STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525482	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Burlington Health and Rehabilitation Center	677 E State St Burlington, WI 53105

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, interview, record review, and facility policy review, the facility failed to assess two of 18 sampled residents (Resident (R) 11 and R6) who were observed with medications at the bedside for the safe self-administration of medications. This failure could potentially lead to medications being left by staff at the residents' bedside where other residents could access them. Findings include: Review of a facility policy titled, Resident Self-Administration of Medication, dated 05/2025 indicated, . It is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medication after the facility's interdisciplinary team has determined which medication may be self-administered safely. 1. Review of R11's Face Sheet, found in the electronic medical record (EMR) under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses that included a left ischium wound. Review of R11's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/03/25 and found under MDS tab of the EMR, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R11's Physician Order, dated 04/03/25 and located under the Orders tab of the EMR, indicated clinical staff were to apply Santyl ointment to the resident's left ischium, with a wet to dry dressing with one quarter strength Dakins solution. A review was conducted of R11's entire EMR, and there was no evidence that the facility assessed the resident's ability to safely apply the Santyl medication. During an interview on 05/06/25 at 1:07 PM, an observation was made in R11's room, and there was a tube of Santyl on his bedside table. R11 stated the staff used it for his wound treatment and he would also apply the Santyl as needed. During an interview on 05/06/25 at 1:15 PM, Licensed Practical Nurse (LPN) 1 verified the Santyl was left at the bedside of R11 and stated she was unaware if the resident had been assessed to be able to safely apply the Santyl. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of R6'sFace Sheet, found in EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE] with diagnoses that included shortness of breath. Review of R6's admission MDS, with an ARD of 02/23/25 and found under the MDS tab of the EMR, indicated the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R6's Physician Order, located under the Orders tab of the EMR, failed to indicate physician orders for the use of Albuterol (an inhaler for treatment of asthma). A review was conducted of R6's entire EMR, and there was no evidence that the facility assessed the resident's ability to safely self-administer an inhaler. During an interview on 05/07/25 at 10:47 AM, an Albuterol inhaler in a box was observed next to R6's bed. R6 stated she was assessed for the safe use of the inhaler to be held at her bedside. During an interview on 05/07/25 at 12:24 PM, the Assistant Director of Nursing (ADON) entered R6's room and gathered the resident's inhaler. The resident told the ADON that she had access to the Albuterol for the past month. The ADON stated there was no safety assessment completed for R6 and the self-administration of the Albuterol. The ADON stated before a resident was to have a medication at bedside, the resident needed to be assessed for the self-administration of the medication.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and policy review, the facility failed to ensure documentation of pre- and post-dialysis assessments and failed to ensure communication occurred between the facility and the dialysis center for one of two residents (Resident (R) 17) reviewed for dialysis out of total sample of 18. This had the potential to affect the health of residents receiving dialysis. Findings include: Review of the facility's policy titled, Hemodialysis, revised 02/15/25, revealed, . The licensed nurse will communicate to the dialysis facility via telephonic communication or written format, such as a dialysis communication form or other form, that will include, but not limit itself to: a.timely medication administration [initiated, held or discontinued] by the nursing home and/or dialysis facility; b. physician/treatment orders, laboratory values, and vital signs; c. advance directive and code status; specific directive about treatment choices ; and any changes or need for further discussion with the resident/representative, and practitioners; d. Nutritional/fluid management including documentation of weights, resident compliance with food/fluid restrictions or the provision of meals before, during and/or after dialysis and monitoring intake and output measurements as ordered; e. Dialysis treatment provided and resident's response, including declines in functional status, falls, and the identification of symptoms that may interfere with treatments; f. Dialysis adverse reactions/complications and/or recommendations for follow up observations and monitoring, and/or concerns related to the vascular access site; g. Changes and/or declines in condition unrelated to dialysis; h. The occurrence or risk of falls and any concerns related to transportation to and from the dialysis facility . Review of