STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	302 ST CLOUD STREET , RAPID CITY, South Dakota, 57701

(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 health survey for compliance with 42 CFR Part 483, Subpart B, requirements for Long Term Care facilities was conducted from 3/17/26 through 3/18/26. Areas surveyed included quality of care and treatment related to a nurse's failure to transcribe and initiate physician orders for a resident on the day the order was placed, and to notify the resident's physician and first emergency contact of the change in the resident's condition. Avantara Saint Cloud was found not in compliance at F580 and to have past non-compliance at F726.	F0000		
F0580 SS = G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to	F0580	1. No additional immediate action could be taken for the delay in notifying the physician of Resident 1's change in condition. The physician and responsible party have already been notified of Resident 1 change in condition as of 02/11/26. All residents are at risk if the physician and responsible party are not notified timely of a change in condition. 2. The Administrator, Director of Nursing (DON), and interdisciplinary team (IDT), in collaboration with the medical director, will review the Notification of Change of Condition policy to ensure timely response to a resident's change of condition, including but not limited to timely notification of a resident's change in condition to the resident's physician for review and recommendations to ensure prompt assessment and treatment. The DON or designee will educate all licensed nurses on the Notification of Change of Condition policy to ensure timely response to a resident's change of condition, including timely notification of a resident's change of condition to the resident's physician for review and recommendations to ensure prompt assessment and treatment. Education will be completed no later than April 14, 2026. Those associates not in attendance at the education session due to vacation, sick leave, or casual work status will be educated prior to their first shift worked. 3. The DON or designee will complete an audit of 5 residents with a change of condition to ensure timely notification to the resident's physician for review and recommendations to ensure prompt assessment and treatment. Audits will be completed weekly x 4 weeks and then monthly for 2 months. Results of audits will be reviewed by the DON or designee with the IDT and Medical Director at monthly Quality Assurance Performance Improvement (QAPI) for analysis and recommendation for continuation or discontinuation/revision of audits based on findings.	4/14/2026

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
Ashaley Altena	Administrator	04/09/26

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F0580 SS = G	Continued from page 1	F0580		

the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident

representative(s).

§483.10(g)(15)

Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).

This REQUIREMENT is NOT MET as evidenced by:

Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure that the physician was promptly notified of a change in condition for review and recommendations to ensure prompt assessment and treatment for one of one sampled resident (1) identified to be vomiting and with increased weakness, by one of one registered nurse (RN) E. This failure resulted in resident 1 being transferred to the emergency room (ER) for evaluation and subsequent hospitalization. The provider also failed to notify the resident's first emergency contact of the resident's change in condition.

Findings include:

1. Review of the provider's submitted SD DOH FRI initial report regarding resident 1revealed that on the morning of 2/11/26, resident 1experienced three to four episodes of bile-colored vomit between 6:00 a.m. and 7:00 a.m. She appeared more tired, but she was able to

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vocalize her needs. Certified nurse aide (CNA) H notified the day nurse, registered nurse (RN) E, about resident 1's dry heaving and episodes of bile-colored vomit. RN E completed an initial assessment and obtained vital signs (measurements of the body's basic functions, such as temperature, blood pressure, pulse, and respiration rate). Resident 1's blood pressure was 128/57, pulse 81, temperature 97.1°F (degrees Fahrenheit), and oxygen saturation (amount of oxygen circulating in blood) ranged from 88 to 89 percent on room air. Her medications were held due to the dry heaving and vomiting episodes. She also experienced an incontinent (involuntary urine or bowel leakage) episode and requested to rest in bed that morning.

CNA I, who worked the night of 2/10/26, stated resident 1 had no episodes of vomiting but noted she had increased weakness during the overnight hours and slept much of the night. RN E stated that resident 1 had no additional dry heaving or vomiting after 7:00 a.m. on 2/11/26.

