STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	675554	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nocona Rehabilitation and Care Center	306 Carolyn Rd Nocona, TX 76255

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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 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. Based on observation, interview, and record review, the facility failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety in one of one kitchen, in that: The facility failed to store nonperishable dry foods in the kitchen that were sealed and/or labeled with open date.The facility failed to store foods in the refrigerator that were labeled with an identifier and/or open date.The facility failed to discard expired or spoiled foods. These failures could place residents at risk for decline in nutritional health status and foodborne illness. The findings included: During observations and interviews on 2/10/2026 beginning at 8:55am, during the initial tour of the kitchen, the following was observed on the shelf above the food preparation area;1 quart size zip lock bag labeled Bacon Bits 1/4 full dated 1/04 opened/not sealed1 5lb bag of Blueberry Muffin Mix 1/4 full in original bag dated 12/27 not sealed/closed or in resealable bag.1 5lb bag [NAME] Gravy Mix in original bag dated 12/19/2025 opened/not sealed or in sealable bag.1 1lb 12oz bag Creamy Wheat in original bag with seal dated 1/3 opened/not sealed.On the bread shelves, a 6-rack rolling storage cart, revealed:1 of 4 packages of Hamburger Buns not dated, in original packaging containing 8 buns with blue green mold affecting all buns.1 package of 1 hamburger buns dated 2/1/26 with expiration date of 2/6/2026 remained on shelving.In #1 of 3 refrigerators inspected revealed:1 sandwich size zip lock bag of yellow firm substance unsealed/opened dated 2/10 with no label. [NAME] A stated it was leftover scrambled eggs from breakfast and she forgot to label it.1 gallon size reusable container labeled Oranges with expiration date of 1/25/20261 sandwich size zip lock bag with no date or label: [NAME] A stated they appeared to be cooked Pork chops, (6 count), left over but did not know when they were prepared.1 gallon size reusable container 1/4 full labeled [NAME] Gravy dated 2/1/2026 and use by dated 2/5/20261 gallon zip lock bag 1/4 full labeled Pork dated 2/4/2026 and use by 2/7/2026. [NAME] A stated it was chopped cooked pork that should have been discarded.1 reusable bowl 1/2 full labeled B. Pudding dated 2/01 and use by dated 2/04In an observation of a sign in sheet taped to the outside door of refrigerator #1 for Freezer and Refrigerator Temperature checks revealed spots for morning and evening shifts to initial areas for 3 refrigerators and 2 freezer temps to be checked and confirmed. Dates of 2/1-2/4 had been initialed, dates 2/5-2/10 were not completed. [NAME] A stated it is the cooks' job to check temperatures in all refrigerators and freezers and she had been checking them but had forgotten to log it. In an interview on 2/13/2026 at 1:32 pm with RNC, she stated her expectations for storage of foods was that they are stored properly, labeled and dated when opened, thrown away before expiration date and possible adverse effects could be GI upset and possible diarrhea/vomiting. Stated her expectations for refrigerator and freezer temps was that they would be checked according to policy by the cooks and dietary aide on AM and PM shift and documented on sign off sheets. Stated possible adverse effects could be spoiled food in the refrigerators and gastrointestinal upset. Stated [NAME] A and dietary manager were responsible for checking storage and dates on food items. Kitchen manager and dietician were not in facility to interview during survey. In an interview on 2/13/2026 at 1:40pm with RDO, she stated her expectations for storage of foods was that they are stored properly, labeled and dated when arrived and opened, thrown away before expiration date and possible adverse effects could be (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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gastrointestinal upset and possible diarrhea/vomiting. She stated her expectations for refrigerator and freezer temps was that they will be checked according to policy by the cooks and dietary aide on AM and PM shift and documented on sign off sheets. She stated possible adverse effects could be spoiled food in the refrigerators and gastrointestinal upset. In an interview with [NAME] A on 2/13/2026 at 2:11pm she stated her expectations was for all foods to be stored and labeled appropriately and for outdated items to be thrown away according to policy. She stated possible negative effects for residents could be they become sick with vomiting or diarrhea. [NAME] A stated the dietary manager and herself were responsible for these duties. Record review of policy Titled Food Storage dated 10/18/2018 and revised on 6/1/2019 stated [in part]:Policy: