STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 The State Agency (SA) conducted a Complaint Investigation (CI) MS #20350, at the facility on 01/04/2023. During the survey, the SA determined that the facility was not in compliance with the requirements of participation in Medicare and Medicaid. The SA found deficient practice in the facility related to F561, a resident's right for self determination for feedings, F655, related to development of baseline care plan, and F726 related to administration of a medication delivered by Percutaneous Gastrostomy Tube (PEG). There were no deficiencies cited related to quality of personal care or environment. The facility held a license for 120 beds, and the census was 91.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.	F 561		1/27/23

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

Electronically Signed | 01/18/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 561	Continued From page 1 §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure Resident #3 was given choices concerning feeding schedules that are important to the resident and Responsible Party (RP), such as feeding times of his percutaneous gastrostomy tube (PEG) feedings for one (1) of two (2) residents reviewed with PEG feedings. Findings include: On 01/03/23 at 1400 an interview with Resident #3's RP revealed the family has not been pleased with the care resident is receiving. The RP stated the facility failed to administer PEG feedings in a timely manner. The RP explained she had waited for the 12 PM feeding for approximately 30 minutes before going to the nurses' station and requesting that the feeding be administered. Resident's RP stated Resident #3 was supposed to get bolus feedings at 0500, 0800, 1200, 1700, and 2000. PR stated she had tried to discuss this with the facility staff but they just looked at her. She stated she was afraid that Resident #3 would begin to lose weight if his feeding were not given on time. She stated she wished she could "just take him home". Observation at this time	F 561	* Resident #3 was assessed on 1/6/2023 by Director of Nursing (DON) with no adverse findings noted. Resident #3 was given choice regarding his feeding schedule on 1/18/2023 by the Staff Development Coordinator. No changes to the feeding schedule was made due to the resident's acceptance of current feeding schedule. *All residents receiving Bolus feedings have the potential to be affected. *Residents receiving Bolus feedings (2) were assessed by DON on 1/6/2023. Nursing department was in-serviced by the Staff Development Coordinator (SDC) on 1/6/2023 regarding Tube feedings. The facility Medical Director reviewed the policy "Tube Feedings" with no recommended changes to the policy on 1/18/2023. *Beginning 1/06/2023, the DON or SDC will observe Bolus tube feedings 2 times weekly for four weeks and then 2 times monthly for two months to ensure ongoing compliance with F tag 561 and will report to the Quality Assessment and Assurance Committee for 3 months. The first Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 561	Continued From page 2	F 561	Assessment and Assurance Committee meeting will be held on 01/27/2023.	

revealed an open case of Isosource 1.5 cal 250 milliliter (ml) in Resident #3's room.

An interview on 01/03/23 at 1505 with Licensed Practical Nurse (LPN) #1 revealed she worked the 700 hall medication cart and provided necessary nutritional needs including tube feedings to the residents on the 700 hall including Resident #3. LPN #1 stated she administers both continuous peg feedings and bolus peg feeding. LPN #1 stated she had a 1 hour window, 30 minutes before and 30 minutes after, in which to administer feedings and medications.

On 01/03/23 at 1520 an observation with LPN #1 of the supply room for the nurses' station revealed a sufficient supply of continuous feeding bags and piston syringes. When examining the cartons of bolus feeding cases, the observation revealed 6 cases and 5 individual cartons of Isosource 1.5 cal feedings. Interview with LPN #1 revealed that depending on the nurse working, a nurse may pull a carton of feeding from the supply room or use a carton of feeding in a resident's room supply. She explained it was the preference of the nurse on duty.

Observation on 01/04/23 at 0910 on 700 hall revealed staff performing tube feedings and med administration. Nurse administering meds was LPN #1. When asked if Resident #3 had received his 0800 medications and 0800 tube feeding, LPN #1 stated," No, I haven't gotten to him yet." LPN #1 confirmed resident was awaiting feeding, then stated resident does not get any meds at this time. LPN stated that residents who receive their meals by mouth (PO) receive their meals from 7:30-8:30 AM. LPN stated Resident #3 was in physical therapy, but did not receive his PEG

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 561	Continued From page 3	F 561		

meal prior to going. Observation of the 700 hall at this time also revealed the smell of breakfast foods and residents finishing their meals.