On Wednesday, 2/11/26, around 10:30 a.m., resident 1's granddaughter arrived at the nursing home, signed resident 1's discharge paperwork, and then went to her grandmother's room. The granddaughter noticed that resident 1 did not look well and asked RN E if she should be evaluated. RN E reassessed resident 1,took her blood pressure, which was documented as 89/57, and noted that resident 1 was more lethargic after sitting up in her wheelchair.

The granddaughter called resident 1's assisted living facility, where she was to be readmitted to that day, and spoke with the executive director. Resident 1's granddaughter told the executive director that resident 1 was not feeling or looking well. The assisted living facility's executive director advised resident 1's granddaughter to take resident 1to urgent care or the ER for further evaluation before being readmitted to the assisted living facility.

At approximately 11:00 a.m., CNA H assisted resident 1's granddaughter with transferring resident 1 into the granddaughter's personal vehicle. During the process, CNA H observed resident 1's condition worsening in the car and not responding. The granddaughter told CNA H that she was taking resident 1 to the ER. Resident 1 was evaluated at the ER and admitted to the hospital.

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F0580 SS = G	Continued from page 3 2. Review of resident 4396's electronic medical record (EMR) revealed that resident 1 was admitted to the facility on 12/22/25 for a rehabilitation stay after hospitalization, after she fell at her assisted living facility, which resulted in a fracture of her left femur. She was taking two 81-milligram (mg) tablets of aspirin two times daily as a blood thinner to prevent blood clots. Her last skin assessment, dated 2/10/26, identified no skin issues, and her last documented fall was unwitnessed on 1/18/26. Her neurological assessments were within normal parameters. Her last lab results from 12/19/25 indicated that her hemoglobin (a protein in red blood cells that carries oxygen from the lungs to the rest of the body) and hematocrit (the total percentage of blood volume composed of packed red blood cells) were mildly low. Her hemoglobin was 10.1 g/dL(grams per deciliter), and her hematocrit was 28.9% (percent). It was determined on 2/9/26 and 2/10/26 by the physician assistant-certified (PA-C) D at the facility and the director of nursing (DON) at resident 1's previous assisted living facility, that she was doing well and was appropriate for readmission to the assisted living facility on 2/11/26 at 11:00 a.m. Resident 1 was transferred to the ER upon her discharge from the facility on 2/11/26 and then hospitalized. Her CAT (CT) scan images revealed that she had an acute and chronic subdural hematoma (an old bleed in the brain that started bleeding again), a 12-millimeter (mm) meningioma brain mass (a type of brain tumor), a pulmonary embolism (a blockage in an artery of the lungs, usually caused by a blood clot), and cholecystitis (inflammation of the gallbladder caused by gallstones blocking the bile duct). There was no documentation indicating that the resident's first emergency contact or physician C was notified at the time of resident 1's change of condition on the morning of 2/11/26 while at the nursing home. 3. Interview on 3/18/26 at 11:15 a.m. with RN E regarding resident 1's change in condition revealed that RN E stated CNA H reported to her that resident 1's symptoms of dry heaving and bile-colored vomit occurred at approximately 7:10 a.m. on 2/11/26. RN E	F0580		

