STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure that quarterly safety evaluations accurately identified and documented the use of elopement-prevention devices, that care plans were developed for residents utilizing wander guards, and that Minimum Data Set (MDS) assessments reflected the presence of these safety devices for three of three residents (Resident (R)3, R8, and R45) reviewed for elopement. As a result of this deficient practice, staff did not recognize wander guards as a safety device to ensure all needed interventions were implemented.re respiratory equipment was stored in a sanitary manner for one of one resident (Resident (R) 15) reviewed for respiratory care out of a total sample of 17. This had the potential to expose the resident to infection. Findings include:1. Review of R3's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 05/07/25 with medical diagnoses including vascular dementia with severe anxiety and major depressive disorder.Review of the Elopement assessment dated [DATE], under the Evaluations tab in the EMR, documented R3 was a high risk for elopement.Review of the physician's orders for R3, located in the EMR under the Orders tab, documented an order on 05/13/25, Wander Guard to Right Ankle. Check function daily. Update nurse if any malfunction.Review of R3's quarterly Safety Evaluation assessment dated [DATE], under the Evaluations tab in the EMR, lacked documentation of a safety device, wander guard, in place.Review of R3's quarterly MDS, located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/31/25, revealed a Brief Interview for Mental Status (BIMS) could not be completed because the resident was rarely/never understood. The assessment lacked documentation of the presence of a wander guard.Review of R3's Treatment Administration Record (TAR), located in the EMR under the Orders tab, documented from May 2025 to March 2026 the presence of a wander guard functioning daily. Review of R3's Care Plan, under the Care Plan tab in the EMR, lacked documentation of a focus for elopement or wander guard.An observation on 03/03/26 at 2:43 PM in R3's room revealed a wander guard in place on the right ankle. 2. Review of R8's admission Record, located in the EMR under the Profile tab, revealed an admission date of 08/06/25 with medical diagnoses including vascular dementia, major depressive disorder, and developmental and epileptic encephalopathy. Review of the physician's orders for R8, located in the EMR under the Orders tab, documented an order on 08/27/25, Wander Guard to Left Ankle. Check function daily. Update nurse if any malfunction.Review of R8's Care Plan, under the Care Plan tab in the EMR, documented a focus for elopement and wander guard placement, initiated on 09/25/25, with interventions to monitor functionality and skin assessment daily.Review of R8's quarterly Safety Evaluation assessment dated [DATE], located under the Evaluations tab in the EMR, lacked documentation of a safety device, wander guard in place.Review of R8's quarterly MDS, located in the EMR under the MDS tab with an ARD of 12/18/25, revealed a BIMS score of 10 out of 15, indicating R8 was moderately cognitively impaired. The assessment lacked documentation of a wander guard.Review of R8's TAR, located in the EMR under the Orders tab, from August 2025 to March 2026 documented the presence of a wander guard functioning daily. 3. Review of R45's admission Record, (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	located in the EMR under the Profile tab, revealed an admission date of 02/09/22 with medical diagnoses including Wernicke's encephalopathy (acute neurological condition) and Alzheimer's disease.Review of R45's Care Plan, under the Care Plan tab in the EMR, documented a focus area for elopement and wander guard placement initiated 05/10/22 with interventions to monitor functionality and skin assessment daily.Review of the physician's orders for R45, located in the EMR under the Orders tab, documented an order on 01/13/24, Wander Guard to Left Ankle. Check function daily. Update nurse if any malfunction.Review of R45's quarterly Safety Evaluation assessment dated [DATE], under the Evaluations tab in the EMR, lacked documentation of a safety device, wander guard in place.Review of R45's TAR from January 2024 to March 2026 documented the presence of a wander guard functioning daily. Review of R45's quarterly MDS assessment with ARD of 03/03/26, located in the EMR under the MDS tab, lacked documentation of the presence of a wander guardDuring an interview on 03/04/26 at 3:15 PM, Certified Nursing Assistant (CNA) 2 confirmed R3, R8, and R45 wore wander guard anklets that set off the elevator alarm when R3, R8 or R45 were near the elevator when it opened.During an interview on 03/05/26 at 10:31 AM, the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) verified the safety devices quarterly assessments and quarterly MDS assessments lacked documentation of a device in use for R3, R8, and R45 and confirmed the devices were in use and needed to be documented as such. The DON confirmed R3 had been in the facility since May of 2025, with a wander guard in place without a care plan for elopement and wander guard. The DON and ADON confirmed they had not considered a wander guard anklet as an assistive device.Review of the facility's policy titled Accidents and Supervision, implemented 10/08/24, revealed, The resident environment will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: 1. identifying hazard(s) and risk(s). 