STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035095	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Desert Cove Nursing Center	1750 West Frye Road Chandler, AZ 85224

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to wear Personal Protective Equipment (PPE) and properly sanitize hands during resident care and interaction. The deficient practice could spread infection to other residents. -Regarding not wearing Personal Protective Equipment (PPE) Resident #2 was admitted to the facility on [DATE], with diagnoses that included neuromuscular dysfunction of the bladder, cellulitis of the right lower limb, Type 2 Diabetes Mellitus, and acquired absence of the left leg above the knee. During initial pool screening on September 22, 2025, at 7:41 AM, Resident #2 was observed to have a Foley catheter bag hanging on her bed rails. Upon entering the room, a Certified Nurse Assistant (CNA/Staff #89) was observed emptying the contents of the Foley bag into a plastic container. The CNA was observed to be wearing gloves, but was not observed to be wearing a gown. An interview was conducted with the CNA (Staff #89) immediately following the observation. The CNA stated that she only wears a gown when performing catheter care, but not during the procedure of emptying the catheter bag. An interview was conducted on September 23, 2025, at 12:51 PM, with the Director of Nursing (DON/Staff #1). The DON stated staff were to follow EBP guidelines by wearing a gown and gloves when performing any care with conditions such as feeding tubes, catheters, intravenous lines, and wounds. The DON stated specifically that she would expect staff to wear a gown and gloves when emptying a Foley catheter bag. A policy titled Indwelling Urinary Catheter (Foley) Management, last reviewed September 10, 2024, revealed that staff should wear gloves and gowns during any manipulation of the catheter or collecting system. A policy titled Transmission-based Precautions and Isolation Procedures, revised on August 19, 2025, revealed that staff should wear gloves and a gown during high-contact resident care activities that would prevent the transfer of viruses to staff hands and clothing. -Regarding not sanitizing hands between meal tray deliveries On September 22, 2025, at 12:03 PM, two CNAs were observed delivering lunch trays to residents (Staff #89 and #24). Staff #89 was observed delivering meal trays to four different residents' rooms. She was not observed to sanitize her hands between any of the rooms. Staff #24 was observed delivering meal trays to three different residents' rooms. She was not observed to sanitize her hands between any of the rooms. (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted with the Dietary Manager (Staff #200) on September 23, 2025, at 9:44 AM. She stated she expected staff to sanitize their hands in between delivering meals and meal trays to different residents, stating, I know they're supposed to sanitize between every resident. -Regarding Resident #44 Resident #44 was admitted to the facility on [DATE], with diagnoses including hereditary spastic paraplegia, epilepsy, neuromuscular dysfunction of the bladder, artificial opening of the urinary tract status, and presence of urogenital implants. A review of physician orders, dated October 28, 2024, revealed orders to secure the catheter with an anchoring device to prevent tension and to provide catheter care with warm water and soap every shift. Further physician orders, dated October 29, 2024, included an order for EnhancedBarrier Precautions (EBP) every shift related to a suprapubic catheter. A quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitive intactness. On September 21, 2025, at 8:20 a.m., Resident #44's room door was observed without Enhanced Barrier Precautions signage and without personal protective equipment (PPE) available at the door. At that time, Resident #44 stated that staff do not wear gowns during catheter changes. On September 22, 2025, at 3:04 p.m., Certified Nursing Assistant (CNA/Staff #119) was interviewed and stated that staff rely on signs at the door to indicate when EBP is in place. If no sign is present, precautions are not implemented. On September 22, 2025, at 3:18 p.m., Registered Nurse (RN/Staff #102) was interviewed and stated that signage at the door indicates when EBP is required, in order to protect residents and staff from potential contamination. On September 23, 2025, at 2:11 p.m., the Assistant Director of Nursing (ADON/Infection Preventionist, Staff #104) stated that the staff is made aware of EPB by a sign outside the door. PPE supplies are also required to be stored outside the resident's door. ADON #104 stated that,after reviewing the clinical record for resident #44, EBP signage and PPE supplies should be located at the door. At 2:23 p.m., ADON #104 visited Resident #44's room, where no signage or supplies were observed. At 2:26 p.m., the DON, Staff #1, was interviewed and confirmed the absence of signage and supplies at Resident #44's room. Staff #1 stated that the lack of supplies and signage posed an infection risk and did not meet the facility's standards. Review of the facility's Infection Prevention and Control Program (IPCP) Plan, revised June 2, 2025, revealed that the program includes the implementation of appropriate transmission-based precautions and use of PPE.