STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035130	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archstone Care Center	1980 West Pecos Road Chandler, AZ 85224

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and review of policy, revealed the facility failed to ensure one resident (#98) received the necessary care and services post fall and that one resident's (#25) durable medical equipment was applied to prevent a reduction in mobility and contracture. The deficient practice could result in residents not receiving the treatment and care, based on their assessed needs, resulting in increased contracture and reduced mobility.Findings Include: -Regarding Resident #98: Resident #98 was admitted on [DATE] with diagnosis including periprosthetic fracture around the internal prosthetic right knee join, hypertension, type 2 diabetes mellitus, chronic kidney disease, acute kidney failure, nonrheumatic mitral valve insufficiency, muscle weakness, and difficulty walking. A review of the electronic health record revealed a fall risk assessment on March 21, 2022 with a score of 13, indicating that the resident was a low fall risk. A review of the care plan revealed a focus area dated March 21, 2022 noting that the resident was at risk for falls due to recent illness, deconditioning and new environment. Interventions included to attempt and anticipate the resident's needs, ensure that the call light is within reach and encourage use, educate resident/family/ caregivers about safety reminders and what to do if a fall occurs, physical therapy to evaluate and treat as ordered, review information on past falls to attempt to determine cause of falls, record possible root causes of falls, remove potential causes of falls and educate regarding causes of falls, as well as that the resident was a 2-person assist. A review of the annual MDS (minimum data set) dated March 25, 2024 revealed a BIMS (brief interview of mental status) score of 07 indicating that the resident was severely cognitively impaired. The MDS further revealed that there had been no documented falls since admission. Under functional abilities and goals, it was documented that the resident was 'dependent' on staff for toileting hygiene, chair to bed as well as tub to shower transfers, with 'dependent' identified as the helper doing all of the effort or the assistance of 2 or more helpers required for the activity. A review of the facility 5-day report noted an incident on April 29, 2024 at 4:55 AM, which documented that resident #98 had 'rolled' out of bed and started falling while staff #111, CNA (certified nursing assistant) assisted her to the floor. The documented interview with staff #111 noted that staff #111 was in the process of changing the resident's sheets and that the resident was unable to balance her legs and subsequently dropped both legs to the floor. It was further noted that the CNA held the resident by the shoulders and let her sit on the floor. Staff #111 then reported that he called a nurse and that after a physical 'checkup' the nurse assisted the CNA to put the resident back into bed. (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 5-day report documented an interview with staff #52 CNA, who stated that when she observed the resident on April 29, 2024 at 8:30 AM, she was crying. The interview further revealed that the resident stated that she was crying because she had been dropped while a staff member was working with her and that the staff member tried to pick her up but couldn't, so he left to find someone else to assist. She then stated that the initial staff member and another staff member got her up and put her back into bed. Staff #52 stated that she pulled back the sheet and saw that the resident's left leg, from the knee up to the thigh, which looked swollen. Staff #52 stated that she reported this to the charge nurse, staff #84, LPN (licensed practical nurse) and the nurse (staff #84) stated that he would take care of it. The report further noted that staff #52 stated that at 9:30 AM on the same day, she reported to staff #74 ADON (assistant director of nursing) that the resident had not yet been 'checked on.' It was documented that the resident relayed to the ADON that when she fell she heard a crack that sounded like a stick breaking. The report further documented the resident was observed to be wet and staff #52 stated that she was 'afraid' to cause the resident further pain, as she was crying and begged not to be moved, but the CNA was instructed by the ADON to change the resident. Further documentation revealed that staff #52 had a conversation with staff #85, LPN (licensed practical nurse) the following day, April 30, 2024, to check on how the resident was doing and staff #85 reported that the resident had fallen out of bed and that no one had reported it. Staff #52 stated that she observed that the resident was still there and had not been treated. The report summary noted that the resident had a fall that resulted in an injury. Follow-up actions noted in the report included education of staff while providing care, proper documentation and communication with providers to ensure prompt care and a written warning to the staff #111, CNA for not following the care plan to ensure safe patient care. A review of the progress notes revealed a health status note dated April 29, 2024 at 7:22 PM noting that resident had complained of left knee pain from recent fall and was awaiting an x-ray which had not been completed yet. The note further revealed that the left knee appeared to be swollen, but no