R17's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R17 was admitted to the facility on [DATE] with diagnoses which included dependence on renal dialysis. Review of R17's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/17/25 and located under the MDS tab of the EMR, revealed R17 received dialysis. It was recorded R17 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated intact cognition. Review of R17's Care Plan, located under the Care Plan tab of the EMR and 10/21/23, revealed, . The resident has a diagnosis of chronic renal failure and receives hemodialysis . The Care Plan did not address communication between the dialysis center and the facility. Review of R7's Physician Order, dated 06/04/24 and located under the Orders tab of the EMR, revealed R17 had dialysis on Mondays, Wednesdays, and Fridays. Nursing staff were directed to . Please complete Dialysis Communication Form and send to dialysis. Make a copy. If dialysis does not return form with resident call for info to complete form . In addition, orders dated 05/13/24 included daily weights on Monday, Wednesday, and Friday before dialysis, vital signs prior to sending resident to dialysis; vital signs upon returning from dialysis; and send a list of medications to the dialysis center every Monday, Wednesday, and Friday. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R17's Medication Administration Records (MARs), dated 04/01/25 through 05/07/25 and located in the Orders tab of the EMR, revealed R17 refused vital signs approximately half of the scheduled pre- and post- dialysis days and refused weights before dialysis except on 04/11/25 and 04/25/25. Nursing signed off completion of the Dialysis Communication Form every dialysis day. During an interview on 05/07/25 at 9:05 AM, Licensed Practical Nurse (LPN) 4 stated she recently finished orientation and was unsure of how the facility communicated with the dialysis centers since she had no residents who received dialysis on her wing. During an interview on 05/07/25 at 9:10 AM, LPN5 stated nursing checked vital signs before residents went to dialysis, filled out the communication form, and sent it in the resident's dialysis binder with the resident to dialysis. During an interview on 05/07/25 at 9:17 AM, Nurse Tech (NT) 1 reported she gave medications to R17 prior to dialysis. NT1 stated the licensed nurse who oversaw her hall prepared the Dialysis Communication Form and the binder for R17, and currently, that nurse was LPN3. During an interview on 05/07/25 at 9:20 AM, LPN3 stated she did not do anything with R17's communication form or binder. LPN3 stated the nurse who worked that hall took care of the binder. LPN3 stated when she took care of residents on dialysis, she ensured they were sent out with their communication form, medication orders, any recent orders, and their vital signs. During an interview on 05/07/25 at 3:05 PM, R17 reported she had just returned from dialysis. R17 stated it was hit or miss whether the facility checked her vital signs before and after dialysis. R17 stated she did not typically refuse vital signs unless it was the middle of the night. R17 stated the dialysis binder was in the bag on the back of her wheelchair, but staff had not touched it for months. During a concurrent observation and interview on 05/07/25 at 3:10 PM, LPN6 came to R17's room to check her vital signs while the dialysis binder was reviewed and observed to not have any communication forms in it since October 2024. LPN6 reported she did not work when R17 went out to dialysis. Upon return from dialysis, LPN6 did not do anything with the dialysis binder. During an interview on 05/07/25 at 4:05 PM, the Director of Nursing (DON) reported the expectation that nursing use the dialysis communication forms. The DON stated the forms were to include pre- and post- vital signs and weights. The DON stated the dialysis center typically obtained the weights. The DON confirmed the binder contained no communication forms since October 2024. During an interview on 05/08/25 at 11:10 AM, the DON stated she had not located any dialysis communication forms since October 2024 for R17. During an interview on 05/08/25 at 2:43, the Assistant Director of Nursing (ADON) stated R17 refused many vital signs and weights since dialysis monitors them. The ADON stated staff should fill out and send the communication forms so the facility was aware of pre- and post- dialysis weights done by dialysis and any order changes. The ADON reported she communicated with dialysis via phone on bigger issues such as when R17 refused labs.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42440 Based on observation, interview, record review, and facility policy review, the facility failed to have medications available to administer as ordered for three of four residents (Resident (R) 7, R18, and R2) reviewed for medication availability out of a total sample of 18. This had the potential to result in adverse health outcomes. Findings include: Review of the facility's policy titled, Medication Reordering, dated December 2024, revealed, . Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. Each time a nurse is administering medications and observes [6] or less doses left of one kind, that nurse will reorder the medication, time permitting . For stat medications, a supply of medications typically used in emergency situations will be maintained in limited supply by the pharmacy in a portable, but sealed emergency box or container [may be used if applicable] . 