VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

June 23, 2025

Ms. Alyssa Maker-Lawal, Administrator
St Johnsbury Health & Rehab
1248 Hospital Drive
Saint Johnsbury, VT 05819-9248

Dear Ms. Maker-Lawal:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **May 28, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	475019	A. BUILDING _____ B. WING _____	C 05/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST JOHNSBURY HEALTH & REHAB	1248 HOSPITAL DRIVE SAINT JOHNSBURY, VT 05819

(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 Division of Licensing and Protection conducted an unannounced, onsite investigation of 1 complaint (#24011) and 1 facility reported incident (#24028) on 5/14/25 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. The following regulatory deficiencies were identified: During off-site review on 5/23/2025, immediate jeopardy was identified at F600 and F658 related to neglect and professional standards. On 5/23/2025, the Licensing Chief notified the facility of deficiencies at the immediate jeopardy (IJ) level. The facility is licensed for 99 beds and had a census of 75 at the time of the survey. This IJ determination also results in substandard quality of care. An onsite assessment of the IJ removal was conducted on 5/28/2025, and the facility had completed sufficient corrective actions to remove the immediate jeopardy for F-600 and F-686 on 5/23/25 by: implementing staff education on professional standards and neglect; ensuring that all residents were safe from neglect by assessing and interviewing residents and terminating neglectful staff; conducting an internal investigation, including initiating a root cause analysis; and implementing a daily audit tool. The non-compliance with this requirement remains. An onsite extended survey was conducted on 5/28/2025 due to the substandard quality of care. No additional deficiencies were identified.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554		

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

NHA | 6/16/25

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.

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F 554	Continued From page 1 §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure 1 resident [Resident #1] of 3 sampled residents did not self-administer medications despite physician orders forbidding this. Findings include: Review of Physician orders for Resident #1 dated 4/14/25 include "Resident MAY NOT administer own meds." Further review of medication orders for Resident #1 includes "Zenpep Oral Capsule Delayed Release Particles-give 5 capsules by mouth before meals for pancreatic enzymes. Start date 5/1/25." The scheduled administration times are 7:30 AM, 11:30 AM, & 4:30 PM. Review of Resident #1's Medication Administration Record [MAR] for May 2025, also includes an order for the Zenpep Oral Capsules- "Give 3 capsules by mouth as needed for PM with snacks, 21 max caps a day," starting 5/1/25. There were no entries documented for the "as needed for PM" dose from the start dated of 5/1/25 to the day of the survey 5/14/25. Per observation and interview with Resident #1 on 5/14/25 at 9:37 AM, the resident stated [s/he] was in possession of the prescribed medication "Zenpep Oral Capsule Delayed Release Particles" and proceeded to show the surveyors multiple capsules in a clear plastic medicine cup. The resident stated this was the only medication [s/he] was allowed to keep by [h/herself], and that all the other medications were kept by nursing.	F 554	F554 – Resident Self-Administration of Medications Regulatory Reference: §483.10(c)(7) Corrective Action for Resident(s) Affected: Resident #1 was assessed by the IDT and self-administration was discontinued. Medications were removed and secured. Resident was educated on policy. Identification of Others Who Could Be Affected: All residents on A Wing had the potential to be affected. Systemic Changes: The facility's self-administration policy was reviewed and clarified. IDT and licensed staff were re-educated. Medication pass and room audits were updated to include checks for unauthorized possession. Monitoring/QA Plan: 5 rooms per week will be audited for 8 weeks, then monthly x4. Audit results will be reviewed through QAPI. Allegation of Compliance Date: June 9, 2025 **Tag F 554 POC accepted on 6/23/25 by S. Stem**	6/9/25

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F 554	Continued From page 2 Resident #1 stated that [s/he] took the medication "whenever [s/he] wanted when [s/he] was about to eat something." The resident stated [s/he] did not report to nursing when [s/he] took the medication or how many times [s/he] took it. An interview was conducted with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and Vice President of Operations [VPO] on 5/14/25 at 1:56 PM. The facility staff confirmed that physician orders prohibited the resident from self-administering the "Zenpep" medication, and that Resident #1's MAR did not accurately reflect how many times the medication was administered, despite an order for a maximum of "21 caps a day."	F 554		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to protect the resident's right to be free from	F 600	F600 – Freedom from Abuse, Neglect, and Exploitation Regulatory Reference: §483.12 Corrective Action for Resident(s) Affected: Resident #1 was stabilized after hospitalization. A care conference was held with the resident, family, and leadership. Resident reported feeling safe. Insulin administration protocols were reinforced in the care plan. Identification of Others Who Could Be Affected: All residents on A Wing had the potential to be affected.	6/9/25

