indicated she would double check to see if she could pull it up. DON B indicated the facility does an initial admission care plan and has specific care plan parameters which are selected for anticoagulants and diabetic medications. Eliquis is included in that, but not aspirin. The facility also does a review at the initial care conference as a double-check, and it includes checking to see if the resident is on an anticoagulant. DON B indicated this should have been caught. Surveyor also asked DON B about RN G's note in R28's chart that referenced CNAs knowing about R28's bloody stool for 1-2 weeks prior to her going to the hospital. DON B indicated she looked into this issue but knew nothing about it. DON B had talked to RN E and she said she was never told about this. DON B indicated she looked through paper notes from December standup meetings and there was nothing noted about R28's change of condition.On 1/27/25 at 12:05 PM, DON B informed Surveyor that she checked with a few people, and the anticoagulant had never been care planned for R28.On 1/27/25 at 1:34 PM, Surveyor spoke with DO H via telephone and asked what her expectation would be if a CNA had notified a nurse that R28 was having blood in her stool, given her history of GI bleeds. DO H indicated the nurse should have (continued on next page)

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F 0757 Level of Harm - Actual harm Residents Affected - Few	contacted her or a provider on call immediately. DO H indicated an assessment should have been completed upon receiving that information. DO H indicated that R28 has a complicated and well-known history of strokes, a-fib, and GI bleeds, and is at high risk for being on medications or off of them. R28 is in a no-win situation. DO H indicated this has been communicated to R28's family and to the staff that these issues are ongoing. The decision was made to start and stop Eliquis, but R28 alternates between GI bleed and strokes, so they are unable to aggressively manage symptoms well. DO H indicated the facility should communicate these risks to staff.On 1/27/25 at 2:08 PM, Surveyor interviewed DON B. DON B indicated nurses always want to observe reported bloody stool, as the CNAs do not always know what blood may look like. DON B indicated collection hats are easily accessible and would be helpful at that moment if there's ever a suspicion of something that wasn't observed.Surveyor asked if RN G should have charted this information after hearing about it from the CNA. DON B indicated charting might not be necessary until a nurse has actually observed the stool in question, but her expectation would be to ensure that a stool sample has actually been captured. DON B also indicated that monitoring R28 for 24 hours would have been a good idea to be proactive.DON B indicated that she looked into R28's history and noted she had a GI bleed sometime in 2023 and noted that R28 had been put back on a medication (Eliquis) that put her at higher risk of this occurring again.DON B indicated RN G had reported R28 was acting normal the weekend of December 20th and 21st. Surveyor indicated nurses' notes state R28 was reporting back pain and confusion, which is why her doctor was contacted and the antibiotic she had been on for a UTI was continued longer. DON B indicated the staff must have been focused on other things, like the UTI, and not only on her stool being potentially bloody.Surveyor asked about R28's care plan being updated on 12/27 to include monitoring for bloody stool. DON B indicated RN G must have put this monitoring in place. R28's TAR included monitoring beginning 12/28 and a notification to staff was put out to contact R28's PCP on 12/29. A CBC lab was drawn on 12/29.DON B indicated in hindsight, yes, the nurse should have put in some monitoring right away. If the nurse had observed the stool earlier, there could have been an order for guaiac and a CBC lab. She should have put a collection hat in the toilet to observe for bloody stool. DON B indicated, I can also see where the nurse is coming from. No other staff members reported this - only the one CNA.DON B indicated if this had been brought up at a morning meeting, knowing R28's history, basic labs could have been ordered and completed to figure this out sooner - potentially the week before she had to go to the hospital.R28 was noted to possibly have blood in her stool by a CNA, RN G did not assess R28. There is no evidence of continued monitoring while taking an anticoagulant and R28 continued to decline and was eventually sent to the Emergency Department (ED) where she received treatment for a gastrointestinal (GI) bleed and two units of blood.

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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 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 observation, interview, and record review, the facility did not ensure residents are free of significant medication errors for 1 (R4) out of 4 sampled residents during the medication administration task.R4 has an order for metoprolol succinate (medication used to lower blood pressure) ER (extended release) 50 MG (milligrams) Tablet Extended Release 24 Hour dose to be administered once a day by mouth. This medication is labeled and ordered as an extended-release medication, meaning it is designed to release the active ingredients slowly over time, and are not to be crushed. During the medication administration observation, Surveyor observed Staff crushing and administering R4's metoprolol. Evidenced by:The facility policy entitled Medication Management Policy, dated 7/2025, states, in part: . Policy and Procedure:Medication AdministrationPolicy: Medications will be administered to residents as prescribed and by persons lawfully authorized to do so in a manner consistent with good infection control and standards of practice.Procedures: .5. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a resident has difficulty swallowing or is tube-fed, using the following guidelines.a. Long acting or enteric coated dosage forms should generally not be crushed; an alternative should be sought. The facility policy entitled Crushed Medications, dated 1/2026, states, in part: . Purpose: Medication management is a multi-faceted process of reconciling, monitoring, and assessing the medications an individual takes to assure compliance with a specific medication regimen, while also ensuring the individual avoids potentially dangerous drug interactions and other complications.Procedure: .A variety of oral solid dosage forms should not be crushed or chewed prior to administration because of their formulation. In general, these include:Extended-release, a term used synonymously with controlled-release, prolonged-action, and sustained release formulations R4 admitted to the facility on [DATE] and has diagnoses that include essential hypertension (high blood pressure) and pulmonary hypertension (serious, progressive type of high blood pressure in the lung arteries that forces the heart to work harder, often leading to right-side heart failure).R4's Physician Orders, dated 1/1/26, states, in part: . Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG. Give 1 tablet by mouth one time a day for a fib (atrial fibrillation- chronic heart rhythm disorder). Order Date: 2/27/24. Start Date: 2/28/24.R4' Medication Administration Record (MAR) states, in part: . Metoprolol Succinate ER Oral Tablet Extended Release 24 Hour 50 MG. Give 1 tablet by mouth one time a day for A-FIB. Start Date: 2/28/24.On 1/26/26 at 9:04 AM, Surveyor observed RN F (Registered Nurse) administer R4's medications. Surveyor observed RN F crush R4's metoprolol succinate ER 50 mg tablet and administer to R4 in applesauce.On 1/26/26 at 4:40 PM, Surveyor notified NHA A (Nursing Home Administrator) of the observation of R4's metoprolol succinate ER being crushed and administered during medication administration observation task. Surveyor asked NHA A if metoprolol succinate ER should be crushed. NHA A indicated no. Surveyor asked NHA A if any extended-release medications should be crushed for safety reasons and NHA A indicated no.