1. Review of R7's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), pulmonary embolism (blood clot in the lung), major depressive disorder, heart failure, and asthma. Review of R7's Orders tab and Medication Administration Records (MARs), dated 12/2024 and 01/2025 and located under the Orders tab of the EMR, revealed orders for the following medications which were documented on the 12/2024 and 01/2025 MARs by nursing with the code 4, which referred the review to other/see nurse notes: a. Rivaroxaban 20 milligrams (mg) (blood thinner) was ordered daily from 12/21/24 to 01/25/25 and reordered on 1/25/25. It was documented as 4 on 12/30/24, 01/03/25, 01/13/25, and 01/24/25. b. Duloxetine HCl 60mg (anti-depressant) was ordered daily from 12/21/24 to 03/05/25 and reordered on 03/05/25. It was documented as 4 from 01/24/25 through 01/27/25. c. Azithryomycin 250mg (antibiotic) was ordered daily from 12/21/24 to 01/21/25. It was documented as 4 on 12/30/24, 01/07/25, 01/15/25, 01/16/25, 01/17/25, and 01/20/25. d. Prednisone (oral steroid)10mg was ordered daily from 12/21/24 to 1/21/25 and was decreased to 5mg daily which started 01/21/25. It was documented as 4 on 12/30/24 and 01/03/25. e. Fluticasone-salmeterol inhaler for COPD 1 puff twice daily was ordered on 12/21/24. It was documented as 4 for the evening doses on 12/24/24, 01/02/25, and 01/03/25. f. Umeclidinium bromide inhaler 1 puff daily for COPD was ordered on 12/21/24. It was documented as 4 from 01/10/25 through 01/13/25 and on 01/30/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	g. Roflumilast 500 micrograms (mcg) daily (for COPD) was ordered on 12/21/24. It was documented as 4 from 01/22/25 through 01/27/25. Review of R7's Orders tab of the EMR revealed orders for Dupixent 300mg subcutaneous injection every 14 days for COPD from 12/21/24 until 01/12/25, reordered from 01/12/25 to 04/20/24, and reordered again on 04/20/24. It was documented on the 02/2025, 03/2025, and 04/2025 MARs by nursing as 4 on 02/09/25, 03/09/25, 03/23/25, and 04/06/25. Review of R7's eMar - Medication Administration Notes, located under the Prog Notes tab of the EMR, revealed the following documentation: a. The rivaroxaban was documented as reorder on 12/30/24, on order on 01/03/25, will recorder not available on 01/13/25, and pending order on 01/24/25. b. The duloxetine was documented as not available on 01/24/25, 01/25/25, and 01/26/25. On 01/27/25, it was documented as not delivered by pharmacy. c. The azithromycin was not available on 12/30/24, not available on 01/01/25 (but signed as given on the MAR), not available on 01/07/25, med unavailable on 01/15/25, not available on 01/16/25 and 01/17/25, and not available, contacted [pharmacy], sending tonight on 01/20/25. d. The prednisone was documented as reorder on 12/30/24 and on order on 01/03/25. e. The fluticasone-salmeterol inhaler was not available on 12/24/25, no rationale for 01/02/25, and on order on 01/03/25. f. The umeclidinium bromide inhaler was documented as not available on 01/10/25, pharmacy has not sent on 01/11/25, 01/12/25, and 01/13/25, and not delivered by pharmacy yet on 01/30/25 g. The roflumilast was documented as medication not available or not available on 01/22/25, 01/23/25, 01/24/25, 01/25/25, pharmacy has not sent on 01/26/25, and not delivered by pharmacy on 01/27/25. h. The Dupixent was documented on 02/09/25 as does not have injection available. The writer made the MD [doctor] aware. The writer called pharmacy to re-order, medication pending delivery. On 03/09/25, it was awaiting delivery. On 03/23/25, medication not available, RN called pharmacy and left message for it to be delivered ASAP. On 04/06/25, it was not available. Review of R7's quarterly Minimum Data Set (MDS), with an assessment reference date (ARD) of 03/28/25 and located under the MDS tab of the EMR, revealed he scored a 15 out of 15 on his Brief Interview for Mental Status (BIMS), which indicated intact cognition. During an interview on 05/06/25 at 10:20 AM, R7 stated there were times he did not receive his medications timely or at all. R7 reported he missed important medications for his COPD such as prednisone, his inhalers, and his Dupixent injections. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 11:30 AM, Pharmacist 2 stated the pharmacy preferred that the facility order medication refills two to three days in advance to ensure the pharmacy had the medications and insurance approval. Pharmacist 2 stated that all medications needed to be requested by the facility when running low as the pharmacy did not send medications on a cycle. Pharmacist 2 stated that R7's rivaroxaban was limited by insurance to a 14-day supply, and it was sent on 12/21/24, 01/08/25, and 01/21/25, so the facility should have had it for the doses documented as unavailable. Pharmacist 2 stated a 30-day supply of the duloxetine and roflumilast were sent on 12/21/24, and the facility requested refills on 01/16/25, but the pharmacy missed that request somehow. Pharmacist 2 stated the facility faxed another request on 01/26/25, and the medications were sent. Pharmacist 2 stated the umeclidinium