2. Evaluating and analyzing hazard(s) and risk(s). j, implementing interventions to reduce hazard(s) and risk(s). 4. Monitoring effectiveness and modifying interventions when necessary . Identification of Hazards and Risks- the process through which the facility becomes aware of potential hazards in the resident environment and the risk of a resident having an avoidable accident. Various sources provide information about hazards and risks in the resident environment. d. These sources may include, but are not limited to: . MDS/Care Area Assessments (CAA) data . Individual observation . This information is to be documented and communicated across all disciplines . Implementation of interventions- using specific interventions to try to reduce a resident's risks from hazards in the environment- The process includes . Communicating the interventions to all relevant staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, record review, and interview, the facility failed to ensure that a resident was transferred in a dignified manner for one resident (Resident (R) 24) out of a total of 17 sampled residents reviewed. This failure has the potential to negatively impact a resident's dignity and psychological well-being. Findings include:Review of R24's Face Sheet, located in the Profile tab of electronic medical record (EMR), revealed R24 was admitted on [DATE] with diagnoses of legal blindness, mild cognitive impairment, major depressive disorder, muscle weakness, difficulty walking, and need assistance with personal care. Review of R24's quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 03/04/26, revealed the resident had a Brief Interview for Mental Status (BIMS) score of nine out of 15, which indicated R24 had moderate cognitive impairment. The MDS also indicated R24 ambulated with a wheelchair, and she was dependent on staff for toilet hygiene.Review of R24's Care Plan Report, located in the Care Plan tab of the EMR, revealed a focus, revised on 12/15/25, which indicated R24 had ADL (Activities of Daily Living) self-care performance deficits and exhibited new onset of decreased strength, decrease in functional mobility, reduced functional activity tolerance, and reduced static and dynamic balance. An intervention, revised on 12/25/25, advised staff that R24 required minimum assistance of two staff members for toilet transfers using a stand to sit assistance device. During an observation on 03/02/26 at 2:10 PM, Certified Nurse Aide (CNA) 1 transferred R24 from the restroom to R24's personal room on a stand to sit device. R24's room was directly across the hall from the restroom. While being transferred, R24 was observed with her black pants around her ankles exposing her in a brief while being transferred. During an interview on 03/03/26 at 9:42 AM, CNA1 confirmed she transferred R24 with her pants around her ankles, exposing R24 in only her brief. She stated she should not have done that, and she did it because R24's room was right across the hall. She stated it was a dignity issue, and she should have made sure she was completely dressed before she was transferred to her room. During an interview on 03/05/26 at 9:41 AM with the Director of Nursing (DON), she stated no resident should be transferred in that manner. All residents should be fully dressed if they are in any common area. The DON added that it is dignity issue and should never happen. Review of the undated facility policy titled, [NAME] of Resident Rights, specified, We will promote your right to receive care and treatment in a manner and in an environment that maintains or enhances your dignity and respect in full recognition of your individuality.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on observation, staff interview, record review, and the Resident Assessment Instrument (RAI) Manual review, the facility failed to ensure three of three residents (Resident (R) 3, R8, and R45) reviewed for wander guard placement had an accurate Minimum Data Set (MDS) assessment. Failure to code the MDS correctly can lead to inaccurate federal reimbursement and inaccurate assessment and care planning for the residents.Findings include: 1. Review of R3's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 05/07/25 with medical diagnoses including vascular dementia with severe anxiety and major depressive disorder.Review of the physician's orders for R3, located in the EMR under the Orders tab, documented an order on 05/13/25, Wander Guard to Right Ankle. Check function daily. Update nurse if any malfunction.Review of R3's quarterly MDS assessment with an Assessment Reference Date (ARD) of 12/31/25, located in the EMR under the MDS tab, lacked documentation of the presence of a wander/elopement alarm.An observation of R3 on 03/02/2026 at 11:33 AM, R3 was in her room with a wander guard on her right ankle.2. Review of R8's admission Record, located in the EMR under the Profile tab, revealed an admission date of 08/06/25 with medical diagnoses including vascular dementia, major depressive disorder, and developmental and epileptic encephalopathy. Review of the physician's orders for R8, located in the EMR under the Orders tab, documented an order on 08/27/25, Wander Guard to Left Ankle. Check function daily. Update nurse if any malfunction.Review of R8's quarterly MDS assessment with an ARD of 12/18/25, located in the EMR under the MDS tab, lacked