STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035094	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sedona	505 Jacks Canyon Road Sedona, AZ 86351

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on review of facility documentation, staff interviews, and facility policy, the facility failed to ensure that the Director of Nursing did not work as Charge nurse when facility census was more than 60 residents. The census was 87. This deficient practice could result in potential harm to residents due to insufficient staffing to adequately meet resident needs. Findings include: The Facility Assessment with completed date of March 21, 2022 included an intent to evaluate its resident population and identify resources needed to provide the necessary person-centered care and services the residents require. The number of residents the facility were licensed to provide care for was 112. Average daily census ranged 85-95 with 20-30+ being short term stays. Average admissions per month is 40-50 and average number of discharges per month is 35-45. Staffing plan included licensed nurses registered nurse (RN), licensed practical nurse (LPN providing direct care, full time Director of Nursing (DON), at least 1 RN per 24 hour period, up to 6 certified nurse assistants (CNAs) in the day and evening shifts, and up to 4 CNAs in the night shift. The assessment included that the individual nursing staff assignments was based on patient care needs and individual staff needs/training. The facility census on April 19, 2026 was 87. The facility is licensed for 112 beds, however this capacity has reportedly not been met. Based on the information provided by Staff #40/ Administrator, the census on dates involved varied from 84 to 98 residents. An interview with the administrator (staff #40) was conducted on April 19, 2026 at 10:29 a.m. The Administrator stated that the DON was unavailable for the duration of the survey and the Clinical Corporate Resource (staff #400) was filling in as the facility's DON. In an interview conducted with the Administrator on April 21, 2026 at 1:20 p.m., the Administrator stated that the DON served as charge nurse and provided direct care in the last several months. In a document request form dated April 21, 2026 the administrator wrote that the Director of Nursing (DON) worked as a charge nurse on the following dates with the corresponding facility census:February 23, 2026 - Census of 90;March 18, 2026 - Census of 98;March 23, 2026 - Census of 90;March 30, 2026 - Census of 90;April 5, 2026 - Census of 84; and,April 6, 2026 - Census of 87.The administrator further stated that on these dates, the DON provided direct resident care, worked on the medication cart and administered medications to the residents. Further, the administrator stated that she was not aware of any date that a nurse was not on duty in the facility; however, the DON will come in and cover any shift that could not be filled, even a CNA position.A review of the facility policy on Administrative Policies: Staffing, Sufficient and Competent Nursing revealed that the DON may only serve as charge nurse when the average daily occupancy is 60 or fewer residents.

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.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy reviews, the facility failed to ensure maintenance, clean, safe and comfortable interior for 7 out of 7 rooms sampled. The census was 87. The deficient practice could result in resident rooms not having a safe, clean, and homelike environment.Findings include:During a walk-through of the 100-Hall conducted on January 19, 2026 at 2:18 p.m. the following was observed:room [ROOM NUMBER]: entryway flooring was uneven, broken, missing the transition strip, and appeared to be dirty with brownish/black grime with the crack embedded with dirt/debris. room [ROOM NUMBER]: entryway flooring was also uneven, broken with visible cracks, missing the transition strip, and appeared to be dirty with brownish/black grime.A follow-up walk-through of the 100-Hall was conducted on April 20, 2026 at 8:31 12:44 p.m. The following was observed:room [ROOM NUMBER]: entryway flooring was still uneven, broken, missing the transition strip, and appeared to be dirty with brownish/black grime.room [ROOM NUMBER]: entryway flooring was still uneven, broken with visible cracks, missing the transition strip, and appeared to be dirty with brownish/black grime.room [ROOM NUMBER]: entryway flooring was uneven, broken with visible cracks, missing the transition strip, and appeared to be dirty with brownish/black grime on the white flooring. Additionally, the crack/gap between the room flooring and the hallway flooring was embedded with dirt/debris.room [ROOM NUMBER]: entryway flooring was uneven, missing transition strip, and appeared to be dirty with dark brown/black grime.room [ROOM NUMBER]: entryway flooring was uneven, broken with visible cracks, missing the transition strip, appeared to be dirty with brownish/black grime. The crack/gap between the room flooring and the hallway flooring was embedded with dirt/debris.room [ROOM NUMBER]: entryway flooring appeared to be missing the transition strip and looked dirty with dark brown/black grime.room [ROOM NUMBER]: entryway flooring appeared broken with visible cracks, missing the transition strip, and appeared dirty with brownish/black grime.The facility's Work Order log over the last 12-months did not reveal any work order that was active, open, pending, completed/closed pertaining to the flooring of the 7 rooms in 100-Hall.An interview with Resident #56 was conducted on April 20, 2026 at 1:19 p.m. According to the resident, he had not noticed the issue but believed that the flooring had always been that way so he just lives with it. An interview with the Corporate Resource for Maintenance (staff #335) was conducted on April 20, 2026 at 1:24 p.m. Staff #334 stated that his expectation is that the facility's Maintenance Director (staff #111) has a rotating schedule of maintenance needs to accomplish as time permits, fix urgent needs, take care of work orders, and close the work orders as he completes them. Per staff #334 he expects the facility to look nice like a place where people want to be. Staff #335 said that if the building has areas that are not fixed then it could give the impression that the staff is not on top of its game, not handling issues, and it would not be an inviting environment.During an interview with the Maintenance Director (staff #111) conducted on April 20, 2026 at 1:29 p.m., staff #111 stated that he does a walk-through of the facility daily and receives work order request through the TELS system. During the walk-through with of the 100-Hall with the both staff #335 and staff #111, the Maintenance Director confirmed that there was no workorder for the flooring of the 7 rooms identified. Per the Maintenance Director, the flooring was not an obstacle but conceded that the flooring issues did not look appealing. The Maintenance Director said that no one had complained/brought to his attention that the flooring of the 7 rooms identified was an issue. According to the Maintenance Director, he only noticed the flooring issue in the 100-Hall less than a month ago. The Maintenance Director said that he does not have an estimate of when it will be fixed or if materials are available. Currently, the flooring is not a priority since the issue is cosmetic. However, if a resident complaints/mentions it then it will be bumped up in priority. The Maintenance Director noted that it could impact homelike environment. However, there are just other priorities. The (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Corporate Resource for Maintenance said that his expectation is that the Maintenance Director does not wait to fix things but rather fix issues as it arises. The Corporate Resource for Maintenance explained that the Maintenance Director is still pretty new in the business and had only been in the position 6-8 months. Therefore, he is still getting things in order. An interview with a Certified Nursing Assistant (CNA/staff #9) was conducted on April 21, 2026 at 7:15 a.m. Staff #9 stated that the flooring issues at 100-Hall has been like that since she started working at the facility over a year ago. According to the CNA, the flooring in the 100-Hall makes the facility unappealing and the uneven surfaces is a hazard to the residents that are unsteady on their feet. Per the CNA the uneven surface of between the room floor and hallway floor is not safe but could probably be considered homelike if your home has similar issues. The CNA said that the impact of the rooms being uneven/cracked/dirty looking is that it probably does not make the residents feel good about the look and where they live. The CNA noted that it is icky and that the residents' family probably feels uneasy about where the resident is staying and probably question if the facility if up to standards. Additionally, the CNA said that it is not safe for staff since if you are not paying attention, something can happen like trip/fall.An email correspondence from the Executive Director (staff #40) dated April 21, 2026 indicated that the facility does not have policies regarding:Maintenance ServicesWork Order PrioritizationDuring an interview with Housekeeping Staff (staff #25) conducted on April 22, 2026 at 8:07 a.m., staff #25 stated that the he had observed the gaps in the flooring in 100-Hall since October 2025. Per the Housekeeping Staff he tries to sanitize the gaps but the uneven surface/cracks meant that housekeeping have to use a special tool to get into the crevices. The Housekeeping Staff said that he had not notice the surface cause a tripping hazard. However, looking at the flooring in the 100-Hall you can tell that it needs work (to be fixed) and some TLC (tender loving care). Per the Housekeeping Staff what comes to mind when you see the flooring issues in 100-Hall is Wow, they could fix that.An interview with the acting Director of Nursing (DON/staff #102) was conducted on April 22, 2026 at 8:28 a.m. The acting DON stated that she had noticed the flooring at the 100-Hall but was unsure how long it had been that way. According to the acting DON she first noticed it the other day. Per the acting DON, she does not consider it as a hazard and she does not really think about it partly because she is aware that the Maintenance Director (staff #111) is working to get to all the facility needs to make the facility look good. The acting DON stated that her expectation is that the Maintenance Director completes work orders prioritizing them accordingly and ensure that the issue is not causing a hazard. The acting DON said that since she is only covering for the survey period and not over the department, she is uncomfortable stating what the potential impact is of the flooring issue over at the 100-Hall.A final walk-through observation of 100-Hall was conducted on April 22 at 9:45 a.m. The following was observed:room [ROOM NUMBER]: entryway flooring was still uneven, broken, missing the transition strip, and appeared to be dirty with brownish/black grime.room [ROOM NUMBER]: entryway flooring was still uneven, broken with visible cracks, missing the transition strip, and appeared to be dirty with brownish/black grime.room [ROOM NUMBER]: entryway flooring was still uneven, broken with visible cracks, missing the transition strip, and appeared to be dirty with brownish/black grime on the white flooring. Additionally, the crack/gap between the room flooring and the hallway flooring was embedded with dirt/debris.room [ROOM NUMBER]: entryway flooring was still uneven, missing transition strip, and appeared to be dirty with dark brown/black grime.room [ROOM NUMBER]: entryway flooring was still uneven, broken with visible cracks, missing the transition strip, appeared to be dirty with brownish/black grime. The crack/gap between the room flooring and the hallway flooring was embedded with dirt/debris.room [ROOM NUMBER]: entryway flooring still appeared to be missing the transition strip and looked dirty with dark brown/black grime.room [ROOM NUMBER]: entryway flooring still appeared broken with visible cracks, missing the transition strip, and appeared dirty with brownish/black grime.An interview with the Executive Director (ED/staff #40) was conducted on April 22, 2026 at 12:09 p.m. Staff #40 stated that her expectation is that the facility is safe and if there is a hazard seen, that it is addressed, and for the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	work orders to be completed based on priority level. Per the ED, they do not necessarily need to have a work order for everything that needs to be done as long as the needs are accomplished. Staff #40 said that with regards to the flooring at 100-Hall, she considers the issue cosmetic, as long as the residents are not complaining about it, then it can take a backseat to more pressing issues. If the resident says something about it then it will make it a higher priority to accomplish. The ED said that it is important to keep up with the upkeep of the facility since you do not want the building falling apart. According to staff #40, she is unsure if the flooring issue in 100-Hall impacts homelike environment or cleanliness but agreed that cosmetically, it does not look good. The ED indicated that she does not think it impacts homelike experience but would want the issue addressed. She would want to ask if the residents are bothered by the transition strip missing and then see what the facility can do to resolve it.The facility policy titled Quality of Life: Homelike Environment version 051123 effective January 1, 2024 indicated that the residents are provided with a safe, clean, comfortable environment. Per the policy, the facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflects a homelike setting such as clean, sanitary, and orderly environment.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and the review of facility process and policy, the facility failed to ensure that a copy of the transfer/discharge notification was sent to the ombudsman for five of five sampled residents (#12, #100, #102, #8, and #107) for discharge. The census was 87. The deficient practice could leave residents without protection against inappropriate transfers or discharges and without access to an advocate to explain their rights and options. Findings include: -Resident #107 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, systolic (congestive) heart failure, muscle, and abnormalities of gait and mobility. An internal medicine progress note dated [DATE], revealed that Resident #107 was seen and examined by the physician and would be transferring to another skilled nursing facility at the family's request. No barriers to discharge were noted by the provider. A health status progress noted dated [DATE], revealed that he was discharged from the facility via transport van. The discharge Minimum Data Set (MDS) assessment dated [DATE] documented an unplanned discharge to a skilled nursing facility. Review of the clinical record for Resident #107 revealed no evidence that notification of discharge was sent to the Office of the State Long-Term Ombudsman. The undated facility policy titled Admissions, Transfers and Discharges revealed that other information should be reported in accordance with facility policy and professional standard of practice. No information regarding requirements of notification the Office of the State Long-Term Ombudsman. -Resident #8 was admitted on [DATE] with diagnoses of COPD (chronic obstructive pulmonary disease), encounter with palliative care, and paroxysmal atrial fibrillation The care plan dated [DATE] revealed Resident #8 wished to establish an appropriate pre-discharge plan. Interventions included to coordinate discharge plans with IDT (interdisciplinary team) and help to provide services according to care plan in an effort to enhance optimum well-being. The discharge order dated [DATE] included that the resident will be discharged to home with portable oxygen tank, oxygen concentrator, physical therapy and home health services. It also included follow-up appointments with the PCP (primary care physician) in 3 weeks. The discharge-transfer note/summary dated [DATE] provided to and signed by the resident's family on [DATE] revealed the resident will be discharged to home with oxygen concentrator and tank, scheduled appointment with PCP on [DATE] at 1:00 p.m.; and, with narcotic medications. The documentation did not include the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; and, an explanation of their right to appeal the discharge. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The discharge MDS (minimum data set) assessment dated [DATE] included the resident had an unplanned discharge to home with return-not anticipated on [DATE]. There was no evidence found in the clinical record that the Ombudsman was notified of the resident's discharge from [DATE] through [DATE]. Review of the email correspondence, including attachments, from the facility's previous Resident Relations Manager (Staff #56), addressed to the Long-Term Care Ombudsman and dated [DATE] (approximately 19 days from the resident's discharge date), included that the attached DC [discharge] Summary for [DATE] was being provided for review. The attached document, titled, Action Summary, in the email included a list of residents that were discharged , deceased , and transferred out to the hospital from [DATE] through [DATE]. Review of the document revealed that Resident #8 was discharged /Transferred to another hospital on [DATE] at 2:53 p.m. This email notification and attachment did not include the reason for discharge of resident #8 and did not include the same information that was provided to the resident family on [DATE]. An interview was conducted on [DATE], at 1:21 p.m. with the current Resident Relations Manager (Staff #89), with the previous Resident Relations Manager (Staff #56) present. Staff #89 stated that discharge planning and goals were discussed during care conferences attended by the resident and/or their representative or family, along with department heads; and that, discharge planning begins at admission, when he completes the initial social services assessment and speaks with the resident to understand their needs, available resources, home setup, location, living situation, preferred pharmacy, and primary care provider. Staff #89 stated that the interdisciplinary team (IDT) meets weekly on Thursdays, and during these meetings he would learn which residents were scheduled for discharge. He said that he then issues the Notice of Medicare Non-Coverage (NOMNC) within 72 hours prior to the discharge date and informs the resident of their appeal rights, who to contact, and their financial responsibility if the appeal was not decided in their favor. He further stated that on the day of discharge, he provides the resident with a physical copy of the discharge summary which included information about durable medical equipment (DME) orders, prescriptions sent to the pharmacy, scheduled follow-up appointments with the primary care provider, and any ordered home health services. Staff #89 said that the document is signed and dated by the resident or their representative and then scanned into the electronic record. An interview with the Corporate MDS (staff #334) was conducted on [DATE] at 4:05 p.m. She stated that the facility does not have no specific policy for discharging residents admitted in the LTC unit; and that, the document, the Notice Requirements Before Transfer/Discharge and Therapeutic LOA (leave of Absence) document was a guide that staff were to follow when discharging a resident. An interview with the MDS Director (staff #334) and the previous Resident Relations Manager (Staff #56) was conducted on [DATE] at 10:23 a.m. The MDS director (staff #334) stated that the facility follow the Notice Requirements before Transfer/Discharge & Therapeutic LOA for notification of Ombudsman and what information needs to be provided to the Ombudsman. The previous resident relations manager (staff #56) stated that the only information she provides the Ombudsman was the facility's discharge log for the month. -Resident #12 was admitted on [DATE] with diagnoses of atherosclerotic heart disease. The discharge MDS assessment dated [DATE] documented an unplanned discharge to hospice (home/non-institutional). Per the MDS the resident was discharged on [DATE]. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NSG/SS Discharge-Transfer-LOA form dated [DATE] indicated the reason for the evaluation as discharge to the community with hospice services. Per the form the discharge was initiated by the resident/representative. Additionally, the form noted that the resident was discharging to a private home/apartment. Review of the resident's Order Summary Report did not reveal a physician's order for discharge. A Discharge Summary progress note dated [DATE] documented that resident was being discharged to the community with hospice services private home/apartment. A Progress Note dated [DATE] documented that resident was discharged home via transport with belongings, medications, and paperwork. Review of the resident's clinical record did not indicate that a copy of the discharge notification was sent to the Office of the State Long-Term Ombudsman. An interview with the Resident Relations Manager (staff #89) and the Business Office Manager (BOM/staff #56) was conducted on [DATE] at 1:51 p.m. According to the BOM, resident #12 was admitted to the facility for 1-week of respite care and was a frequent flyer. The Resident Relations Manager said that a copy of the notification is not sent to the ombudsman. Additionally, the Resident Relations Manager said that he does not provide the ombudsman information to the residents. -Resident #100 was admitted on [DATE] with diagnoses of chronic obstructive pulmonary disease. The Order Summary Report revealed an order dated [DATE] to send the resident to the ED (emergency department) for SOB (shortness of breath). The Discharge Summary progress note dated [DATE] documented that the resident was in respiratory distress and was transported via ambulance to an acute care hospital. A Social Services Progress Note dated [DATE] documented that the resident/resident representative was provided a written notice of transfer, notice of bed hold, readmission policy, ombudsman and appeals information. However, review of the resident's clinical record did not reveal any evidence that a copy of the notice of transfer was sent to the Office of the State Long-Term Care Ombudsman. -Resident #102 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses of hepatic encephalopathy, influenza, and cirrhosis of the liver. A Skilled Needs Review note dated [DATE] documented an estimated discharge date of [DATE]. Per the note the resident is expected to be discharged to the community. An NP (Nurse Practitioner) note dated [DATE] documented that resident is being discharged to prior living arrangements unless otherwise set up by case manager. The discharge MDS assessment dated [DATE] documented an unplanned discharge to home/community. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NSG/SS Discharge-Transfer-LOA form dated [DATE] documented the reason for the evaluation as discharge to the community without hospice services. Per the form the discharge was initiated by the resident/resident representative. The form indicated that the resident was discharging to the a private home/apartment. The Order Summary Report did not reveal a physician order for discharge. A Discharge Summary progress note dated [DATE] documented that the resident was discharged to the community without hospice service. A Social Services Progress Note dated [DATE] documented that the resident's family picked him up and took the resident back to the reservation. Review of the resident's clinical record did not indicate that a copy of the discharge notification was sent to the Office of the State Long-Term Ombudsman. A telephonic interview with the Ombudsman (staff #333) was conducted on [DATE] at 11:17 a.m. Staff #333 stated that their office used to receive a list of residents that were discharged /transferred. However, they have not received anything for February and March which he assumed might be related to changes in facility staffing. According to the Ombudsman the list used to go to his boss but lately they have not gotten it. According to staff #333 they were sent a list of residents but not a copy of the discharge/transfer notification. An interview with the Resident Relations Manager (staff #89) and the Business Office Manager (BOM/staff #56) was conducted on [DATE] at 1:51 p.m. Per the BOM, Resident Relations is responsible for presenting the notice of proposed discharge/transfer. Staff #56 said that the notice is presented as early as 72-hours prior to discharge depending on who is proposing the discharge. The Resident Relations Manager stated that the notice is presented to the resident or the responsible part. The Resident Relations Manager said that a copy of the notification is not sent to the ombudsman. However, a list of transferred/discharged residents is sent to the ombudsman on the first of the month via email. The BOM said that the notice of discharge contains the last date of coverage and the appeals info. The Resident Relations Manager said that the notice does not contain the info for the ombudsman. Additionally, the Resident Relations Manager said that he does not provide the ombudsman information to the residents. Both the Resident Relations Manager and the BOM stated that they are not sure if there is a policy/guidance that outlines requirements of what information should be included in the notice of transfer/discharge. A NOMNC (Notice of Medicare Non-Coverage) was presented by both the Resident Relations Manager and BOM as the notice of discharge/transfer. According to the both of them, there is no other for that the facility uses as a notice of transfer/discharge. During review of the NOMNC which the members considered as the notice of discharge/transfer form, they concurred that the form did not contain the ombudsman information. Per the Resident Relations Manager the ombudsman is the residents' advocate. The Resident Relations Manager stated that the purpose of notifying the ombudsman of the transfer/discharge is to ensure that the ombudsman is aware of the discharged /transferred residents. According to the Resident Relations Manager the purpose of notifying resident/resident representative is to let them know about the discharge, liability and to ensure a safe discharge. The Resident Relations Manager said that the impact of not providing a discharge/transfer notification is that the resident would not know that they are being discharged . Review of the NOMNC (Notice of Medicare Non-Coverage) form that the BOM and Resident Relations (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Manager presented as the facility's notice of transfer/discharge on [DATE] at 1:57 p.m. revealed that the form did not include the following information: The effective date for the transfer or discharge; The location to which the resident is transferred or discharged ; The name, address and telephone number of the Office of the State Long-Term Care Ombudsman; The contact information for the agency responsible for the protection and advocacy of individual with developmental disabilities (if applicable) The contact information for the agency responsible for the protection and advocacy of individual with mental disorder (if applicable). During a follow-up interview with the Ombudsman (staff #333) conducted on [DATE] at 3:48 p.m., he stated that the notification was supposed to be sent to his boss. Staff #333 said that the notification is important because he used them as verification to double check appeals and other issues that could arise. The Ombudsman indicated that the discharge/transfer notification kept him informed. Per staff #333 harm could arise if their office is not notified of the resident's appeals. Additionally, the Ombudsman noted that he wants to be aware of the appeal process. According to the Resident Relations Manager resident #102 was picked up by his family. The Resident Relations Manager said that resident #102's family informed the facility that the resident will be picked up 3-days prior to when the resident left. An interview with the acting Director of Nursing (DON/102) was conducted on [DATE] at 8:28 a.m. The acting DON stated that she is unfamiliar with the requirements of notification of discharge/transfer as she has not been part of that process and can only speak in the capacity of her involvement with wound care residents. An interview with the Executive Director (ED/staff #40) was conducted on [DATE] at 12:09 p.m. The ED stated that the only form used for discharge/transfer is the NOMNC. Per staff #44 there is no paper notice and the facility is not required to provide paper notice. The ED noted that to her knowledge there is no other notification of discharge/transfer that has to be given to the residents. The ED said that the facility sends a list of residents transferred/discharged to the ombudsman monthly per their policy. According to the ED, the purpose of the notification of discharge/transfer is for the residents to participate in the discharge planning ahead of time and know what is going on. However, if the resident is just deciding that they are going home then they are the ones notifying the facility about the discharge. The ED stated that the ombudsman is the residents' advocate so informing the ombudsman about transfer/discharge is to make the ombudsman aware of what is going on, allow the ombudsman to contact the resident and know where the resident is at, and that the resident is no longer at the facility. The ED noted that the impact of not notifying the ombudsman is that it impacts the ombudsman's ability to know what is going on with the resident. Additionally, the ED stated that the facility wants the ombudsman to be aware. The ED indicated that to her knowledge all that had to be provided to the ombudsman was a list of the discharge/transfer. The ED was not aware that a copy of the transfer/discharge notification had to be provided to the ombudsman.