bromide inhaler was sent as a seven-day supply due to insurance, and it was sent on 12/21/24, 01/13/25, 01/21/25, and 2/2/25. Pharmacist 2 stated six doses of the azithromycin were sent on 12/21/24, with a note requesting an indication and/or a stop date as the order did not indicate either. Pharmacist 2 stated the facility did not clarify the order but continued to request it so six doses were sent on 12/30/24, on 01/03/25, and on 01/20/25. Pharmacist 2 stated thirty doses of prednisone 10mg were sent on 12/21/24 and thirty doses of 5mg were sent on 1/21/25 when the order changed, so the missed doses should have been available at the facility. Pharmacist 2 stated the fluticasone-salmeterol inhaler was sent as a 30-day supply on 12/21/24 and again on 02/10/25, so was available for the missed doses but likely not available for other doses as it went over 30 days between refills. Pharmacist 2 stated the Dupixent was sent as two pens (two doses) on 1/14/25 and 02/10/25, and the facility requested it a couple of times in March but insurance was not covering it, so it was not delivered until 04/08/25. Pharmacist 2 stated the facility had a contingency supply, which likely included the azithromycin but probably did not have the rivaroxaban and did not include inhalers. During a concurrent observation and interview on 05/07/25 at 5:10 PM, Licensed Practical Nurse (LPN) 2 administered R7's medications to him. LPN2 went to a supply room to obtain one stock medication that was unavailable. LPN2 reported the facility had a Pyxis (contingency supply of medications) in a medication room. LPN2 stated in order to reorder medications, she removed stickers from the cards of medications when the medication was running low and placed the sticker on a pharmacy re-order paper. LPN2 stated medications usually arrived within a day or two and more important medications, such as antibiotics, were delivered STAT (as soon as possible) if requested and not in the Pyxis. During an interview on 05/07/25 at 5:20 PM, LPN6 stated medications were reordered by fax or phone call. LPN6 stated the pharmacy sometimes said medication was arriving on their next delivery, but then it did not come. LPN6 stated that even STAT orders were not always timely. During an interview on 05/08/25 at 2:45 PM, the Assistant Director of Nursing (ADON) recalled R7 had concerns about missed medications but had not realized some were unavailable and not given for multiple days in a row. 2. Review of R18's Admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses which included mood disorder and depression. Review of R18's admission MDS, with an ARD of 03/26/25 and located in the MDS tab of the EMR, revealed R18 scored a 13 out of 15 on his BIMS, which indicated intact cognition. Review of R18's Orders tab of the EMR revealed an order for fluoxetine HCl 40mg daily for depression/mood disorder, dated 12/18/24. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 05/08/25 at 7:46 AM, LPN9 prepared R18's morning medications and stated, The fluoxetine is on order. Let me see if it came. LPN9 looked through R18's medications and stated, No, it didn't. LPN9 documented on a pharmacy re-order form that the medication was needed, documented that the medication was not available, and administered R18's other medications to him. During an interview on 05/08/25 at 8:15 AM, LPN9 stated she had ordered the fluoxetine the day before, and medications were delivered nightly. LPN9 stated usually the pharmacy sent a note as to why they did not send medication. LPN9 stated lots of medications had been on backorder lately. During an interview on 05/08/25 at 9:00 AM, R18 stated he did not pay much attention to the pills he received. During an interview on 05/08/25 at 11:30 AM, Pharmacist 2 stated the pharmacy filled R18's fluoxetine and were sending it out that night. Pharmacist 2 stated the pharmacy had a refill sticker sent the day before and sent out medications daily, but there were cut-off times and insurance hold-ups. Pharmacist 2 stated R18 last received a card of 30 doses of fluoxetine on 4/4/25. She stated, It is in the contingency supply, so they could have gotten it from there. During an interview on 05/08/25 at 12:25 PM, Physician 1 stated he was aware of pharmacy issues, especially around the December/January time frame and felt the facility not having medications available that were needed was unacceptable. Physician 1 stated he had spoken to the nurses about his concerns. During an interview on 05/08/25 at 12:50 PM, LPN9 stated she had contacted the pharmacy, and they needed a new prescription and were sending the fluoxetine on their nightly delivery. During an interview on 05/08/25 at 1:45 PM, the Director of Nursing (DON) stated if medications were unavailable, staff were expected to go to the contingency supply, and if medications were not available in contingency, staff were expected to contact the pharmacy, have the medication delivered STAT, and contact the provider. During an interview on 05/08/25 at 1:48 PM, Registered Nurse (RN) 2 stated that not having automatic cycle fills was a challenge. RN2 stated the nurses were to call and re-order when requested medications were not available. During an interview on 05/08/25 at 2:45 PM, the ADON stated staff were supposed to be able to order medications