Interview on 01/04/23 0920 with Resident #2 revealed she had no concerns and that she had eaten breakfast already.

At 0934 on 01/04/23, observation revealed Resident #3 was returned by staff to his room and left alone in wheelchair. Resident #3 interviewed and responded appropriately. When asked if he had received therapy for swallowing issues, he said yes and they (therapy) did a good job. He stated he had to make sounds and yawns for the therapist. He stated he was hungry and thirsty and began talking about foods that he planned to eat when he was discharged home.

Observation on 01/04/23 at 1000 revealed LPN #1 arrived in room to give meds and 0800 PEG feeding. This was 2 hours after order to give at 0800. Resident #3 received one carton of Isosource 1.5 and 200 cc of water via tube. LPN #1 explained she was just now giving Resident #1 he's 0800 PEG feeding due to him going to physical therapy before she could get to him.

Record review of Resident #3's physician orders revealed an order for Isosource 1.5 cal bolus feeding- one carton (250 ml) per peg tube 5 X Day. Order start date 12/31/22. Record review of the resident's eMAR revealed times of administration were listed as 5 AM, 8 AM, 12 PM, 4 PM, 8 PM.

Interview on 01/03/23 at 1455 with Dietary Manager (DM) revealed the facility nurses obtain orders for the tube feedings based off of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 561	Continued From page 4 physician's orders. The DM stated the Registered Dietician (RD) consults with the facility and visits the facility weekly. DM stated that RD calculates calories needed for each resident and would consult the physician for changes if needed.	F 561		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).	F 655		2/3/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 655	Continued From page 5 §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and record review, the facility failed to develop a baseline care plan that contained dietary orders feeding amount or times to administer Percutaneous Gastrostomy (PEG) feedings for one (1) of three (3) resident care plans reviewed, Resident #3. Findings Include: Review of the facilities policy on baseline care plans revealed a policy titled, "Care Plan Process" revised 08/17, that read "The facility shall develop and implement a Baseline Care plan and Summary for each resident that includes instructions needed to provide effective and person-centered care... The baseline care plan shall: ... include the minimum healthcare information necessary to properly care for a resident immediately upon their admission, which address resident-specific health and safety concerns including... Physician orders and Dietary orders." Record review of Baseline Care Plan for Resident	F 655	*Resident #3 was assessed on 1/6/23 by the Director of Nursing (DON) with no adverse findings noted. Resident #3's care plan was updated on 1/18/2023 by the Minimum Data Set (MDS) Case Manager. *All residents receiving Bolus feedings have the potential to be affected. *Care plans for residents receiving Bolus feedings were reviewed on 1/18/2023 by the MDS Case Manager and updated. Nursing department was in-serviced by Staff Development Coordinator on 1/6/2023 regarding the Care Plan process. The facility Medical Director reviewed the policy "Care Plan Process" with no recommended changes to the policy on 1/18/2023. * Beginning 1/18/2023, the DON or SDC will observe Bolus feeding care plans 2 times weekly for four weeks and then 2 times monthly for two months to ensure ongoing compliance with F tag 655 and will report to the Quality Assessment and Assurance Committee monthly for 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 655	Continued From page 6 #3 revealed under "Nutritional Status/Diet", "Goal: Maintain stable weight, NPO/Peg tube, Diet as ordered, Fluid Consistency, monitor meal %'s, Report problems to Charge Nurse, Malnutrition/Risk for malnutrition, Isosource 1.5 Bolus. Review revealed the care plan failed to address the amount of Isosource bolus or the times it should be administered. An interview with Resident #3's Representative (RP) on 01/03/23 at 1400 revealed the family has not been pleased with the care resident is receiving and the failure to administer PEG (Percutaneous Tube) feedings in a timely manner. The RP stated it was her understanding that Resident #3 was supposed to get bolus feedings at 0500, 0800, 1200, 1700, and 2000. Record review of Resident #3's orders revealed a physician order for Isosource 1.5 cal bolus feeding- one carton (250 ml) per peg tube 5 X Day. Order start date 12/31/22. Record review of the resident's eMAR revealed times of administration were listed as 5 AM, 8 AM, 12 PM, 4 PM, 8 PM.	F 655	months. The first Quality Assessment and Assurance Committee meeting will be held on 02/03/2023.	