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and resident interview, and review of the clinical record and facility policy, the facility failed to ensure that medications were administered with a physician order for one (Resident #4); and, and failed to ensure the accurate dispensing and administration of medications for one resident (#72) of 25 sampled residents for medications. The universe was 87. The deficient practice could result in residents needs not met and inaccurate and unsafe provision of medications. Findings include:-Resident #4 was admitted on [DATE], with diagnoses that included unspecified dementia, adult failure to thrive, and cognitive communication deficit. An interview was conducted with Resident #4 on April 19, 2026 at 10:09AM. Resident #4 stated that she wanted to receive her eye drops more often. An observation was conducted on April 21, 2026, at 10:22 a.m. The registered nurse (RN/Staff #61 was at of the medication storage cart; and, removed a box of eye drops labeled with the name of Resident #4 in black ink. An interview was conducted on April 21, 2026 at 10:22 a.m. with a Certified Medication Assistant (CMA/Staff #2) who stated he had administered the eye drops to Resident #4 earlier that day because the resident had asked for them and he wanted to accommodate the resident; and, he only gave the eye drops that morning, and had not administered them previously. He further stated that he did not think it was a big deal. The CMA stated he can only give scheduled medications and cannot give any as needed medications ordered. Further, the CMA stated that he was unaware if other staff members were also giving the eye drops to Resident #4; and that, he did not look to see if there was an order when he administered them. A physician order dated December 18, 2022 included for Artificial Tears Solution 1%. The documentation included that this order was discontinued on March 10, 2023. The Annual Minimum Data Set (MDS) dated [DATE], revealed that the resident had vision impairment, and a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The care plan, last reviewed March 3, 2026, revealed resident had vision impairment. Interventions included arranging a consultation with an eye care practitioner, and monitoring and documenting any changes of condition related to vision. The progress notes from January 22 through April 16, 2026 revealed no evidence of an order for the eye drops and there were no documentation that any eye drops were administered to the resident Further review of the clinical record revealed there were no physician order for the use of any eye drops found in the clinical record from March 10, 2023 through April 20, 2026. The Medication Administration Record for April 2026 revealed no order for an eye drop was transcribed and no eye drops were documented as administered to Resident #4. The clinical record revealed no documentation that the eye drop was administered to Resident #4 on April 21, 2026. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On April 21, 2026, at 10:12 a.m., an interview was conducted with Registered Nurse (RN/Staff #61) who stated that she was aware that Resident #4 wanted her eye drops and that the resident had glaucoma and believed the eye drops helped her vision. The RN further stated that no physician's order for the eye drops was found in the medical record. She stated she did not know when the eye drops were last administered because there was no active order and, therefore, the drops should not have been administered. The RN also stated that Resident #4 had not asked her for the eye drops. However, she did not know why there was no order in the medical record. Staff #61 stated she had been under the impression that an order for the eye drops existed in the clinical record and stated that she would contact the provider. A physician order dated April 21, 2026 at 10:30 a.m.-shortly after the observation, was written for Artificial Tears Ophthalmic Solution [ophthalmic lubricant] 1 drop in both eyes every 4 hours as needed for dry eyes. In a later interview with the RN (staff #61) was conducted on April 21, 2026, at 10:56 a.m., the RN stated that as the nurse, she would give any medications ordered as needed, and, throughout the medication administration process the CMA can check in and ask questions. The RN said that the CMAs go through a course for certification and she trusts that the CMAs had been trained properly to do their job. The RN said that anyone giving medications should ensure that medications, including over the counter medications such as eye drops, had an order prior to its administration. The RN further stated that after finding the eye drops in the medication cart earlier she threw the box away since there was no order found in the clinical record for its use. In another interview with Resident #4 conducted on April 21, 2026 at 11:07 a.m., Resident #4 stated that she received her eye drops about three times a day because she reminded staff she needed them. Further, resident #4 said that she received her eye drops earlier that morning, April 21, 2026. In another interview with the CMA (staff #2) conducted on April 21, 2026 at 11:11 a.m., the CMA stated that part of his job responsibilities included administering medications under the direction of a nurse and that he would normally verify a physician's order before administering medication. However, the CMA stated that Resident #4 was upset, and he wanted to accommodate the resident, so he administered the eye drops to the resident earlier that morning without checking for an order. The CMA further stated that he had administered the eye drops to Resident #4 prior to that day as well. He also said that a physician's order was required before administering medications and stated that risks associated with administering medications without an order included adverse reactions, such as an allergic reaction. An interview was conducted with the acting Director of Nursing (DON/ Staff #102) on April 22, 2026 at 10:00 a.m. The DON stated that part of the medication administration process included opening the MAR and checking the provider's orders for medications, checking the order three times as it compares to the resident to ensure that the rights of medication administration were being followed. She further stated that it was not an acceptable practice to administer medications without an order; and, the risks associated with administering medications without an order included any adverse event, leading up to death. In a later interview with the DON (staff #102) conducted on April 22, 2026 at 11:18 a.m., the DON stated medications and treatments are administered as ordered by the physician. -Resident #72 was admitted on [DATE] with diagnoses of hip and spinal fractures, dementia, major (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Depressive Disorder, single episode, Chronic Obstructive Pulmonary Disease, and insomnia. A physician order dated March 13, 2026 included for Lidocaine (topical analgesic) External Patch 4% apply to affected areas topically one time a day for pain and remove per schedule. This order had a discontinued date of March 14, 2026. The Medication Regimen Review dated March 17, 2026 revealed the pharmacist did not identify any issue with the resident's external lidocaine patches 4%. The physician order dated March 17, 2026 included for pain evaluation every shift, using a pain scale of 0-10, Lidocaine external patch 4% order to apply the patch to the affected areas topically one time a day for pain (start date of March 17, 2026). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5 indicating the resident had severe cognitive impairment. The assessment included the resident had no hallucinations or delusions, rejection of care, or wandering. Active diagnoses included fractures and other multiple trauma, hip fracture, and other fracture, Non-Alzheimer's Dementia. It also included that the resident had no indicators for pain during the lookback period. This MDS also determined that this resident often required help reading instructions, pamphlets, or other written material from physician or pharmacy. (March 19, 2026). The progress notes dated March 16, 21, 22, 25, and 29, 2026 revealed Lidocaine external patch 4% was administered to the resident per physician order. However, there was no documentation that the patch was removed and/or when it was removed after it was applied on these dates. A care plan initiated on March 26, 2026 revealed that resident was at risk for impaired cognitive function/dementia or impaired thought processes related to dementia and was on pain management for arthritis. Interventions included to administer medications as ordered, provide supervision/assistance with all decision-making, monitor and document for side effects. The Medication Regimen Review dated April 14, 2026 revealed the pharmacist did not identify any issue with the resident's external lidocaine patches 4%. The April 2026 Medication Administration Record/Treatment Administration Record (MAR/TAR) included that pain evaluation was completed on every shift, pain level ranged from 0-2, and the patch was documented as administered on April 1 through 5, April 6 through 10, April 13 through 17, and, April 20 through 22, 2026. There was no documentation in the clinical record that the patch was removed and/or when it was removed after it was applied on these dates. An interview was conducted with Licensed Practical Nurse (LPN/Staff #38) on April 22, 2026, at 8:50 a.m. The LPN stated that the protocol for Lidocaine patches was 12 hours on and 12 hours off the resident, and that only one patch was used unless otherwise ordered by the physician. The LPN stated that Lidocaine patches were generally ordered on an as-needed (PRN) basis and that residents often refused them. The LPN further stated that the protocol for physician-ordered Lidocaine patches was to apply the patch for 12 hours and remove it after 12 hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with Registered Nurse (RN/Staff #102) on April 22, 2026, at 9:00 a.m. The RN stated that the normal protocol for Lidocaine patches was 12 hours on and 12 hours off; however, the physician's order would determine the specific instructions. The RN also said that there was no medical risk to the resident other than possible skin irritation. An interview was conducted with Certified Medication Assistant (CMA/Staff #101) on April 22, 2026, at 10:20 a.m. Staff #101, who regularly cared for Resident #72, stated that he applied a 4% Lidocaine patch to the resident's lower back that morning and removed the previous day's patch at the same time. He further stated that this was the normal procedure for Resident #72 and another resident on the hall who received Lidocaine patches. During the interview, a photograph of the Lidocaine patch packaging was taken. Review of the manufacturer's directions for use indicated the patch should not be used more than one at a time, could be applied three to four times daily, and should be removed after no more than eight hours of application. An observation was conducted April 22, 2026 at 10:47 a.m. of the medication cart containing Resident #72's lidocaine patch medication. A photo of the medication box was taken and manufacturer's instructions reviewed. The instructions on the medication's package advised the removal of the lidocaine patch after eight hours. A telephone interview was conducted with the pharmacist (Staff #400) on April 22, 2026, at 11:34 a.m. The pharmacist stated there were no physician orders in Resident #72's clinical record regarding removal of the 4% external Lidocaine patch. The pharmacist stated that Lidocaine patches were generally removed every 12 hours and that failure to remove the patch within the recommended timeframe posed a low risk to the resident; however, the medication could continue to be absorbed systemically.The pharmacist further stated that risks associated with not removing the patch included drowsiness, toxicity, and skin irritation, and that documentation of patch removal every 12 hours was important because of these risks. The pharmacist also stated that the order for Resident #72's Lidocaine patch should be changed to an as-needed (PRN) basis. Additionally, the pharmacist stated that her previous medication regimen review process included reviewing physician orders and documentation for patch removals in every instance. However, because experienced staff routinely removed the patches after 12 hours, she had discontinued that practice. The pharmacist stated she would consider resuming review of Lidocaine patch removal documentation, as well as documentation for other medications requiring removal records. An interview was conducted with Licensed Practical Nurse (LPN/Staff #75) on April 22, 2026, at 12:11 p.m. The LPN stated that physician orders for the application and removal of a Lidocaine patch should be included in the MAR/TAR. The LPN also stated that when a patch was applied, the location on the resident's body should be documented in a drop-down tab within the MAR/TAR, and the removal of the patch should also be documented in the same section. She further stated that there were no other locations in the clinical record where the application and removal of Lidocaine patches were documented. Review of the facility policy titled, Medication: Administering Medications, revealed that medications are administered in accordance with prescriber orders. Facility policy further revealed that the individual administering medication should document the date and time the medication was administered. Policy review also revealed that the director of nursing services supervised all personnel who administer medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interviews, and review of facility policy, the facility failed to ensure sanitary conditions were maintained in the kitchen by requiring dietary staff to utilize appropriate hair restraints, including beard coverings, during food preparation. The deficient practice had the risk of physical contamination of food served to residents. The census was 87, and the sample was 85 residents. Findings include:During the initial kitchen tour conducted on April 19, 2026, at 9:50 a.m., two dietary staff (Cook/Staff #203 and Dietary Aid/Staff #42) were observed in the kitchen actively preparing lunch for residents. Both staff were observed wearing hair restraints on the top of their heads. However, Staff #203, had a full beard with long hair covering the sides of his face, chin and upper lip. Staff #203 was observed preparing food without wearing a beard restraint.This observation indicated a failure to follow sanitary food handling practices, as exposed facial hair was not contained during active food preparation. Further kitchen observations were completed on April 20, 2026 at 11:20 a.m. and April 21, 2026 at 7:40 a.m. all observed staff was observed properly wearing hair and beard restraints. During an interview on April 22, 2026, at 8:26 a.m., the Dietary Manager (Staff #208) stated that all dietary staff were expected to wear hair restraints while working in the kitchen. Staff #208 further stated that staff with facial hair, including Staff #203, were required to wear beard nets at all times while in the kitchen and when preparing food. Staff #208 confirmed that failure to wear appropriate hair and beard restraints posed a risk of hair falling into food and contaminating meals served to residents.Review of the facility policy titled Dietary Services: Sanitation, effective January 1, 2024, revealed that the food service area shall be maintained in a clean and sanitary manner.Review of the facility policy titled Dietary Services: Preventing Foodborne Illness- Food Handling effective January 1, 2024, revealed that all employees who handle, prepare or serve food will be trained in the practices of safe food handling. Further, employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff interviews, facility documentation and policy and