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F0580 SS = G	Continued from page 4 assessed resident 1, took her vital signs, and said they were within her baseline (the initial, "normal" measurements). She also said that resident 1 was left in her bed at that time with the head of the bed elevated. She was provided with a vomit bag and a call light, her morning medications were held, and the garbage can was placed next to her bed. RN E stated that around 8:30 a.m., she and CNA H assisted resident 1 with personal hygiene after she had an incontinent bowel episode. At that time, RN E stated that resident 1 appeared weak and pale in color and could not remain upright at the end of her care. Resident 1 asked to return to bed. RN E said she did not contact the physician or resident 1's first emergency contact at that time because she planned to discharge her later that morning to the assisted living facility and intended to update the family member when they arrived. She did not think to call the physician about resident 1's change in condition. RN E said that resident 1's granddaughter arrived between 10:30 a.m. and 11:00 a.m. for resident 1's discharge from the nursing home to the assisted living facility. RN E said that the granddaughter was concerned about her grandmother and said to RN E that resident 1 looked pale, didn't look well and questioned RN E whether resident 1 should be evaluated before being discharged from the nursing home and readmitted back to the assisted living facility. RN E said she reassessed resident 1 at that time and took resident 1's blood pressure, which was low at 89/57 and that resident 1 was more lethargic after sitting up in her wheelchair. RN E stated that the granddaughter was on her cell phone texting but was unsure who she was texting. RN E said she and CNA H escorted and pushed resident 1 to the nurse's station; by that time, the granddaughter was on her cell phone, talking to someone, though RN E was unsure who. RN E stated that around 11:00 a.m., she asked CNA H to help the granddaughter assist resident 1 into her private vehicle. CNA H returned to the nurse's station and reported to RN E that resident 1's condition appeared to have worsened and she became unresponsive after being assisted into the granddaughter's car. CNA H also told RN E that the granddaughter said she was taking resident 1 to the ER.	F0580		

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RN E acknowledged that she did not call resident 1's physician and her first emergency contact when her condition changed, and she knew it was her responsibility to notify them promptly. She also recognized that she should have completed this before resident 1 was discharged from the facility.

4. Interview on 3/18/26 at 1:05 p.m. with administrator A and DON B revealed that administrator A and DON B stated that neither of them saw resident 1 the morning of her planned discharge from the nursing home on 2/11/26, and neither of them was aware of her change in condition.

DON B said she was updated later that day by social services designee (SSD) J about the events that occurred that morning involving resident 1 and her transfer to the ER by her granddaughter after SSD J received a phone call from the hospital regarding resident 1. DON B notified administrator A, and together they contacted physician C, resident 1's facility doctor, and provided him with the information.

Administrator A stated that RN E's employment was suspended on 2/11/26, received disciplinary action and education on the facility's notification of change policy, and her employment was reinstated on 2/20/26. Administrator A and DON B acknowledged that resident 1's doctor and first emergency contact were not contacted on 2/11/26 when resident 1's condition changed, and RN E should have notified them promptly on the morning of 2/11/26 before her discharge from the nursing home.

5. A telephone interview on 3/18/26 at 2:36 p.m. with physician C regarding resident 1's change in condition revealed that physician C stated resident 1 was taking aspirin twice daily as a blood thinner for blood clot prevention, which could increase the risk of brain bleeding but would not affect her pulmonary embolism. He said it was difficult to determine exactly what had happened with resident 1, but she had several chronic conditions that put her at risk. He added that she did not experience any recent fall or trauma, but her change in condition could have been due to being over-coagulated (a state where the blood is clotting excessively) from her recent hip surgery. He also stated that he or PA-C D should have been notified of

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F0580 SS = G	Continued from page 6 her change in condition that morning before her discharge from the nursing home. 6. Interview on 3/18/26 at 3:16 p.m. with CNA I regarding resident 1's change in condition revealed that CNA I worked the night shift on 2/10/26 and finished his shift around 6:30 a.m. on 2/11/26. He said that resident 1 did not experience any dry heaving or vomiting during that shift. CNA I did not notice anything different or unusual with resident 1, except for some weakness, and stated that she slept most of the night. 7. A telephone interview on 3/18/26 at 11:50 a.m. was attempted with the granddaughter, and a voicemail was left to return a call; no return phone call was received during the survey. 8. A telephone interview on 3/18/26 at 12:58 p.m. with CNA H was unable to be completed as she was unavailable to interview due to a family death. 9. A telephone interview on 3/18/26 at 2:28 p.m. was attempted with PA-C D, and a voicemail was left to return a call; no return phone call was received during the survey. 10. Review of the provider's 12/1/2019 Registered Nurse (RN) Floor Nurse job description revealed the nurses were, "Responsible for all nursing care of assigned Guests [residents] while on duty. Must notify appropriate persons if there is any significant change in a Guest's [resident's] condition or any transfer to a hospital," and "Communicates and interacts effectively and tactfully with Guests [residents], visitors, families, peers, and supervisors." 11. Review of the provider's 11/18/25 Notification of Change of Condition policy revealed, "The facility must promptly inform the resident; consult with the resident's medical provider; and notify, consistent with his or her authority, the resident representative(s) when:" "A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications)."	F0580		

