STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THERMOPOLIS REHABILITATION AND WELLNESS	1210 CANYON HILLS RD , THERMOPOLIS, Wyoming, 82443

(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
F0000	INITIAL COMMENTS A complaint investigation was performed on 7/7/25 to 7/7/25. The survey was prompted by complaints WY00004468, and WY00004469. The following common abbreviations are used throughout this document: MDS: Minimum Data Set PT: Physical Therapy/Physical Therapist PTA: Physical Therapy Assistant RN: Registered Nurse LPN: Licensed Practical Nurse DNS: Director of Nursing Services MD: Medical Doctor LLE: Left lower extremity ROM: Range of motion F/U: Follow up d/t: Due to CIC: Change in condition NOC: Night PIP: Performance Improvement Plan EHR: Electronic Health Record WBAT: Weight bear as tolerated	F0000		07/09/2025
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)	F0658	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of	07/09/2025

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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F0658 SS = D	Continued from page 1 §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 record review, resident representative and staff interview and policy and procedure review, the facility failed to meet professional standards of quality for 1 of 3 sample residents (#1) reviewed for diagnostic service orders. The findings were: 1. Review of the re-entry MDS assessment dated 6/20/25 showed resident #1 had severely impaired cognitive skills, did not ambulate, and required substantial/maximal assistance for transfers. Resident #1 had diagnoses which included presence of left artificial hip joint, difficulty in walking, and neurocognitive disorder with Lewy bodies. The following concerns were identified: a. Review of a progress note dated 6/6/25 and timed 2:39 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t very tight tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers..." b. Review of a progress note dated 6/7/25 and timed 2:46 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t very tight tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers. Therapy requests that staff continue using the manual glider at this time and provide resident proper verbal and tactile cues ..." c. Review of a progress note dated 6/8/25 and timed 4:58 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t verytight [sic] tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers. Therapy requests that staff continue using the manual glider at this time and provide resident proper verbal and tactile cues ..." d. Review of a progress note dated 6/9/25 and timed 2:34 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t verytight [sic] tension and limited ROM. Resident will work on improving LLE strength and ROM	F0658	Continued from page 1 deficiencies, The plan of correction is prepared and/ or executed solely because it is required by the provisions of the state and federal law, For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operations Manual. Corrective Action: X-Ray for Resident #1 was completed on 6/16/2025 No negative outcomes were identified from the x-ray results. Identification: An audit of radiology orders for the past 14 days was conducted by DNS/Designee to identify any other residents with potential delays in imaging services. No additional residents were identified as being affected. Systemic Changes: Implemented a Radiology Order Tracking Log to be maintained by the DNS/Designee to track the radiology orders from time of ordering to completion and result of receipt. Staff Education by DNS/Designee on the revised radiology coordination procedure, including timely scheduling, documentation, confirmed with the provider the urgency of the x-ray, physician and family notification protocols. Monitoring: DNS/Designee will audit the x-ray orders weekly for follow-up for 90 days. The DNS/Designee will report on tracking and trending of audits to the facility monthly QAPI meeting for 90 days or until substantial compliance has been achieved	

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F0658 SS = D	Continued from page 2 for glider transfers. Therapy requests that staff continue using the manual glider at this time and provide resident proper verbal and tactile cues ..." e. Review of a progress note dated 6/9/25 and timed 8:30 AM showed "Called Dr. [primary physician] office talked to [office nurse], asked if we could get an order for X-Ray to the left hip. f/u with response." f. Review of a progress note dated 6/9/25 and timed 4:56 PM showed "Dr, [sic] [primary physician] office called talked to [office nurse], there is an X-ray order over at the hospital. Will set up transportation to get [him/her] over there tomorrow." g. Review of a progress note dated 6/10/25 and dated 2:59 AM showed " ...PT has requested nursing to see about getting an x-ray to the left hip d/t very tight tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers ..." h. Review of a progress note dated 6/11/25 and timed 2:17 AM showed "...Abductor wedge in use for proper leg placement to avoid hip/joint issues. PT has requested nursing to see about getting an x-ray to the left hip d/t very tight tension and limited ROM ..." i. Review of a progress note dated 6/12/25 and timed 4 PM showed "LATE ENTRY Appointment / Transportation Follow Up: Called radiology to confirm order was received. Called [name of outside entity] for transportation. Appointment scheduled for 6/16 at 9 AM. Notified staff." j. Review of a progress note dated 6/13/25 and timed 4:05 PM showed " ...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and also when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d.t continuation of odd alignment of hips seated and standing ..." k. Review of a progress note dated 6/14/25 and timed 3:29 AM showed "...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d/t continuation of odd alignment of hips seated and standing..." l. Review of a progress note dated 6/15/25 and timed	F0658	Continued from page 2 or sustained as directed by the committee.	