procedures, the facility failed to maintain infection prevention and control pertaining to sanitizing medical equipment for five out of five sampled residents (#1, #82, #24 #35 & #23). The census was 87. The deficient practice could result in transmission of disease and infection to residents. Findings include:During an observation of physical therapy services for resident #1 provided by staff #336 (Certified Occupational Therapy Assistant) conducted on April 20, 2026 at 10:17 a.m., the following was observed:Staff #336 pace a blood pressure (BP) cuff on resident #1's arm. The BP cuff was not disinfected/sanitized prior to placing it on the resident's arm or after the resident's use.The same un-sanitized BP cuff was passed on to staff #340 (Director of Rehab). Staff #340 then placed the BP cuff on resident #82's arm to take the resident's blood pressure. The BP cuff was not disinfected/sanitized prior to placing it on the resident's arm or after the resident's use.The same un-sanitized BP cuff was then used by staff #345 (Physical Therapy Assistant) and placed on resident #24's arm to take her blood pressure. The BP cuff was not disinfected/sanitized prior to placing it on the resident's arm or after the resident's use.Staff #345 then used the same un-sanitized BP cuff and placed it on resident #35's arm to take his blood pressure. The BP cuff was not disinfected/sanitized prior to placing it on the resident's arm or after the resident's use.Staff #345 then again used the same un-sanitized BP cuff on placed it on resident #23's arm to take his blood pressure. The BP cuff was not disinfected/sanitized prior to placing it on the resident's arm or after the resident's use and placed on the basket on the BP machine.During group therapy, staff #345 had resident #23 use the same therapy resistance band that was used by resident #24. The band was not wiped down with a disinfecting wipe prior to or after use of resident.The same therapy resistance band was passed on to resident #35 for use. The band was not wiped down with a disinfecting wipe prior to or after use of resident.The same therapy resistance band was then used on resident #1 for open/close leg and leg pull exercises. The band was not wiped down with a disinfecting wipe prior to or after use of resident.An interview with a Certified Nursing Assistant (CNA/staff #209) was conducted on April 21, 2026 at 7:15 a.m. The CNA stated that the BP cuff should be cleaned with sanitary/disinfecting cloths before and after use especially in isolation rooms and in the therapy room. Additionally, staff should hand sanitize in between using the BP cuff. The CNA said that it is inappropriate to use the BP cuff multiple times without sanitizing since you want to prevent germs from spreading. Per the CNA it is important to sanitize equipment such as BP cuff to stop contamination since you never know if someone is sick. Therefore, you want to sanitize for infection control purposes. The CNA noted that the impact of not sanitizing equipment such as the BP cuff is that sickness could be spread, and germs/disease that should not be touched by other people is then transmitted. During an interview with the Director of Rehab (staff #340) conducted on April 21, 2026 at 7:39 a.m., staff #340 stated that rehab/therapy staff members disinfect equipment and wipe down surfaces at the beginning and at the end of the day. According to staff #340 it is important to disinfect/sanitize equipment for infection control between resident-to-resident interaction and equipment usage since you do not want anyone to get sick. Per the Director of Rehab, the impact of not sanitizing/disinfecting equipment is that residents can get sick or infected. Sometimes residents have wounds and you do not want to spread bacteria. According to staff #340 BB cuffs and therapy resistance bands follows the same protocol as the rest of the rehab equipment and are soaked in the disinfecting station. The current protocol is that these items are sanitized before the beginning and after the end of the day. Staff #340 said that she would have to check what the infection control protocol was for BP cuffs since the rehab's current protocol has not been brought up as a concern so not sure if it meets or not. Additionally, the therapy resistance bands are placed on top of resident's clothing and depending on the location of resident can potentially be an infection control issue. However, the bands are over the resident's clothing so not sure if it is an infection control issue to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	only disinfect at the beginning and end of the day. The Director of Rehab admitted that she was not familiar with the manufacturer's instruction and indicated that disinfecting/sanitizing degrades the material so she is unsure if the bands should be disinfected in between residents' use.An interview with the acting Infection Preventionist (IP)/acting Director of Nursing (DON) (staff #102) was conducted on April 22, 2026 at 8:28 a.m. The acting IP/acting DON stated that her expectation is equipment such as BP cuffs should be sanitized between resident use. Additionally, she stated that her expectation is that therapy resistance bands should either be used specifically for a resident and not shared or cleaned in between use of multiple residents. Staff #102 said that this is important to not spread infection since there is a population of compromised individuals, and you want to try to prevent the spread of infection. Per the acting IP/acting DON, the impact of not sanitizing/disinfecting equipment is that it can put the residents at risk for possible multiple outbreak. You have to clean the equipment in between resident use because if one person has something then it can be passed on to the other resident. The acting IP/acting DON stated that it is inappropriate to not disinfect/sanitize equipment in between resident use and it does not adhere to standard practice.During an interview with a Licensed Practical Nurse (LPN/staff #70) conducted on April 22, 2026 at 10:07 a.m., staff #70 stated that BP cuffs should be disinfected in between use and before being used on the next resident. The LPN said this was important for infection control so that germs are not spread. According to the LPN, the impact of not disinfecting equipment is that it puts residents at risk for the spread of infection. The LPN said that is someone is carrying something contagious, it can be spread. Per the LPN, not disinfecting the BP cuff in between resident use is inappropriate.The facility policy titled Infection Control: Cleaning and Disinfection of Resident-Care Items and Equipment version 051123 in effect January 1, 2024 indicated that resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC (Centers for Disease Control and Prevention) for disinfection and OSHA (Occupational Safety and Health Administration) Bloodborne Pathogens Standard. Per the policy, non-critical resident-care items include blood pressure cuffs. Non-critical items require cleaning followed by either low or intermediate-level disinfection following manufacturer's instruction. The policy noted that reusable resident care equipment is decontaminated and/or sterilized between resident use according to manufacturer's instructions. Reusable items are cleaned and disinfected or sterilized between resident use.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, clinical record review, and facility policy review, the facility failed to ensure that care and services were provided in accordance with accepted standards of quality by failing to provide appropriate staff supervision during medication administration for one (#4) of 25 sampled residents. The facility census was 87 residents. The deficient practice resulted in unsupervised staff administering medication to the resident without a physician's order.Findings include:-Resident #4 was admitted on [DATE], with diagnoses that included unspecified dementia, adult failure to thrive, and cognitive communication deficit.A physician order dated December 18, 2022 included for Artificial Tears Solution 1%. The documentation included that this order was discontinued on March 10, 2023.The progress notes from January 22 through April 16, 2026 revealed no evidence of an order for the eye drops and there were no documentation that any eye drops were administered to the resident.Review of the clinical record revealed there were no physician order for the use of any eye drops found in the clinical record from March 10, 2023 through April 20, 2026.The clinical record revealed no documentation that the eye drop was administered to Resident #4 on April 21, 2026. Review of the personnel record for the CMA (staff #2) revealed the following information:A job description for a Certified Medication Assistant signed by CMA (staff #2) and dated September 4, 2025, indicating that he was aware of the job responsibilities of a CMA, which included the limitations to medication administration and being directed by a licensed nurse; and,A CMA Annual skills checklist dated January 13, 2026 indicating that CMA (staff #2) was competent in administering medications in accordance with Resident Rights.An interview was conducted on April 21, 2026 at 10:22 a.m. with a Certified Medication Assistant (CMA/Staff #2) who stated he had administered the eye drops to Resident #4 earlier that day because the resident had asked for them and he wanted to accommodate the resident; and, he only gave the eye drops that morning, and had not administered them previously. He further stated that he did not think it was a big deal. The CMA stated he can only give scheduled medications and cannot give any as needed medications ordered. Further, the CMA stated that he was unaware if other staff members were also giving the eye drops to Resident #4; and that, he did not look to see if there was an order when he administered them.On April 21, 2026, at 10:12 a.m., an interview was conducted with Registered Nurse (RN/Staff #61) who stated that no physician's order for the eye drops was found in the medical record. She stated she did not know when the eye drops were last administered because there was no active order and, therefore, the drops should not have been administered. The RN also stated that Resident #4 had not asked her for the eye drops. However, she did not know why there was no order in the medical record. Staff #61 stated she had been under the impression that an order for the eye drops existed in the clinical record and stated that she would contact the provider.A physician order dated April 21, 2026 at 10:30 a.m.-shortly after the observation, was written for Artificial Tears Ophthalmic Solution [ophthalmic lubricant] 1 drop in both eyes every 4 hours as needed for dry eyes. In a later interview with the RN (staff #61) was conducted on April 21, 2026, at 10:56 a.m., the RN stated that she supervised any CMAs on the floor by conducting an initial assessment of the residents, then followed up with a CMA by checking the electronic Medication Administration Record (eMAR) to see what was being administered. The RN also said that as the nurse, she would give any medications ordered as needed, and, throughout the medication administration process the CMA can check in and ask questions. The RN said that the CMAs go through a course for certification and she trusts that the CMAs had been trained properly to do their job. The RN said that anyone giving medications should ensure that medications, including over the counter medications such as eye drops, had an order prior to its administration. The RN further stated that after finding the eye drops in the medication cart earlier she threw the box away since there was no order found in the clinical record for its use. In another interview with Resident #4 conducted on April 21, 2026 at 11:07 a.m., Resident #4 stated that she (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received her eye drops about three times a day because she reminded staff she needed them. Further, resident #4 said that she received her eye drops earlier that morning, April 21, 2026.In an interview with the CMA (staff #2) conducted on April 21, 2026 at 11:11 a.m., the CMA stated that part of his job responsibilities included administering medications under the direction of a nurse and that he would normally verify a physician's order before administering medication. However, the CMA stated that Resident #4 was upset, and he wanted to accommodate the resident, so he administered the eye drops to the resident earlier that morning without checking for an order. The CMA further stated that he had administered the eye drops to Resident #4 prior to that day as well. He also said that a physician's order was required before administering medications and stated that risks associated with administering medications without an order included adverse reactions, such as an allergic reaction.Another interview was conducted on April 22, 2026, at 9:01 a.m. with the CMA (staff #2) who stated that his process for administering medications was to review the electronic Medication Administration Record (eMAR) prior to administering medications.On April 22, 2026, at 9:12 a.m., an interview was conducted with Licensed Practical Nurse (LPN/Staff #70) who stated that she supervised Certified Medication Aides (CMAs) by initially following them while they administered several medications. She further stated that once she felt she could trust the CMA, she would monitor medication administration by reviewing the Medication Administration Record (MAR) to determine which medications were being administered. The LPN said that CMAs were only permitted to administer medications that had an order documented. However, the LPN did not describe any specific process CMAs used or do to verify that medications were administered only with a valid physician's order.During an interview with the acting Director of Nursing (acting DON/staff #102) conducted on April 22, 2026 at 10:00 a.m., the acting DON stated that part of the medication administration process included opening the MAR and checking the provider's orders for medications, checking the order three times as it compares to the resident to ensure that the rights of medication administration were being followed. She further stated that it was not an acceptable practice to administer medications without an order; and, the risks associated with administering medications without an order included any adverse event, leading up to death. The acting DON also said that the she heard of the incident regarding CMA (staff #2) administering the eye drops without an order to Resident #4; and that, it was not okay.An interview was conducted on April 22, 2026 at 10:20 a.m., with the CMA (Staff #20) who stated that the LPN (staff #31) was supervising him for this day. In an interview conducted on April 22, 2026, at 10:42 a.m., LPN (Staff #70) stated that she was not supervising CMA (Staff #2) on that day.Despite CMA (Staff #2) reporting that LPN (Staff #31) was supervising him on April 22, 2026, in an interview conducted with LPN (Staff #31) on April 22, 2026, at 10:47 a.m., the LPN (Staff #31) stated that another LPN (Staff #70), was supervising CMA (Staff #2).After the interviews conducted, it was not clear who was responsible for supervising the CMA (staff #2) on April 22, 2026.Review of the job description for both the RN and the LPN included that the RNs and/or LPNs are responsible for ensuring all assigned nursing personnel comply with written policies and procedures. Further review of the job description revealed that LPNs are also responsible for supervising nursing staff to ensure that all personnel are performing their work assignments in accordance with acceptable nursing standards.Review of the job description for a Certified Medication Assistant (CMA) revealed that CMAs are responsible for following performance standards and perform duties according to the nursing policies and procedures. Further review of the job description revealed that medication administration restrictions and limitations included being directed by a licensed nurse.The facility policy titled, Medication: Administering Medications, revealed that medications are administered in accordance with prescriber orders. Facility policy further revealed that the individual administering medication should document the date and time the medication was administered. Policy review also revealed that the director of nursing services supervises all personnel who administer medications.The facility policy on Staffing, Sufficient & Competent Nursing included that it is their policy to provide sufficient numbers of nursing staff with (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate skills and competency necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The policy also include that licensed nurses are required to supervise nurse aides/nursing assistants and are scheduled in such a way that permits adequate time to do so.