STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345006	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	**3724 Wireless Drive , Greensboro, North Carolina, 27455**

(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
E0000	Initial Comments The survey team entered the facility on 11/24/25 to conduct an onsite revisit and exited on 11/25/25. Additional information was obtained on 11/26/25, 12/1/25, 12/2/25, 12/3/25, 12/5/25, and 12/8/25. The survey team returned to the facility on 12/9/25 to investigate a new intake and exited on 12/9/25. Therefore, the exit date was changed to 12/9/25. Tags E004 was corrected as of 12/9/25. Event ID# 1D5953-H2.	E0000		12/23/2025
F0000	INITIAL COMMENTS The survey team entered the facility on 11/24/25 to conduct an onsite revisit and exited on 11/25/25. Additional information was obtained on 11/26/25, 12/1/25, 12/2/25, 12/3/25, 12/5/25, and 12/8/25. The survey team returned to the facility on 12/9/25 to investigate a new intake and exited on 12/9/25. Therefore, the exit date was changed to 12/9/25. Tags F554, F582, F585, F600, F636, F637, F641, F656, F657, F677, F679, F694, F695, F697, F725, F761, F812, F880, F883, and F887 were corrected as of 12/9/25. Repeat tags were cited. New tags were also cited as a result of the complaint investigation survey conducted at the same time as the revisit. The facility is still out of compliance. Event ID# 1D5953-H2.	F0000		12/23/2025
F0684 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 record review, and staff, Guardian, Nurse Practitioner, Infectious Disease Physician interviews, the facility failed to ensure Resident #24 attended a	F0684	F684 – Quality of Care Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 24 appointment was rescheduled for 12/12/2025, at Atrium Health Wake Forest Baptist Infectious Disease High Point and the resident attended the appointment. Address how the facility will identify other residents having the potential to be affected by the same deficient practice	11/11/2025

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 reverse for further 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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F0684 SS = D	Continued from page 1 scheduled infectious disease clinic appointment as ordered, for 1 of 5 residents reviewed for professional standards of care (Resident #24). Findings included: Record review of a hospital discharge summary dated 10/9/2025 revealed Resident #24 was prescribed Biktarvy, an antiretroviral medication used to treat human immunodeficiency virus (HIV), filled by the hospital retail pharmacy prior to discharge, with instructions to closely follow up at the infectious disease clinic. The discharge summary further documented a follow-up appointment scheduled for 11/12/2025. Resident #24 was admitted to the facility on 10/9/2025 with cumulative diagnoses including a mental health disorder and HIV infection. Physician's orders for Resident #24, dated 10/10/2025, directed administration of Biktarvy 50-200-25 milligrams, one tablet orally daily. Review of the care plan for Resident #24 initiated 10/14/2025 identified chronic disease management as a focus area with interventions to administer medications as ordered and monitor for complications related to HIV. The admission Minimum Data Set dated 10/15/2025 documented Resident #24 had moderate cognitive impairment. Interview with the Guardian for Resident #24 on 11/26/2025 at 11:03 AM revealed she was not notified of the 11/12/2025 infectious disease clinic appointment. The Guardian stated she did not receive a phone call or message regarding the appointment and reported that, prior to hospitalization from 10/4/2025 to 10/9/2025, a mental health service employee typically accompanied Resident #24 to appointments. The Guardian was uncertain when the 11/12/2025 appointment was cancelled. Interview with the facility Transportation Coordinator on 11/26/2025 at 11:57 AM revealed Resident #24's 11/12/2025 appointment required accompaniment per administrative policy. The Guardian was called several times the week prior, but no response was received, and no message could be left. The Transportation Coordinator cancelled the appointment one to two days prior and rescheduled it for 11/24/2025.	F0684	Continued from page 1 On 12/10/2025, the Regional Director of Nursing reviewed the appointments for the month of December to ensure current residents attended the appointment. If an appointment was missed, the Regional Director of Nursing reviewed the reason and confirmed that a new appointment was rescheduled. Completed 12/10/2025 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/10/2025, the Regional Director of Nursing educated the Transport Scheduler on reviewing all consultations and transcribing the appointments correctly on the calendar, ensuring residents do not miss any appointments, and when an appointment is missed it will need to be rescheduled as soon as the provider is available. Education included notifying the Director of Nursing, Representative Party, and Medical Provider when an appointment is missed. Completed 12/10/2025. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and/or designee will review all consultations for new appointments, new orders, and appointment schedules to ensure residents attend their appointments weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance date 12/16/2025	