To ensure that all food served by the facility is of good quality and safe for consumption, all foods will be stored according to the state, federal and US Food Codes and HACCP guidelines.1. Dry Storage rooms- d. All containers must be labeled and dated2. Refrigerators- d. date label and tightly seal all refrigerated foodse. use all leftovers within 72 hours. Discard items that are over 72 hours old.h. check the temperatures of all refrigerators using the internal thermometer to make sure the temperature stays at 41 degrees F or below. Temperatures should be checked each morning and again on the PM shift.3. Freezers-h. Place a thermometer inside freezers near the door where the temperature is warmest. Check the temperature of all freezers using the internal thermometer to make sure the temperature stays at 0 degrees F or below. Temperatures should be checked each morning and again on the PM shift. Record the temperatures on a log that is kept near the freezer. Record review of facility policy titled Food Storage in the Pantry (Shelf Stable- Foods) dated 2013 by Academy Of Nutrition and Dietitians revealed in partKeeping Food Safe:Throw away moldy bread. Record review of a policy on the #1 refrigerator door titled Sunday Food Safety Checklist for Dietary Departments stated [in part]:All food in dry storage and on kitchen shelves are covered, labeled, and dated.All food in reach-in and walk in coolers are properly covered/sealed, labeled, and dated INCLUDING use by dates on opened items.No expired food in coolers/freezersAll logs are up to date: Coolers, Freezers

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to electronically submit to Center for Medicare and Medicaid Services (CMS) complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS for 1 of 4 Fiscal Year (FY) quarters reviewed. FY Quarter 4 2025 (July 1 - September 30) reviewed for administration. The facility failed to submit data to CMS for FY Quarter 4 2025 (July 1 - September 30). This failure could place residents at risk for personal needs not being identified and met, decreased quality of care, decline in health status, and decreased feelings of well-being within their living environment.Findings included: Review of the facility's Employee List dated 2/10/2026 indicated the following:1 Administrator 5 RNs (including Director of Nursing and MDS Coordinator)7 LVNs 16 CNAs (including 1 MA and Activity Director)1 Maintenance Personnel3 Housekeeping Personnel1 BOM (Business Office Manager)2 Laundry Personnel5 Dietary Personnel (Included Dietary Supervisor)7 Therapist (Included Director of Rehabilitation, Physical/Occupational and Speech Therapists)1 Social Worker Record review of the facility CMS form 802 Matrix (Resident Census and Conditions of Residents) dated 2/10/2026 provided by the MDS Coordinator indicated a total of 32 residents in the facility. Record Review of the CMS Payroll Based Journal report for CMS for FY Quarter 4 2025 (July 1 - September 30) indicated the facility had failed to submit data for the quarter triggered. On 2/12/2026 at 9:20am a policy was requested from the Regional Nurse Consultant for maintaining resident and facility records. In an interview on 02/12/2026 at 11:15am with the Director of Information Services (DIS) stated the new management group partners with a third party company who will submit their payroll reports to CMS on their behalf starting that week. She stated in attempts to retrieve information from the previous management company, their [NAME] President of Human Resources was very difficult to contact, and she had been awaiting a response from her as to why their company did not submit their payroll information for quarter 4 of 2025 to CMS. She stated when the previous management team left, their administrator took all documentation out of the facility leaving them with nothing regarding staffing, training, and other information. During this interview it was revealed she could not find a policy regarding maintaining records. In an interview on 02/12/2026 at 11:45am with the [NAME] President of Clinical Services (VPCS), she stated her expectation was for the CMS PBJ reports to be submitted on time and accurate. Stated a negative outcome could have a negative impact on resident care. In a follow up email received on 02/13/2026 at 11:17am the DIS stated she had not received any follow up information from the previous management group after submitting two emails highlighting the urgency to receive an update. In an interview on 02/13/2026 at 11:30am with the Regional Nurse Consultant, she stated she did not have an individual policy for PBJ Reporting. She stated they followed the CMS Electronic Staffing Data Submission Payroll-Base Journal Long-Term Care Facility Policy Manual as their policy for PBJ Reporting.