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F 600	Continued From page 3 neglect for 1 [Resident #1] of 3 sampled residents regarding staff having the knowledge and ability to provide care and services, but choosing not to do it, or acknowledge the request for assistance from a resident resulting in care deficits to a resident. Resident #1 suffered serious harm that rose to the immediate jeopardy level due to the facility's failure to prevent neglect. As a result, Resident #1 expereinced symptoms related to very high, unsafe blood sugar and psychosocial harm. Findings include: Review of the Admission Packet given to every resident in the facility includes the facility's "Abuse, Neglect and Exploitation Policy." The policy defines "Neglect" as the "intentional or reckless failure or omission by a caregiver to: Provide care or arrange for goods or services necessary to maintain the health or safety of a vulnerable adult, including, but not limited to ... medicine ... supervision and medical services." Review of the facility's "Annual Mandatory Education-All Staff" includes training titled "Resident Neglect". The training reads "Neglect is the failure to provide the required structures and processes in order to meet the needs of one or more residents. This may include ...the facility's failure to provide necessary staff ...services ...or staff supervision and oversight to meet the resident's needs. Neglect of goods or services may occur when staff are aware, or should be aware, of residents' care needs, based on assessment and care planning, but are unable to meet the identified needs due to other circumstances ..." Review of Resident #1's medical record reveals	F 600	Systemic Changes: The involved employee was suspended and terminated. A root cause analysis identified the issue as isolated. Staff were educated on: - Blood glucose monitoring protocols - Diabetic care standards - When to notify a physician for abnormal results and/or transfers - Call 911 when requested by resident - Assessing resident when requested Monitoring/QA Plan: DON or designee will review blood glucose and insulin administration daily for 5 insulin-dependent residents x2 weeks, then weekly x8 weeks. Reviewed through QAPI. Allegation of Compliance Date: June 9, 2025 **Tag F 600 POC accepted on 6/23/25 by S. Stem**	

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F 600	Continued From page 4 the resident has diagnoses that include: Diabetes mellitus [a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine] due to a underlying condition with hyperglycemia [high blood sugar], a history of a pancreatectomy [surgical procedure involving the removal of the pancreas]- [Your pancreas makes hormones (like insulin) that help control the levels of sugar in your bloodstream. When your blood sugar is too high, your pancreas makes insulin to lower it. Your body needs balanced blood sugar to run properly.] (https://my.clevelandclinic.org/health/body/21743-pancreas). Resident #1's medical history also includes hyperglycemic-hyperosmolar coma [a serious complication of diabetes characterized by extremely high blood sugar, significant dehydration, and altered mental state that can lead to coma. It's a life-threatening emergency]. According to the Mayo Clinic: "It's important to treat High blood sugar, also called hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart. Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL). When to see a doctor: Seek immediate help from your care provider or call 911 if: Your blood glucose levels stay above 240 milligrams per deciliter (mg/dL)" (https://www.mayoclinic.org/diseases-conditions/h	F 600		

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F 600	Continued From page 5 yperglycemia/symptoms-causes/syc-20373631) Review of the facility's "NURSING CARE OF THE RESIDENT WITH DIABETES MELLITUS" policy [revised 1/2024] reads, "The purposes of this guideline are to: Recognize, manage, and document the treatment of complications commonly associated with diabetes." The policy includes "Glucose Monitoring", which lists "The management of individuals with diabetes mellitus should follow relevant protocols and guidelines" and "Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation." The Nursing Care" lists "Normal ranges are defined as 80-130 before meals and <180 after meals. Hyperglycemia is considered anything above target reference ranges." An interview was conducted with Resident #1 on 5/14/25 at 9:37 AM. The resident stated s/he had h/her pancreas removed, and utilized a "Dexcom" device to monitor h/her blood sugar levels at all times. The resident raised the sleeve on h/her right arm to show a small white disk affixed to their upper arm. [the "Dexcom" is a wearable sensor sending real-time glucose readings automatically to a compatible smart device (such as an I-phone) or Dexcom receiver] (https://www.dexcom.com/get-started-cgm). Resident #1 demonstrated their present blood sugar reading on their I-phone, listed as 149. Resident #1 stated "Last Friday my Dexcom read >400. It only goes up to 400. I told my nurse [Staff LPN] that my blood sugar was high. I don't have a pancreas. [Staff LPN] said 'you're only scheduled for blood sugar checks before meals. There are no checks after 5:00 PM.' This was at approximately 8:00 PM. The nurse said to 'go	F 600		

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sleep it off.' I kept bugging her about 8 times to check my sugar. She got pissed, checked my sugar and it was the high 300's. I was mortified. I said I need to go to the Emergency Room. She said, 'Absolutely not.' I talked on the phone with my [Representative], who told me to call 911. So, I called the 911. [EMT #1 & #2] (Emergency Medical Technician- is a healthcare professional trained to provide basic emergency medical care) came and took me to the Emergency Department [ED]. They checked my blood sugar and it was 563." The resident reported at the time s/he was "suffering from massive headaches, blurry vision, dots in my vision, nausea, and feeling mentally "fuzzy."

Per interview with Resident #1's Representative on 5/14/25 at 2:59 PM, the Representative reported on the phone call the resident "was slurring [h/her] words," which the Representative reported he/she had witnessed in the past when the resident's blood sugars were extremely high.

