STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106090	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENDERSON FAMILY SKILLED NURSING AND REHAB CENTER	1959 N HONORE AVE SARASOTA, FL 34235

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted on through at Benderson Family Skilled Nursing and Rehab Center, a nursing home in Sarasota, Florida. Benderson Family Skilled Nursing and Rehab Center is not in compliance with Code of Federal Regulations (CFR) 42, Part 483, Subparts B-F, Requirements for Long-Term Care Facilities.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure quality of care by not following physicians' orders for 3 residents (#13, #133, and #29) of 3 residents reviewed for following physician's orders. The findings included: Review of the Policy for Physician Services dated #8 revealed, "All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift."	F 684	Resident #13 had order for discontinued on . Resident #133 had physician order reviewed and placed on resident for remainder of his stay. Resident discharged on . Resident #29 had lab order incorrectly entered on . , level drawn on and results required no change in orders. Education provided to licensed nurses	

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

Electronically Signed /2025

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106090	A. BUILDING ______ B. WING ______	06/12/2025

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F 684

Continued From page 1

1. Review of the medical revealed Resident #13 was admitted on . The Quarterly Minimum Data Set (MDS) with a target date of revealed Resident #13's ( ) score was 11, indicating moderate , . The MDS revealed Resident #13 did not reject care and was dependent on staff for of the lower body. The MDS included, but was not limited to, , , , and .

Review of the physician's orders revealed an active order dated for " on during day, off at night." (, also known as -embolic deterrent hose, is an acronym that refers to a type of , hosiery. They are specifically designed to help prevent clots, or , by applying pressure to the and .)

Review of the Medication Administration Record for revealed on , , , , , , , , , and the nurses documented the were applied to the resident's .

Review of Resident #13's medical record did not reveal information that the resident refused the .

On at 12:05 p.m., observed Resident #13 in the activity dining room area sitting in the wheelchair. Resident #13 was not wearing the .

On at 2:49 p.m., Resident #13 was observed in the wheelchair being pushed down the hall by a friend. Resident #13 was not wearing the .

F 684

and ARNP's on staff responsibility of resident to receive treatment and care in accordance with professional standards of practice in regards to following physician orders with and lab orders.

Audit other physician orders for and labs to ensure professional standards of practice are being followed.

Audits to be conducted to ensure compliance with professional standards of practice by DON/designee of physician orders for and labs daily for four weeks, and three times a week for eight weeks thereafter. Results to be taken to monthly QAPI meeting for three months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106090	A. BUILDING _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENDERSON FAMILY SKILLED NURSING AND REHAB CENTER	1959 N HONORE AVE SARASOTA, FL 34235

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F 684	Continued From page 2	F 684		

On at 9:53 a.m., observed Resident #13 sitting in the wheelchair watching TV in the bedroom. The were not applied to the . During an interview, the resident said she never wears . She said she wore them years ago but does not wear them now and no one applies them. She said if someone told her to wear them, she would refuse. Resident #13's private duty aid was sitting in the chair near the resident. The private duty aid said she dressed the resident this morning and did not apply the . The private aid said no one ever told her to apply them. *

On at 2:58 p.m., during an interview Certified Nursing Assistant (CNA) Staff A said if the resident refuses to put on the , you tell the nurse. She said the nurse, or the CNA can apply them. Staff A said Resident #13 has a private duty sitter that dresses her and puts on the , hose. She said the nurse would tell her to put them on if she needed them. Staff A said no one told her to apply the

On at 3:23 p.m., Registered Nurse (RN) Staff C said she documented in the MAR (Medication Administration Record) the were applied to Resident #13, but she was not sure they were applied. She said she thought the private duty aid applied them.

On at 3:30 p.m., RN Staff C went to the room and saw Resident #13 was not wearing the

On at 4:04 p.m. the Director of Nursing (DON) said the RNs should not document any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 684	Continued From page 3	F 684		

treatment that was not completed, including the . If the resident refuses a treatment or the , the nurse should document the refusal in the medical record and notify the physician.

On at 9:58 a.m., the DON said private duty sitters do not apply for the residents.

2. Review of the medical revealed Resident #133 was admitted on . Diagnoses included aftercare following , replacement and left , with a history of atherosclerotic .

Review of the physician's orders revealed an active order dated at 7:00 p.m. for " high both every shift."

Review of the MAR for revealed the nurses documented the were applied on , , , and .