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F0658 SS = D	Continued from page 3 3:12 AM showed "...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d/t continuation of odd alignment of hips seated and standing..." m. Review of a progress note dated 6/16/25 and timed 12:38 AM showed "...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d/t continuation of odd alignment of hips seated and standing..." n. Review of a progress note dated 6/16/25 and dated 1:14 PM showed "Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Trauma (fall or related) ... Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: sent out for evaluation B: New Testing Orders: -X-ray ..." o. Review of a progress note dated 6/16/25 and dated 5:42 PM showed "Called hospital talked to [name], asked how [resident #1] was doing and if they decided on what they were going to do with [his/her] left hip, she stated that they have tried to put it back in place a couple of times unsuccessfully. they [sic] are still waiting for the doctor to make a decision for surgery. I will f/u again tomorrow." p. Review of a progress note dated 6/17/25 and dated 4:42 AM showed "Resident sent our [sic] to [hospital name] for XR of previously repaired hip. Hip found to be out of socket at that time and Resident has been out of facility all NOC ..." q. Review of a progress note dated 6/17/25 and dated 4:37 PM showed "[Resident] returned from [hospital] with our transportation around 14:45. [S/he] has dislocated internal Left hip prosthesis. Non weight bearing to left side. weights [sic] and vitals taken and placed in charting. [s/he] has a fentanyl 12.5 mg patch to the right side for mild pain. and [sic] Tramadol 50mg every 6 hours PRN for a higher level of pain ..." r. Review of a progress note dated 6/24/25 and timed 1:56 PM showed "Per [orthopedic physician] verbal: Resident is WBAT. Hip will always be this way. Resident may participate in activities as comfortable and able."	F0658		

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F0658 SS = D	Continued from page 4 s. Review of a progress note dated 6/24/25 and dated 5:01 PM showed "[name] from Dr. [physician] office called states that [resident #1] is to be non weight bearing. Again [sic] non weight bearing, placed in communication as well." t. Review of a progress note dated 6/25/25 and dated 12:32 PM showed "Notified MD of orthopedic MD recommendation to be WBAT. No changes at this time." 2. Interview with resident #1's representative on 7/7/25 at 1:48 PM revealed s/he had not complained of additional pain, but had not been putting weight on his/her left leg during transfers, and stated "maybe s/he did the thing s/he wasn't supposed to do after her hip surgery in March, like leaning over; s/he doesn't know what s/he's doing." 3. Interview with LPN #1 on 7/7/25 at 2:07 PM revealed she had called the physician and asked for an order at the request of therapy because they wanted to know the placement of the resident's hip. She reported the resident had reported increased pain "a couple of weeks prior" and it was under control and managed with Tramadol. Further interview revealed that she was unaware there had been no transportation available. 4. Interview with PTA #1 on 7/7/25 at 2:18 PM revealed the resident had fallen in March 2025, and was sent out of town for a hemiarthoplasty. She reported that surgeon did not want to see the resident for a follow-up appointment, and gave orders for toe touch weight bearing and to use a glider for transfers. She reported therapy had discharged the resident after one month of treatment because s/he had met her goals, and then at the end of May, they received another referral because the resident had more difficulty with transfers. She reported the PT requested a urinalysis and a hip x-ray from the nurse, and it had to be requested a few times in order to get it done. 5. Interview with the hospital social worker on 7/7/25 at 2:40 PM revealed there had been a delay in making the decision to send the resident in for the x-ray. She confirmed the physician's order was a routine order that had been put in on 6/9/25. She stated the physician had signed the verbal order on 6/10/25 at 8:11 AM, and the x-ray was scheduled by the facility for 6/16/25. She reported she spoke with the DNS on	F0658		