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F0684 SS = D	Continued from page 2 During a follow-up interview on 12/1/2025 at 8:02 AM, the Transportation Coordinator acknowledged awareness of the importance of the 11/12/2025 appointment and stated she notified the Administrator, Unit Manager #1, and Nurse Practitioner #1 of the rescheduling. Interview with the Social Worker on 11/26/2025 at 1:19 PM revealed the Transportation Coordinator was responsible for arranging Resident #24's appointments. The Social Worker confirmed the Guardian was sometimes difficult to contact. Review of the November Medication Administration Record and notes written by Nurse #8 on 11/13/2025 at 1:23 PM revealed Biktarvy was not administered. Interview with Nurse #8 on 11/26/2025 at 12:40 PM confirmed the medication was unavailable on the medication cart beginning 11/13/2025. Nurse #8 reported contacting the physician, who indicated Resident #24 needed to be seen at the infectious disease clinic before the pharmacy would dispense additional medication. Review of a communication progress note dated 11/18/2025 at 9:36 AM by the Assistant Director of Nursing (ADON) documented the Guardian was updated regarding Resident #24's HIV medication. The note revealed the pharmacy would not dispense Biktarvy until Resident #24 was seen at the clinic, and an appointment was scheduled for the following week. Interview with the ADON on 11/25/2025 at 6:24 PM confirmed Resident #24 had run out of Biktarvy and required a clinic visit for refill authorization. The ADON stated the facility pharmacy ultimately obtained Biktarvy after insurance was willing to pay for it prior to the rescheduled clinic appointment. Review of a progress note dated 11/18/2025 at 10:19 PM by Nurse Practitioner #1 documented Resident #24 was not receiving Biktarvy due to lack of insurance coverage and refusal by the infectious disease provider to refill without a recent clinic visit. Interview with NP #1 on 11/26/2025 at 12:13 PM revealed the ADON informed him of the lapse in medication. NP #1 confirmed the infectious disease physician declined to refill until Resident #24 was seen. NP #1 acknowledged awareness of multiple cancellations and rescheduling of the clinic appointment. NP #1 stated the facility pharmacy ultimately obtained Biktarvy, and Resident #24 resumed therapy on 11/22/2025.	F0684		

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F0684 SS = D	Continued from page 3 Interview with the Guardian on 11/26/2025 at 11:03 AM revealed she was notified on 11/17/2025 that the 11/12/2025 appointment was cancelled and rescheduled for 11/24/2025. She was also informed Resident #24 was not receiving Biktarvy pending clinic evaluation. The Guardian arranged for a mental health service representative to accompany Resident #24 to the 11/24/2025 appointment. Interview with the Transportation Coordinator on 11/26/2025 at 11:57 AM revealed she believed the appointment was scheduled for 11/24/2025 and contacted the Guardian accordingly. The Guardian arranged accompaniment. However, the actual appointment was on 11/17/2025, which Resident #24 missed. The Transportation Coordinator acknowledged recording the wrong date. Resident #24 was subsequently placed on a waiting list, with the next appointment scheduled for 2/2/2026. Interview with the infectious disease Physician on 12/8/2025 at 1:03 PM confirmed the 11/12/2025 appointment was cancelled and rescheduled for 11/17/2025. Resident #24 did not attend the 11/17/2025 clinic appointment but did attend an orthopedic appointment later that day. The Physician stated Resident #24 was rescheduled for February 2026 and reported her nursing staff was having difficulty contacting the facility Transportation Coordinator to arrange a sooner date. The Physician further stated Resident #24 had uncontrolled HIV in October 2025 and required follow-up viral load testing after initiation of Biktarvy. Interview with the Administrator on 12/1/2025 at 12:15 PM revealed she did not recall being informed by the Transportation Coordinator that the 11/12/2025 appointment was cancelled. The Administrator stated her expectation was that Resident #24 would attend scheduled appointments and that the Transportation Coordinator would accurately record appointment dates.	F0684		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F0689	F689 – Free of Accident Hazards/Supervision/Devices Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 22 received a smoking assessment on 12/12/2025 and the resident is a safe smoker. Resident # 19 Anti-tippers were placed on the resident wheelchair on 11/7/2025. Resident # 19 wheelchair is stabilized, and front wheels do not come off the	11/11/2025