Review of the facility's "NURSING CARE OF THE RESIDENT WITH DIABETES MELLITUS" policy includes: "symptoms of hyperglycemia may include the following:
-Headache
-Restlessness
-Nausea and/or vomiting
-Decreased awareness/senses"

An interview was conducted on 5/14/25 at 3:30 PM with the EMT #1 who responded to Resident #1's 911 call on 5/9/25. The EMT provided a written statement regarding what occurred between themselves and the Staff LPN and Resident #1, and during the interview confirmed the accuracy of h/her written account. Per review

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of the EMT #1's written statement:
"On May 9, 2025, I responded to an emergency call along with my assigned partner, [EMT #2]. At approximately 9:25 PM, we were dispatched to (Health and Rehab facility) for a patient-reported emergency. The initial dispatch information stated that a patient at the facility had personally called 911 and reported that '[h/her] sugar is out of control and the staff won't give [h/her] [h/her] insulin; [s/he] is experiencing nausea and has a headache.'
We were met by a facility staff member who would later be identified as Licensed Practical Nurse [Staff LPN].
Upon requesting a report from [Staff LPN], [s/he] responded: 'We didn't call you guys. I told the patient if [s/he] really thought [h/her] sugar was a problem, [s/he] could call 911 themselves.'
When asked to provide further details regarding the incident and the patient's condition, [Staff LPN] made the following statements:
'[Resident #1] has been saying that [h/her] device, an implanted DexCom blood glucose monitor, shows [h/her] levels as 'High' and has been asking for me to check [h/her] blood sugar for a while. [S/he] doesn't have orders for [h/her] blood sugar to be checked after 5:00 PM., but [s/he] hounded me enough that I checked it anyways at 7:00 p.m., and it read 356.'
When I, [EMT #1] asked what interventions were initiated to address the patient's elevated blood glucose, [Staff LPN] stated:
'Well, I don't have orders for [h/her] insulin after 5:00 PM., I wasn't going to call the physician after hours, and I definitely wasn't going to call the ambulance.'
'I wasn't even supposed to take a blood sugar after 5:00 PM., but [s/he] kept bugging me and if I hadn't, then it wouldn't be a problem now.' [S/he]

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further added:
'[S/he] kept telling me that [s/he] needed to go to the hospital, but I wasn't going to send [h/her] out because [s/he] can just go to bed.'
The patient reported multiple symptoms consistent with hyperglycemia, including but not limited to: Blurred vision with spots in the visual field, Excessive thirst and frequent urination, Headache and Nausea. The patient also presented [h/her] Dexcom continuous glucose monitor, which was actively displaying a reading of 'High.'
The patient reported that [s/he] had repeatedly informed [Staff LPN] of [h/her] symptoms and the need for insulin to reduce [h/her] blood glucose levels. According to the patient, [Staff LPN] declined to provide insulin, did not consult with the on-call physician, and refused to initiate transport to the hospital. The patient reported that [Staff LPN's] only recommendation was to 'not worry and go to bed.' This is consistent with [Staff LPN's] own statements to [EMT #1 & #2].
Prior to departing the facility with the patient, EMT personnel requested standard transfer documentation from [Staff LPN], including but not limited to:
-Patient's medical history
-Current medications
-Known allergies
-Recent medication administration or dispensation records
In response, [Staff LPN] declined, stating:
'We're not sending [h/her] out, so we're not sending any paperwork. [S/he] chose to do this [h/herself].'
The patient was escorted to the ambulance, where EMT performed an independent blood glucose check, which yielded a reading of 563 mg/dL. This result is critically elevated, falling well

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outside the normal range, and indicative of a condition requiring immediate medical and pharmacological intervention. It is also more than 200 points higher than the level previously documented by [Staff LPN]: (356 at approximately 7:00 PM), indicating continued physiological deterioration over the period without intervention. Upon arrival at [the hospital], The patient was subsequently evaluated and treated in accordance with hospital protocols for severe hyperglycemia."

Review of Emergency Department notes for Resident #1, dated 5/9/25 at 10:02 PM record "This is a 50-year-old who currently resides at health and rehab. Patient states that [h/her] Dexcom is still on, it was registering high this evening. Patient states that [s/he] asked the nurse at health and rehab for insulin. Patient states that the nurse stated that [s/he] did not have an order for glucose check, or insulin and because [s/he] did not have these [s/he]was not going to give the insulin. Patient states that [s/he] requested that the facility doctor be contacted, and nursing recommended that if the patient wanted further evaluation [s/he] contact 911. Patient contacted EMS [Emergency Medical Services] they came to health and rehab and per EMS they also corroborated the story as well. Patient was then brought to the emergency department for further evaluation. [S/he] admits to feeling slightly dizzy and nauseous with a mild headache, and states that this is common when [h/her] sugars are high. Blood glucose was noted to be over 500. Concern for DKA versus HHNK. [DKA (Diabetic Ketoacidosis) and HHNK or Hyperosmolar Hyperglycemic Nonketotic Syndrome) are both serious complications of diabetes characterized by high blood sugar

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(hyperglycemia)] Will give a liter of normal saline, will give 12 units of insulin ..."

Physician notes at 12:36 AM on 5/10/25 continue: "We recommend to health and rehab staff that regular orders of glucose checks and as needed insulin be part of the patient's continued medical regiment. This was made clear in the discharge instructions."

Review of Discharge Instructions for Resident #1 read: "When you arrived your blood glucose level was over 500. You were given an appropriate amount of insulin which has now brought your glucose levels back down to a more normal limit. Please continue to monitor your sugars closely. ORDERS FOR HEALTH AND REHAB: It is critical that the patient has his blood sugars monitored regularly. Please make sure that there are in place orders from your facility physician for administration of insulin if the patient becomes hyperglycemic. If the patient does have concern for hyperglycemia, please reach out to your staff physician for insulin orders for administration."