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F0580 SS = G	Continued from page 7 12. Review of the provider's 4/28/25 Discharge and Transfer of Residents/Bed Hold policy revealed the facility was, "To ensure a safe transition is planned for any resident with a discharge or transfer to another setting. "To ensure adequate care is given to any resident with a change in condition." "If the resident's needs change during the discharge planning process, the discharge plan may be updated to address the resident's needs." "If the location of discharge does not meet the resident's needs and preferences and does not provide needed support and resources, do not proceed with discharge and contact the resident's medical provider."	F0580		
F0726 SS = D	Competent Nursing Staff CFR(s): §483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan	F0726	"Past Noncompliance - no plan of correction required"	

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F0726 SS = D	Continued from page 8 of care. This REQUIREMENT is NOT MET as evidenced by: Based on South Dakota Department of Health (SD DOH) facility-reported incident (FRI), record review, interview, and policy review, the provider failed to ensure that physician orders for an antibiotic, a medicated nebulizer (a device that converts liquid medication into an inhalable mist) treatment, and cough syrup were transcribed and initiated by one of one registered nurse (RN) F which resulted in a delay of treatment for one of one sampled resident 2, which potentially contributed to his transfer to the emergency room (ER). This citation is considered past non-compliance based on a review of the corrective actions the provider implemented following the incident. Findings include: 1. Review of the provider's 3/4/26 submitted SD DOH FRI report regarding resident 2 revealed that on 3/3/26, RN F reported that resident 2 was experiencing symptoms of cough and congestion to physician assistant-certified (PA-C) D. PA-C D then saw (evaluated) resident 2 at the facility. PA-C D reported to RN F and the director of nursing (DON) B that resident 2 should continue to be monitored. PA-C D did not report to either RN F or DON B that she was starting resident 2 on an antibiotic or other medications for his cough and congestion, nor did she enter the orders into the resident's electronic medical record (EMR) in the nursing home's computerized medical record system on 3/3/26. On 3/4/26 at 11:00 a.m., resident 2 went out to lunch with his family and returned at approximately 1:00 p.m. Upon his return to the facility, the nursing staff observed that he had an acute (urgent) change in condition with altered mental status. He was sent out to the ER for evaluation at approximately 2:15 p.m. and was admitted to a hospital with diagnosed sepsis (an infection that triggers a chain reaction that causes the immune system to stop fighting germs and start damaging the body's own organs) related to pneumonia, elevated troponin level (a blood marker indicating damage to the heart muscle), acute kidney injury (a sudden, often reversible, drop in kidney function), acute encephalopathy (a sudden, temporary brain dysfunction causing rapid onset of altered mental status), and metabolic acidosis (a condition where blood becomes too acidic).	F0726		