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: 2Number of residents cited: 2Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure advance directives were completed and maintained for two residents (#9 and #58). The deficient practice could result in residents not receiving proper care according to their preferences or potential harm to the resident's life.-Regarding Resident #58 Resident #58 was admitted to the facility on [DATE], with diagnoses that included paraplegia, hypertension, major depressive disorder, chronic pain, anxiety disorder, and heart failure. During an initial pool record review on [DATE], evidence of Resident #58's advance directive wishes could not be located in the physician's orders or in the miscellaneous tab of his electronic record. Resident 58's Care Plan, dated [DATE], revealed that the resident was a full code, meaning he wanted cardiopulmonary resuscitation performed in the event of an emergency. An interview was conducted with a Licensed Practical Nurse (LPN/Staff #5) on [DATE], at 12:37 PM. The LPN reviewed Resident #58's electronic medical record and could not locate his code status. The LPN reviewed the resident's paper chart and located a notation indicating that the resident had chosen to be a full code. A physician had not signed the paper. The LPN stated that residents' code status should be documented in the electronic clinical record so staff can quickly refer to it in case of an emergency. On [DATE], at 12:56 PM, an interview was conducted with the Director of Nursing (DON/Staff #1). The DON looked in the electronic medical record and was unable to locate Resident #58's order for his code status. The DON stated the error most likely occurred when the resident returned from a recent hospital stay. She noted that all physician orders are discontinued when the resident is admitted to the hospital and then have to be reinstated upon the resident's return to the facility. The DON stated that Resident #58 was discharged from the hospital on [DATE], and returned to the facility. She stated that his advance directive orders were not reinstated into the system. The risk of not having a physician's order for a resident's advance directives could be that the resident's wishes would not be honored in case of an emergency. Resident #9 was admitted to the facility on [DATE], with diagnoses that included chronic obstructive pulmonary disease, asthma, type 2 diabetes, acute kidney failure, hypertension, anemia, urinary tract infection, major depressive disorder, infection and inflammatory reaction due to an indwelling urethral catheter, and hyperlipidemia. An admission Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. There was no evidence of an advance directive for full code or Do Not Resuscitate (DNR) in the MDS. There was no evidence of an order for full code or DNR. There was no evidence in the care plan of an advance directive. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no evidence of an advance directive document in the clinical record. An interview was conducted on [DATE] at 11:41 a.m. with a Certified Nursing Assistant (CNA/Staff#11) who stated that in case of an emergency, she would know to find a residents code status on the tablet at the nurses station, and that they do not have a physically-stored copy of the residents code status as far as she knew. An interview was conducted on [DATE] at 11:45 a.m. with a Licensed Practical Nurse (LPN/Staff#38) who stated that advance directives were established by alert residents or their Power of Attorney (POA), and upon admission they would have residents sign a paper, the nursing staff would get an order from the doctor, and the advance directive would then be found in the Electronic Health Record (EHR) under documents. The LPN stated that the document would be uploaded to the clinical record right away, and the paper would be stored in a binder within the resident's paper chart. The LPN stated that the MDS coordinator would also get a copy of the advance directives, and in an emergency situation, she would look into the physical chart or the EHR, and she would find the order on the banner. The LPN looked into Resident #9's EHR to find an advance directive and stated that she was not sure if he was a DNR or full code because there was no order or any evidence in the clinical record to show an advance directive was completed. The LPN stated that if the resident were to code, she would call the resident's wife to know what his advance directives were, but she would not have time for that in an emergency. The LPN looked in the paper chart for Resident #9 at the nurses' station and was unable to find an advance directive worksheet that was filled out for the resident in the full paper chart. The LPN spoke to the Nurse Practitioner (FNP/Staff#136) at the nurses' station and made her aware that Resident #9 did not have an advance directive order. The LPN stated that there was no advance directive form completed for Resident #9, as evidenced by the absence of the form in the EHR and paper chart. The LPN stated that the risk of not completing, maintaining, or obtaining an order for advance directives would be putting the patient's life at risk. An interview was conducted on [DATE], at 11:59 a.m. with the FNP, Staff #136, who stated that it was her understanding that Resident #9 was a full code; she did not have an order for the resident's advance directive, but that she was adding one right now. The FNP stated that she knew he was a full code because she saw a provider note that indicated it, but that there was not