Review of the only progress note written by Staff LPN regarding Resident #1's care and treatment that evening, dated 5/10/25 at 2:40 AM reveals: "Requested blood sugar check around 7:30 PM. Result 391. Resident requesting nurse contact physician for orders for insulin. Resident educated that it might not be a great idea to take short acting insulin at bedtime, that blood sugar might drop too low during night. Resident informed that I could check blood sugar in the AM if [s/he] wants. Resident spoke to [h/her] [Representative] and [Representative] told [h/her] to go to hospital if [s/he] wants this issue addressed. Resident then called 911 to bring

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F 600	Continued From page 11	F 600		

[h/her] to ED across street. EMTs arrived for resident and nurse informed them of situation. Resident transported to ED. Around 2:00 AM ED called with report on resident stating that they checked [h/her] blood sugar and it was >500. Resident given 1 liter of saline and 12 units of insulin that was effective bringing down blood sugar to 130. Resident returned to facility with no further complaints. DON [Director of Nursing] made aware of situation."

Further review of progress notes reveals no documentation of when or what information the DON was "made aware of" or any actions taken by the DON or Staff LPN upon Resident #1's return. Per review of Resident #1's medical record, there was no documentation of any materials received from the hospital after Resident #1's Emergency Room visit, or any required documents given to the resident prior to their transfer.

Per the interview with EMT #1 on 5/14/25 at 3:30 PM, the EMT stated that he transported Resident #1 both to and from the Emergency Department on 5/9/25 and early morning 5/10/25. Per interview the EMT stated that Discharge Instructions including new physician orders were hand delivered upon Resident #1's return to the facility to the same Staff LPN who was responsible for Resident #1's care prior to the ED visit. The EMT stated that the new physician orders were handed directly to the Staff LPN and were highlighted and underlined and included orders for the resident's physician to be notified.

Per interview with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and Vice President of Operations [VPO] on

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F 600	Continued From page 12 5/14/25 at 1:56 PM, The Vice President of Operations [VPO] stated that the "usual situation" of a resident being sent to the hospital would include the facility "documenting a change in condition and the physician being notified" and confirmed this was not done for Resident #1. After reviewing Resident #1's medical record, the VPO stated that on 5/9/25 the resident's "presentation was out of the 'norm' for the patient", with ADM adding "In my opinion, the nurse should have called the doctor." Further review of Resident #1's medical record revealed 2 days earlier, on 5/7/25, Resident #1's blood sugar level at 7:53 PM was elevated and recorded at 346, and Resident #1's nurse at the time contacted the on-call physician service and received insulin orders to address the resident's elevated blood sugar level. Regarding the actions on 5/9/25, The ADM, RDN, and VPO stated the Staff LPN's actions toward Resident #1 "were not handled professionally" and the Staff LPN "was not listening to [h/her] education," Including the facility's "Annual Mandatory Education-All Staff" regarding resident Abuse and Neglect, and professional standards regarding staff having the knowledge and ability to provide care and services, but choosing not to do it, or acknowledge the request for assistance from a resident resulting in care deficits to a resident. The ADM, RDN, and VPO confirmed that despite the Staff LPN being handed ED notes and physician orders, the Staff LPN failed to enter any documentation of the ED visit in Resident #1's medical record, and no new physician orders were entered into the record or implemented in the resident's care and treatment, and no documentation that Resident #1's	F 600		

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F 600	Continued From page 13 physician was notified of the ED visit or of elevated blood sugar levels.	F 600		6/9/25
F 628 SS=D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The	F 628	Regulatory References: §483.15(c)(2)(iii)(3)-(6)(8); §483.21(c)(2)(i)-(iii) Corrective Action for Resident(s) Affected: A complete discharge summary was entered into Resident #1's clinical record. Hospital documentation was reviewed for continuity of care. Identification of Others Who Could Be Affected: All residents on A Wing had the potential to be affected. Systemic Changes: The discharge checklist was revised to include all required elements. The IDT was re-educated on CMS discharge standards. An EHR reminder was added to ensure timely completion for non-returning residents. Monitoring/QA Plan: All discharges will be audited weekly x8 weeks, then monthly x4. QAPI will monitor compliance. Allegation of Compliance Date: June 9, 2025 **Tag F 628 POC accepted on 6/23/25 by S. Stem**	

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F 628	Continued From page 14 facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 628		

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F 628	Continued From page 15 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 628		

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F 628	Continued From page 16 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 628		

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F 628	Continued From page 17 §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure for1 of 3 sampled residents [Resident #1], that prior to transfer to an Emergency Department, appropriate information was communicated to the receiving health care institution or provider, and before a nursing facility transfers a resident to a hospital the nursing facility must provide written information to the resident or resident representative that specifies the nursing facility's policies regarding bed-hold periods, during which the resident is permitted to return and resume residence in the nursing facility. Findings include: Review of Resident #1's medical record reveals the resident has diagnoses that include: Diabetes mellitus [a disease in which the body's ability to	F 628		