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F0658 SS = D	Continued from page 5 6/16/25 and asked why the x-ray had not been scheduled in a timely manner, and was told the facility van did not work and outside transportation had to be arranged. 6. Interview with LPN #1 on 7/7/25 at 3:16 PM confirmed the order for the x-ray was verbal, and there was no confirmation by fax for the order. 7. Interview with the DNS on 7/7/25 at 3:20 PM confirmed transportation had to be scheduled from an outside source because the facility van was broken, and she did not think it was a huge rush. She reported she called the radiology department on 6/12/25 to confirm the order was in, called the clinic and set up the appointment for 6/16/25, and then scheduled transportation with a community provider. She reported she called the hospital and let them know the resident had been non-ambulatory because "there had been confusion" and the hospital staff and physicians were unaware the resident was non-ambulatory. Further interview revealed if an order is taken by an LPN it "goes through the LPN" and was not signed off by an RN. Further, she confirmed the facility administration was aware of the delay to obtain xrays for resident #1 and a PIP had been initiated to address the timeliness of the services. 8. Interview with the DNS on 7/7/25 at 4:40 PM revealed when a verbal order was taken it was then documented in the chart, not with a fax. She confirmed there was no evidence of the priority of the order and no evidence the order was clarified. 9. Review of the "Physician Order Recaps" policy last updated April 2024 showed "...Policy Statement: Physician orders are reviewed and revised daily, via the Electronic Health Record ...Procedure 1. The licensed nursing staff is responsible for inputting admission, telephone and verbal physician's orders into the EHR immediately upon receipt from the provider. 2. The Director of Nursing establishes the licensed clinician responsible for recap and reconciliation of New, Discontinued, or Completed orders in the EHR daily and initiates corrections daily. 3. New Telephone and Verbal Physicians orders are signed routinely or a minimum of once per month by the provider either electronically via the EHR, or printed and signed in wet ink and scanned into the Documents tab ..."	F0658		

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F0658 SS = D	Continued from page 6 10. Review of the State of Wyoming Board of Nursing, Chapter 3: Scope and Standards of Nursing Practice and CNA Role effective date 9/7/2017 to current showed "...Section 4. Scope of Nursing Practice for the RN and the LPN...(v) Seek clarifications of orders or direction when needed;..."	F0658		
F0776 SS = D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare. This REQUIREMENT is NOT MET as evidenced by: Based on record review, resident representative and staff interview, and policy and procedure review, the facility failed to meet the needs of residents with regard to the quality and/or timeliness of providing radiology or other diagnostic services for 1 of 3 sample residents (#1) reviewed for diagnostic service orders. The findings were: 1. Review of the re-entry MDS assessment dated 6/20/25 showed resident #1 had severely impaired cognitive skills, did not ambulate, and required substantial/maximal assistance for transfers. Resident #1 had diagnoses which included presence of left artificial hip joint, difficulty in walking, and neurocognitive disorder with Lewy bodies. The following concerns were identified: a. Review of a progress note dated 6/6/25 and timed 2:39 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t very tight tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers..."	F0776	Preparation and execution of the response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the statement of deficiencies The plan of correction is prepared and/or executed solely because it is required by the provision of the state and federal law, For the purpose of any allegation that the facility is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with the State Operation Manual. Corrective Action: Xray for Resident #1 was completed on 6/16/2023 No negative outcomes were identified from the x-ray results. Identification of Other Residents Potentially Affected: An audit of radiology orders for the past 14-day was conducted by DNS/Designee to identify any other residents with potential delays in imaging services. No additional residents were identified as being affected. Systemic Changes: Implemented a Radiology Order Tracking log to be maintained by the DNS or Designee to track the radiology orders from time of ordering to completion and result of receipt. Staff education by DNS/Designee on the revised radiology coordination procedure, including timely scheduling, documentation, confirmed with the provider the urgency of the x-ray, physician and family notification protocols.	07/09/2025