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record reviews the facility failed to maintain documentation and demonstrate evidence of its ongoing QAPI program for 1 of 1 facility's reviewed for QAPI. The facility failed to maintain documentation of QAPI meetings prior to November of 2025. This failure placed residents at risk of maintaining and improving safety and quality of life.Findings included: Record review of QAPI meetings revealed: Facility had maintained QAPI meeting minutes from 11/20/2025. No previous meeting documentation was available.In an interview on 02/12/2026 at 10:30am with the Regional Nurse Consultant (RNC), she stated she was unable to provide any documentation from dates prior to their takeover on 11/19/2025. She stated the previous management company took all records when they left. She stated she along with other employees have sent multiple emails to the prior company asking for them to return records and they have not received a response as of that day. She stated this act left them with no way to produce records the survey team had requested prior to that date. She said the expectation of the management company would be to maintain and provide all records requested to remain in compliance with federal and state laws. She stated a negative outcome could be a resident's not receiving proper care. Record review of the QAPI Plan revised 11/19/2025 revealed on page 3 [in part]:Meeting frequency: Monthly QAPI Meeting and Ad-Hoc QAPI meeting as the need arises. During an interview on 02/13/2026 at 3:45pm, the corporate administrative staff did not have facility policies and procedures for maintaining facility records.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on interview and record reviews the facility failed to maintain documentation and demonstrate evidence of its ongoing Antibiotic Stewardship program for 1 of 1 facility's reviewed for Antibiotic Stewardship. The facility failed to provide documentation of appropriate monitoring of antibiotic use for residents by not providing the track and trending log prior to November 2025. These failures could place residents receiving antibiotics at risk for unnecessary antibiotic use, inappropriate antibiotic use, and increased antibiotic-resistant infections.Findings included: Record review of antibiotics and infection tracking revealed: Facility had maintained tracking for November 2025, December 2025, and January 2026. No previous records were available for review. In an interview on 02/12/2026 at 10:30am with the Regional Nurse Consultant (RNC), she stated she was unable to provide any documentation from dates prior to their takeover on 11/19/2025. She stated the previous management company took all records when they left. She stated she along with other employees have sent multiple emails to the prior company asking for them to return records and they have not received a response as of that day. She stated this act left them with no way to produce records the survey team had requested prior to that date. She said the expectation of the management company would be to maintain and provide all records requested to remain in compliance with federal and state laws. She stated a negative outcome could be a resident's not receiving proper care. Review of facility provided policy titled Antibiotic Stewardship Program undated, revealed [in part]:4. The program includes antibiotic use protocols and a system to monitor antibiotic use.b. Monitoring antibiotic use:vi. Antibiotic use shall be measured by (monthly prevalence, antibiotic starts, and/or antibiotic days of therapy).vii. At least one outcome measure associated with antibiotic use will be tracked monthly, as prioritized from the facilities infection control risk assessment and other infection surveillance data. During an interview on 02/13/2026 at 3:45pm, the corporate administrative staff did not have facility policies and procedures for maintaining facility records.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on interview and record reviews the facility failed to maintain documentation and demonstrate evidence of training requirements for 7 of 16 (DON, RN C, RN D, LVN E, CNA F, Laundry G, and Housekeeping H) employees reviewed for training.The facility failed to maintain evidence that the DON, RN C, RN D, LVN E, CNA F, Laundry G, and Housekeeping H were trained for infection control.The facility failed to maintain evidence that RN C, RN D, LVN E, CNA F, Laundry G, and Housekeeping H were trained for compliance and ethics.The facility failed to maintain evidence that RN C, RN D, CNA F, and Laundry G were trained for Resident Rights.The facility failed to maintain evidence that RN C, LVN E, CNA F, Laundry G, and Housekeeping H were trained for QAPI.The facility failed to maintain evidence that RN C, CNA F, and Laundry G were trained for abuse and neglect.The facility failed to maintain evidence that RN C, CNA F, Laundry G, and Housekeeping H were trained for communication.The facility failed to maintain evidence that RN C, CNA F, Laundry G, and Housekeeping H were trained for Behavioral Health.The facility failed to maintain evidence that the DON, RN C, RN D, LVN E, CNA F, Laundry G, and Housekeeping