online but were unable to do so, and so they faxed all refill requests. The ADON stated they maybe received half of the medications requested. She stated staff then called the pharmacy. She stated there were sometimes insurance issues. The ADON reported she told staff to order when there was around a week's supply left, but some medications were only sent out as a seven- or eight-day supply. She stated the contingency supply did not contain many of the needed medications. The ADON stated she updated the physician and tried to change medications when she was notified they were not available. During an interview on 05/08/25 at 4:15 PM, the DON stated the managers spent a lot of time calling the pharmacy and tracking medications. The DON reported she expected nurses to notify the nurse managers or herself when ordered medications did not arrive. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12679 3. Review of R2's Face Sheet, located in the EMR under the Profile tab, indicated the resident was admitted to the facility on [DATE]. Review of R2's Physician Orders, located under the Orders tab of the EMR and dated 10/15/24, indicated the resident had an order for Rosuvastatin five mg two tablets to be administered one time a day for hypercholesteremia (high cholesterol blood level). Review of R2's quarterly MDS, with an ARD of 01/15/25 and located under the MDS tab of the EMR, indicated the resident had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R2's MAR, located under the Orders tab of the EMR and dated 02/2025, revealed R2's Rosuvastatin 5 mg times two tablets were not documented as administered on the following dates: 02/06/25, 02/07/25, 02/08/25, 02/16/25, and 02/17/25. The MAR directed to read the associated clinical documentation for reasons medication was not administered: a. On 02/06/25 Rosuvastatin 5 mg two tablets were unavailable and were reordered. b. On 02/07/25 Rosuvastatin 5 mg two tablets were unavailable and were reordered. c. On 02/08/25 Rosuvastatin 5 mg two tablets, waiting on pharmacy delivery. d. On 02/16/25 Rosuvastatin 5 mg two tablets, waiting on delivery. e. On 02/17/25 Rosuvastatin 5 mg two tablets, reordered. Review of Physician Orders, located under the Orders tab of the EMR and dated 02/28/25, indicated the resident had an order for Rosuvastatin 10 mg one tablet to be administered one time a day for hypercholesteremia. Review of R2's MAR, located under the Orders tab of the EMR and dated 03/2025, revealed R2's Rosuvastatin 10 mg was not documented as administered on the following dates: 03/15/25, 03/16/25, 03/17/25, 03/30/25 and 03/31/25. The MAR directed to read the associated clinical documentation for reasons medication was not administered: a. On 03/15/25 Rosuvastatin 10 mg was unavailable. b. On 03/16/25 Rosuvastatin 10 mg was ordered and waiting on delivery. c. On 03/17/25 Rosuvastatin 10 mg was ordered and waiting on delivery. d. On 03/30/25 Rosuvastatin 10 mg was unavailable and ordered from pharmacy. e. On 03/31/25 Rosuvastatin 10 mg was not available. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 11:05 AM, Pharmacist 2, a pharmacist with the company that the facility placed orders for medications from, stated the facility placed the following orders for Rosuvastatin on the following dates: a. On 01/13/25 the facility ordered a 30-day supply of Rosuvastatin, and it was delivered on the same day. b. On 02/08/25 the facility ordered a seven-day supply of Rosuvastatin, and it was delivered on the same date. Pharmacist 2 stated R2's insurance must have authorized a lower amount to dispense. c. On 02/15/25 the facility ordered a seven-day supply of Rosuvastatin but was unable to state when the medication was delivered. d. On 02/18/25 the facility ordered a seven-day supply of Rosuvastatin, and it was delivered on the same date. e. On 02/24/25 the facility ordered a seven-day supply of Rosuvastatin and was delivered early in the morning on 02/25/25. Pharmacist 2 stated the facility must have placed an order for R2's medication late in the day. f. On 03/06/25 the facility ordered a seven-day supply of Rosuvastatin, and it was delivered early in the morning on 03/07/25. g. On 03/17/25 the facility ordered a 14-day supply of Rosuvastatin, and it was delivered early in the morning on 03/18/25. Pharmacist 2 stated R2's insurance must have authorized this amount. h. On 03/31/25 the facility ordered R2's Rosuvastatin and an eight-day supply was authorized by the resident's insurance, and the medication were delivered on 04/02/25. Pharmacist 2 stated it was ideal for the facility to re-order medication two to three days in advance to ensure there was coverage for the residents' medications. When Pharmacist 2 was asked if there should have been enough Rosuvastatin coverage for R2 for the month of 02/2025, she stated there should have been. Pharmacist 2 stated there should have been enough Rosuvastatin coverage for 03/15/25, 03/16/25, and 03/17/25 but not enough of Rosuvastatin for 03/30/25 and 03/31/25. During an interview on 05/08/25 at 1:48 PM, RN2, who was also the Unit Manager for the 500 and 600 Units, stated she would get on the phone with the pharmacy regarding R2's Rosuvastatin and was told it was a change in the insurance authorization for a lower dispensing amount. RN2 stated she wanted to check the contingency box (emergency medications storage) to see if there was Rosuvastatin in it. At 2:26 PM, RN2 stated there was no Rosuvastatin in the contingency box. RN2 stated she did not remember ever seeing a 30-day supply sent from the pharmacy for R2's Rosuvastatin. During an interview on 05/08/25 at 2:34 PM, Medication Technician (MT) 1 stated there were multiple times R2 would run out of her Rosuvastatin, and there was always a delay from the Pharmacy. MT1 stated she had reported these delays to all the nurses and her supervisor. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 4:04 PM, the DON stated she did some training on medication availability and presented a document titled Medication Report dated 02/19/25. There was no specific medication identified on this report for R2, and the DON agreed the report was not specific enough to address the delay in R2's medications.

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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** 42440 Based on interview, record review, and facility policy review, the facility failed to ensure one of three residents (Resident (R) 7) reviewed for medications was free from significant medication errors when medications were not available and/or were not administered per physician orders. This had the potential to result in adverse health outcomes. Findings include: Review of the facility's policy titled, Medication Error Reporting and Counseling Procedure, reviewed/revised 12/2024, revealed a significant medication error meant one which caused the resident discomfort or jeopardized his or her health and safety. The policy recorded, . The relative significance of medication errors is a matter of professional judgment. Three general guidelines in determining whether a medication error is significant or not: resident condition, drug category, and frequency of error . Review of R7's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R7 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD), pulmonary embolism (blood clot in the lung), and asthma. Review of R7's Orders tab and Medication Administration Records (MARs), dated 12/2024 and 01/2025 and located under the Orders tab of the EMR, revealed orders for the following medications which were documented on the 12/2024 and 01/2025 MARs by nursing with the code 4, which referred the reviewer to other/see nurse notes: a. Rivaroxaban 20mg (blood thinner) was ordered daily from 12/21/24 to 01/25/25 and reordered on 1/25/25. It was documented as 4 on 12/30/24, 01/03/25, 01/13/25, and 01/24/25. b. Umeclidinium bromide inhaler 1 puff daily for COPD was ordered on 12/21/24. It was documented as 4 from 01/10/25 through 01/13/25 and on 01/30/25. c. Roflumilast 500 micrograms (mcg) daily (for COPD) was ordered on 12/21/24. It was documented as 4 from 01/22/25 through 01/27/25. Review of R7's Orders tab of the EMR revealed orders for Dupixent 300mg subcutaneous injection every 14 days for COPD from 12/21/24 until 01/12/25, reordered from 01/12/25 to 04/20/24, and reordered again on 04/20/24. It was documented on the 02/2025, 03/2025, and 04/2025 MARs by nursing as 4 on 02/09/25, 03/09/25, 03/23/25, and 04/06/25. Review of R7's eMar - Medication Administration Notes, located under the Prog Notes tab of the EMR, revealed the following documentation: a. The rivaroxaban was documented as reorder on 12/30/24, on order on 01/03/25, will recorder not available on 01/13/25, and pending order on 01/24/25. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	b. The umeclidinium bromide inhaler was documented as not available on 01/10/25, pharmacy has not sent on 01/11/25, 01/12/25, and 01/13/25, and not delivered by pharmacy yet on 01/30/25. c. The roflumilast was documented as medication not available or not available on 01/22/25, 01/23/25, 01/24/25, 01/25/25, pharmacy has not sent on 01/26/25, and not delivered by pharmacy on 01/27/25. d. The Dupixent was documented on 02/09/25 as: does not have injection available. The writer made the MD [doctor] aware. The writer called pharmacy to re-order, medication pending delivery. On 03/09/25, it was awaiting delivery. On 03/23/25, medication not available, RN called pharmacy and left message for it to be delivered ASAP. On 04/06/25, it was not available. Review of R7's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/28/25 and located under the MDS tab of the EMR, revealed R7 scored a 15 out of 15 on his Brief Interview for Mental Status (BIMS), which indicated intact cognition. During an interview on 05/06/25 at 10:20 AM, R7 stated there were times he did not receive his medications timely or at all. R7 reported he missed important medications for his COPD such as prednisone, his inhalers, and his Dupixent injections. He stated he had not had respiratory concerns during the time nor any blood clots. During an interview on 05/08/25 at 11:30 AM, Pharmacist 2 stated the pharmacy preferred that the facility ordered medication refills two to three days in advance to ensure the pharmacy had the medications and insurance approval. She stated all medications needed to be requested by the facility when running low as the pharmacy did not send medications on a cycle. Pharmacist2 stated R7's rivaroxaban was limited by insurance to a 14-day supply. She stated it was sent