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F0689 SS = D	Continued from page 4 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with resident, staff, and Physician, the facility failed to 1) ensure interventions to stabilize a resident's wheelchair were in place for a resident who had a history of tipping over in her wheelchair (Resident # 19) 2) ensure a system was in place in order that staff know when a resident (Resident # 22), who was assessed to need supervision to smoke, was going outside to smoke in order that the resident be supervised while smoking. This was for 2 of 3 residents who were reviewed for staff supervision to prevent accidents (Resident #19 and Resident #22). The findings included: 1. Record review revealed Resident # 19 was admitted to the facility on 7/1/25. The resident had diagnoses which included a cognitive communication deficit, chronic pain, disease of the peripheral nervous system, and bilateral above knee amputations. Resident # 19's significant Minimum Data Set assessment, dated 9/22/25, coded the resident as cognitively intact and as experiencing two or more falls during the last assessment period. Review of Resident # 19's care plan, updated on 11/7/25, revealed the facility had identified Resident # 19 was at risk for falls. According to the care plan this had been originally initiated on the care plan on 7/1/25 and remained as an active problem on the resident's care plan. The resident's current care plan also included the notation, "OT referral for safety-8/14/25." On 11/24/25 at 3:35 PM Resident # 19 was interviewed and reported the following information. She thought she needed a different type of wheelchair and one which had a higher back to it. She reported that hers would tilt back when she rolled and she had fallen backwards in it, hit her head, and "had a bleed" in past times. Resident # 19 was observed to be in a wheelchair which had anti- tipper devices on the back of the wheelchair. There were no anti-tippers on the front. Nurse Aide # 2 was assigned to care for Resident # 19 on 11/24/25. Nurse Aide # 2 was interviewed on 11/24/25 at 4:00 PM and reported she knew Resident # 19 had a	F0689	Continued from page 4 ground. This was verified by the Director of Rehab and the Regional Director of Nursing on 12/10/2025. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 12/12/2025, the unit managers and house supervisors assessed current smokers to verify if the residents are supervised or unsupervised smokers. Completed 12/15/2025. On 12/10/2025, the Regional Director of Nursing, Assistant Director of Nursing, and Director of Rehab reviewed current residents to ensure residents have equipment that was referred to by the therapist. Completed 12/12/2025 Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/12/2025 the Director of Social Services re-educated current residents that are smokers and responsible parties/emergency contacts on the smoking policy. Completed 12/15/2025. On 12/12/2025, the Regional Director of Nursing initiated education with current staff on who the current smokers are and if they become aware of a resident that is coded as supervised with smoking materials, they are to notify the Director of Nursing and/or Administrator immediately. Education, including the list of smokers and the location as follows, at each nurse's station, in the department head offices, at the receptionist desk, care plan, and Kardex. On 12/12/2025 the Activities Director received education when a smoking resident is newly admitted or there is a status change it is her responsible for ensuring the changes are posted at each nurse's station, in the department head offices and at the receptionist's desk. Completed 12/15/2025. Any staff that did not receive the education by 12/15/2025 removed from the schedule until the training has been completed. Education will continue with new hire orientation. On 12/10/2025, the Regional Director of Nursing educated the Director of Rehab to present the changes for the residents regarding equipment in the clinical meeting for discussion. On 12/10/2025, the Regional Director of Nursing educated the Assistant Director of Nursing and Unit Managers that they are responsible for	