H were trained for Fall Prevention.The facility failed to maintain evidence that the DON, RN C, RN D, LVN E, CNA F, Laundry G and Housekeeping H were trained for Restraint Reduction.The facility failed to maintain evidence that RN C, Laundry G, and Housekeeping H were trained for HIV.The facility failed to maintain evidence that RN C, and LVN E were trained for Annual 1hr Dementia. These failures could place residents at risk of receiving care from incompetent/untrained staff.Findings included: Record review of personnel files revealed the following evidence of training documents could not be provided.DON hired 12/1/2025:Infection control RN C hired 06/01/2021:Resident rightsInfection controlCompliance and ethicsQAPIAbuse and NeglectCommunicationBehavioral HealthFall PreventionHIVRestraint ReductionAnnual 1hr Dementia RN D hired 02/01/2026Resident RightsInfection controlCompliance and ethicsFall PreventionRestraint reduction LVN E hired 11/03/2024Infection controlCompliance and ethicsQAPIFall preventionRestraint reductionAnnual 1hr Dementia CNA F hired 04/17/2025Resident rightsInfection controlCompliance and ethicsQAPIAbuse and NeglectCommunicationBehavioral HealthFall PreventionRestraint ReductionAnnual 1hr Dementia Laundry G hired 07/03/2018Resident rightsInfection controlCompliance and ethicsQAPIAbuse and NeglectCommunicationBehavioral HealthFall PreventionHIVRestraint Reduction Housekeeping H hired 5/17/2024Infection controlCompliance and ethicsQAPICommunicationBehavioral HealthFall PreventionHIVRestraint ReductionAnnual 1hr Dementia In an interview on 02/10/2026 at 10:00am with CNA F, she stated she had worked there for about 8 months. Stated she works here PRN and full time at another facility. She stated she was hired by the previous management company and completed some training when she was hired and has been there for an in-service or two. She stated it was important to know about abuse and neglect and who to talk to if she were to witness any that she would go to the administrator. In an interview on 02/10/2026 at 11:40am, with Housekeeping H, stated she has worked here for a couple of years. She stated she hasn't done as much training with the current company but did a bunch with the company that was there before who hired her. She further stated it was important to be trained to know how to take care of the residents and if she witnessed or was informed of abuse or neglect she would speak with the administrator or DON. In an interview on 02/11/2026 at 3:15pm with the BOM, she stated the records she has delivered to the conference room are all of the personnel records and trainings she has available. She stated the previous management company took all records the last day they were there leaving them with nothing so they had to start all over with files unless an employee happened to keep a copy of records they had nothing to go by. In an interview on 02/12/2026 at 10:30am with the Regional Nurse Consultant (RNC), she stated she was unable to provide any documentation from dates prior to their takeover on 11/19/2025. She stated the previous management company took all records when they left. She stated she along with (continued on next page)

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other employees have sent multiple emails to the prior company asking for them to return records and they have not received a response as of that day. She stated this act left them with no way to produce records the survey team had requested prior to that date. She said the expectation of the management company would be to maintain and provide all records requested to remain in compliance with federal and state laws. She stated a negative outcome could be a resident's not receiving proper care. In an interview on 02/12/2026 at 11:45 AM with the [NAME] President of Clinical Services, she stated with the personnel records they can only provide what they have which was what they had completed since the takeover. She stated they were doing the best they could with what they were left with and were expecting to receive citations for those missing records, but it was out of their control. Record review of facility provided policy titled Orientation Policy undated, revealed [in part]:11. All documentation to support completion of the orientation process shall be maintained in the staff member's personnel file. During an interview on 02/13/2026 at 3:45pm, the corporate administrative staff did not have facility policies and procedures for maintaining facility records.