an order for him to be a full code. An interview was conducted on [DATE], at 12:08 p.m. with the Director of Nursing (DON/Staff#1) who stated that there should always be an advance directive in the hard chart on the unit and in the EHR. The DON stated that an order should be entered into the EHR for a full code or DNR so that it would show up on the banner and profile of the residents. The DON opened the clinical record of Resident #9 and stated that there was an order pending from the FNP, and stated which meant there was no order in the record before that. The DON further stated that the advance directives should have been completed as soon as possible upon admission, and the risk of not completing an advance directive for residents could be that they would not have their preferences honored. Review of a policy titled, Advance Directives and Advance Care Planning, with a review date of [DATE], revealed that the physician must give an order for any changes in the advance directives. The policy further revealed that residents who were competent at the time of admission and who had not previously executed an advance directive were given the opportunity to do so with the assistance of an interdisciplinary team, consisting of, but not limited to: the Medical Director, Executive Director, Director of Nursing, Director of Social Services, Chaplain, and others as appropriate. The policy also (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed that Social Services would ensure that a copy of the advance directive was obtained for the resident's medical record and verified that there was an appropriate physician's order in the resident's medical record as well. The policy revealed that documentation in the Minimum Data Set (MDS) should reflect the appropriate advance directives, and the information would be reviewed or updated. Review of a policy titled, CPR & First Aid, with a revision date of [DATE], revealed the facility would provide cardiopulmonary resuscitation (CPR) to any resident requiring such care in accordance with related physicians' orders, such as DNRs and the resident's advance directives. The policy further revealed that the facility would need to verify the presence of advance directives or the resident's wishes in regards to CPR upon admission, and immediately document it in the resident's medical record and contact the physician to obtain an order. The policy also revealed that the resident preferences and physician orders related to CPR and advance directives would need to be communicated so that staff would immediately know what action to take when an emergency arose.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documents, staff interviews and facility policy, the facility failed to ensure that 2 residents (#6, 66) were not abused. Findings include:--Regarding the incident between resident #100 and resident #66 -Resident #100 was admitted on [DATE], with diagnoses of Major Depressive Disorder, and Hemiplegia and Hemiparesis following cerebral infarction affecting the right dominant side. A quarterly Minimum Data Set (MDS) dated [DATE], included that this resident had moderately impaired cognition and that the resident used a wheelchair. A care plan dated January 4, 2024, included that resident #100 has impaired cognitive ability with impaired insight and poor recall. Interventions included to cue, reorient, and supervise. A Health Status Note dated March 19, 2024, included that resident #100 was witnessed by a CNA to be pulling on another resident's shirt as the other resident was propelling herself in her wheelchair by this resident. This note included that the other resident yelled, and the Licensed Practical Nurse (LPN) intervened, and this resident let go of the other resident's shirt. A Health Status Note dated April 1, 2024, included that resident #100 was in the dining room and was witnessed propelling herself towards another resident in an aggressive manner staff stopped her and redirected her back to where her lunch was. A Health Status Note dated April 10, 2024, included that at 1210pm, resident #100 was being pushed in her wheelchair by a kitchen aide, and she stated that resident #100 reached to her left and grabbed the left upper arm of another resident in the middle of the 100 hallway and pinched the other resident's arm. This note included that the Kitchen staff member said it was completely unprovoked and that the other resident was not even looking in this resident's direction prior to this occurring. The Kitchen aide stated that resident #100 quickly pinched her arm and let go, and the other resident touched her own upper arm discoloration with scratch marks noted immediately after the incident. This note included that the Kitchen aide asked in Spanish why she grabbed the other resident's arm, and resident #100 said because she is telling lies and saying they are a couple. Resident #100 took herself to her room, and resident #66 went into the dayroom. This note included that a complete body assessment was done for both residents and that family, staff, the physician, and the police were notified. -Resident #66 was admitted on [DATE], with diagnoses of Major Depressive Disorder and dementia. A quarterly MDS dated [DATE], included that this resident was severely cognitively impaired and had episodes of inattention and wandering. This document included that this resident used a wheelchair. A care plan dated June 17, 2023, included that this resident has