Review of Resident #113's medical record did not contain information that the resident refused the .

On at 12:17 p.m., observed Resident #133 in the room wearing shorts. There were no applied to the . The resident said he does not wear , and no one asked him to wear them. He said he came to the facility with an Wrap for the left , but it was removed the next morning and there has been nothing else for the since then. The original surgical was observed to the left .

On at 10:12 a.m., observed Resident

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F 684	Continued From page 4 #133 in the room wearing shorts. The resident was not wearing . * On at 2:56 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 3:04 p.m., CNA Staff B said she has taken care of Resident #133. She said the nurse did not tell her to apply the and she has not. On at 3:36 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 3:34 p.m. RN Staff C confirmed she documented in the MAR Resident #133 was wearing the , when the resident was not wearing them. Staff C said she had not put them on the resident, and she did not instruct the CNA to do it. Staff C looked for a pair of in the room, but there were none. On at 4:04 p.m., the DON said the nurses should not be documenting the hose were on if the hose were not. The DON said the medical record was inaccurate. 3. Review of the medical record revealed Resident #29 was admitted to the facility on . Review of the record revealed an order dated for , , 125 milligrams (mg) Give 250mg by every 12 hours for disturbance. On the physician ordered a ,	F		

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F 684	Continued From page 5 level to be drawn in the morning. Review of the laboratory results, progress notes, and MARS revealed the facility had not obtained the , level in the morning on . Review of the medical record revealed the nurse had not documented why the level was not obtained. Review of the laboratory results revealed a , level was collected on . On at 12:32 p.m., the DON said the facility had not obtained the , level in the morning of as the physician ordered. He said he expects the nurses to follow the orders and document in the medical record the reason if the nurse could not follow the physician's order.	F 684		
F 842 SS=D	*Photographic evidence obtained Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident	F 842		

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F 842	Continued From page 6 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and ( ) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; ( ) For public health activities, reporting of , neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain-	F 842		

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F 842	Continued From page 7 (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; ( ) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, , and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate medical records for 2 residents (#13 and #133) of 3 residents reviewed for accuracy of medical records. The findings included: 1. Review of the medical revealed Resident #13 was admitted on . The Quarterly Minimum Data Set (MDS) with a target date of revealed Resident #13's ( ) score was 11, indicating moderate . The MDS revealed Resident #13 did not reject care and was dependent on staff for of the lower body. The MDS diagnoses included, but was not limited to, , , , , and . Review of the physician's orders revealed an active order dated for " on during day, off at night." (, also known as -embolic deterrent hose, is an acronym that refers to a type of , hosiery. They are specifically designed to help prevent clots, or , by	F 842	Resident #13 had order for discontinued on . Resident #133 had physician order reviewed and placed on resident for remainder of his stay. Resident discharged on . Education provided to licensed nurses, ARNP's and physicians on need for medical records to be complete and accurate. Audit medical records to ensure professional standards of practice are being followed in regards to documentation of orders for . Audits to be conducted to ensure compliance with professional standards of practice by DON/designee of documentation for orders of daily for four weeks, and three times a week for eight weeks thereafter. Results to be taken to monthly QAPI meeting for three	

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F 842	Continued From page 8 applying pressure to the and .) Review of the Medication Administration Record for revealed the nurses documented the were applied on , , , , , , , . On at 12:05 p.m., observed Resident #13 in the activity dining room area sitting in the wheelchair. Resident #13 was not wearing the . On at 2:49 p.m., Resident #13 was observed in the wheelchair being pushed down the hall by a friend. Resident #13 was not wearing the . On at 9:53 a.m., observed Resident #13 sitting in the wheelchair watching TV in the bedroom. The were not applied to the . During an interview, the resident said she never wears . She said she wore them years ago but does not wear them now and no one applies them. She said if someone told her to wear them, she would refuse. Resident #13's private duty aide was sitting in the chair near the resident. The private duty aide said she dressed the resident this morning and did not apply the . The private aide said no one ever told her to apply them. * On at 2:58 p.m., during an interview with Certified Nursing Assistant (CNA) Staff A, she said if the resident refuses to put on the , you tell the nurse. She said the nurse, or the CNA can apply them. Staff A said Resident #13 has a private duty sitter that dresses her and puts on the , hose. She said the	F 842	months.	