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interview and record review the facility failed to implement a grievance policy that included the maintenance of documentation of all grievances for no less than 3 years from the issuance of the grievance decision.The facility failed to have documentation and evidence of grievances filed for the previous 3 years.This failure could place the residents at risk for a decreased quality of life and care within their living environment, and/or not having their needs met.The findings included: Record review of grievance files provided by AD revealed no grievance log tracking or copies of filed grievances prior to 11/19/2025. In a group interview on 02/11/2026 at 2:30pm with the Resident Council, stated since the new management company has taken over things seem to be getting better, especially the answering of call lights and that was a big issue before. In an interview on 02/12/2026 at 10:30am with the Regional Nurse Consultant (RNC), she stated she was unable to provide any documentation from dates prior to their takeover on 11/19/2025. She stated the previous management company took all records when they left. She stated she along with other employees have sent multiple emails to the prior company asking for them to return records and they have not received a response as of that day. She stated this act left them with no way to produce records the survey team had requested prior to that date. She said the expectation of the management company would be to maintain and provide all records requested to remain in compliance with federal and state laws. She stated a negative outcome could be a residents' feelings not heard or corrections made to things they would like done. During an interview on 02/13/2026 at 3:45pm, the corporate administrative staff did not have facility policies and procedures for maintaining facility records.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to act upon the consultant pharmacist's medication regimen review report to the attending physician for 1 of 5 residents (Resident #7) reviewed for unnecessary medications. Resident #7's attending physician wrote an order dated 1/11/2026 for a dose reduction in the antipsychotic medication Seroquel 50 mg at HS to Seroquel 25 mg at HS per the Consultant Pharmacist's recommendation dated 11/23/2025. The order was not noted by the facility's licensed nursing staff and the order was not changed. This failure placed the resident at risk for adverse effects from continued medication administration at a dose that was not reduced as ordered by the physician.The findings included: Record review of Resident #7's admission Record, dated 2/13/2026, indicated a [AGE] year-old female admitted to the facility on [DATE]. The resident's diagnoses included non-Hodgkin lymphoma (cancer cells in the lymph nodes), type 2 diabetes mellitus (development of high blood sugar level over the course of time), dementia (mental decline that affects memory, thinking, and behavior), hypertension (high blood pressure), atrial fibrillation (rapid and irregular heartbeat), hyperlipidemia (high cholesterol), Parkinsonism (physical movement impaired by rigidity, tremor, or slowness of motion), left femur fracture (hip fracture), hallucinations (false perceptions of sensory experiences), and insomnia (sleep disorder). Record review of Resident #7's Order Summary Report, dated 2/13/2026, indicated an order dated 8/22/2025 for the antipsychotic medication of Seroquel 50 mg by mouth at bedtime for hallucinations. Record review of the Pharmaceutical Consultant Report - Psychotropic Gradual Dose Reduction, dated 11/23/2025, indicated the Consultant Pharmacist documented a letter to Resident #7's attending physician. The Consultant Pharmacist documented the recommendation for evaluation of Seroquel 50 mg at HS, consideration of a dose reduction, and a rationale for continued use. The form was signed by the facility's DON. The Physician Response to Review section was signed and dated by Resident #7's attending physician on 1/11/2026. The physician selected A dose reduction is appropriate and he wrote a new order for Seroquel 25 mg at HS. The physician selected the options for other causes for symptoms have been ruled out, symptoms are persistent enough to warrant continuation, non-pharmacological interventions were considered, medication clinically indicated to manage the symptom, and actual benefit sufficient to justify the potential risk(s) or adverse consequences associated with the selected medication dose and duration. There was no documented evidence the order had been noted by the facility's DON or other licensed nursing staff.[The order for the dose reduction in Seroquel 50 mg at HS to Seroquel 25 mg at HS was not changed on Resident #7's order summary.] In a telephone interview on 02/12/2026 at 11:07 AM, the contracted Consultant Pharmacist stated he began working with the facility in February 2025. He stated after he completed the GDR/MRR reviews, he emailed the reports and recommendations in a PDF format to the designated staff member, usually the DON. He stated that staff member was responsible for getting the reports to the ordering physician to review to make his or her recommendations or changes and sign the report. He stated once the reports were signed the facility staff were responsible for entering the changed or new orders if needed into the residents' electronic health records. In a telephone