impaired cognitive ability and/or impaired thought processes related to Alzheimer's dementia. This document included an intervention to cue, reorient, and supervise as needed. An event note dated April 10, 2024 included that at approximately 12:10 PM a dietary aide reported to the nurse that as she was pushing resident #100 in her wheelchair in the hallway toward the nurse's station, when resident #66 was propelling herself the opposite way, and the resident she was pushing reached out and grabbed the left upper arm of resident #66 but immediately let go. This note included that resident #66's left upper arm was checked by the nurse and that she is noted to have 3 discolored purple and red areas on her left upper arm. This note included that resident #66's family and physician were called. A skin check dated April 10, 2024, included that an area of impairment was found after an altercation with another resident that had purple/red discoloration on the left upper arm in 3 areas, which included the left hand, thumb side, and right forearm. An interview was conducted on September 23, 2025, at 1:36 PM with an LPN (staff #5) who said that resident #100 was not aggressive but that she did not like one of the residents who used to be in a room next to hers and that she said it was because she did not have friends like that. This nurse said that resident #100's son talked to her and told her it was because she believed the other resident wanted to be more than friends. This nurse confirmed that the resident was #66 and that the kitchen aide had come to her and said that she had seen resident #100 pinching resident #66. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This nurse said that she did not remember who the kitchen aide was. --Regarding the incident between resident #120 and #6:-Resident #120 was admitted on [DATE], with diagnoses of Bipolar disorder, other sequelae of cerebral infarction, and chronic pain syndrome.A quarterly MDS dated [DATE], included that this resident had a memory problem with short- and long-term memory and that this resident was severely impaired in making decisions regarding the tasks of daily life. This document included that this resident had impairment in all extremities. This document included that this resident used a wheelchair and that he required supervision for wheeling 50 feet with 2 turns and to wheel 150 feet.A health status note dated May 1, 2024, included that it was reported to the nurse that resident #120 was sitting outside his room in the hallway facing east, and struck the other resident on her right upper arm with an action figure, and that the victim's sister witnessed from the front desk. This nurse included that a 15-minute patient check was initiated.A psychosocial note dated May 3, 2024, included that resident #120's family was contacted to discuss care plan interventions related to resident #120's impulse control and discussed moving the resident's room. This note included that resident #120 continues to be monitored by staff and is with staff members when out of the room, dining, or in an activity. This note also included that when around other residents in his wheelchair, this resident should remain at least an arm's length away related to poor impulse control.-Resident #6 was admitted [DATE], with diagnoses of aphasia following cerebral infarction, muscle weakness, and hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side.A quarterly MDS dated [DATE], included that the resident was severely cognitively impaired and that this resident was impaired on one side of the upper and lower extremities. This document included that this resident used a wheelchair and that she required supervision for wheeling 50 feet with 2 turns and partial/moderate assistance to wheel 150 feet.An event note dated August 14, 2023, included that resident #120 was sitting in the lobby in her wheelchair next to resident #6. This note included that a sales representative was exiting the building and did knuckles with resident #120, and that resident #120 then reached over and hit resident #6 in her left arm 2-3 times and on her left neck area. This note included that the receptionist and admission director saw the incident and were able to separate the residents, and both were returned to their rooms. This note included that no injuries were found, that a new placement was being sought for resident #120, and that resident #120 will have staff present whenever he is out of bed.However, a health status note dated April 30, 2024, included that resident #6 was wheeling west down the hallway and got struck by another resident who was sitting outside his room in the hallway facing east. This note included that resident #6 got hit on her right upper arm with an action figure. This note included that the resident's sister witnessed from the front desk, heard her saying Ow, that hurt and that she looked and saw the other resident hit her. This note included that the other resident continued to wheel down the hall and that no other staff or residents observed the incident.An interview was conducted on September 23, 2025, at 10:53 with the family member who had witnessed the April 30, 2024, altercation. This family member said that resident #6 was sitting in the hallway in and resident #120 came by and he had this doll and he was hitting her, and I had told him to stop hitting, and he kept doing it. This family member said that resident #120 was hitting her on the arm and that there