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F 628	Continued From page 18 produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine] due to a underlying condition with hyperglycemia [high blood sugar], a history of a pancreatectomy [surgical procedure involving the removal of the pancreas]- [Your pancreas makes hormones (like insulin) that help control the levels of sugar in your bloodstream. When your blood sugar is too high, your pancreas makes insulin to lower it. Your body needs balanced blood sugar to run properly] (https://my.clevelandclinic.org/health/body/21743-pancreas). Resident #1's medical history also includes hyperglycemic-hyperosmolar coma [a serious complication of diabetes characterized by extremely high blood sugar, significant dehydration, and altered mental state that can lead to coma. It's a life-threatening emergency]. According to the Mayo Clinic: "It's important to treat High blood sugar, also called hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart. Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL). When to see a doctor: Seek immediate help from your care provider or call 911 if: Your blood glucose levels stay above 240 milligrams per deciliter (mg/dL)" (https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631)	F 628		

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An interview was conducted with Resident #1 on 5/14/25 at 9:37 AM. The resident stated s/he had h/her pancreas removed, and utilized a "Dexcom" device to monitor h/her blood sugar levels at all times. The resident raised the sleeve on h/her right arm to show a small white disk affixed to their upper arm. [the "Dexcom" is a wearable sensor sending real-time glucose readings automatically to a compatible smart device (such as an I-phone) or Dexcom receiver] (https://www.dexcom.com/get-started-cgm). Resident #1 demonstrated their present blood sugar reading on their I-phone, listed as 149. Resident #1 stated "Last Friday my Dexcom read >400. It only goes up to 400. I told my nurse [Staff LPN] that my blood sugar was high. I don't have a pancreas. [Staff LPN] said 'you're only scheduled for blood sugar checks before meals. There are no checks after 5:00 PM.' This was at approximately 8:00 PM. The nurse said to 'go sleep it off.' I kept bugging her about 8 times to check my sugar. She got pissed, checked my sugar and it was the high 300's. I was mortified. I said I need to go to the Emergency Room. She said, 'Absolutely not.' I talked on the phone with my [Representative], who told me to call 911. So, I called the 911."

An interview was conducted on 5/14/25 at 3:30 PM with the EMT #1 who responded to Resident #1's 911 call on 5/9/25. The EMT provided a written statement regarding what occurred between themselves and the Staff LPN and Resident #1, and during the interview confirmed the accuracy of h/her written account.
Per review of the EMT #1's written statement: "On May 9, 2025, I responded to an emergency call along with my assigned partner, [EMT #2]. At

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F 628	Continued From page 20 approximately 9:25 PM, we were dispatched to (Health and Rehab facility) for a patient-reported emergency. The initial dispatch information stated that a patient at the facility had personally called 911 and reported that '[h/her] sugar is out of control and the staff won't give [h/her] [h/her] insulin; [s/he] is experiencing nausea and has a headache.' We were met by a facility staff member who would later be identified as Licensed Practical Nurse [Staff LPN]. Upon requesting a report from [Staff LPN], [s/he] responded: 'We didn't call you guys. I told the patient if [s/he] really thought [h/her] sugar was a problem, [s/he] could call 911 themselves.' Prior to departing the facility with the patient, EMT personnel requested standard transfer documentation from [Staff LPN], including but not limited to: -Patient's medical history -Current medications -Known allergies -Recent medication administration or dispensation records In response, [Staff LPN] declined, stating: 'We're not sending [h/her] out, so we're not sending any paperwork. [S/he] chose to do this [h/herself].' The patient was escorted to the ambulance, where EMT performed an independent blood glucose check, which yielded a reading of 563 mg/dL. Upon arrival at [the hospital], The patient was subsequently evaluated and treated in accordance with hospital protocols for severe hyperglycemia." Review of Emergency Department notes for Resident #1, dated 5/9/25 at 10:02 PM record "We recommend to health and rehab staff that regular orders of glucose checks and as needed insulin be part of the patient's continued medical	F 628		

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F 628	Continued From page 21 regiment. This was made clear in the discharge instructions." Review of Discharge Instructions for Resident #1 read: "When you arrived your blood glucose level was over 500. You were given an appropriate amount of insulin which has now brought your glucose levels back down to a more normal limit. Please continue to monitor your sugars closely. ORDERS FOR HEALTH AND REHAB: It is critical that the patient has his blood sugars monitored regularly. Please make sure that there are in place orders from your facility physician for administration of insulin if the patient becomes hyperglycemic. If the patient does have concern for hyperglycemia, please reach out to your staff physician for insulin orders for administration." Review of the only progress note written by Staff LPN regarding Resident #1's care and treatment that evening, dated 5/10/25 at 2:40 AM reveals: "Around 2:00 AM ED called with report on resident stating that they checked [h/her] blood sugar and it was >500. Resident given 1 liter of saline and 12 units of insulin that was effective bringing down blood sugar to 130. Resident returned to facility with no further complaints. DON [Director of Nursing] made aware of situation." Further review of progress notes reveals no documentation of when or what information the DON was "made aware of" or any actions taken by the DON or Staff LPN upon Resident #1's return. Per review of Resident #1's medical record, there was no documentation of any materials received from the hospital after Resident #1's Emergency Room visit, or any required documents given to the resident prior to	F 628		