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F0689 SS = D	Continued from page 5 history of falling backwards in her wheelchair. On 11/25/25 at 3:05 PM Resident # 19 was observed as she rolled her wheelchair down the facility hallway. The faster the resident rolled, the wheelchair would make a noise, and the front wheels would slightly lift off the ground. Resident # 19 voiced a concern about this and reported she did not think the wheelchair should be lifting off the ground when she rolled. Unit Manager # 1 was interviewed on 11/25/25 at 1:30 PM and reported Resident # 19 had a history of her wheelchair tipping backwards on more than one occasion. The facility Occupational Therapist was interviewed via phone on 11/25/25 at 2:20 PM and reported the following information. The resident's weight was mainly concentrated in her torso because she was a bilateral above knee amputee and her amputations were high. Therefore, this made her at risk for sliding out of the front of the wheelchair. She (the Occupational Therapist) had evaluated Resident # 19 in August 2025 and recommended at that time that the resident have both front and back anti tippers on her wheelchair as well as for the seat to be slightly tipped upwards in the front in order that the back be slightly lower. At that time, she had told the Rehabilitation Director he could order the anti-tippers. She had not continued to work with the resident after August 2025. After the resident fell in the early part of November 2025, she looked through her previous recommendations she had given and again made the same recommendations. At some point, the back tippers were added but the resident never had the front tippers she had recommended. A wheelchair with a higher back would not be a good option for the resident. It would be the last option given that the resident's weight was in the back of the wheelchair. The Rehabilitation Director was interviewed on 11/24/25 at 11:50 AM and reported the following information. The front anti- tippers never came in but the back tippers did. According to the Rehabilitation Director, the anti-tipping devices helped with stabilization of the wheelchair. The Former Director of Nursing (DON), who had been employed up to the date of 11/21/25, was interviewed via phone on 11/25/25 at 5:11 PM and reported the following information. As of his last day in the facility no one had brought to his attention that Resident # 19's wheelchair was still tilting off the floor on the front when she rolled. If he had been made aware, then he would have asked for therapy to	F0689	Continued from page 5 ensuring the equipment is in place timely. Completed 12/10/2025 Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing and/or designee will round on the smoking area 3 times daily and supervisor will round 3 times during night hours to ensure supervised residents that smoke are not outside during unsupervised times 5 x week x 8 weeks. The Director of Nursing and/or designee will review falls in the clinical meeting and observe residents' equipment to ensure it is in place weekly x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance date 12/16/2025	

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F0689 SS = D	Continued from page 6 reevaluate. He (the former DON) did not know anything about the resident needing front anti-tippers per the Occupational Therapist's recommendations. The Regional Director of Clinical Services was interviewed on 11/25/25 at 12:40 PM and again on 11/25/25 at 4:40 PM and reported the following. The prior DON's last day was 11/21/25. The Regional Clinical Consultant was acting as interim DON until a full time DON could be hired. The Regional Clinical Consultant was also out the week of the survey, and she (the Regional Director of Clinical Services) was filling in while she was away. She (the Regional Director of Clinical Services) attended clinical meetings virtually and remotely. She knew Resident # 19's wheelchair had been adjusted somehow following falls earlier in November 2025 but did not know anything about missing front anti tippers. On 12/1/25 at 8:56 AM the Regional Clinical Consultant who was acting as interim DON was interviewed via phone and reported the following information. Prior to 11/26/25 she had last been in the facility on 11/18/25. She knew therapy had been asked to look at Resident # 19's wheelchair after falls during the first of November 2025. She knew the resident had gotten back anti tippers and the last time she had seen the resident, her wheelchair was not tipping off the ground as she rolled. The Administrator was interviewed on 11/25/25 at 5:50 PM and reported she recalled the clinical staff had talked about how to make Resident #19's wheelchair safer and at some point anti tippers were put on the back. 2. Resident #22 was admitted to the facility on 08/26/25 with diagnoses including type 2 diabetes, neuropathy, chronic congestive heart failure, and cognitive communication deficit. The quarterly Minimum Data Set (MDS) dated 09/01/25 indicated that Resident #22 was cognitively intact. The facility's smoking policy, dated 01/29/24, stated that residents must undergo a Smoking Safety Screen Assessment upon admission and as needed. Residents must also sign a Patient Smoking Acknowledgement Form. Based on the assessment, residents may smoke independently or with supervision. If supervision is required, staff or designated individuals must provide it. Failure to comply with smoking rules may result in discharge. Progress notes from the previous Director of Nursing	F0689		