were no injuries except a red mark that went away. This family member said that the staff moved resident #120 further back into the nursing home and that resident #120 would always shake his fist at resident #6.An interview was conducted on September 23, 2025, at 1:08 with an LPN (staff #38) who said that resident #6 was forgetful and that she was not aggressive. This nurse said that resident #120 is still in the facility and that he does not speak, but that when he's excited, he will swing his fist that which means that he's happy about you, and that some people take it as aggression. This nurse said that she was told about the altercation and that she believes that resident #120 tried to use his toy to show he was excited and not in a bad way. This nurse said that she asked resident #66 about this incident the next day, and that she did not remember. An interview was conducted on September 23, 2025, at 3:36 PM with the Director of Nursing (DON/staff #1), who (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said that her expectation is that abuse does not happen. This DON said that she was not in the facility at the time of the incident, as she started work at the facility in May to June of 2024. This DON reviewed the incident between resident #120 and resident #6, and said that it is abuse because a resident is touching someone, and that he should not be touching someone. This DON said that if resident #120 had hit someone with the toy, then it would be abuse. This DON then reviewed the incident between resident #100 and resident #66 and said that pinching is abuse and that this incident sounded like abuse. A policy reviewed May 6, 2025, titled Abuse - Prevention included that it is the policy of this facility to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, staff interview, and facility policy review, the facility failed to ensure that 2 of 3 sampled direct-care staff (#87 and #118) maintained valid Cardiopulmonary Resuscitation (CPR) and first aid certifications as per their job descriptions. The deficient practice could result in potential harm to residents due to staff not being knowledgeable about how to provide emergency care to residents.Findings include: Review of a personnel file for a Licensed Practical Nurse (LPN/Staff#87) revealed no evidence of CPR or first aid certification. The personnel file also revealed a job description signed on [DATE], that says an LPN must have CPR certification upon hire or obtain during orientation. CPR certification must remain current during employment. Review of a personnel file for a Certified Nursing Assistant (CNA/Staff#118) revealed no evidence of CPR or first aid certification. The personnel file also revealed a job description signed on [DATE], that says a CNA must have CPR certification upon hire or obtain during orientation. CPR certification must remain current during employment. An interview was conducted on [DATE] and 2:22 p.m. with the admissions assistant and fill-in staffing coordinator (Admissions Assistant/Staff#113) who stated that the facility did not have a CPR and first aid certification for Staff #87 or Staff #118. An interview was conducted on [DATE] and 3:05 p.m. with the Interim Administrator (Administrator/Staff#201) who stated that Staff #118 was a CNA, and that the facility did not have a CPR or first aid certification for her. The administrator also stated that the facility did not have a CPR and first aid certification for Staff #87 who was an LPN, and she would have expected the personnel files to be complete and accurate. The administrator stated that it was her expectation that all direct-care staff including CNAs and LPNs obtain and maintain a CPR and first aid certification, and that it was the practice of the company for them to have a CPR card. The administrator further stated that the risk of direct-care staff not possessing a CPR and first aid certification could be that in an emergency situation, one or more staff responsible for life-saving care would not have the training. Review of a policy titled, Cardiopulmonary Resuscitation (CPR) Policy, with a revision date of [DATE] revealed that the facility would ensure that associates maintained current CPR certifications for Healthcare Providers through a CPR provider whose training was in accordance with accepted national standards, and with the required in-person skills assessment. Review of the Arizona Revised Statutes (A.R.S.) R9-10-403 (C)(1)(A,E, &F) revealed that an administrator shall ensure that policies and procedures are established, documented, and implemented to protect the health and safety of a resident that cover job descriptions, duties, and qualifications, including required skills, knowledge, education, and experience for personnel members, employees, volunteers, and students. The A.R.S. further revealed that the established and implemented policies and procedures cover cardiopulmonary resuscitation training including: which personnel members are required to obtain cardiopulmonary resuscitation training, the method and content of cardiopulmonary resuscitation training, the qualifications for an individual to provide cardiopulmonary resuscitation training, the time-frame for renewal of cardiopulmonary resuscitation training, and the documentation that verifies an individual has received cardiopulmonary resuscitation training. The A.R.S. also revealed that the established and implemented policies and procedures cover first aid training.