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and facility policies and procedures, the facility failed to ensure was ADL (activities of daily living) care such as toileting hygiene was provided for 1 of 2 residents (#55) sampled for ADLs. The census was 87. The deficient practice could result in residents' hygiene needs not being met.Findings include:Resident #55 was admitted on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting his left, non-dominant side, schizophrenia, and major depressive disorder. A care plan initiated on October 15, 2025 revealed that the resident was at risk for functional self-care deficits and/or functional mobility limitations. Interventions indicated that the resident required assistance with toileting hygiene; required assistance to washing/rinsing/drying himself for shower/bathing; indicated to provide a bath/shower per scheduled preference as necessary.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status of 15 indicating that the resident was cognitively intact. The MDS noted that the resident did not exhibit indicators of psychosis, behavioral symptoms, or rejection of care during the assessment period. The assessment documented that the resident had bilateral upper and lower extremity impairment which interfered with his daily functions. Per the assessment the resident utilized a wheelchair as a mobility device and was dependent on staff for: toileting hygiene, shower/bathing, oral hygiene, personal hygiene, upper/lower body dressing, and putting on/taking off footwear.The December 2025 CNA (Certified Nursing Assistant) Task log for Bowel and Bladder revealed that following dates/shift was left unmarked/undocumented:December 5: 2:00 p.m. - 10:00 p.m.December 9: 6:00 a.m. - 2:00 p.m.December 11: 10:00 p.m. - 6:00 a.m.December 11: 2:00 p.m. - 10:00 p.m.December 12: 10:00 p.m. - 6:00 a.m.December 18: 2:00 p.m. - 10:00 p.m.December 19: 2:00 p.m. - 10:00 p.m.December 20: 2:00 p.m. - 10:00 p.m.December 21: 10:00 p.m. - 6:00 a.m.The December 2025 CNA Task log for Toilet Use revealed that the following dates/shift were left unmarked/undocumented:December 5: 2:00 p.m. - 10:00 p.m.December 11: 10:00 p.m. - 6:00 a.m.December 11: 2:00 p.m. - 10:00 p.m.December 12: 10:00 p.m. - 6:00 a.m.December 15: 6:00 a.m. - 2:00 p.m.December 18: 2:00 p.m. - 10:00 p.m.December 18: 6:00 a.m. - 2:00 p.m.December 19: 2:00 p.m. - 10:00 p.m.December 20: 2:00 p.m. - 10:00 p.m.December 21: 10:00 p.m. - 6:00 a.m.A NP (Nurse Practitioner) note dated November 3, 2025 documented an initial psychiatric evaluation and treatment recommendation with a PMHNP-BC (Psychiatric-Mental Health Nurse Practitioner-Board Certified). The note indicated that the resident had documented behaviors which included episodes of sexually inappropriate comments directed towards staff, verbal agitation when his requests were not immediately met, and argumentative responses during care interactions. According to the note, the resident exhibited mocking and verbally abusive remarks toward staff, including making derogatory comments and mimicking movements in a taunting manner.A Behavior progress note dated November 22, 2025 documented that it was the resident's shower day. Per the note, the resident was in the shower room half-way undressed and set-up when the resident decided that he no longer wanted his shower. The note indicated that the resident's reason was that he only needed one shower a week.A NP note dated November 24, 2025 revealed that the resident was seen for a follow-up visit with the PMHNP-BC and had been exhibiting impulsive tendencies. According to the note the resident had increased verbal aggression, specifically name calling directed at staff which included uttering profanities. The note indicated that the resident had a documented behavior of resistance to care during scheduled showers. The note documented that the resident had refused to abruptly refused to proceed with a shower after the staff had brought him to the shower room and prepared him. Per the note, the resident had inappropriate sexual behavior, specifically, masturbating outside of private settings. A Behavior note dated November 28, 2025 documented that resident cussed out staff when they tried to get him out of bed. The note indicated that the resident called staff worthless and (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	useless.An Alert Charting progress note dated November 30, 2025 documented that resident was yelling and reported he wanted to get up to eat dinner. The note stated the resident was informed that the CNAs (Certified Nursing Assistants) were in the middle of passing dinner trays. The note indicated that the resident started yelling and cursing at the nurse. When the CNA arrived to and asked if he wanted his dinner, the resident continued to yell after he was told that he was a cares-in-pairs and had to wait until another staff was available to assist in getting him up. According to the note, when a staff member went in the room to get the roommate's tray, the resident threw his urinal at the staff member. The Executive Director, and Director of Nursing (DON) were informed of the resident's behavior. Per the note, the DON contacted the resident's brother who gave permission to move resident to the behavioral unit. During the room change, the resident cursed at the staff and told the nurse that he was going to kill her when he got better. The resident screamed f@$% you, you stupid b!#@$ and tried to throw his phone at the nurse.A NP note dated December 3, 2025 documented a follow-up visit with the PMHNP-BC. The note indicated that the resident had exhibited persistent verbal aggression which included cursing at staff during care, calling staff worthless, yelling demands for medication, and speaking rudely to staff. According to the note, the resident had frequently become loud when his requests are not met immediately, repeatedly activated his call light after staff had already addressed his needs, directed inappropriate and derogatory comments towards female CNAs.A Behavior progress note dated December 13, 2025 documented that resident was upset with CNA because yesterday the CNA did not shower him the way he wanted so the resident refused the shower. The CNA at the time of the documentation informed the resident that he had 6 other showers scheduled which angered the resident. According to the note, the resident told the CNA I hope a car crashes into this building with all the staff inside and the building blows up and the staff all dies.Another Behavior progress note dated December 13, 2025 documented that the resident had a BM (bowel movement) and CNA cleaned him. Per the note, as soon as the CNA left, the resident activated his call light, the nurse came and the resident informed her that the CNA did not clean under my penis. The note indicated that the nurse checked the resident's peri area and brief and both were completely clean and dry.A Behavior progress note also dated December 13, 2025 documented that after asking the CNA for a glove, the resident grabbed a cleaning wipe and demonstrated to the CNA that he was capable of cleaning his peri area. The resident wiped himself then threw the wipe down and told the staff here's all the shit you missed. The nurse entered the room to talk to the resident but the resident told the nurse to get the f@$& out of here.A Social Services Progress Note dated December 15, 2025 documented that the Resident Relations Manager (staff #56) spoke with the resident's brother about a transfer to another facility. Per the note, the resident's brother was onboard with the transfer. The note indicated that the resident's brother understood the resident's continued behaviors and agreed that it was probably best to transfer the resident. A NP note dated December 15, 2026 revealed a follow-up visit with a PMHNP-BC. The note indicated that the resident had exhibited frequent agitation, oppositional behavior, and verbal aggression toward staff and other residents. According to the note, the resident displayed disruptive behavior. The resident yelled, mocked staff, interrupted other resident's care, and expressed frustration over unmet preferences, and hygiene assistanceA Grievance Report and Resolution Form signed by the Resident Relations Manager and Executive Director (staff #40) on December 16, 2025 documented that the resident filed a complaint regarding a concern which occurred on December 15, 2026. The concern was in regards to the resident feeling that he was being ignored by staff and is not getting the care he needs or wants. The form indicated that the response/resolution provided as the Executive Director met with resident and discussed concerns and decision was made to look for more appropriate placement that could better meet the resident's needs. Per the form, the Executive Director would educate staff on resident's care preferences until the placement could be made. The State Agency's complaint/incident tracking system revealed a complaint filed on December 19, 2025 involving the resident. According to the complaint, the resident had diarrhea and the staff only cleaned his bottom but not his front. The (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	complaint indicated that the resident asked the staff to clean his front side since he was soiled all over and was unable to clean himself due to his impairment. The complaint alleged that there were multiple incidents when staff refused to clean the resident. The complaint did not indicate when the alleged incident occurred. The IDT (Interdisciplinary Team) GG (Functional Status) assessment dated [DATE] documented that the resident required substantial/maximal assistance for the following tasks: oral hygiene, toileting hygiene, shower/bathing; upper/lower body dressing, personal hygiene, and putting on/taking off footwear.A Discharge Summary progress note dated December 22, 2025 documented that resident was discharged to another long-term care nursing facility.An interview with the acting Director of Nursing (DON/staff #102) was conducted on April 22, 2026 at 8:28 a.m. Staff #102 indicated that she was only the acting DON for the duration of the survey. The acting DON said that with regards to ADL care, there is a fine line between the right to refuse so staff should make multiple attempt to see if there is a person that has a better relationship with the resident who the resident would allow to provide the care. Additionally, she expects that depending on the behavior the resident should see psychiatry. According to the acting DON, working as a wound nurse in the facility, she had never witnessed the staff leave a resident soiled/wet. Each time she came in to work on a resident, the resident is clean. She noted that she is unfamiliar with resident #55 and recommended to speak to staff #107 (CNA) and staff #70 (LPN) who both work in the unit where the resident was located.An interview with a Certified Nursing Assistant (CNA/staff #107) was conducted on April 22, 2026 at 9:51 a.m. Staff #107 stated that care/services provided by CNAs are documented on the resident's electronic health record (EHR). The CNA noted that there is a section specifically for CNA's to document their tasks. The tasks are documented as coded in the system depending on what the task is and what type of assistance is provided. The CNA said that there is a code for refusal, and resident being unavailable. According to the CNA, if the task is left blank then it meant that the staff member did not chart. It could mean that it was not provided. However, normally if a task is not provided then it should be coded as such. Per the CNA, if you did not do the task then you should put NA. Otherwise, if left blank then it becomes questionable whether the care was provided or not. The CNA said that it is important to provide the residents ADL care because it is for the resident's quality of life. The residents are in the facility to get help and the staff are there to help provide the care that the residents need. The CNA noted that the impact of not providing ADL care is that the residents would get angry, especially in the BU (Behavior Unit). The CNA said that you can tell when someone is not taken care. It affects the resident's mood, body, health and the quality of life goes down. According to the CNA, she is familiar with resident #55. Staff #107 said that the resident was a 2-person assist because of his behaviors. The CNA said that the resident did not use the toilet and used briefs. The CNA noted that the resident was very sexual and made the female CNAs wipe him extra, and refused care from men. The resident made you do extra wiping. The CNA indicated that they had to implement cares-in-pairs since the resident would complaint that he was not clean, and asked for extra changes. The CNA admitted that the staff was hesitant but still provided the resident care in the nicest way possible in order to get in and out of there. The CNA said that the staff had to start showing the resident the wipes after each wipe to prove that he was clean. The Bowel and Bladder task log for December 2025 was reviewed with the CNA. Staff #107 said that the blanks probably meant that the CNA did not chart. According to the CNA, the blank areas meant that you would not know if the care was provided. The CNA said that it is a problem because everything should be charted. The CNA said that she is unsure how it would impact the resident. However, for the overall look of the care it would be impactful since when the care conference is conducted, if the data is not there then if the resident for example was refusing care the staff would be unable to discuss since the data is not there for them to determine that that is an issue.During an interview with a Licensed Practical Nurse (LPN/staff #70) conducted on April 22, 2026 at 10:07 a.m., staff #70 stated that with regards to ADL care, her expectation is that residents are rounded on at least