on 12/21/24, 01/08/25, and 01/21/25, so the facility should have had it for the doses documented as unavailable. Pharmacist 2 stated a 30-day supply of the roflumilast were sent on 12/21/24, and the facility requested a refill on 01/16/25, but the pharmacy missed that request somehow. She stated the facility faxed another request on 01/26/25, and the medication was sent. Pharmacist2 stated the umeclidinium bromide inhaler was sent as a seven-day supply due to insurance, and it was sent on 12/21/24, 01/13/25, 01/21/25, and 2/2/25. She stated the Dupixent was sent as two pens (two doses) on 1/14/25 and 02/10/25. Pharmacist2 stated the facility requested it a couple of times in March but insurance was not covering it, so it was not delivered until 04/08/25. She stated the facility had a contingency supply, which probably did not have any of these medications. Pharmacist2 stated she was concerned that missing the blood thinner was a significant concern to R7. She stated the inhalers were important as well. During an interview on 05/07/25 at 5:10 PM, Licensed Practical Nurse (LPN) reported the facility had a Pyxis (contingency supply of medications) in a medication room. LPN2 stated she faxed the pharmacy when medications were running low. LPN2 stated medications usually arrived within a day or two and more important medications were delivered STAT (as soon as possible) if requested and not in the Pyxis. During an interview on 05/07/25 at 5:20 PM, LPN6 stated medications were reordered by fax or phone call. LPN6 stated the pharmacy sometimes said medication was arriving on their next delivery, but then it did not come. LPN6 stated that even STAT orders were not always timely. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/08/25 at 2:45 PM, the Assistant Director of Nursing (ADON) recalled R7 had concerns about missed medications but had not realized some were unavailable and not given for multiple days in a row. During an interview on 05/08/25 at 12:25 PM, Physician1 stated he was aware of pharmacy issues, especially around the December/January time frame and felt the facility not having medications available that were needed was unacceptable. He stated he had spoken to the nurses about his concerns. Physician1 stated with R7's history of COPD and risk for blood clots, he considered the missed doses of his COPD medications and blood thinner to be significant medication errors. During an interview on 05/08/25 at 1:45 PM, the Director of Nursing (DON) stated if medications were unavailable, staff were expected to go to the contingency supply. She stated if medications were not available in contingency, staff were expected to contact the pharmacy, have the medication delivered STAT, and contact the provider. During an interview on 05/08/25 at 4:15 PM, the DON reported she was unaware that R7 had missed COPD medications multiple days in a row. The DON stated that when any medication was not administered, especially significant medications, she expected staff to notify her and the physician and increase monitoring of symptoms for which the medications were used to treat.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 12679 Based on interview and record review, the facility failed to ensure a Dietary Manager (DM) was designated to act as the director of food and nutrition services, when the DM position was vacant. This had the potential to affect 89 of 89 residents in the facility. Findings include: Review of a document provided by the facility titled job description for Food Service Manager indicated . The primary purpose of your job position is to assist the Dietitian in planning, organizing, developing and directing the overall operation of the Food Services Department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility, and as may be directed by the Administrator, to assure that quality nutritional services are provided on a daily basis and that the Food Services Department is maintained in a clean, safe, and sanitary manner. Graduate of an accredited course in dietetic training approved by the American Dietetic Association. Review of an employee file provided by the facility and referred to as the employee file for the former Dietary Manager indicated the former Dietary Manager ended her employment with the facility on 04/02/25. During an interview on 05/06/25 at 9:52 AM, the current Dietary Manager stated he and the contracted company took over the facility's kitchen on 05/05/25. During an interview on 05/06/25 at 10:16 AM, Dietary Aide (DA) 1 stated there was no full-time dietary manager, overseeing the kitchen, for approximately one month. During an interview on 05/06/25 at 10:23 AM, [NAME] 1 stated the kitchen had been without a dietary manager for the past month. Cook1 stated there was no dietary manager to oversee the kitchen during this time. During an interview on 05/08/25 at 12:15 PM, the Administrator stated that he had been in his position for the past three weeks and was aware of the former Dietary Manager had walked out unexpectedly. He stated the contract just went through with the company to oversee the kitchen this week.