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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 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. Based on observation, staff interviews, and policy review, the facility failed to ensure current nurse staffing information was accurate for actual hours worked by licensed direct care nursing staff. The deficient practice could result in residents and visitors not being informed of accurate and current staffing information. Findings include:A review of August and September 2025 staff postings compared with the actual hours worked revealed that 3 out of 7 staff postings did not match the actual hours worked by staff. -August 26, 2025: staff posting indicated 6 Certified Nursing Assistants (CNAs) worked 48 hours on the night shift. Review of the total actual hours worked revealed that 5 CNAs worked 60 hours. -September 7, 2025: staff posting indicated 3 Licensed Practical Nurses (LPNs) worked the day shift, but the actual hours worked revealed 2 LPNs worked. The staff posting also indicated there were 4 LPNs who worked the night shift for 42 hours, but the actual hours worked should have been 48. The staff posting indicated 6 CNAs worked 48 hours on the night shift, but the total actual hours worked revealed 5 CNAs worked 60 hours. -September 16, 2025: staff posting indicated 3 LPNs worked the night shift, but actual hours worked revealed 2 LPNs on the night shift. An interview was conducted on September 23, 2025, at 10:57 a.m. with the Interim Administrator (Admin/Staff#201), who stated that the staff postings for August 26, September 7, and September 16, 2025, were all incorrect, and it was her expectation that the postings be correct and accurate. The administrator stated that there was a risk of improper documentation that could lead to a lot of issues, and although there was not necessarily a direct-care risk, there could be inherent risk in the inaccurate representation of staffing. A review of a policy titled, Staffing Posting and PBJ Submission, was revised in September 2025 and revealed that the facility must post the total number and actual hours worked by Registered Nurses (RNs), LPNs, and CNAs directly responsible for resident care per shift.

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	035095	A. Building B. Wing	11/19/2025

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and record review, the facility failed to ensure that medications were accurately acquired and administered to meet the needs of one resident (#58). This deficient practice could lead to mismanagement of the residents' symptoms.Resident #58 was initially admitted to the facility on [DATE], and most recently admitted on [DATE], with diagnoses that included paraplegia, hypertension, chronic pain, heart failure, major depressive disorder, and anxiety disorder.During initial pool screening, on September 21, 2025, at 11:58 AM, Resident #58 explained that the facility oftentimes runs out of his scheduled pain medication, leaving the resident to experience extreme pain.Resident #58's initial care plan indicated he was at risk for pain related to neuropathy, chronic pain, and generalized pain. One of the interventions was to administer pain medications as ordered.A review of Resident #58's provider orders revealed an order for Oxycodone, 15 milligrams (mg), one tablet every four hours.A review of the resident's medication administration record (MAR) was conducted for April 2025 through September 2025. The MAR revealed that the resident had not received his scheduled Oxycodone on April 24, 2025, June 24, 2025, July 6, 2025, July 29, 2025, August 22, 2025, and September 8, 2025. Progress notes for those dates revealed that the medication was not available. Additionally, the resident's pain levels had been scored between 9 and 10 on a 0-10 pain scale, with 10 being the worst pain.An interview was conducted with the Director of Nursing (DON/Staff #1) on September 23, 2025, at 1:00 PM. The DON stated that controlled substances, such as Oxycodone, require a signed prescription from the physician. She said there was sometimes a delay between the time the staff requests a new prescription and the time the physician signs it and gets it to the pharmacy. However, she also stated that the physician comes into the building regularly and is willing to sign prescriptions. The DON stated the facility should not be running out of residents' pain medications and that she expected staff to order the refill for the medications sooner, to prevent the issue from occurring.A policy titled Pain Assessment and Management, most recently reviewed on August 29, 2025, indicated that the facility must ensure that pain management was provided to residents consistent with professional standards and the residents' goals and preferences.