every 2-hours. The importance of providing ADL care is for the resident's dignity so that the resident is not sitting in (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, staff interviews and facility policy review the facility failed to ensure supervision was provided to one of 2 sampled resident (#93) for smoking, who was care planned to need supervision while smoking. The deficient practice could result resident needing supervision may not be able to manage their smoking in a way that minimizes harm. Findings include:Resident #93 was admitted on [DATE] with diagnoses of Parkinson's disease without dyskinesia, epilepsy, hereditary and idiopathic neuropathy, wedge compression fracture of T3 vertebrae, bipolar disorder and need to assistance with personal care. The admission note dated March 13, 2026 revealed that the resident was alert with no LOC (loss of consciousness) noted, was oriented to person, place , time and situation, required substantial/maximal assistance with chair/bed-to-chair transfer, and, had frequent pain and had limited participation in rehabilitation therapy sessions and day-to-day activities because of pain in the last 5 days of the assessment . Per the documentation, the resident will be smoking while at the facility. The smoking care plan included a goal that the resident will smoke safely; and, an intervention that facility staff will supervise the resident while smoking at designated times and will store smoking materials between designated times. The baseline care plan dated March 13, 2026 included the resident was at risk for functional self care deficits and/or functional mobility limitation. The care plan dated March 13, 2026 included that the resident wished to smoke while residing at the facility. The goal was that resident will smoke safely. Interventions included smoking evaluation completed on admission, quarterly and as needed, been evaluated to smoke independently, continually demonstrate safe smoking techniques including safe lighting materials, holding smoking materials safely, disposal of ashes, response to fallen ashes, secure storage of materials, and, facility staff will supervise the resident while smoking at designated times and will store smoking materials between designated times. The smoking assessment dated [DATE] revealed the resident used tobacco, did not demonstrate impaired ROM (range of motion), tremors, weak grasp, impaired cognition, oxygen use and impaired vision. The smoking care plan included that the resident wished to smoke while residing at the facility. Scoring determination included that the resident may smoke independently. However, care planning intervention included that facility staff will supervise the resident while smoking at designated times and will store smoking materials between designated times. The late entry NP (nurse practitioner) note dated March 24, 2026 included the resident was a current smoker. Assessments included tobacco use disorder and epilepsy. Per the documentation, resident was counseled on smoking cessation. The care plan dated March 26, 2026 revealed the resident was at risk for impaired cognitive function or impaired thought processes as evidenced by a BIMS (brief Interview for Mental Status) score of 8 indicating resident had moderate cognitive impairment. Interventions included resident needed supervision/assistance with all decision-making, use task segmentation to support short term memory deficits and present just one thought, idea, question or direction at a time. An observation was conducted on April 19, 2026 at 1:10 p.m. Resident #93 went to the nurse station to get lighter from the nurse who instructed resident to return the lighter back. Resident #93 then wheeled himself to the patio, lit his cigarette and smoked independently. There were no staff present in the patio the whole time the resident was smoking at the patio. Another observation was conducted on April 21, 2026 from 1:02 p.m. through 1:06 p.m. Resident #93 was sitting in a wheelchair on the designated smoking patio, smoking with three other residents. No staff were present on the patio at any time during this period. An interview with a certified nurse assistant (CNA/staff #36) was conducted on April 21, 2026 at 10:51 a.m. the CNA stated that, upon admission, staff would ask residents if they smoked; and, if a resident said yes, staff would inform the resident of the scheduled smoking times and the designated smoking area on the patio. She stated that the nurse kept the cigarettes and lighters. The CNA also said that if a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was independent with smoking, the nurse would give the resident a cigarette and lighter during the scheduled smoking time and the resident would then proceed to the patio and smoke alone. She stated that no staff were present on the patio during that time. The CNA said that if a resident required supervision while smoking, the nurse would give the cigarette and lighter to the resident, and a staff member would go with the resident to the smoking patio and would stay with the resident the entire time. In interview with the licensed practical nurse (LPN/staff #38) conducted on April 21, 2026 at 4:48 p.m., the LPN stated that staff assessed residents for smoking upon admission if the resident reported smoking or if staff found cigarettes on the resident. She stated that she would then conduct a smoking assessment by observing the resident light a cigarette and begin smoking; and, based on this, she would determine whether the resident could smoke safely. The LPN said that if a resident was independent with smoking, staff would inform the resident of the facility's smoking policy and schedule; and, at designated smoking times, residents would come to the nurse, who would then give the residents a lighter and two cigarettes. The LPN said that the resident would then go to the patio alone, and no staff were present because the resident was assessed as independent. Further, the LPN stated that on the unit where Resident #93 was admitted , she had never had a resident who required supervision while smoking. Another LPN (staff #31) joined the interview and stated that the priority for residents who smoke was to ensure they remained safe while smoking.During an interview conducted on April 22, 2026, at 11:18 a.m., the acting Director of Nursing (DON/staff #102) who stated that staff assessed residents for smoking safety upon admission; and, the facility had a designated smoking area and scheduled smoking times. The acting DON stated that staff kept cigarettes and lighters at the nurses' station; and at smoking time, residents goes to the nurse who would then give the residents two cigarettes and a lighter. She stated that the residents would then go to the designated smoking area and smoke independently. The acting DON said that residents who required supervision while smoking and were not safe to smoke were not allowed to smoke at all. She also stated that residents on the rehab unit, where Resident #93 was admitted , were generally independent with smoking. Regarding Resident #93, the acting DON stated that the resident was assessed as independent with smoking and had interventions in the care plan related to smoking safely. During the interview, the acting DON reviewed Resident #93's smoking assessment and stated that she understood how the assessment could be confusing because the section stating, facility staff will supervise [resident] while smoking at designated times and will store smoking materials, was checked on the intervention section of the form. The acting DON stated that she understood how the wording could cause confusion about whether Resident #93 could smoke independently without staff present or required staff supervision while smoking. The smoking policy with effective date of January 1, 2024 included that the facility has established policy and maintains safe resident smoking practices. Prior to, upon admission, residents are informed of the facility smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences. Smoking is only permitted in designated resident smoking areas, which are located outside of the building. Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: (a) current level of tobacco consumption; (b) method of tobacco consumption; (c) desire to quit smoking; and, (d) ability to smoke safely with or without supervision (per completed Safe Smoking Evaluation). The facility may impose smoking restrictions on a resident at any time if it is determined that the resident cannot smoke safely with the available levels of support and supervision. Any resident with smoking privileges requiring monitoring shall have direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking. Residents who have independent smoking privileges are permitted to keep cigarettes, electronic-cigarettes, pipes, tobacco, and other smoking items in their possession.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, interviews and facility polity, the facility failed to ensure staff changed oxygen tubing as ordered by the physician for 1 of 1 sampled resident (#2) for respiratory care. This deficient practice could lead to contaminated tubing and increase the risk of respiratory infections.Resident #2 was admitted on [DATE] with diagnoses of quadriplegia, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia and dependence on supplemental oxygen. A health status note dated March 25, 2026 included that the resident was alert and oriented x 4, answered all questions appropriately and had a caregiver at bedside upon admission. The baseline care plan dated March 25, 2026 included the resident was on oxygen therapy related to COPD. Intervention included oxygen per physician order. The baseline care plan did not include interventions related to oxygen use care such as tubing changes. The physician order dated March 25, 2026 revealed orders for oxygen at 0-5 LPM (liters per minute) as needed to keep oxygen saturation above 89% every shift; and to change oxygen tubing, humidifier bottle and to clean filter one time a day every Sunday for oxygen therapy. The daily skilled evaluation dated March 28, 2026 included that oxygen was in use. The orders for oxygen use, changing of tubing/humidifier bottle and cleaning the filter were transcribed onto the TAR (treatment administration record) for March 2026. Review of the March 2026 TAR included that the oxygen was administered as ordered on March 29, 2026; but, the changing of tubing/humidifier bottle and cleaning the filter was documented as code 9 indicating Other/see nurse notes on March 29, 2026. The clinical record revealed no documentation that the resident's oxygen tubing was changed as ordered on March 29, 2026, and no explanation for why it was not. The daily skilled evaluation dated March 30, 2026 included that oxygen was in use. The documentation did not include that the oxygen tubing was changed The admission MDS (Minimum Data Set) assessment dated [DATE] included active diagnoses of asthma/chronic lung disease, respiratory failure and chronic respiratory failure with hypoxia. The assessment also code use of oxygen. The daily skilled evaluations dated April 2, 3 and 13 2026 revealed that resident used oxygen. The orders for oxygen use, changing of tubing/humidifier bottle and cleaning the filter continued to be transcribed onto the TAR for April 2026. Review of the April 2026 TAR included that the changing of oxygen tubing/humidifier bottle and cleaning of the filter was documented as administered as ordered on April 5 and 12, 2026. Continued review of the TAR revealed that the changing of oxygen tubing/humidifier bottle and cleaning of the filter was documented as code 9 indicating Other/see nurse notes on April 19, 2026. The clinical record revealed no documentation that the resident's oxygen tubing was changed as ordered on April 19, 2026, and no explanation for why it was not.An observation was conducted on April 19, 2026 at 10:24 a.m. Resident #2 was observed lying in bed watching TV with a sitter in the room. She was using oxygen at 3.5 LPM and had her nasal cannula on and off during the observation. The oxygen tubing was connected to the concentrator. The oxygen tubing nasal prongs were brown-stained and had a small brown substance/particles inside the individual nasal prongs. There was no date on the tubing to show when it was last changed. Resident #2 said she uses oxygen all the time but did not know when the tubing was last replaced. In another observation conducted on April 20, 2026 at 4:20 p.m., Resident #2 was in bed watching TV with a nasal cannula in place. The oxygen tubing was connected to a humidifier on the floor, which was attached to an oxygen concentrator set at 3.5 LPM. There were no dates on the oxygen tubing or the humidifier. The caregiver in the room said she did not know when the oxygen tubing was last changed or when the humidifier was replaced; and that, the resident was on continuous oxygen and always has a caregiver present. The caregiver also said she works from 8:00 a.m. to 8:00 p.m. and did not see the tubing changed or the humidifier replaced during her shift. Resident #2 stated that she did know when her oxygen tubing was last changed. An interview was conducted with a licensed practical nurse (LPN/staff #84) on April 20, 2026 at 4:35 p.m. The LPN stated that staff changed the oxygen tubing (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	every night shift and replaced the humidifier as needed, and that they should date both the tubing and the humidifier to show when they last changed or replaced them. During the interview, an observation of Resident #2 was conducted with the LPN. The humidifier bottle was on the floor, and the LPN stated it should not have been placed there. She said that the bottle had no date showing when staff started using it; however, based on the amount of liquid, she believed it may have been started during the morning shift. The LPN further stated that the oxygen tubing had no date, and because of this, she could not determine when staff last changed the tubing or started the humidifier. An interview was conducted on April 21, 2026 at 11:59 a.m. with a registered nurse (RN/staff #61) who stated that when a resident was on oxygen staff changed oxygen tubing weekly and as needed and dated it each time they changed it. She also stated that staff replaced the humidifier bottle attached to the concentrator as needed, typically when the liquid level was almost empty. In an interview with another LPN (staff #38) conducted on April 21, 2026 at 4:48 p.m., the LPN stated that staff changed the oxygen tubing weekly, every Sunday, and that they needed to place a date on the tubing to show when it was changed. Another observation was conducted on April 22, 2026 at 9:05 a.m. Resident #2 and her caregiver was in the room. The caregiver stated that Resident #2 had been on continuous oxygen for five years and that the oxygen tubing was changed as needed when the resident was at home. She also stated that since the resident was admitted to the facility, she did not know when and how often the oxygen tubing was changed or who had changed it. Further, the caregiver stated that she did not know when the resident's oxygen tubing was last changed. During an interview with the acting Director of Nursing (acting DON/staff #102) conducted on April 22, 2026 at 11:18 a.m., the acting DON stated oxygen use must have an order that includes oxygen care