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F 842	Continued From page 9 nurse would tell her to put them on if she needed them. Staff A said no one told her to apply the . On at 3:23 p.m. Registered Nurse (RN) Staff C said she documented in the MAR (Medication Administration Record) that the were applied to Resident #13. Staff C said the hose were not applied and the MAR is not accurate. On at 3:30 p.m., RN Staff C went to the room and saw Resident #13 was not wearing the . On at 4:04 p.m. the Director of Nursing (DON) said the RNs should not document any treatment that was not completed, including the . The DON said the MAR was not accurate. 2. Review of the medical revealed Resident #133 was admitted on . Diagnoses included aftercare following , replacement, left , , and history of atherosclerotic . Review of the physician's orders revealed an active order dated at 7:00 p.m. for " high both every shift." Review of the MAR for revealed the nurses documented the were applied on , , , and . On at 12:17 p.m., observed Resident #133 in the room wearing shorts. The resident	F 842		

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F 842	Continued From page 10	F 842		

was not wearing the . The resident said he has not worn at the facility and does not have a pair. The resident said no one at the facility told him to wear them. He said he came to the facility with an Wrap for the left , but it was removed the next morning, and he had not worn anything since. The original surgical was observed to the left only.

On at 10:12 a.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . *

On at 2:56 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . *

On at 3:04 p.m., CNA Staff B said she has taken care of Resident #133. She said the nurse did not tell her to apply the and she has not.

On at 3:36 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . *

On at 3:34 p.m., RN Staff C confirmed she documented in the MAR Resident #133 was wearing the , but she had not confirmed the resident had them on. Staff C said they did not put them on the resident or ask the CNA to do it. Staff C looked for a pair of in the room, but there were none.

On at 4:04 p.m., the DON said the nurses should not be documenting the were applied to the resident if they were not. The DON said the medical record was inaccurate.

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F 842	Continued From page 11 *Photographic evidence obtained	F 842		

Agency for Health Care Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35961033	A. BUILDING: _____ B. WING _____	06/12/2025

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BENDERSON FAMILY SKILLED NURSING AND REHAI	1959 N HONORE AVE SARASOTA, FL 34235

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N 000	INITIAL COMMENTS A relicensure survey was conducted on through at Benderson Family Skilled Nursing and Rehab Center, a nursing home in Sarasota, Florida. The following is a description of the deficiencies.	N 000		
N 054 SS=D	59A-4.107(5), FAC Follow Physician Orders All physician orders must be followed as prescribed, and if not followed, the reason must be recorded on the resident's medical record during that shift. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure quality of care by not following physicians' orders for 3 residents (#13, #133, and #29) of 3 residents reviewed for following physician's orders. The findings included: Review of the Policy for Physician Services dated #8 revealed, "All physician orders will be followed as prescribed and if not followed, the reason shall be recorded on the resident's medical record during that shift." 1. Review of the medical revealed Resident #13 was admitted on . The Quarterly Minimum Data Set (MDS) with a target date of revealed Resident #13's ( ) score was 11, indicating moderate , . The MDS revealed Resident #13 did not reject care and was dependent on staff for of the lower body. The MDS included, but was not limited to, , , , and .	N 054	Resident #13 had order for discontinued on . Resident #133 had physician order reviewed and placed on resident for remainder of his stay. Resident discharged on . Resident #29 had lab order incorrectly entered on . , level drawn on and results required no change in orders. Education provided to licensed nurses and ARNP's on staff responsibility of resident to receive treatment and care in accordance with professional standards of practice in regards to following physician orders with and lab orders. Audit other physician orders for and labs to ensure professional standards of practice are being followed.	

AHCA Form 3020-0001

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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BENDERSON FAMILY SKILLED NURSING AND REHAI	1959 N HONORE AVE SARASOTA, FL 34235