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to ensure that one resident (#8) was free from significant medication errors. This deficient practice could lead to adverse outcomes for residents.Findings include:Resident #8 was admitted to the facility on [DATE], with diagnoses that included paraplegia, neuromuscular dysfunction of the bladder, diabetes mellitus, hypertensive heart disease, and bipolar disorder.A review of Resident #8's medication administration record (MAR) indicated the resident had the following medications due at 8:00 AM:-Dapagliflozin Propanediol, 10 milligrams (mg), one tablet in the morning-Aspirin EC (enteric coated) Delayed Release, 81 mg, one tablet one time a day-Baclofen, 10 mg, one tablet three times a day-Famotidine, 20 mg, one tablet two times a day-Fluticasone Propionate Nasal Suspension, 50 mcg/act (micrograms per actuation), one inhalation two times a day-Gabapentin, 100 mg, one tablet three times a day-Insulin Glargine 100 units/ml (milliliter), 35 units two times a day-Methocarbamol, 750 mg, one tablet two times a day-Multi-Vitamin, one tablet one time a day-Progesterone, 200 mg, one capsule one time a day-Propranolol HCl, 20 mg, one tablet two times a day-Simethicone Chewable, 80 mg, one tablet four times a day-Vitron-C, 65-125 mg, one tablet two times a [NAME] September 23, 2025, at 10:50 AM, a dressing change was being observed with a Registered Nurse (RN/Staff #111). During the dressing change, Resident #8 informed the wound nurse that she had not received her morning medications.On September 23, 2025, at 11:00 AM, a Licensed Practical Nurse (LPN/Staff #38) entered Resident #8's room to assess her blood glucose level and administer her morning medications. The RN (Staff #111) asked her to return after the dressing change was completed.On September 23, 2025, at 11:30 AM, an interview was conducted with the LPN (Staff #38), who stated she had not administered Resident #8's morning medications. She said she attempted to distribute them at 11:00 AM. The nurse reviewed the MAR and stated the medicines were due at 8:00 AM. The nurse indicated that she had tried to assess Resident #8's blood glucose level earlier in the morning, but the resident had refused. However, she had not attempted to administer the resident's medications at the time they were due.An interview was conducted with the Director of Nursing (DON/Staff #1) on September 23, 2025, at 1:14 PM. The DON reviewed the MAR and stated that Resident 8's medications were charted as administered at 10:57 AM. The DON confirmed that some medicines were scheduled to be administered at 8:00 AM, while others were scheduled to be administered between 6:00 and 10:00 AM. The abovementioned medicines were scheduled to be administered at 8:00 AM. The DON stated that she expected medications to be administered to residents one hour before they were due, up to one hour after they were due. She stated that the medicines that were due at 8:00 AM had been administered late and acknowledged that that was a medication error.A policy titled Administration of Medications, most recently reviewed on September 16, 2024, revealed that medications should be given at the time specified by the provider's order.

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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. Number of residents sampled: Number of residents cited: Based on observations, staff interviews, and a review of facility policies, the facility failed to ensure that expired medications were properly discarded and not available for use. These deficient practices could result in residents receiving expired medications, and could result in resident injury, medication overdose, or contradictions. The facility census was 69.An observation was conducted of the Central medication room on September 22, 2025, at 02:46 PM with the Assistant Director of Nursing (ADON/staff #104). The following expired medications were identified: Five boxes of unopened one-daily Multivitamin dietary supplement, with an expiration date of April 2025. One unopened box of zinc 50mg, with an expiration date of March 2025. Four unopened boxes of vitamin B-12 100mcs, with an expiration date of July 2025.During this observation, an interview was conducted with the ADON (Staff # 104). Staff #104 stated that all the nurses are responsible for checking and disposing of expired medications. Staff # 104 stated that she conducts weekly checks, and the pharmacy reviews them monthly. Expired meds are either returned to the pharmacy (if accepted) or destroyed using our Drug Buster system. It is expected that expired medications, especially in large quantities, will be promptly and properly disposed of. Staff # 104 stated that it falls below her expectations. Administering expired meds can harm residents, requiring physician notification and at least 72 hours of monitoring for adverse reactions. An interview was conducted with an LPN (Staff # 64) on September 23, 2025, at 2:26 PM, which revealed that all nurses were responsible for checking medications. The medication room is inspected monthly to identify expired meds and reorder low supplies. For narcotics, disposal of