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F0726 SS = D	Continued from page 9 When resident 2 was getting prepared to be discharged to the ER, licensed practical nurse (LPN) G logged into the nursing home's HUCU messaging system (a secure messaging channel system) on 3/4/26 between 1:00 and 2:15 p.m. to send a notification to resident 2's primary care provider about his status and transfer to the ER. LPN G then discovered that PA-C D had entered orders into the HUCU messaging system for resident 2 on 3/3/26 at 12:16 p.m. The orders revealed that resident 2 was prescribed an antibiotic, a medicated nebulizer treatment, and cough syrup on 3/3/26. It was then discovered, on 3/4/26, approximately 24 hours later, that PA-C D's orders had not been transcribed or initiated by the day nurse, RN F, on 3/3/26. RN F did not log in to the HUCU messaging system to check for orders for resident 2 after receiving the verbal report from PA-C D to monitor him. RN F stated that resident 2 had no additional acute needs during her shift on 3/3/26 and did not inform the night shift of any new medications. The HUCU messaging system did not alert nurses when orders or messages were sent, and the only way to know if there was an order or message was to log in manually and check. There was a progress note in resident 2's EMR that was completed by PA-C D on 3/3/26 at 12:16 p.m., which documented resident 2's orders for his antibiotic, the medicated nebulizer treatment, and cough syrup. A medication error report was completed by DON B on 3/4/26 related to RN F's medication error for resident 2 on 3/3/26. RN F was called and notified by DON B of resident 2's orders, transfer, and the new process and procedure that would be put into place for the HUCU messaging system and physician visits. Physician C was notified on 3/4/26 of RN F's medication error report regarding resident 2. Resident 2 returned to the facility on 3/9/26, stable and back at his baseline health status. 2. Review of resident 2's EMR revealed that he was admitted to the facility on 12/29/25. His diagnoses included pneumonia, severe sepsis, acute cough, upper respiratory infection, and vascular dementia (a decline in thinking and memory skills caused by reduced blood flow to the brain, which damages brain cells). His 1/4/26 Brief Interview for Mental Status (BIMS) assessment score was 8, which indicated his cognition	F0726		

FORM APPROVED
OMB NO. 0938-0391

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F0726 SS = D	Continued from page 10 was moderately impaired. Resident 2's immunizations for the pneumonia vaccinations were up to date, his emergency contact was his niece, and he was sent to the ER on 2/10/26 and diagnosed with pneumonia. He returned to the facility that same day and was treated with a five-day course of Azithromycin (an antibiotic), which was completed on 2/15/26. Resident 2 was discharged from the nursing home to the hospital on 3/4/26 and returned to the nursing home on 3/9/26 with no continued orders for antibiotic treatment. 3. Interview on 3/18/26 at 12:17 p.m. with LPN G revealed that she was working the day shift on 3/4/26. She stated that resident 2 appeared to be at his baseline when she saw him at the nurse's station before he left the facility with family to go out for lunch. She said that he left the facility around 11:00 a.m. with his stepdaughter and returned at approximately 1:00 p.m. LPN G reported that a CNA, whose name she could not recall, told her around 1:20 p.m. that resident 2 was weak and not responding. LPN G entered resident 2's room and found him seated in his recliner. She said he was sluggish, non-verbal, and not responding to her commands. She quickly tried to contact resident 2's niece, his emergency contact, but she did not answer. She contacted his son, resident 2's second-listed emergency contact, and he agreed to send resident 2 to the ER for evaluation. LPN G acknowledged that the orders entered for resident 2 by PA-C D on 3/3/26 were neither transcribed nor initiated, and was unsure how they were overlooked. 4. A telephone call on 3/18/26 at 12:27 p.m. was placed to resident 2's niece, a voicemail was left for her to return the call; no return call was received during the survey. 5. Interview on 3/18/26 at 1:05 p.m. with administrator A and DON B regarding resident 2's physician orders that were not transcribed or initiated revealed that both administrator A and DON B stated they were unaware that resident 2 was not feeling well with cold and congestion symptoms on 3/3/26.	F0726		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 435060	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVANTARA SAINT CLOUD	**302 ST CLOUD STREET , RAPID CITY, South Dakota, 57701**