documentation of the presence of a wander/elopement alarm.An observation on 03/02/2026 at 1:59 PM, R8 had a wander guard on his left ankle while sitting in a wheelchair during activity in the activity room on the second floor.3. Review of R45's admission Record, located in the EMR under the Profile tab, revealed an admission date of 02/09/22 with medical diagnoses including Wernicke's encephalopathy (an acute neurological condition) and Alzheimer's disease.Review of the physician's orders for R45, located in the EMR under the Orders tab, documented an order on 01/13/24, Wander Guard to Left Ankle. Check function daily. Update nurse if any malfunction.Review of R45's quarterly MDS assessment with an ARD of 03/03/26, located in the EMR under the MDS tab, lacked documentation of the presence of a wander/elopement alarm.Observation on 03/03/26 at 10:45 AM, R45 was ambulating in the hallway on the second floor with the wander guard visible on her right ankle.During an interview on 03/04/36 at 3:15 PM, Certified Nursing Assistant (CNA) 2 confirmed R3, R8, and R45 wear wander guards that set off the elevator alarm when they were near the elevator when it opened. During an interview on 03/04/26 at 12:48 PM, the MDS Coordinator confirmed that R3, R8, and R45 had wander guards and were not coded on the MDS when they should have been coded as having a wander/elopement alarm in place. The MDS Coordinator confirmed using the RAI Manual as guidance for completing the MDS assessments for the residents.During an interview on 03/04/26 at 3:30 PM, the Director of Nursing (DON) confirmed the MDS assessments were to be accurate, and the facility used the RAI Manual guidelines for accuracy.Review of the RAI Manual, dated 10/01/25 and located at https://www.cms.gov/files/document/final-mds-3-0-rai-manual-v1-20-1-october-2025.pdf, indicated, " . It is important to note here that information obtained should cover the same observation period as specified by the MDS items on the assessment, and should be validated for accuracy (what the resident's actual status was during that observation period) by the IDT [interdisciplinary team] completing the assessment ."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, the facility failed to ensure a care plan was developed for one of three residents (Resident (R) 3) reviewed for wander guard placement to prevent elopement. This deficient practice increases the risk of inconsistent staff responses and elopement.Findings include:Review of R3's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 05/07/25 with medical diagnoses including vascular dementia with severe anxiety and major depressive disorder.Review of the Elopement assessment dated [DATE], located under the Evaluations tab in the EMR, documented R3 was a high risk for elopement.Review of the physician's orders for R3, located in the EMR under the Orders tab, documented an order on 05/13/25, Wander Guard to Right Ankle. Check function daily. Update nurse if any malfunction.Review of R3's quarterly Minimum Data Set (MDS), located in the EMR under the MDS tab with an Assessment Reference Date (ARD) of 12/31/25, revealed a Brief Interview for Mental Status (BIMS) was unable to be completed because the resident was rarely/never understood. Review of R4's Care Plan, under the Care Plan tab in the EMR, lacked documentation of a care focus for elopement and wander guard.An observation on 03/03/26 at 2:43 PM in R3's room revealed a wander guard on the resident's right ankle. During an interview on 03/04/36 at 3:15 PM, Certified Nursing Assistant (CNA) 2 confirmed R3 wore a wander guard that set off the elevator alarm if R3 was near the elevator when it opened.During an interview on 03/04/26 at 3:15 PM, Registered Nurse (RN) 1 verified R3 had a wander guard. Nursing documented skin condition under, and functioning of, the wander guard. RN1 confirmed there was no care plan in place for R3 for elopement or a wander guard.During an interview on 03/05/26 at 10:31 AM, the Director of Nursing (DON) verified that R3 had a wander guard in place since admission in May 2025 and there was no care plan in place. The DON stated a care plan should have been there to ensure needed interventions were in place.Review of the facility's policy titled, Comprehensive Care Plans, revised 05/05/25, documented The comprehensive care plan will describe at a minimum the following: . resident specific interventions that reflect the resident's needs .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and policy review, the facility failed to ensure respiratory equipment was stored in a sanitary manner for one of one resident (Resident (R) 15) reviewed for respiratory care out of a total sample of 17. This had the potential to expose the resident to infection. Findings include:Review of R15's Face Sheet, located in the Profile tab of electronic medical record (EMR), revealed R15 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD), malignant neoplasm of unspecified right bronchus or lung, and acquired absence of lung. Review of R15's Care Plan Report, located in the Care Plan tab of the EMR, revealed a focus, revised on 04/04/25, which indicated R15 had PRN (as needed) oxygen therapy due to end of life and lung cancer. A focus, revised on 04/17/25, indicated R15 had altered respiratory status or difficulty breathing due to lung cancer and COPD. Review of R15's quarterly Minimum Data Set (MDS), located in