interview on 02/12/2026 at 2:23 PM, the facility's Medical Director stated he was unaware that the facility was missing so many records. He Sstated he could remember signing some GDR/MRR reviews recently but he was not sure if the facility picked them up or what happened to them. He sStated his expectation would be for the facility to keep records according to federal and state law, and once the facility received the GDR/MRR reports, the facility staff were to print and bring them to his office for his review and signature. The Medical Director stated a negative outcome could be a missed medication change or unnecessary administration of medications. During an observation and interview on 2/13/2026 at 9:20 AM, LVN B unlocked the medication cart and pulled out the medication card with (continued on next page)

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Seroquel for Resident #7. Resident #7's medication card was labeled as Seroquel 50 mg at HS. LVN B stated the resident had been on the medication for a long time. LVN B stated she did not know the physician wrote an order to decrease the Seroquel dose to 25 mg at HS. She stated the resident's family member may not have agreed to a dose reduction. LVN B stated she would research it. In an interview on 2/13/2026 at 9:52 AM, the RN Regional Clinical Support Nurse Consultant stated there was not a specific facility policy for follow-up to Pharmacy Consultant recommendations. She stated the facility had policies for medication orders and GDRs. The RN Regional Clinical Support Nurse Consultant stated the expectation was that the Consultant Pharmacist would send a recommendation letter for the physician to the facility, the DON would review and sign the recommendation letter and send the letter to the physician, and the physician would document a response of the letter and return it to the facility. She stated the DON would note and date the physician's response and make the order change or give a copy of the order to the charge nurse to make the change. The RN Regional Clinical Support Nurse Consultant stated she had already spoken with LVN B regarding Resident #7's Seroquel dose not being changed as ordered. She stated LVN B had called the physician's office and was waiting for a return call. The RN Regional Clinical Support Nurse Consultant stated she had instructed LVN B to notify the physician that the dose reduction and order change for Seroquel was not done and verify that he still wanted to reduce the medication. Review of the facility policy for Medication Orders, dated 2025, indicated [in part]: Policy:This facility shall use uniform guidelines for the ordering of medications.Policy Explanation and Compliance Guidelines:1. Medications should be administered only upon the signed order of a person lawfully authorized to prescribe.4. Documentation of Medication Orders:a. Each medication order should be documented with the date, time, and signature of the person receiving the order. The order should be recorded on the physician order sheet, and the Medication Administration Record (MAR).b. Clarify the order.d. If using electronic medication records, input the medication order according to the electronic health record (E.H.R.) instructions and facility policy.e. Call or fax the medication order to the provider pharmacy.f. Transcribe newly prescribed medications on the MAR or treatment record or ensure the order is in the electronic MAR.g. When a new order changes the dosage of a previously prescribed medication, discontinue previous entry by writing DC'd [discontinued] and the date, or discontinue the order as per the electronic software instructions and retype the new order. h. Enter the new order on the MAR or ensure the new order is in the electronic MAR.i. Notify resident's sponsor/family of new medication order.5. Specific Procedures for Medication Orders:a. Handwritten Order Signed by the Physician - The charge nurse on duty at the time the order is received should note the order and enter it on the physician order sheet or electronic order format, if not written by the physician. If necessary, the order should be clarified before the physician leaves the nursing station, whenever possible. Review of the facility policy for Gradual Dose Reduction of Psychotropic Drugs, dated 2025, indicated [in part]: Policy:Residents who use psychotropic drugs receive gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs.Compliance Guidelines:3. The timeframes and duration of attempts to taper any medication shall depend on factors including the coexisting medication regimen, the underlying causes of symptoms, individual risk factors, and pharmacological characteristics of the medications.c. Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or otherwise modified include:i. During the monthly medication regimen review by the pharmacist.ii. When the physician or prescribing practitioner evaluates the resident's progress.iii. During the quarterly MDS review by the interdisciplinary team.