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F0726 SS = D	Continued from page 11 DON B stated that PA-C D passed by her near the nurse's station after evaluating resident 2 and told DON B that "we will continue to monitor him" [resident 2]. DON B reported that PA-C D did not inform her at that time that PA-C D was going to prescribe resident 2 an antibiotic or any other medication. Administrator A stated that on 3/4/26, LPN G discovered that PA-C D had entered orders for resident 2 into the HUCU messaging system. Additionally, a progress note was completed in the nursing home's computerized medical record system for resident 2, indicating the medications PA-C D wanted to initiate for the resident 2. Administrator A noted that providers (such as physicians and PA-C's) often send orders and messages through the HUCU messaging system, but nursing and management staff were unsure when those orders or messages would be sent or when the physicians would complete their progress notes in the nursing home's computerized medical record system for the nurses to refer to. Both Administrator A and DON B stated that physicians did not use the nursing home's computerized medical record system to enter resident orders, which made it difficult for the nursing staff to track orders in the resident's progress notes. Both Administrator A and DON B stated that it was inconvenient for nurses to routinely log in to the HUCU messaging system throughout their shifts to check for physician orders. Administrator A stated that they identified the issue and, about six months ago, created a new area in the HUCU system for physician orders during resident visits. After the medication error on 3/3/26, the facility developed a new written procedure for nurses to conduct secondary checks of the HUCU messaging system and for written orders related to physician facility visits, and nurse education began on 3/6/26. Nurses were required to complete the education prior to working their next scheduled shifts. 6. A telephone call on 3/18/26 at 2:28 p.m. was placed to PA-C D; a voicemail was left for her to return the call; no return call was received during the survey.	F0726		

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F0726 SS = D	Continued from page 12	F0726		

7. Interview on 3/18/26 at 3:25 p.m. was attempted with resident 2; this was unable to be completed due to his dementia, as he could not answer simple questions; he jumped from one thought to another, and he exhibited a nonsensical mixture of words.

8. RN F was not available for an interview, and no phone number for her was provided by the end of the survey.

9. Review of the provider's 3/4/26 through 3/6/26 audit information for 3/2/26 through 3/4/26 showed that all resident charts were reviewed for new physician orders. They also conducted an audit of physician facility visits with resident orders from 2/3/26 to 3/4/26. This information was reviewed, and no further errors were found. It was confirmed that resident 2's orders on 3/3/26 were not documented in the nursing home's computerized medical record system but entered into the HUCU messaging system by PA-C D. There were no physician orders, neither transcribed nor initiated by RN F, on 3/3/26 for resident 2.

10. The completion of the nurse's education materials and signature sheet was confirmed on 3/18/26. The education signature sheet indicated that RN F completed the education review before her next scheduled shift on 3/16/26. She signed the signature record form, which indicated she understood the new physician order process and procedure.

11. Review of the provider's 12/1/2019 Registered Nurse (RN) Floor Nurse job description revealed the nurses were to "Administer medications within the scope of practice of the RN Licensure," and "Place pharmacy orders, for and administer all newly prescribed medications and document."

12. Review of the provider's 11/18/25 Following Physician Orders policy revealed that nurses were to, "Correctly and safely receive and transcribe physician's orders so correct order is followed/administered," and the "Orders may be received through written communication in the resident's chart, verbally, by fax, electronically entered into PCC [PointClick Care], or per the telephone."

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F0726 SS = D	Continued from page 13 13. The provider's implemented actions to ensure that the deficient practice does not reoccur were verified on 3/18/26 after record reviews and interviews revealed that the facility had followed its quality assurance (QAPI) process regarding medication errors and held a nursing and management meeting on 3/6/26 regarding physician orders and physician facility visits. If staff could not attend, they were expected to review the information and sign the education signature sheet before their next scheduled shift. Audits were conducted, and the audit results are planned to be reported to the quality assurance committee at their scheduled monthly meetings for four months or until compliance is achieved. Based on the above information, non-compliance at F726 occurred on 3/4/26, and based on the provider's 3/6/26 and additional corrective action plans implemented for the deficient practice confirmed on 3/18/26, the non-compliance is considered past non-compliance.	F0726		