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F0689 SS = D	Continued from page 7 (DON), dated 10/14/25, read in part: "Spoke with Resident #22 regarding smoking status and policy. Resident #22 stated they didn't realize. Residents are reeducated on the smoking policy. Administrator was made aware." The Smoking Acknowledgement Form showed that Resident #22 signed the form on 10/16/25, agreeing to follow the facility's smoking policy. The care plan dated 10/27/25 noted that Resident #22 preferred to smoke cigarettes. Interventions included education on the facility's smoking policy, use of smoking aprons, smoking assessments as needed, and supervision during smoking. Progress notes from the previous DON dated 11/03/25 stated: "Resident #22 (Unsafe smoker) found outside not during supervised times. Resident #22 was educated on smoking policy. Resident verbalized understanding. Administrator made aware." On 11/25/25 at 5:11 pm, the previous DON reported during an interview that residents requiring supervision were frequently found smoking unsupervised, which occurred daily during his tenure. He explained that Nursing Assistants and Activity staff had scheduled supervision times, but unsafe residents still obtained cigarettes and lighters and smoked during unscheduled times. He stated that he informed the Administrator, who told him he "needed to get a better handle on things." He added that he was "just one person" and could not manage the issue alone. At 5:40 pm on 11/25/25, Resident #22 was observed smoking unsupervised in the outdoor smoking area while seated in her wheelchair. She extinguished the cigarette after the Scheduler instructed her to return inside. During an interview at 5:43 pm on 11/25/25, the Scheduler confirmed that Resident #22 was not supposed to be smoking unsupervised. At 5:45 pm on 11/25/25, Resident #22 stated, "I know I'm not supposed to be out here smoking, but I haven't burned myself. I don't know why they say somebody has to be out there with me." At 5:50 pm on 11/25/25, the Administrator indicated she was unaware that any residents requiring supervised smoking had been found smoking unsupervised. She also said staff had not reported such incidents to her.	F0689		

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F0689 SS = D	Continued from page 8 During an interview on 11/26/25 at 3:01 pm, the Regional Director of Clinical Services reported that she completed a smoking assessment for Resident #22. She determined that the resident required supervision while smoking after observing her fall asleep twice while smoking and noting her stiff hand dexterity. On 11/26/25 at 3:15 pm, the current DON endorsed that the doors to the outdoor courtyard were not locked, allowing Resident #22 to go outside and smoke unsupervised without staff knowledge. She confirmed that Resident #22 should have been supervised while smoking.	F0689		
F0842 SS = E	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 that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) 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;	F0842	F842 – Resident Records – Identifiable Information Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 12/10/2025, the Regional Director of Nursing wrote Medication Errors Report for residents #13 and #24 and had them reviewed by the medical director. Address how the facility will identify other residents having the potential to be affected by the same deficient practice On 12/9/2025, the pharmacy performed and medication administration record and cart audit to ensure current residents' medications were available. Medication that was not available was reordered on 12/9/2025 and delivered by 12/12/2025. The Regional Director of Nursing, Assistant Director of Nursing, and Unit Manger reviewed the Medication Administration Record against the MAR to cart audit to ensure documentation was accurate. If the documentation was noted to be inaccurate a medication error report was written and reviewed by the medical director. Completed 12/15/2025. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/12/2025, the Regional Director of Nursing and/or designee-initiated education with licensed nurses and medication aides on documenting in the resident's electronic medication administration accurately. Any license nurses and medication aides that did not receive this education by 12/15 /2025 will be allowed	11/11/2025

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blumenthal Health and Rehabilitation Center	**3724 Wireless Drive , Greensboro, North Carolina, 27455**

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F0842 SS = E	Continued from page 9 (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, 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- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) 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, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with resident and	F0842	Continued from page 9 to take an assignment until the training has been completed. Education will continue with new hire orientation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The Director of Nursing or designee will audit 5 residents per unit electronic medication administration during the clinical meeting for accuracy 3x week x 8 weeks. Results of these audits will be reviewed at Quarterly Quality Assurance Meeting X 2 for further problem resolution if needed. The Administrator will review the results of weekly audits to ensure any issues identified are corrected. Compliance date 12/16/2025	