bruising or redness to the area. A review of the radiology report dated April 30, 2024 revealed a left femoral view documenting that resident #98 had a fracture of the distal femoral shaft with slight malalignment. A health status note on April 30, 2024 at 12:49 PM documented that an x-ray was conducted at 7:00 AM in the morning, which revealed that the resident had an acute femoral fracture and that an order was given to send the resident to the emergency room. The note further documented that transport arrived around 11:00 AM. An interview was conducted on January 15, 2026 at 2:40 PM with staff #102 LPN. Staff #102 stated that to ensure a resident's safety, transfers and brief changes should always be conducted as outlined in the resident's care plan, but if a fall occurs and the CNA is there or witnesses the fall, a nurse should be called to assess the resident and make sure that they are okay to be moved back into bed. The LPN further stated that if swelling to an extremity were present, she would call the doctor to see if the resident could be sent out for further assessment/ treatment. Staff #102 stated that she was familiar with resident #98 but was not on site when the fall occurred. She stated that she had heard that the resident was not sent to the hospital until a day or two later and stated that in her opinion, this was unacceptable. Staff #102 further stated that she had heard that the resident had been complaining of pain for a day or two prior to being sent to the hospital. Staff #102 stated that she knew who the CNA, involved with the fall, was and stated that she did not feel he had the skill set needed to be a CNA and that she didn't think he cared about the residents. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone call was placed on January 15, 2026 at 4:30 PM to staff #52, CNA. A message was left on the voicemail; however, no return call was received. A telephone call was placed on January 15, 2026 at 4:41 PM to staff #111, CNA. A message was left on the voicemail but no return call was received. The staff member was observed not to be on schedule during the duration of the survey. A telephone call was placed on January 15, 2026 at 4:43 PM to staff #11, CNA. A message was left on the voicemail requesting a call back. No return call was received. Additional calls were placed on January 16, 2026 at 8:45 AM and 9:00 AM to staff #111. Messages were left on the voicemail, but no return call received. A telephone call was placed on Januray 16, 2026 at 8:50 AM to staff # 45, RN (registered nurse). Message was left on the voicemail; however, the call was not returned. An interview was conducted on January 16, 2026 at 9:03 AM with staff #54 LPN. Staff #54 stated that if a fall occurred, a nurse would need to conduct an assessment to determine if there are any injuries, vitals would be taken and neuro-checks started if the fall was unwitnessed. The LPN stated that a CNA should never lift a resident back into bed, even if it was a witnessed fall, without the resident first being assessed by a nurse. Staff #54 further stated that the doctor would be contacted and notifications to family would take place, post fall. Staff #54 stated if the resident had pain in the arm(s) or leg(s) then range of motion should be established and that at times 911 may need to be called to assist with getting the resident up. Staff #54 stated that if the resident experienced a fall, had pain and needed an x-ray, this would be done the same day. Staff #54 stated that if the x-ray was not done the same day the risk could include increased pain and potential for embolism. Staff #54 stated that he did not recall resident #98. An interview was conducted on January 16, 2026 at 9:13 AM with staff, #98 CNA. Staff #98 stated that if a resident falls, he would first check that they are not injured and then call for help, but not leave the resident unattended in the room. Staff #98 stated that he would never attempt to get the resident back into bed until first having clearance from a nurse. He stated that if clearance was not obtained prior to moving the resident, it could result in further injury to the resident. Staff #98 further stated that if conducting a brief or sheet change, he would ensure that the resident is not too close to the edge, would use his body to block the resident, so they would not fall and ask for help if the resident was a 2-person assist. An interview was conducted on January 16, 2026 at 9:26 AM with staff #74 ADON (assistant director of nursing). Staff #74 stated that a resident's care plan is to be followed when providing care or treatment to a resident. She further stated that if a CNA observed a fall that they are expected to get help, and ensure that a nurse has assessed them before they can be moved. She further stated that the expectation would be that the doctor should be notified as well as their representative. Staff #74 further stated that pain or swelling should be relayed to the doctor and orders should be obtained to send the resident out if an injury was suspected. Staff #74 stated that a nurse is the doctor's eyes post fall, to relay if there is pain, swelling, redness, and different limb length, so the doctor can make an informed decision. Staff #74 stated that if some of the aforementioned were present or if there were other indicators of serious injury, a STAT x-ray would be ordered. Staff #74 stated that turn around for a STAT x-ray is generally 2-3 hours and that if it takes longer than that the resident should be sent out for evaluation and treatment. Staff #74 stated that