and tubing changes. She stated that oxygen tubing is changed every seven days and as needed, per manufacturer guidelines. She also stated that when tubing is changed, staff document it on the TAR and that tubing changes required an order. She further stated that, per facility policy, staff do not date oxygen tubing when it is changed. The facility policy on Oxygen Administration included a purpose to provide guidelines for safe oxygen administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and facility policy review, the facility failed to ensure pre and post dialysis assessment was completed for 1 of 1 sampled resident (#3) for dialysis. The deficient practice could result in resident not consistently monitored after returning from receiving offsite dialysis. Findings include:Resident #3 was admitted on [DATE] with diagnoses of hypertensive CHD (chronic kidney disease) and ESRD (end-stage renal disease). The admission evaluation dated March 30, 2026 included that the resident was alert and oriented x 4 and was on EBP (enhanced barrier precautions) for dialysis catheter/port and chronic wounds. The physician order dated March 30, 2026 included for dialysis site care per facility protocol, to observe dialysis access site for signs/symptoms of infection every shift, and dialysis days of Monday-Wednesday-Friday at 5:45 a.m. The care plan dated March 30, 2026 revealed Resident #3 required hemodialysis related to ESRD. Interventions included to obtain vital signs and weight per protocol and to report significant changes in pulse, respirations and BP immediately. The NP (nurse practitioner) notes dated March 31 and April 2, 2026 included an assessment of ESRD. Plan was to continue hemodialysis Monday-Wednesday-Friday, left upper extremity AVF (arteriovenous fistula) care and to monitor laboratories, weight and fluid status. The offsite dialysis treatment note dated April 3, 2026 revealed that resident received dialysis treatment and left dialysis center at 2:55 p.m. The PT (physical therapy) note dated April 3, 2026 included that the resident was fatigued at the end of session and returned to his room as he had dialysis. However, there was no evidence found in the clinical record that a pre- and post dialysis assessments was completed by the facility on April 3, 2026. There was no documentation that resident's vitals signs were taken and dialysis access site was checked for presence or absence of bruits/thrills and signs/symptoms of bleeding and/or infection before and after dialysis on April 3, 2026. The admission MDS (Minimum Data Set) assessment dated [DATE] included resident was coded for dialysis. The vitals signs record for April 8, 2026 included the following documented vital signs:At 6:29 a.m., BP (blood pressure) of 139/68, pulse rate of 56 bpm (beats per minute), respiratory rate of 18 and temperature of 96.5 degrees Fahrenheit.At 9:44 a.m., BP of 124/61, pulse rate of 58, respiratory rate of 18 and temperature of 98.1 degrees Fahrenheit.The dialysis pre- and post eval note dated April 8, 2026 revealed no post-dialysis vital signs documented. The offsite dialysis treatment note dated April 8, 2026 included that the resident's departure time from dialysis was 3:40 p.m. on April 8, 2026 There were no vital signs documented found in the clinical record after the resident came back at the facility from dialysis on April 8, 2026. The daily skilled evaluations dated April 8 and 14, 2026 revealed the resident was on dialysis 3x/week. The dialysis pre- and post eval note dated April 17, 2026 revealed no post-dialysis vital signs documented. The vitals signs record for April 17, 2026 included the following documented vital signs:At 7:05 a.m., BP of 139/68, pulse rate of 76 bpm, respiratory rate of 20 and temperature of 97.3 degrees Fahrenheit.At 10:00 a.m., BP of 157/70, pulse rate of 76, respiratory rate of 20 and temperature of 97.3 degrees Fahrenheit.There were no vital signs documented found in the clinical record after the resident came back at the facility from dialysis on April 17, 2026. Review of the clinical record revealed no documentation of any reason why the resident's vitals signs were not taken after coming back from dialysis on April 8 and 17, 2026. An interview with a certified nurse assistant (CNA/staff #36) conducted on April 21, 2026 at 10:51 a.m. The CNA stated that if a resident was on dialysis, she would prepare the resident before they leave, takes vital signs, and records them in the clinical record before departure and after the resident returns from dialysis. Regarding Resident #3, the CNA stated that the resident goes to dialysis 3x/week. In an interview with another CNA (staff #20) conducted on April 21, 2026 at 11:30 a.m., the CNA stated that when a resident was on dialysis, she ensures that prior to dialysis, the resident was wearing clean clothes and have socks on. She said that she takes the weights and vital signs of a resident on dialysis before the resident goes to and after the resident (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comes back from dialysis. Regarding resident #3, the CNA stated that the resident goes to dialysis 3x/week. An interview with a registered nurse (RN, staff #61) was conducted on April 21, 2026 at 11:59 a.m. The RN stated that when a resident was on dialysis, a pre-dialysis assessment was completed, including the resident's weight, vital signs, pain level, and mood before leaving. She said that when the resident returns, the nurse on duty would then complete a post-dialysis assessment, which includes the same items as the pre-dialysis assessment. An interview was conducted on April 21, 2026 at 4:48 p.m. with a licensed practical nurse (LPN, staff #38) who stated that for residents on dialysis, she completes pre- and post-dialysis assessments, including weight, vital signs, and checking the access site for signs of infection, bleeding, and the presence of a bruit or thrill. She said the post-dialysis assessment includes the same items as the pre-dialysis assessment. She further stated that when the resident returns from dialysis, she also ensures the dressing is secure and pressure is applied to the access site, as some residents may pick at the dressing after dialysis. During an interview with the acting Director of Nursing (acting DON/staff #102) conducted on April 22, 2026, the acting DON stated that when a resident was on dialysis, the nurse completes pre- and post-dialysis assessments to ensure the resident was stable before and after treatment. She stated that the post-dialysis assessment must also confirm that pressure was applied to the dressing. The acting DON also said that pre- and post-dialysis assessments include documentation of vital signs, weight, and the condition of the access site; and, if the vital signs section was missing, the assessment is considered incomplete. The facility policy on Care of a Resident with ESRD, in effect on January 1, 2024, revealed that it is their policy that residents with end-stage renal disease (ESRD) will be cared for according to currently recognized standards of care.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews, and review of the clinical record and facility policy, the facility failed to ensure consulting pharmacy services identified and reported medication irregularities for one of 5 sampled residents (#72) for medications. The census was 87. The deficient practice could result in inaccurate administration of prescribed medications, incomplete documentation, and potential adverse medication reactions including toxicity, skin irritation, and drowsiness. Findings include: -Resident #72 was admitted on [DATE] with diagnoses of hip and spinal fractures, Dementia, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, and insomnia. A physician order dated March 13, 2026 included for Lidocaine (topical analgesic) External Patch 4% apply to affected areas topically one time a day for pain and remove per schedule. This order had a discontinued date of March 14, 2026. The progress notes dated March 16, 2026 revealed Lidocaine external patch 4% was administered to the resident per physician order.The physician order dated March 17, 2026 included for pain evaluation every shift, using a pain scale of 0-10, Lidocaine external patch 4% order to apply the patch to the affected areas topically one time a day for pain (start date of March 17, 2026). The Medication Regimen Review dated March 17, 2026 revealed the pharmacist did not identify any concerns/issue with the resident's external lidocaine patches 4%. The pharmacist did not identify that there was no order for the removal of the patch after application, and did not identify the lack of documentation indicating how long the patch remained on the resident after application. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 5 indicating the resident had severe cognitive impairment. The assessment included the resident had no hallucinations or delusions, rejection of care, or wandering. The progress notes dated March 21, 22, 25, and 29, 2026 revealed Lidocaine external patch 4% was administered to the resident per physician orderHowever, there was no documentation that the patch was removed and/or when it was removed after it was applied on these dates. A care plan initiated on March 26, 2026 revealed that resident was at risk for impaired cognitive function/dementia or impaired thought processes related to dementia and was on pain management for arthritis. Interventions included to administer medications as ordered, provide supervision/assistance with all decision-making, monitor and document for side effects. The order for the Lidocaine patch continued to be transcribed onto the April 2026 Medication Administration Record/Treatment Administration Record (MAR/TAR). The documentation in the MAR/TAR revealed that pain evaluation was completed on every shift, pain level ranged from 0-2, and the patch was documented as administered in the morning shift on April 1 through 5, April 6 through 10, April 13 through 17, and, April 20 through 22, 2026. However, the MAR/TAR did not include documentation indicating how long the patch remained in place and/or whether the patch was removed after application. Further review of the MAR revealed documentation that the resident refused application of the patch on April 2, 11, 12, 18, and 19, 2026. However, the documentation did not indicate whether a previously applied patch had been removed on those dates. Despite the lack of documentation in the clinical record regarding removal of the patch and/or the time of removal following application, the Medication Regimen Review dated April 14, 2026, revealed that the pharmacist did not identify any issues/concerns related to the resident's external Lidocaine 4% patches, did not identify the absence of an order addressing removal of the patch after application, and did not identify the lack of documentation indicating how long the patch remained on the resident after application. An interview was conducted with Licensed Practical Nurse (LPN/Staff #38) on April 22, 2026, at 8:50 a.m. The LPN stated that the protocol for Lidocaine patches was 12 hours on and 12 hours off the resident, and that only one patch was used unless otherwise ordered by the physician. The LPN stated that Lidocaine patches were generally ordered on an as-needed (PRN) basis and that residents often (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	refused them. The LPN further stated that the protocol for physician-ordered Lidocaine patches was to apply the patch for 12 hours and remove it after 12 hours. An interview was conducted with Registered Nurse (RN/Staff #102) on April 22, 2026, at 9:00 a.m. The RN stated that the normal protocol for Lidocaine patches was 12 hours on and 12 hours off; however, the physician's order would determine the specific instructions. The RN also said that there was no medical risk to the resident other than possible skin irritation. An interview was conducted with Certified Medication Assistant (CMA/Staff #101) on April 22, 2026, at 10:20 a.m. Staff #101, who regularly cared for Resident #72, stated that he applied a 4% Lidocaine patch to the resident's lower back that morning and removed the previous day's patch at the same time. He further stated that this was the normal procedure for Resident #72 and another resident on the hall who received Lidocaine patches. During the interview, a photograph of the Lidocaine patch packaging was taken. Review of the manufacturer's directions for use indicated the patch should not be used more than one at a time, could be applied three to four times daily, and should be removed after no more than eight hours of application. An observation was conducted April 22, 2026 at 10:47 a.m. of the medication cart containing Resident #72's lidocaine patch medication. A photo of the medication box was taken and manufacturer's instructions reviewed. The instructions on the medication's package advised the removal of the lidocaine patch after eight hours. A telephone interview was conducted with the pharmacist (Staff #400) on April 22, 2026, at 11:34 a.m. The pharmacist stated there were no physician orders in Resident #72's clinical record regarding removal of the 4% external Lidocaine patch. The pharmacist stated that Lidocaine patches were generally removed every 12 hours and that failure to remove the patch within the recommended timeframe posed a low risk to the resident; however, the medication could continue to be absorbed systemically.The pharmacist further stated that risks associated with not removing the patch included drowsiness, toxicity, and skin irritation, and that documentation of patch removal every 12 hours was important because of these risks. The pharmacist also stated that the order for Resident #72's Lidocaine patch should be changed to an as-needed (PRN) basis. Additionally, the pharmacist stated that her previous medication regimen review process included reviewing physician orders and documentation for patch removals in every instance. However, because experienced staff routinely removed the patches after 12 hours, she had discontinued that practice. The pharmacist stated she would consider resuming review of Lidocaine patch removal documentation, as well as documentation for other medications requiring removal records. The facility policy on Consultant Pharmacist Services, dated January 2026, revealed that services are to be rendered in accordance with local, state, and federal laws and regulations, facility guidelines, policy, and procedures, and the community standards of practice. This policy also revealed that the Consulting Pharmacist provides services including but not limited to: reviewing the medical record of each resident at least monthly, utilizing federally mandated standards of care in addition to other applicable standards, and documenting the review and findings in the resident's medical record. The facility is to then utilize this information in the resident's care plan and remedy any problems identified. Finally, the Consulting Pharmacist is to communicate to the responsible physician any potential or actual problems detected relating to medication therapy orders or found in the resident's record.This policy goes on to detail other responsibilities such as conducting annual in-service training for nursing staff on medication-related topics, serving on pertinent committees, assessing nursing staff performance in medication administration, and similar.