the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 12/22/25, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated R15 was cognitively intact.Review of R15's Physician Orders, located in the Orders tab of the EMR, revealed the following order dated 01/27/26: Albuterol sulfate inhalation nebulization solution 2.5mg [milligram]/3 ml [milliliter] 0.083% 1 inhalation every 6 hours as needed for shortness of breath [SOB] or wheezing.During an observation and interview on 03/02/26 at 10:46 AM, R15's nebulizer mask was propped up next to the nebulizer machine. R15's stated the mask was never stored in a bag; he confirmed it was propped up next to the machine. He added his last treatment was the night before. During an observation on 03/03/26 at 12:00 PM, R15's nebulizer mask was propped up next to the machine with a blue liquid in the reservoir of the mask. During an interview on 03/03/26 at 12:05 PM, Registered Nurse (RN) 3 stated breathing treatment masks should be cleaned once the treatment is complete. Masks were rinsed off and left to dry on a paper towel. She stated for infection control purposes, the mask should be stored in a bag once they have completely dried. RN3 confirmed the mask was not stored in anything. She also indicated that the mask was dirty and there was treatment solution still in the mask reservoir. During an interview on 03/05/26 at 9:41 AM with the Director of Nursing (DON) and the Infection Preventionist, the DON stated the mask needed to be stored in a bag after it was cleaned and dried. Review of the National Institutes of Health article titled, How to Use a Nebulizer, dated 10/2021 and located at https://www.nhlbi.nih.gov/sites/default/files/publications/How-to-Use-a-Nebulizer-21-HL-8163.pdf, revealed, . store nebulizer parts in a dry, clean plastic storage bag . Review of the facility's policy titled, Nebulizer Therapy, dated 04/09/25, specified It is the expectation of this facility for nebulizer treatments, once ordered, to be administered by nursing staff as directed using proper technique and standard precautions . Care of Equipment . once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525731	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Ann Health and Rehabilitation Center	2020 S Muskego Ave Milwaukee, WI 53204

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interviews, record review, and policy review, the facility failed to ensure that resident (Resident (R)13) received medications in the correct dosage and as ordered. This resulted in two medication errors out of 32 opportunities, yielding a medication error rate of 6.25%. These errors had the potential to reduce the effectiveness of the prescribed treatment due to underdosing.Findings include:1. Review of R13's admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed an admission date of 08/26/22 and readmission date of 09/12/25 with medical diagnoses that included major depressive disorder and chronic (diastolic) congestive heart failure (CHF).Review of R13's quarterly Minimum Data Set (MDS) assessment, under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/11/25, revealed R13 used antidepressant and diuretic medications, and review of her drug regimen revealed no significant issues.Review of the March 2026 Medication Administration Record (MAR), located under the Orders tab of the EMR, revealed an order dated 03/03/26 for Prozac Oral capsule 10 milligrams [mg] [fluoxetine HCL]. Give 30 mg by mouth one time a day related to major depressive disorder, recurrent and an order dated 09/19/25 for furosemide Oral Tablet 20 mg. Give 2 tablet by mouth one time a day for edema.During a medication administration observation on the first floor with Registered Nurse (RN) 2 on 03/04/26 at 8:52 AM, RN2 pulled the medication card out of the medication cart for R13 that contained Prozac 10 mg tablets. RN2 placed one tablet into the medication cup, along with other ordered medications. RN2 then counted the number of oral medications (pills) to be administered and confirmed there were 16 pills in the medication cup to be administered. RN2 entered R13's room and administered the medications.Upon review of the March 2026 MAR and review of the medication cards, the number of oral medications (pills) to be administered should have been 19, not 16.During an interview on 03/04/26 at 10:28 AM, RN2 confirmed that one 10 mg tablet of Prozac was administered and confirmed the order on the MAR in the resident's record was for 30 mg to be administered or three 10 mg tablets. RN2 confirmed the medication furosemide 40 mg was not administered. The medication card for furosemide contained 40 mg doses to be administered. RN2 confirmed there should have been 19 pills administered and verified the missing pills were two 10 mg Prozac and one 40 mg furosemide that were not administered and should have been, confirming the errors.During an interview on 03/04/26 at 11:03 AM, the Director of Nursing (DON) confirmed medications ordered should be given using the correct dosage and following all the orders for medication administration. Review of the facility's policy titled Medication Administration, revised 04/09/25, revealed, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice . Review MAR to identify medication to be administered, . Ensure that the six rights of medication administration are followed: a. Right resident, b. Right drug, c. Right dosage, d. Right route, e. Right time, and f. Right documentation.