it would never be okay for a resident to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wait more than 24 hours to have an x-ray post fall, further more if a resident exhibits extreme pain stating that they do not want to be moved, they should be sent out. The ADON stated that the risk for not conducting a timely x-ray or sending a resident out, could include increased pain and a worsening condition. Staff #74 reviewed the 5-day report and stated that the dates did not seem appropriate and that the x-ray order should have been a STAT, not routine order. Staff #74 stated that the time it took for the resident to obtain an x-ray and be sent out did not meet her expectations. She further stated that the nurse on duty at the time of the incident should have followed up, prior to going off duty and ensured the appropriate notifications transpired. Staff #74 further stated that doctor and family were not notified at the time of the incident and notifications had not occurred until April 30, 2024 at 12:14 PM. She further stated that a lapse in notifying the doctor or family timely, as well as not following the care plan did not meet professional standards nor quality of care for the resident. She stated that if professional standards are not followed then the resident is at risk for injury or a delay in treatment. A follow-up interview was conducted on January 16, 2026 at 1:25 PM with staff #74 (ADON). The ADON stated that staff #111, CNA was 'written-up' for not following the care plan for resident #98, as the resident should have been a 2-person assist. A review of the policy titled Compliance Risks-Resident Quality fo Care and Quality of Life with a revision date of January 2025 revealed that residents are to be provided a safe, clean and comfortable environment that is free from accident hazards and adequately supervised and that nursing staff have the appropriate training and levels of competency to ensure resident safety. A review of the policy titled Request for Diagnostic Services revised April 2007 revealed that emergency requests must be labled stat' to assure that prompt action is taken. A review of the policy titled Change in a Resident's Condition or Status revised February 2021 revealed that the facility is to promptly notify the resident, his or her attending physician and the resident representative of changes in the resident's medical/ mental condition and/ or status. The policy further documented that unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in injury. -Regarding Resident #25: Resident #25 was admitted to the facility on [DATE] with diagnosis that includes unspecified displaced fracture of surgical neck of right humerus, subsequent encounter for fracture with routine healing, Parkinson's disease without dyskinesia, without mention of fluctuations, unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, difficulty in walking, not elsewhere classified, need for assistance with personal care. Review of the annual Minimum Data Set (MDS) dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 3, indicating severely impaired cognition. There were no indicators for behaviors. Further review of the MDS revealed impairment on one side of the upper extremity and no impairment to the lower extremity. Review of the Care Plan revealed a focus for right humeral neck fracture. Interventions include encouraged use of the affected limb as much as tolerated to help maintain the range of motion and maintain the resident's body alignment. Further review revealed that focus areas for Parkinson's (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disease interventions include monitoring for muscle cramps or rigidity, decline in range of motion, and skin breakdown. Review of the physician orders revealed active orders for Pressure Relief Ankle -Foot Orthosis (PRAFO) boots to be worn on the left lower extremity for proper positioning due to foot drop. To be worn all day with a skin check from staff or nursing on every shift for skin integrity, redness, or irritation. Nursing to don and doff left hand roll: On at all times except during meals, as the patient uses the right hand to help feed self. Left hand roll to decrease further risk for contractures and or proper hand positioning. Perform skin checks for redness or skin irritation, Ankle -Foot Orthosis (AFO) to the left lower extremity when the patient is up in a wheelchair (WC). Remove when returning to bed. An initial observation was made of resident #25 during initial screening on January 13, 2026, at 8:42 am. Resident #25 was observed in a hallway in front of a nurse's station. Resident #25 is non-verbal, noted left hand contracture, clenched inward towards the chest. No devices in the resident's palm. A dressing to the right side of the neck with date, the wheelchair was tilted, and both feet were turned inwards. An observation was conducted on January 15, 2026, at 9:28 am of resident #25. The resident was observed in a wheelchair. There was no administration of the PRAFO boot to the left lower extremity for positioning due to foot drop, no AFO to the left lower extremity, and no left-hand roll. The resident was observed sitting in the wheelchair with both feet in a padded device on the footrests. The left wrist was curled against the stomach with the left fist contacted against the middle of the chest. An observation was conducted on January 16, 2026, at 8:14 am on resident #25. The resident was in the dining room being assisted with her breakfast. The resident did not have on the physician-ordered PRAFO boot to the left lower extremity