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 12679 Based on observation, menu review, interview, and facility policy review, the facility failed to ensure the menus and menu extensions were followed which included providing appropriate approved food substitutions and ensuring recipes were followed for 89 out of 89 residents. This failure had the potential to cause residents to lose weight. Findings include: Review of an undated facility policy titled, Menu indicated, . Menus will be planned to meet the nutritional needs of the residents/patients in accordance with established national guidelines . Review of a document provided by the facility, referred to as the weekly menu for 05/06/25, indicated the residents were to be served the following meal items: baked potato, crusted fish, rice pilaf, steamed zucchini and tomatoes, a dinner roll, and bread pudding. A tray line observation was conducted on 05/06/25 at 11:53 AM. [NAME] 1 began to serve resident meals. Kitchen staff had placed mixed fruit on resident trays at this time. [NAME] 1 stated the bread pudding was to be made the night before, and it was not available. [NAME] 2 was interviewed during this observation, and she verified that she was responsible for the preparation of the bread pudding the night before. She stated she did not have the time to make it. When asked how the residents would know of a menu substitution, [NAME] 2 stated the residents did not mind when menu items were substituted. The current Dietary Manager stated residents were to be notified in advance of any menu substitutions made. During an interview on 05/08/25 at 12:15 PM, the Administrator stated if there were changes to the menu, the residents needed to be alerted in advance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 12679 Based on observation, interview, and policy review, the facility failed to ensure the kitchen was maintained in a sanitary condition to prevent the potential spread of foodborne illness. This had the potential to affect 89 of 89 residents. Specifically, the facility failed to label, date, and store food properly. Findings include: Review of a facility policy titled, Food Storage: Dry Goods, dated 02/2023, indicated . All dry goods will be appropriately stored in accordance with the FDA Food Code . Review of a facility policy titled, Food Storage: Cold Foods, dated 02/2023, indicated . All time/Temperature Control for Safety (TCS) foods, frozen and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code . All food will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination . During the initial tour of the kitchen on 05/06/25 at 10:30 AM with the current Dietary Manager, the following was observed: The dry storage area held an 18-quart container which was partially filled with rice. It was labeled 03/02/25 and had an expiration date of 04/02/25. The dry storage area held a 22-quart container which contained sugar and had a small plastic cup on the inside of the container which touched the contents. The container was not labeled and dated. The Dietary Manager confirmed the observation and stated this was a potential infection control issue and any open food was to have a date open with an expiration date. The walk-in freezer had a partial sheet of ice in the corners and entrance of the walk-in freezer, the ceiling had iced condensation, and a stack of boxes to the right of the entrance had frost on several boxes. [NAME] 1 stated there were no temperature logs for the freezer for the month of 05/2025. Cook1 verified there were no temperature logs for the walk-in refrigerator either. The current Dietary Manager was asked for a cleaning schedule of the kitchen, and the Dietary Manager stated he was not aware of one. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Inside the walk-in refrigerator there was a plastic gallon container with fruit cocktail, partially full, with no date of when opened or an expiration date. There was a five-pound container of strawberry yogurt produced by [NAME], and there was no open or use by date. Also present in the walk-in refrigerator was a container of grated parmesan cheese, with an open date of 03/03/25 and no use by date; a large plastic container of slaw with an expiration date of 04/29/25; and a gallon container of breaded chicken breasts with no label, no open date, or a use by date. There was a metal quarter pan which contained an unknown product, covered with plastic. On the plastic cover was spilled pink substance. There were seven bags of a yellow unknown product which had no label and no use by date on a metal cookie sheet. Behind the stove were multiple disposable plates with slices of pie. [NAME] 1 stated the pies were there since the former Dietary Manager walked out of her job approximately one month ago. There were two employee jackets hanging on the rack of clean metal cooking pans and clean plate covers. Per the current Dietary Manager, this was an infection control issue. The current Dietary Manager ran a test on the facility dishwasher. The current Dietary Manager confirmed the rinse temperature was to be at 150 degrees Fahrenheit but did not reach the appropriate temperature when the dish machine was run. A request was made for the temperature logs for the dish machine, and the current Dietary Manager verified these were not completed. During an interview on 05/08/25 at 12:15 PM, the Administrator stated that he had been three weeks and was aware that the kitchen needed some attention with sanitation.