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N 054	Continued From page 1 Review of the physician's orders revealed an active order dated for " on during day, off at night." (, also known as -embolic deterrent hose, is an acronym that refers to a type of , hosiery. They are specifically designed to help prevent clots, or , by applying pressure to the and .) Review of the Medication Administration Record for revealed on , , , , , , , , , , , , , and the nurses documented the were applied to the resident's . Review of Resident #13's medical record did not reveal information that the resident refused the . On at 12:05 p.m., observed Resident #13 in the activity dining room area sitting in the wheelchair. Resident #13 was not wearing the . On at 2:49 p.m., Resident #13 was observed in the wheelchair being pushed down the hall by a friend. Resident #13 was not wearing the . On at 9:53 a.m., observed Resident #13 sitting in the wheelchair watching TV in the bedroom. The were not applied to the . During an interview, the resident said she never wears . She said she wore them years ago but does not wear them now and no one applies them. She said if someone told her to wear them, she would refuse. Resident #13's private duty aide was sitting in the chair near the resident. The private duty aide said she dressed	N 054	Audits to be conducted to ensure compliance with professional standards of practice by DON/designee of physician orders for and labs daily for four weeks, and three times a week for eight weeks thereafter. Results to be taken to monthly QAPI meeting for three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	35961033	A. BUILDING: _____ B. WING _____	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BENDERSON FAMILY SKILLED NURSING AND REHAI	1959 N HONORE AVE SARASOTA, FL 34235

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N 054	Continued From page 2 the resident this morning and did not apply the . The private aide said no one ever told her to apply them. * On at 2:58 p.m., during an interview Certified Nursing Assistant (CNA) Staff A said if the resident refuses to put on the , you tell the nurse. She said the nurse, or the CNA can apply them. Staff A said Resident #13 has a private duty sitter that dresses her and puts on the , hose. She said the nurse would tell her to put them on if she needed them. Staff A said no one told her to apply the . On at 3:23 p.m., Registered Nurse (RN) Staff C said she documented in the MAR (Medication Administration Record) the were applied to Resident #13, but she was not sure they were applied. She said she thought the private duty aid applied them. On at 3:30 p.m., RN Staff C went to the room and saw Resident #13 was not wearing the . On at 4:04 p.m. the Director of Nursing (DON) said the RNs should not document any treatment that was not completed, including the . If the resident refuses a treatment or the , the nurse should document the refusal in the medical record and notify the physician. On at 9:58 a.m., the DON said private duty sitters do not apply for the residents. 2. Review of the medical revealed Resident #133	N 054		

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N 054	Continued From page 3 was admitted on . Diagnoses included aftercare following , replacement and left , with a history of atherosclerotic . Review of the physician's orders revealed an active order dated at 7:00 p.m. for " high both every shift." Review of the MAR for revealed the nurses documented the were applied on , , , and . Review of Resident #113's medical record did not contain information that the resident refused the . On at 12:17 p.m., observed Resident #133 in the room wearing shorts. There were no applied to the . The resident said he does not wear , and no one asked him to wear them. He said he came to the facility with an Wrap for the left , but it was removed the next morning and there has been nothing else for the since then. The original surgical was observed to the left . On at 10:12 a.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 2:56 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 3:04 p.m., CNA Staff B said she has taken care of Resident #133. She said the nurse did not tell her to apply the and she has not.	N 054		

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N 054	Continued From page 4 On at 3:36 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 3:34 p.m. RN Staff C confirmed she documented in the MAR Resident #133 was wearing the , when the resident was not wearing them. Staff C said she had not put them on the resident, and she did not instruct the CNA to do it. Staff C looked for a pair of in the room, but there were none. On at 4:04 p.m., the DON said the nurses should not be documenting the hose were on if the hose were not. The DON said the medical record was inaccurate. 3. Review of the medical record revealed Resident #29 was admitted to the facility on . Review of the record revealed an order dated for , , 125 milligrams (mg) Give 250mg by every 12 hours for disturbance. On the physician ordered a , level to be drawn in the morning. Review of the laboratory results, progress notes, and MARS revealed the facility had not obtained the , level in the morning on . Review of the medical record revealed the nurse had not documented why the level was not obtained. Review of the laboratory results revealed a , level was collected on .	N 054		

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N 054	Continued From page 5 On at 12:32 p.m., the DON said the facility had not obtained the , level in the morning of as the physician ordered. He said he expects the nurses to follow the orders and document in the medical record the reason if the nurse could not follow the physician's order. *Photographic evidence obtained	N 054		
N 101 SS=D	400.141(1)(j), FS; 59A-4.118(2), FAC Resident Medical Records 400.141(1)(j) FS Keep full records of resident admissions and discharges; medical and general health status, including medical records, personal and social history, and identity and address of next of kin or other persons who may have responsibility for the affairs of the resident; and individual resident care plans, including, but not limited to, prescribed services, service frequency and duration, and service goals. The records must be open to agency inspection. The licensee shall maintain clinical records on each resident in accordance with accepted professional standards and practices, which must be complete, accurately documented, readily accessible, and systematically organized. 59A-4.118(2) FAC Each medical record must contain sufficient information to clearly identify the resident, his or her diagnosis and treatment, and results. This Statute or Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure accurate	N 101	Resident #13 had order for discontinued on .	