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F 628	Continued From page 22 their transfer. Per the interview with EMT #1 on 5/14/25 at 3:30 PM, the EMT stated that he transported Resident #1 both to and from the Emergency Department on 5/9/25 and early morning 5/10/25. Per interview the EMT stated that Discharge Instructions including new physician orders were hand delivered upon Resident #1's return to the facility to the same Staff LPN who was responsible for Resident #1's care prior to the ED visit. The EMT stated that the new physician orders were handed directly to the Staff LPN and were highlighted and underlined and included orders for the resident's physician to be notified. Per interview with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and Vice President of Operations [VPO] on 5/14/25 at 1:56 PM, the Vice President of Operations [VPO] stated that the "usual situation" of a resident being sent to the hospital would include the facility "documenting a change in condition and the physician being notified" and confirmed this was not done for Resident #1. The facility's Administrator [ADM], the Regional Director of Nursing [RDN], and Vice President of Operations [VPO] stated the facility's expectation was to receive treatment information and a visit summary after any resident's transfer and return from the hospital. The facility's process includes scanning the materials into the electronic record and entering and immediately implementing any new orders received. The facility confirmed they did not possess any paperwork or discharge information after Resident #1's ED visit on 5/9/25. At 4:15 PM on 5/14/25, the facility contacted the ED for copies of Resident #1's ED visit record. The facility immediately received copies of	F 628		

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F 628	Continued From page 23 Resident #1's Hospital Record and ED Visit Note, dated 5/9/25, which included new physician orders from the ED. The ADM, RDN, and VPO confirmed that despite the Staff LPN being handed ED notes and physician orders, the Staff LPN failed to enter any documentation of the ED visit in Resident #1's medical record, and no new physician orders were entered into the record or implemented in the resident's care and treatment, and no documentation that Resident #1's physician was notified of the ED visit or of elevated blood sugar levels. Additionally, it was confirmed that Resident #1 was transferred out of the facility without any documentation from [Staff LPN], including the resident's medical history, current medications, known allergies, recent medication administration or dispensation records, and no required bed hold notification allowing the resident to return to the facility after the ED visit.	F 628		
F 658 SS=J	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure 1 [Resident #1] of 3 sampled residents received care and services according to accepted standards of clinical practice. Resident #1 suffered serious harm that rose to the immediate jeopardy level due to the facility's failure to provide care in accordance with professional standards, As a result, Resident #1	F 658	Regulatory Reference: §483.21(b)(3)(i) Corrective Action for Resident(s) Affected: The nurse was removed from the floor and investigated. Resident #1's care plan was updated for increased clinical monitoring. Identification of Others Who Could Be Affected: All residents on A Wing had the potential to be affected.	6/9/25

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F 658	Continued From page 24 experienced symptoms related to very high, unsafe blood sugar and psychosocial harm. Findings include: According to the American Nurses Association: Scope and Standards of Practice (http://www.Nursingworld.org © 2010 American Nurses Association) "The Standards of Professional Nursing Practice are authoritative statements of the duties that all registered nurses, regardless of role, population, or specialty, are expected to perform competently." The Standards of Professional Nursing Practice include: 1.) "Recognizes the healthcare consumer as the authority on her or his own health by honoring their care preferences." An interview was conducted with Resident #1 on 5/14/25 at 9:37 AM. The resident stated s/he had h/her pancreas removed, and utilized a "Dexcom" device to monitor h/her blood sugar levels at all times. The resident raised the sleeve on h/her right arm to show a small white disk affixed to their upper arm. [the "Dexcom" is a wearable sensor sending real-time glucose readings automatically to a compatible smart device (such as an I-phone) or Dexcom receiver] (https://www.dexcom.com/get-started-cgm). Resident #1 demonstrated their present blood sugar reading on their I-phone, listed as 149. Resident #1 stated "Last Friday my Dexcom read >400. It only goes up to 400. I told my nurse [Staff LPN] that my blood sugar was high. I don't have a pancreas. [Staff LPN] said 'you're only scheduled for blood sugar checks before meals. There are no checks after 5:00 PM.' This was at	F 658	Systemic Changes: Education provided to all licensed nursing staff on: - Blood glucose monitoring protocols - Diabetic care standards - When to notify a physician for abnormal results and/or transfers - Call 911 when requested by resident - Assessing resident when requested A daily 24-hour report audit process was implemented by the RDON to review RMS, hospital transfers, and physician notifications. Monitoring/QA Plan: 5 clinical notes per week will be reviewed x8 weeks, then monthly x4. Findings discussed in QAPI. Allegation of Compliance Date: June 9, 2025 **Tag F 658 POC accepted on 6/23/25 by S. Stem**	

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F 658	Continued From page 25 approximately 8:00 PM. The nurse said to 'go sleep it off.' I kept bugging her about 8 times to check my sugar. She got pissed, checked my sugar and it was the high 300's. I was mortified. I said I need to go to the Emergency Room. She said, 'Absolutely not.'" 2.) "Derives the diagnoses or issues from assessment data." - "Uses standardized classification systems and clinical decision support tools, when available, in identifying diagnoses." - "Initiates and interprets diagnostic tests and procedures relevant to the healthcare consumer's current status." Review of Resident #1's medical record reveals the resident has diagnoses that include: Diabetes mellitus [a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose in the blood and urine] due to a underlying condition with hyperglycemia [high blood sugar], a history of a pancreatectomy [surgical procedure involving the removal of the pancreas]- [Your pancreas makes hormones (like insulin) that help control the levels of sugar in your bloodstream. When your blood sugar is too high, your pancreas makes insulin to lower it. Your body needs balanced blood sugar to run properly] (https://my.clevelandclinic.org/health/body/21743-pancreas). Resident #1's medical history also includes hyperglycemic-hyperosmolar coma [a serious complication of diabetes characterized by extremely high blood sugar, significant dehydration, and altered mental state that can lead to coma. It's a life-threatening emergency].	F 658		