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in	F 726		1/27/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 726	Continued From page 7 accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and record review, the facility failed to administer an extended release medication per professional standards as evidenced by crushing the extended release medication to administer per gastrostomy tube for one (1) of three (3) resident's reviewed, Resident #3. Findings include: Review of the facility policy titled, Crushing Medications, revised 10/17, revealed, "1. Some medications such as capsules or enteric-coated tablets are not to be crushed or chewed." Review of Mucinex Drug Facts under "Directions" revealed "Do not crush, chew, or break tablet."	F 726	*Resident #3 was assessed on 1/6/23 by Director of Nursing (DON) with no adverse findings noted. Licensed Practical Nurse (LPN)#1 was educated on Administration of Medications on 1/6/23 and 1/9/23 by the Staff Development Coordinator (SDC). *All residents receiving medication via gastrostomy tube have the potential to be affected. *Residents receiving medications per gastrostomy tube were assessed by DON on 1/6/2023 with no adverse outcomes noted. Nursing department was in-serviced by Staff Development on 1/6/2023 regarding Administration of Medication and on 1/9/2023 regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 726	Continued From page 8 On 01/04/23 at 100, Licensed Practical Nurse (LPN) #1 stated Resident #3 received a "baby aspirin" and a "Mucinex". LPN #1 checked placement of PEG tube with no concerns noted. LPN pulled ASA (Aspirin) 81 milligram (mg) and crushed then pulled Mucinex ER 600 mg and crushed it. The medications were administered separately with 30 cubic centimeters (cc) flush between each med. The Resident then received 200 cc of water via tube. An interview on 01/04/23 at 1020 with LPN #1 revealed when questioned about crushing the extended release Mucinex, the LPN stated, "He's NPO (nothing by mouth), so I had to crush it to get the medication down the tube." 01/04/23 at 1025 with Registered Nurse (RN) Charge Nurse revealed the facility received an order for Mucinex for Resident #3 on 01/02/23 for congestion. The RN Charge Nurse stated the facility did not have any liquid Mucinex for administering via PEG tube. Record review of Resident #3 revealed a physician order for Mucinex ER 600 milligram (mg) tablet one per peg twice a day X 7 days/congestion. The order start date was 01/02/23. Record review of the resident's eMAR revealed time of administration was listed as 8:00 AM. Interview at 01/04/23 at 11:00 AM revealed Resident #3's physician stated he did not foresee any consequences from the one time dose of Mucinex. He also stated that the facility had request an order for Tussin DM from his Nurse Practitioner within the past hour.	F 726	crushing medications. The facility Medical Director reviewed the policy Administration of Medications on 1/18/23 with no recommended changes to the policy. *Beginning 1/06/2023, the DON or SDC will observe medications received per gastrostomy tube two times weekly for four weeks and then 2 times monthly for two months to ensure ongoing compliance with F tag 726 and will report to the Quality Assessment and Assurance Committee monthly for 3 months. The first Quality Assessment and Assurance Committee meeting will be held on 1/27/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	255274	A. BUILDING _____ B. WING _____	C 01/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND HOME	638 HIGHLAND COLONY PARKWAY RIDGELAND, MS 39157

(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 726	Continued From page 9 Interview 01/04/23 at 12:00 PM with Director of Nurses (DON) revealed there was policies for administering medications and confirmed an extended-release medication should not have been crushed. Resident #3 was admitted to the facility on 12/30/22.	F 726		