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F0842 SS = E	Continued from page 10 staff the facility failed to ensure the medical record was accurate regarding the administration of medications. This was for 2 of 8 residents whose medications were reviewed (Residents # 13 and Resident # 24). The findings included: 1. Record review revealed Resident # 13 was admitted to the facility on 2/12/20. Review of current physician orders revealed an order, which was initiated on 9/27/24, for Fluticasone propionate nasal spray 50 micrograms/ACT (actuation) one spray in both nostrils two times per day. Review of Resident # 13's November MAR (Medication Administration Record) revealed the following information: 11/20/25 for the 9:00 PM dose-Nurse # 7 documented a check mark indicating the Fluticasone was given. 11/21/25 for the 9:00 PM dose-Nurse # 7 documented a check mark indicating the Fluticasone was given. 11/22/25 for the 9:00 AM dose-Nurse # 6 documented a check mark indicating the Fluticasone was given. 11/24/25 for the 9:00 AM dose-MA # 2 documented a check mark indicating the Fluticasone was given. During an interview with Resident # 13 on 11/24 25 at 10:16 AM the resident reported she had not received her Fluticasone for several weeks. Medication Aide (MA) # 2 was interviewed on 11/24/25 at 3:05 PM about Resident # 13 reporting not receiving the Fluticasone. MA # 2 reported he had not given the Fluticasone because he could not find it. He had not meant to sign that he had given it on the MAR, and this had been an unintentional mistake. He further reported he would report the error in documentation to Nurse # 3 who was covering for him (when a nurse fulfilled the responsibilities which a medication aide was not certified to do). According to MA # 2, Nurse # 3 would know how to document to show that the medication was not given. During a later review of the MAR, it was observed that Nurse # 3's initials appeared by the 11/24/25 dose at 9:00 AM as a check mark which indicated the medication had been given. MA # 2's initials were gone. Interview with Nurse # 3 on 11/25/25 at 9:30 AM	F0842		

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F0842 SS = E	Continued from page 11 revealed she covered for MA #2 on 11/24/25. She had tried to fix the mistake in the documentation to accurately reflect that the Fluticasone dose had been omitted on 11/24/25 at 9:00 AM and she did not know why it was showing up as a check mark that she had administered it. She confirmed she had not administered it. Nurse # 7 was interviewed on 11/25/25 at 7:50 PM via phone and reported the following information. She had not administered the Fluticasone on 11/20/25 and 11/21/25 as the MAR reflected. Nurse #7 indicated this had been an inadvertent error in checking that it was given. Nurse # 6 was interviewed on 11/24/25 at 7:35 PM via phone and reported the following information. She indicated she may have inadvertently clicked that the Fluticasone was administered on 11/22/25 and she had not given the Fluticasone as the MAR reflected. Interview on 12/1/25 with the Corporate Clinical Consultant, who was acting as interim Director of Nursing (DON), revealed it was her expectation that the medical record accurately reflect medications that were administered. 2. Resident #24 was admitted to the facility on 10/9/2025 with cumulative diagnoses, one of which was human immunodeficiency virus infection (HIV). Resident #24 had a physician's order initiated on 10/10/2025 for 50-200-25 milligrams of Biktarvy (Bictegravir-Emtricitabine-Tenofovir) oral tablets to be administered as one tablet by mouth one time a day for HIV. Documentation on the November Medication Administration Record (MAR) revealed Nurse #2 administered an ordered dose of Biktarvy to Resident #24 on 11/15/2025. Nurse #2 was interviewed on 11/25/2025 at 6:13 PM. Nurse #2 revealed that she did not administer medications from the cart that held medications for Resident #24, but she oversaw the medication aides who used that medication cart. Nurse #2 stated she did not administer the medication Biktarvy to Resident #24 on 11/15/2025. Nurse #2 stated that she likely saw the medication on the electronic MAR that was not documented as administered and clicked it for the sake of completing the documentation. Documentation on the November MAR revealed Medication	F0842		

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F0842 SS = E	Continued from page 12 Aide #1 administered an ordered dose of Biktarvy to Resident #24 on 11/20/2025. Medication Aide #1 was interviewed on 11/25/2025 at 6:02 PM. Medication Aide #1 stated that she documented that the medication Biktarvy was administered to Resident #24 by mistake on 11/20/2025. Medication Aide #1 stated that everybody knew that the medication Biktarvy was not available on the medication cart that week. The Interim Director of Nursing (DON) was interviewed on 12/1/2025 at 11:54 AM. The Interim DON stated that it was her expectation that the nurses and the medication aides document the administration of medications accurately on the MAR.	F0842		