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F0776 SS = D	Continued from page 7 b. Review of a progress note dated 6/7/25 and timed 2:46 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t very tight tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers. Therapy requests that staff continue using the manual glider at this time and provide resident proper verbal and tactile cues ..." c. Review of a progress note dated 6/8/25 and timed 4:58 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t verytight [sic] tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers. Therapy requests that staff continue using the manual glider at this time and provide resident proper verbal and tactile cues ..." d. Review of a progress note dated 6/9/25 and timed 2:34 AM showed " ...PT is seeing resident and has requested staff to see about getting an x-ray to the left hip d/t verytight [sic] tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers. Therapy requests that staff continue using the manual glider at this time and provide resident proper verbal and tactile cues ..." e. Review of a progress note dated 6/9/25 and timed 8:30 AM showed "Called Dr. [primary physician] office talked to [office nurse], asked if we could get an order for X-Ray to the left hip. f/u with response." f. Review of a progress note dated 6/9/25 and timed 4:56 PM showed "Dr, [sic] [primary physician] office called talked to [office nurse], there is an X-ray order over at the hospital. Will set up transportation to get [him/her] over there tomorrow." g. Review of a progress note dated 6/10/25 and dated 2:59 AM showed " ...PT has requested nursing to see about getting an x-ray to the left hip d/t very tight tension and limited ROM. Resident will work on improving LLE strength and ROM for glider transfers ..." h. Review of a progress note dated 6/11/25 and timed 2:17 AM showed "...Abductor wedge in use for proper leg placement to avoid hip/joint issues. PT has requested nursing to see about getting an x-ray to the left hip d/t very tight tension and limited ROM ..." i. Review of a progress note dated 6/12/25 and timed 4 PM showed "LATE ENTRY Appointment / Transportation Follow Up: Called radiology to confirm order was	F0776	Continued from page 7 Monitoring and Quality Assurance: DNS/designee will audit the x-ray orders weekly for follow-up for 90 days. The DNS/Designee will report on tracking and trending audits to the facility monthly QAPI meeting for 90 days or until substantial compliance has been achieved or sustained as directed by the committee.	

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F0776 SS = D	Continued from page 8 received. Called [name of outside entity] for transportation. Appointment scheduled for 6/16 at 9 AM. Notified staff." j. Review of a progress note dated 6/13/25 and timed 4:05 PM showed " ...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and also when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d.t continuation of odd alignment of hips seated and standing ..." k. Review of a progress note dated 6/14/25 and timed 3:29 AM showed "...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d/t continuation of odd alignment of hips seated and standing..." l. Review of a progress note dated 6/15/25 and timed 3:12 AM showed "...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d/t continuation of odd alignment of hips seated and standing..." m. Review of a progress note dated 6/16/25 and timed 12:38 AM showed "...Hip abduction support with straps is on resident when [s/he] is up in [his/her] wheelchair and when [s/he] is in bed to help with pain management to hip/knee, along with ensuring proper alignment and positioning. Resident has x-ray of left hip scheduled for Monday 6.16.25 d/t continuation of odd alignment of hips seated and standing..." n. Review of a progress note dated 6/16/25 and dated 1:14 PM showed "Situation: The Change in Condition/s reported on this CIC Evaluation are/were: Trauma (fall or related) ... Primary Care Provider Feedback: Primary Care Provider responded with the following feedback: A. Recommendations: sent out for evaluation B: New Testing Orders: -X-ray ..." o. Review of a progress note dated 6/16/25 and dated 5:42 PM showed "Called hospital talked to [name], asked how [resident #1] was doing and if they decided on what they were going to do with [his/her] left hip, she stated that they have tried to put it back in place a couple of times unsuccessfully. they [sic] are still	F0776		