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N 101	Continued From page 6 medical records for 2 residents (#13 and #133) of 3 residents reviewed for accuracy of medical records. The findings included: 1. Review of the medical revealed Resident #13 was admitted on . The Quarterly Minimum Data Set (MDS) with a target date of revealed Resident #13's ( ) score was 11, indicating moderate . The MDS revealed Resident #13 did not reject care and was dependent on staff for of the lower body. The MDS diagnoses included, but was not limited to, , and . Review of the physician's orders revealed an active order dated for " on during day, off at night." (, also known as -embolic deterrent hose, is an acronym that refers to a type of , hosiery. They are specifically designed to help prevent clots, or , by applying pressure to the and .) Review of the Medication Administration Record for revealed the nurses documented the were applied on , , , , , , , , . On at 12:05 p.m., observed Resident #13 in the activity dining room area sitting in the wheelchair. Resident #13 was not wearing the . On at 2:49 p.m., Resident #13 was observed in the wheelchair being pushed down the hall by a friend. Resident #13 was not	N 101	Resident #133 had physician order reviewed and placed on resident for remainder of his stay. Resident discharged on . Education provided to licensed nurses, ARNP's and physicians on need for medical records to be complete and accurate. Audit medical records to ensure professional standards of practice are being followed in regards to documentation of orders for . Audits to be conducted to ensure compliance with professional standards of practice by DON/designee of documentation for orders of daily for four weeks, and three times a week for eight weeks thereafter. Results to be taken to monthly QAPI meeting for three months.	

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N 101	Continued From page 7 wearing the . On at 9:53 a.m., observed Resident #13 sitting in the wheelchair watching TV in the bedroom. The were not applied to the . During an interview, the resident said she never wears . She said she wore them years ago but does not wear them now and no one applies them. She said if someone told her to wear them, she would refuse. Resident #13's private duty aide was sitting in the chair near the resident. The private duty aide said she dressed the resident this morning and did not apply the . The private aide said no one ever told her to apply them. * On at 2:58 p.m., during an interview with Certified Nursing Assistant (CNA) Staff A, she said if the resident refuses to put on the , you tell the nurse. She said the nurse, or the CNA can apply them. Staff A said Resident #13 has a private duty sitter that dresses her and puts on the , hose. She said the nurse would tell her to put them on if she needed them. Staff A said no one told her to apply the . On at 3:23 p.m. Registered Nurse (RN) Staff C said she documented in the MAR (Medication Administration Record) that the were applied to Resident #13. Staff C said the hose were not applied and the MAR is not accurate. On at 3:30 p.m., RN Staff C went to the room and saw Resident #13 was not wearing the . On at 4:04 p.m. the Director of Nursing (DON) said the RNs should not document any	N 101		

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N 101	Continued From page 8 treatment that was not completed, including the . The DON said the MAR was not accurate. 2. Review of the medical revealed Resident #133 was admitted on . Diagnoses included aftercare following , replacement, left , , and history of atherosclerotic . Review of the physician's orders revealed an active order dated at 7:00 p.m. for " high both every shift." Review of the MAR for revealed the nurses documented the were applied on , , , and . On at 12:17 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing the . The resident said he has not worn at the facility and does not have a pair. The resident said no one at the facility told him to wear them. He said he came to the facility with an Wrap for the left , but it was removed the next morning, and he had not worn anything since. The original surgical was observed to the left only. On at 10:12 a.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 2:56 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 3:04 p.m., CNA Staff B said she	N 101		

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N 101	Continued From page 9 has taken care of Resident #133. She said the nurse did not tell her to apply the and she has not. On at 3:36 p.m., observed Resident #133 in the room wearing shorts. The resident was not wearing . * On at 3:34 p.m., RN Staff C confirmed she documented in the MAR Resident #133 was wearing the , but she had not confirmed the resident had them on. Staff C said they did not put them on the resident or ask the CNA to do it. Staff C looked for a pair of in the room, but there were none. On at 4:04 p.m., the DON said the nurses should not be documenting the were applied to the resident if they were not. The DON said the medical record was inaccurate. *Photographic evidence obtained	N 101		