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F 658	Continued From page 26 According to the Mayo Clinic: "It's important to treat High blood sugar, also called hyperglycemia. If it's not treated, hyperglycemia can become severe and cause serious health problems that require emergency care, including a diabetic coma. Hyperglycemia that lasts, even if it's not severe, can lead to health problems that affect the eyes, kidneys, nerves and heart. Hyperglycemia usually doesn't cause symptoms until blood sugar (glucose) levels are high - above 180 to 200 milligrams per deciliter (mg/dL When to see a doctor: Seek immediate help from your care provider or call 911 if: Your blood glucose levels stay above 240 milligrams per deciliter (mg/dL)" (https://www.mayoclinic.org/diseases-conditions/hyperglycemia/symptoms-causes/syc-20373631) Per interview with Resident #1 on 5/14/25 at 9:37 AM, the resident stated after Staff LPN refused to call the physician, the resident spoke with [h/her] [Representative] on the phone and followed their instructions to call 911. Resident #1 reported "So, I called the 911. [EMT #1 & #2] (Emergency Medical Technician- is a healthcare professional trained to provide basic emergency medical care) came and took me to the Emergency Department [ED]. They checked my blood sugar and it was 563." The resident reported at the time s/he was "suffering from massive headaches, blurry vision, dots in my vision, nausea, and feeling mentally 'fuzzy'." Per interview with Resident #1's Representative on 5/14/25 at 2:59 PM, the representative reported on the phone call the resident "was	F 658		

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F 658	Continued From page 27 slurring [h/her] words", which the Representative reported s/he had witnessed in the past when the resident's blood sugars were extremely high. 3.) "Modifies expected outcomes according to changes in the status of the healthcare consumer or evaluation of the situation." - "Develops an individualized plan to provide direction to other members of the healthcare team." - "Demonstrates caring behaviors toward healthcare consumers" - "Utilizes community resources and systems to implement the plan." An interview was conducted on 5/14/25 at 3:30 PM with the EMT #1 who responded to Resident #1's 911 call on 5/9/25. The EMT provided a written statement regarding what occurred between themselves and the Staff LPN and Resident #1, and during the interview confirmed the accuracy of h/her written account. Per review of the EMT #1's written statement: "On May 9, 2025, I responded to an emergency call along with my assigned partner, [EMT #2]. At approximately 9:25 PM, we were dispatched to (Health and Rehab facility) for a patient-reported emergency. We were met by a facility staff member who would later be identified as Licensed Practical Nurse [Staff LPN]. Upon requesting a report from [Staff LPN], [s/he] responded: 'We didn't call you guys. I told the patient if [s/he] really thought [h/her] sugar was a problem, [s/he] could call 911 themselves.' When I, [EMT #1] asked what interventions were initiated to address the patient's elevated blood glucose, [Staff LPN] stated: 'Well, I don't have orders for	F 658		

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F 658	Continued From page 28 [h/her] insulin after 5:00 PM., I wasn't going to call the physician after hours, and I definitely wasn't going to call the ambulance.' 'I wasn't even supposed to take a blood sugar after 5:00 PM., but [s/he] kept bugging me and if I hadn't, then it wouldn't be a problem now.' [S/he] further added: '[S/he] kept telling me that [s/he] needed to go to the hospital, but I wasn't going to send [h/her] out because [s/he] can just go to bed.' Prior to departing the facility with the patient, EMT personnel requested standard transfer documentation from [Staff LPN], including but not limited to: -Patient's medical history -Current medications -Known allergies -Recent medication administration or dispensation records In response, [Staff LPN] declined, stating: 'We're not sending [h/her] out, so we're not sending any paperwork. [S/he] chose to do this [h/herself].' The patient was escorted to the ambulance, where EMT performed an independent blood glucose check, which yielded a reading of 563 mg/dL. This result is critically elevated, falling well outside the normal range, and indicative of a condition requiring immediate medical and pharmacological intervention. It is also more than 200 points higher than the level previously documented by [Staff LPN]. Upon arrival at [the hospital], The patient was subsequently evaluated and treated in accordance with hospital protocols for severe hyperglycemia." Review of Emergency Department notes for Resident #1, dated 5/9/25 record "We recommend to health and rehab staff that regular orders of glucose checks and as needed insulin	F 658		