a single pill requires two nurses to witness, while full cards or expired narcotics must be handed to the DON or ADON. Expired medications should never be administered, as adverse effects may vary by drug. If an expired medication is given, even without a reaction, the physician and family will be notified immediately. Expired meds should never be left in storage; once identified, they must be destroyed without any delay.An interview was conducted with the Director of Nursing (Staff # 1) on September 23, 2025, at 2:50 PM stated that, as per the facility's policy, medications should be checked regularly, ideally monthly, and destroyed using the Drug Buster if expired. Nurses must check expiration dates when opening new bottles and label all opened OTC medications immediately. There is no designated person for medication storage; all the staff members share this responsibility. Storage rooms and carts should be checked at least monthly. Staff # 1 further stated that there is no formal reminder system; staff are expected to check expiration dates during the handling of medications. Administering expired meds carries risks, including reduced therapeutic effects, depending on the drug. Staff #1 further stated that the recently found expired medications practice was unacceptable and fell far below her expected standards.The facility's policy titled Storage and Expiration Dating of Medications and Biologicals, revised on August 1, 2024, included the following: The facility's policy requires that the facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with pharmacy return/destruction guidelines and other applicable law, and in accordance with policy.

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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 observations, record review, and staff interviews, the facility failed to ensure that the medication administration record (MAR) was accurately documented for one resident (#8). This deficient practice could lead to adverse outcomes for residents.Findings include:Resident #8 was admitted to the facility on [DATE], with diagnoses that included paraplegia, neuromuscular dysfunction of the bladder, diabetes mellitus, hypertensive heart disease, and bipolar disorder.A review of Resident #8's MAR indicated the resident had the following medications due at 8:00 AM:-Dapagliflozin Propanediol, 10 milligrams (mg), one tablet in the morning-Aspirin EC (enteric coated), Delayed Release, 81 mg, one tablet one time a day-Baclofen, 10 mg, one tablet three times a day-Famotidine, 20 mg, one tablet two times a day-Fluticasone Propionate Nasal Suspension, 50 mcg/act (micrograms per actuation), one inhalation two times a day-Gabapentin, 100 mg, one tablet three times a day-Insulin Glargine 100 units/ml (milliliter), 35 units two times a day-Methocarbamol, 750 mg, one tablet two times a day-Multi-Vitamin, one tablet one time a day-Progesterone, 200 mg, one capsule one time a day-Propranolol HCl, 20 mg, one tablet two times a day-Simethicone Chewable, 80 mg, one tablet four times a day-Vitron-C, 65-125 mg, one tablet two times a [NAME] September 23, 2025, at 10:50 AM, a dressing change was being observed with a Registered Nurse (RN/Staff #111). During the dressing change, Resident #8 informed the wound nurse that she had not received her morning medications.On September 23, 2025, at 11:00 AM, a Licensed Practical Nurse (LPN/Staff #38) entered Resident #8's room to assess her blood glucose level and administer her morning medications. The RN (Staff #111) asked her to return after the dressing change was completed.On September 23, 2025, at 11:30 AM, an interview was conducted with the LPN (Staff #38), who stated she had not administered Resident #8's morning medications. She said she attempted to distribute them at 11:00 AM. The LPN reviewed the MAR and stated the medicines were due at 8:00 AM. The nurse indicated that she had tried to assess Resident #8's blood glucose level earlier in the morning, but the resident had refused. However, she had not attempted to administer the resident's medications at the time they were due.While reviewing the MAR, it was noted that Resident #8's medications had been charted as having already been administered. The LPN stated that she had charted the medications as administered because she knew which medications Resident #8 would take, even though she had not yet administered them. The LPN acknowledged that that was a charting error.An interview was conducted with the Director of Nursing (DON/Staff #1) on September 23, 2025, at 1:14 PM. The DON reviewed the MAR and stated that Resident 8's medications were charted as administered at 10:57 AM. The DON stated that she expected medications to be charted as administered after the resident took the medicines.A policy titled Administration of Medications, most recently reviewed on September 16, 2024, revealed that medication administrations should be documented in a timely manner following the administration to the resident.