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	035094	A. Building B. Wing	04/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Sedona	505 Jacks Canyon Road Sedona, AZ 86351

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure proper control and accountability of medications, as evidenced by an unidentified medication left unattended on the floor for approximately 36 minutes, accessible to staff and residents, and not promptly addressed by multiple staff passing by. Additionally, the facility could not account for the origin of the medication. Census was 87.Findings include:Observation: On 04/20/2026 beginning at 9:58 AM, a small white pill was observed on the floor in the 100 hall, in front of room [ROOM NUMBER]. At 9:59 AM, a nurse walked past the pill without identifying or removing it. At 10:00 AM, the resource nurse was seated at the nurses' station; two CNAs walked past the pill, and three residents in wheelchairs passed by it. At 10:04 AM, another nurse and an additional resource staff member walked past the pill without intervention. Two additional residents and CNAs also passed the pill. At 10:09 AM, an RN and the facility chef walked past the pill; an RN was observed standing at the medication cart while the pill remained on the floor. At 10:14 AM, a Certified Nursing Assistant (CNA) wheeled a resident into room [ROOM NUMBER], rolling directly over the pill while looking down at the floor. At 10:19 AM, residents continued to traverse the hallway. At 10:20 AM, an LPN walked past the pill while appearing to scan the floor but did not remove it.At 10:23 AM, a CNA exited room [ROOM NUMBER] with a resident and again walked over the pill. At 10:26 AM, the Administrator walked down the hall and did not identify the pill. Throughout this time, multiple staff and residents had access to the unattended medication on the floor.At 10:34 AM, after being directed by the surveyor, an RN Staff # 61 retrieved the pill from the floor and identified it as Loratadine.The RN stated the medication did not belong to either resident in room [ROOM NUMBER] and was unable to identify its origin.On 04/20/2026 at 10:34 AM, RN (Staff #61) stated she administers medications on the hall using medication cups and spoons as needed and remains with residents until medications are taken. She further stated the resident in room [ROOM NUMBER] chooses which medications to take and may take them outside of her room.On 04/21/2026 at 7:10 AM, RN (Staff #61) stated a student nurse administered loratadine to a resident the prior day. The RN acknowledged the resident receiving loratadine had no documented allergy symptoms at that time.On 04/21/2026 at 9:06 AM, an interview was conducted with the resident identified by the RN (staff#61) who receives loratadine. The resident who had a Brief Interview for Mental Status (BIMS) score of 15 stated she was certain she received her medication the previous day and that a student administered it. The resident reported she knows her medications.The medication administration policy dated 2023 and identified as in effect on January 1, 2024 revealed that the medications must be kept in the locked medication cart and the cart must be inaccessible to residents or others passing by.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews and and review of facility policies and procedures, the facility failed to ensure the care plan reflected accurate documentation of the current assessment information for one (#6) of 25 sampled residents for care plan reviews. The census was 87. The deficient practice could result in staff relying on inaccurate or conflicting information, potentially impacting the resident's safety and/or level of independence.Findings include:Resident #6 was admitted to the facility on [DATE], with diagnoses including unilateral primary osteoarthritis (left knee), anxiety disorder, need for assistance with personal care, muscle weakness, post-traumatic stress disorder, history of falls on the same level, depression, and insomnia.A Nursing Smoking Evaluation dated February 3, 2026 included Resident #6 had no impairments and was assessed as able to smoke independently.Review of the care plan revealed a smoking focus initiated on February 3, 2026, indicating that Resident #6 wished to smoke while residing at the facility. The goal was that the resident would smoke safely through the review period. Interventions included that staff would supervise Resident #6 while smoking at designated times and store smoking materials between those times. An additional intervention indicated that Resident #6 was evaluated to smoke independently.Another Nursing Smoking Evaluation dated February 12, 2026 continued to document Resident #6 had no impairments and was assessed as able to smoke independently.On April 22, 2026, at 7:27 a.m., an interview was conducted with Certified Nursing Assistant (CNA/Staff #6) who stated that CNAs were trained to refer to residents' care plans to understand their needs and care requirements; and, if conflicting information was identified in a care plan, she would report the discrepancy to the nurse on duty.An interview was conducted with Licensed Practical Nurse (LPN/Staff #70) on April 22, 2026, at 8:12 a.m The LPN stated that nurses referenced care plans to ensure safe and appropriate care; and, may refer to either the smoking assessment or the care plan to determine whether a resident required supervision while smoking. The LPN further stated that if there were conflicting information identified, she would then report it to the Director of Nursing (DON).On April 22, 2026, at 9:33 a.m., an interview was conducted with the Acting Director of Nursing (DON/Staff #102) who stated it was the facility's expectation that clinical records and care plans are complete, accurate, and reflective of current assessments. During the interview, a review of the clinical record of Resident #6 was conducted by the acting DON who acknowledged the conflicting information in the care plan; and, stated that this did not meet the facility expectations and could potentially result in a loss of the resident's independence.Review of the facility policy titled Documentation: Charting and Documentation, effective January 1, 2024, indicated that all services provided to the resident, as well as progress toward care plan goals, must be documented in the medical record, and that documentation must be complete and accurate.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, and review of the clinical record and facility policy, the facility failed to ensure that vaccinations were administered in accordance with professional standards for one of five sampled residents (#87). The universe was 87. The deficient practice could result in the acquisition, transmission, or complications from influenza or pneumococcal disease.Findings include:-Resident #87 was admitted on [DATE], with diagnoses that included primary adrenocortical insufficiency, ulcerative colitis, immunodeficiency due to drugs, and adult failure to thrive.The immunization record of the resident revealed that the resident was pending immunization for the influenza vaccine and pneumococcal vaccine. The informed consent for influenza and pneumococcal vaccinations, dated January 13, 2026, revealed that the resident consented to receive both the influenza and pneumococcal vaccinations. Further review revealed that the influenza informed consent documented that the vaccination is to be administered annually between October and March.The physician order dated January 13, 2026 included for a prescription to receive the influenza vaccine, dated for January 13, 2026. The provider's orders also revealed a prescription for the resident to receive the pneumococcal vaccine, dated January 13, 2026.Review of the admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating the resident cognitively intact. Further review of the MDS also revealed that the resident was not up to date on their influenza or pneumococcal vaccination.An interview with Resident #87 was conducted on April 22, 2026, at 8:16 AM. Resident #87 stated she had consented to receive both the influenza and pneumococcal vaccinations, but had not received them. She further stated that the facility never explained why she had not received these vaccinations, and that she still wanted to receive these vaccinations.An interview was conducted on April 22, 2026, at 10:00AM with the acting Infection Preventionist/ Director of Nursing (IP/ DON/ Staff #102). Staff #102 stated that the process for administering vaccinations included nursing staff verifying allergies, resident consent, and appropriate timing as it related to the influenza vaccinations. Staff #102 further stated that after verification is complete, an order is entered by the provider, the vaccination is ordered from the pharmacy, then the vaccinations is administered by nursing staff and charted in the MAR. Staff #102 stated that a vaccination may not be administered if the resident refuses administration after previously accepting. Staff #102 confirmed there was not anything in Resident #87's chart to indicate a reason why vaccinations were not administered; she stated that she saw where the resident had consented to receive the influenza and pneumococcal vaccinations, the chart indicated that vaccination was pending, but there was no record of vaccine administration in the MAR. Staff #102 stated that this does not follow facility expectation.Signed documentation was provided on April 22, 2026, at 12:41PM that stated the facility had no documentation of her (Resident #87) vaccinations.Review of facility policy titled, Employee Health and Safety: Influenza Vaccine, stated that the influenza vaccination is offered between October 1 and March 31 every year; furthermore, administration of the influenza vaccination should be documented in the resident's medical record.Review of facility policy titled, Quality of Care: Pneumococcal Vaccine, stated that pneumococcal vaccinations are administered to residents per physician-approved protocols, and administration is documented in the resident's medical record.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on review of facility staffing documentation, and staff interviews, the facility failed to accurately post required daily information impacting all residents and visitors of the facility. The universe is 87. The deficient practice could result in residents and visitors being provided with inaccurate nursing staffing information. Findings include: The Facility Assessment with completed date of March 21, 2022 included an intent to evaluate its resident population and identify resources needed to provide the necessary person-centered care and services the residents require. The number of residents the facility were licensed to provide care for was 112. Average daily census ranged 85-95 with 20-30+ being short term stays. Average admissions per month is 40-50 and average number of discharges per month is 35-45. Staffing plan included licensed nurses registered nurse (RN), licensed practical nurse (LPN providing direct care, full time Director of Nursing (DON), at least 1 RN per 24 hour period, up to 6 certified nurse assistants (CNAs) in the day and evening shifts, and up to 4 CNAs in the night shift. The assessment included that the individual nursing staff assignments was based on patient care needs and individual staff needs/training.The Payroll-based journal Staffing Data Report (PBJ) for the facility indicated Excessively Low Weekend Staffing for July through December 2025. Review of the weekend Daily Staff Postings from July through December 2025 revealed that the staffing postings did not include the facility name, did not identify which staff were assigned to specific units and did not indicate whether staff working in the behavior unit were licensed and/or unlicensed.The Daily Staff Posting for September 28, 2025 included 211.5 total hours; however, the accurate number of Total Hours was 268.5.An interview with the administrator (staff #40) and human resources (HR/staff #53) conducted on April 21, 2026 at 9:33 a.m. Both staff stated that facility assessment, acuity and staff availability determines the staffing schedule; and that the facility was always appropriately staffed. The administrator stated that the facility also used agency staffing if needed but has not used it recently.An interview was conducted with the Administrator (Staff #40) on April 21, 2026, at 1:20 p.m. The Administrator stated that staffing levels were based on resident acuity, with the goal of meeting resident needs. She said that the staffing team, which included Human Resources, the Staffing Coordinator, and herself, reviewed and monitored areas requiring increased nursing care or time, such as residents with catheters, wounds, IV antibiotics, behavioral concerns, or transfer needs. The Administrator stated the Behavior Unit had 20 beds and the Long-Term Care Unit had 36 beds. She said the Staffing Coordinator, who was also present on the units, was aware of resident acuity in each area. She further stated that staffing decisions were guided by the Facility Assessment and were determined by both resident acuity and census. The Administrator stated she was not aware of any date when a nurse was not on duty in the facility. She said that the Director of Nursing (DON) would cover any unfilled shift, including CNA shifts, and that the Staffing Coordinator, who was a CNA, could also provide coverage if needed; and, that agency nursing staff would be used when necessary. Regarding the Daily Staff Posting, the Administrator stated the postings did not identify specific staff assignments or licensure designations. She said that notation BHU: 2 meant one nurse and one Certified Nursing Assistant (CNA) were assigned to the Behavior Unit during that shift. She also stated she was not aware that if a Certified Medication Assistant (CMA) provided incontinence care instead of passing medications, that CMA should be counted as a CNA rather than a CMA on the staffing posting. She also stated stated not being aware that if a Licensed Practical Nurse (LPN) worked or covered a CNA shift, those hours should be counted as CNA hours rather than LPN hours.