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F 658	Continued From page 29 be part of the patient's continued medical regiment. This was made clear in the discharge instructions." Review of Discharge Instructions for Resident #1 read: "When you arrived your blood glucose level was over 500. You were given an appropriate amount of insulin which has now brought your glucose levels back down to a more normal limit. Please continue to monitor your sugars closely. ORDERS FOR HEALTH AND REHAB: It is critical that the patient has his blood sugars monitored regularly. Please make sure that there are in place orders from your facility physician for administration of insulin if the patient becomes hyperglycemic. If the patient does have concern for hyperglycemia, please reach out to your staff physician for insulin orders for administration." 4.) "Assumes responsibility for the safe and efficient implementation of the plan." - "Communicates consultation recommendations." Per review of the Lippincott Manual of Nursing, "Common Departures from the Standards of Nursing Care include: failure to follow physician orders, follow appropriate nursing measures, communicate information about the patient". [Lippincott Manual of Nursing Practice-11th Edition 2018] Review of the only progress note written by Staff LPN regarding Resident #1's care and treatment that evening, dated 5/10/25 at 2:40 AM reveals: "Around 2:00 AM ED called with report on resident stating that they checked [h/her] blood sugar and it was >500. Resident given 1 liter of saline and 12 units of insulin that was effective	F 658		

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F 658	Continued From page 30	F 658		

bringing down blood sugar to 130. Resident returned to facility with no further complaints. DON [Director of Nursing] made aware of situation." Further review of progress notes reveals no documentation of when or what information the DON was "made aware of" or any actions taken by the DON or Staff LPN upon Resident #1's return. Per review of Resident #1's medical record, there was no documentation of any materials received from the hospital after Resident #1's Emergency Room visit, or any required documents given to the resident prior to their transfer.

Per the interview with EMT #1 on 5/14/25 at 3:30 PM, the EMT stated that [s/he] transported Resident #1 both to and from the Emergency Department on 5/9/25 and early morning 5/10/25. Per interview the EMT stated that Discharge Instructions including new physician orders were hand delivered upon Resident #1's return to the facility to the same Staff LPN who was responsible for Resident #1's care prior to the ED visit. The EMT stated that the new physician orders were handed directly to the Staff LPN and were highlighted and underlined and included orders for the resident's physician to be notified.

An interview was conducted with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and Vice President of Operations [VPO] on 5/14/25 at 1:56 PM. Regarding the actions on 5/9/25, the ADM, RDN, and VPO stated the Staff LPN's actions toward Resident #1 "were not handled professionally" and the Staff LPN "was not listening to [h/her] education", including professional standards regarding staff having the knowledge and ability to provide care and services, but choosing not to do it, or

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F 658	Continued From page 31 acknowledge the request for assistance from a resident resulting in care deficits to a resident. The facility staff confirmed they did not possess any paperwork or discharge information after Resident #1's ED visit on 5/9/25. At 4:15 PM on 5/14/25, the facility contacted the ED for copies of Resident #1's ED visit record. The facility immediately received copies of Resident #1's Hospital Record and ED Visit Note, dated 5/9/25, which included new physician orders from the ED. The ADM, RDN, and VPO confirmed that despite the Staff LPN being handed ED notes and physician orders, the Staff LPN failed to enter any documentation of the ED visit in Resident #1's medical record, and no new physician orders were entered into the record or implemented in the resident's care and treatment, and no documentation that Resident #1's physician was notified of the ED visit or of elevated blood sugar levels. Additionally, it was confirmed that Resident #1 was transferred out of the facility without any documentation from [Staff LPN], Including the resident's medical history, current medications, known allergies, recent medication administration or dispensation records, and no required bed hold notification allowing the resident to return to the facility after the ED visit.	F 658		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		

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F 761	Continued From page 32 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were safely stored and accessible only by authorized personnel for 1 resident [Resident #1] of 3 sampled residents. Findings include: Review of Physician orders for Resident #1 dated 4/14/25 include medication orders for "Zenpep Oral Capsule Delayed Release Particles-give 5 capsules by mouth before meals for pancreatic enzymes. Start date 5/1/25." Review of Resident #1's Medication Administration Record [MAR] for May 2025, also includes an order for the Zenpep Oral Capsules- "Give 3 capsules by mouth as needed for PM with snacks, 21 max caps a day," starting 5/1/25.	F 761	Regulatory Reference: §483.45 (g) Corrective Action for Resident (s) Affected: Expired medications were removed and properly disposed of. No resident harm occurred. Identification of Others Who Could Be Affected: All residents on A Wing had the potential to be affected. Systemic Changes: The med storage audit checklist was revised. Nurses were retrained on medication dating, labeling, and storage protocols. Monitoring/QA Plan: Weekly audits of med rooms and carts x8 weeks, then monthly x4. Compliance tracked via QAPI. Allegation of Compliance Date: June 9, 2025 **Tag F 761 POC accepted on 6/23/25 by S. Stem**	

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F 761	Continued From page 33 Per observation and interview with Resident #1 on 5/14/25 at 9:37 AM, the resident stated [s/he] was in possession of the prescribed medication "Zenpep Oral Capsule Delayed Release Particles" and proceeded to show the surveyors multiple capsules in a clear plastic medicine cup. The resident stated this was the only medication [s/he] was allowed to keep by [h/herself], and that all the other medications were kept by nursing. Resident #1 stated that [s/he] took the medication "whenever [s/he] wanted when [s/he] was about to eat something." The resident stated [s/he] did not report to nursing when [s/he] took the medication or how many times [s/he] took it. An interview was conducted with the facility's Administrator [ADM], the Regional Director of Nursing [RDN], and Vice President of Operations [VPO] on 5/14/25 at 1:56 PM. The facility staff confirmed the resident should not be in the possession of the "Zenpep" medication at any time and nursing failed to ensure that medication was stored and administered as ordered.	F 761		