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F0776 SS = D	Continued from page 9 waiting for the doctor to make a decision for surgery. I will f/u again tomorrow." p. Review of a progress note dated 6/17/25 and dated 4:42 AM showed "Resident sent our [sic] to [hospital name] for XR of previously repaired hip. Hip found to be out of socket at that time and Resident has been out of facility all NOC ..." q. Review of a progress note dated 6/17/25 and dated 4:37 PM showed "[Resident] returned from [hospital] with our transportation around 14:45. [S/he] has dislocated internal Left hip prosthesis. Non weight bearing to left side. weights [sic] and vitals taken and placed in charting. [s/he] has a fentanyl 12.5 mg patch to the right side for mild pain. and [sic] Tramadol 50mg every 6 hours PRN for a higher level of pain ..." r. Review of a progress note dated 6/24/25 and timed 1:56 PM showed "Per [orthopedic physician] verbal: Resident is WBAT. Hip will always be this way. Resident may participate in activities as comfortable and able." s. Review of a progress note dated 6/24/25 and dated 5:01 PM showed "[name] from Dr. [physician] office called states that [resident #1] is to be non weight bearing. Again [sic] non weight bearing, placed in communication as well." t. Review of a progress note dated 6/25/25 and dated 12:32 PM showed "Notified MD of orthopedic MD recommendation to be WBAT. No changes at this time." 2. Interview with resident #1's representative on 7/7/25 at 1:48 PM revealed s/he had not complained of additional pain, but had not been putting weight on his/her left leg during transfers, and stated "maybe s/he did the thing s/he wasn't supposed to do after her hip surgery in March, like leaning over; s/he doesn't know what s/he's doing." 3. Interview with LPN #1 on 7/7/25 at 2:07 PM revealed she had called the physician and asked for an order at the request of therapy because they wanted to know the placement of the resident's hip. She reported the resident had reported increased pain "a couple of weeks prior" and it was under control and managed with Tramadol. Further interview revealed that she was unaware there had been no transportation available.	F0776		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535051	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0776 SS = D	Continued from page 10 4. Interview with PTA #1 on 7/7/25 at 2:18 PM revealed the resident had fallen in March 2025, and was sent out of town for a hemiarthoplasty. She reported that surgeon did not want to see the resident for a follow-up appointment, and gave orders for toe touch weight bearing and to use a glider for transfers. She reported therapy had discharged the resident after one month of treatment because s/he had met her goals, and then at the end of May they received another referral because the resident had more difficulty with transfers. She reported the PT requested a urinalysis and a hip x-ray from the nurse, and it had to be requested a few times in order to get it done. 5. Interview with the hospital social worker on 7/7/25 at 2:40 PM revealed there had been a delay in making the decision to send the resident in for the x-ray. She confirmed the physician's order was a routine order that had been put in on 6/9/25. She stated the physician had signed the verbal order on 6/10/25 at 8:11 AM, and the x-ray was scheduled by the facility for 6/16/25. She reported she spoke with the DNS on 6/16/25 and asked why the x-ray had not been scheduled in a timely manner, and was told the facility van did not work and outside transportation had to be arranged. 6. Interview with LPN #1 on 7/7/25 at 3:16 PM confirmed the order for the x-ray was verbal, and there was no confirmation by fax for the order. 7. Interview with the DNS on 7/7/25 at 3:20 PM confirmed transportation had to be scheduled from an outside source because the facility van was broken, and she did not think it was a huge rush. She reported she called the radiology department on 6/12/25 to confirm the order was in, called the clinic and set up the appointment for 6/16/25, and then scheduled transportation with a community provider. She reported she called the hospital and let them know the resident had been non-ambulatory because "there had been confusion" and the hospital staff and physicians were unaware the resident was non-ambulatory. Further interview revealed if an order is taken by an LPN it "goes through the LPN" and was not signed off by an RN. Further, she confirmed the facility administration was aware of the delay to obtain xrays for resident #1 and a PIP had been initiated to address the timeliness of the services. 8. Interview with the DNS on 7/7/25 at 4:40 PM revealed	F0776		

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F0776 SS = D	Continued from page 11 when a verbal order was taken it was then documented in the chart, not with a fax. She confirmed there was no evidence of the priority of the order and no evidence the order was clarified. 9. Review of the "Physician Order Recaps" policy last updated April 2024 showed "...Policy Statement: Physician orders are reviewed and revised daily, via the Electronic Health Record ...Procedure 1. The licensed nursing staff is responsible for inputting admission, telephone and verbal physician's orders into the EHR immediately upon receipt from the provider. 2. The Director of Nursing establishes the licensed clinician responsible for recap and reconciliation of New, Discontinued, or Completed orders in the EHR daily and initiates corrections daily. 3. New Telephone and Verbal Physicians orders are signed routinely or a minimum of once per month by the provider either electronically via the EHR, or printed and signed in wet ink and scanned into the Documents tab ..."	F0776		