for positioning due to foot drop, no AFO to the left lower extremity, and no left-hand roll. An observation was conducted on January 16, 2026, at 9:29 am on resident #25. The resident was in activities. The resident did not have on the physician-ordered PRAFO boot to the left lower extremity for positioning due to foot drop, or the AFO to the left lower extremity, nor a left-hand roll. Review of the Medication and Treatment Administration Record (MAR/TAR) for January 2026 revealed AFO to the left lower extremity when the patient is up in WC. Remove when returning to bed. Every shift for the contracture of the ankle. Order Date September 14, 2025, at 5:51 pm; PRAFO boots to be worn on the lower left extremity for proper positioning due to the foot drop. To be worn all day with skin checks from the staff or nursing on every shift for skin integrity, redness, or irritation. Order Date July 8, 2025, at 10:00 pm; Nursing to don and off left-hand roll: On at all times except during meals as patient uses B hands to help feed self. Left hand roll to decrease further risk for contractures and or proper hand positioning. Perform skin checks for redness or skin. -Order Date July 8, 2025, at 9:57 pm. Further review of. The MAR/TAR for these orders revealed check marks on January 13 and January 14, 2026 at 6 AM and 6 PM-6 AM. Review of MAR and TAR for December 2025 revealed no documentation for the administration of the physician-ordered AFO, PROFO, or hand roll for resident #25. An interview was conducted with Licensed Practical Nurse (LPN/Staff #54) on January 16, 2026, at 9:31 am. Staff # stated that the PRAFO boot is to keep the feet straight and stated the AFO has (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	contradicting orders. Staff #54 stated the purpose of the handroll is to stop the hand from contracting. Staff #54 conducted an observation of resident #25, noting the PRAFO, AFO, or the handroll for the left hand had been placed on the resident. Staff#54 stated the devices would be placed on the resident, but she would remove them, so they stopped placing them on her. Staff #54 declined to comment on why it was documented that the resident had the DME placed when it had not. Staff #54 stated that there is no documentation that the family was consulted or agreed that the boots and handroll were no longer feasible for the resident, and that he should have notified the physician. Staff #54 stated the boots were causing the resident's wounds on her legs, but there is no documentation to support this. Staff #54 stated that the risks with not documenting, not placing, or following physician orders for durable medical equipment place the resident at risk for further decline in functional ability, further contracture of the hand and further foot drop. Staff #54 stated he did not document that the resident did not tolerate the boot, and this was his mistake. An interview was conducted on January 16, 2026, at 10:30 am with Certified Nursing Assistant (CNA/Staff#61). Staff #61 stated she was that the resident was supposed to be wearing them since she had not for a while, but had not been informed to stop placing the resident's DME. Staff #61 stated the resident had not worn the boots for a while because they were hurting her legs, but she does have a foam cushion on her footrests to protect her legs. An interview was conducted with the Assistant Director of Nursing (ADON/Staff #74) on January 16, 2026, at 11:22 am. The ADON stated she expects staff to follow doctors' orders or notify if there is a concern. The ADON stated the restorative nursing assistant may have completed that documentation as to why the DME had not been placed and stated, I will have to check as see if there is RNA documentation and get back to you. The ADON stated that the risks of not following physicians' orders for DME can cause further contracture or a limited range of motion. The ADON did not provide any documentation regarding the residents' administration of DME. Review of the facility policy titled Assistive Device and Equipment states, our facility maintains and supervises the use of assistive devices and equipment for residents.1. Certain devices and equipment that assist with resident mobility, safety, and independence are provided for residents.

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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 clinical record reviews, staff interviews, facility documentation, policy and procedures, the facility failed to ensure that one resident (#98) received adequate supervision and assistance to mitigate falls and to abide by professional standards regarding post fall protocol. The universe was 81 and the sample size was 22. The deficient practice could contribute to resident injuries and delay in treatment/ notifications. Findings include:Resident #98 was admitted on [DATE] with diagnosis including periprosthetic fracture around the internal prosthetic right knee join, hypertension, type 2 diabetes mellitus, chronic kidney disease, acute kidney failure, nonrheumatic mitral valve insufficiency, muscle weakness, and difficulty walking.A review of the annual MDS (minimum data set) dated March 25, 2024 revealed a BIMS (brief interview of mental status) score of 07 indicating that the resident was severely cognitively impaired. The MDS further revealed that there had been no documented falls since admission. Under functional abilities and goals, it was documented that the resident was ?dependent' on staff for toileting hygiene, chair to bed as well as tub to shower transfers, with ?dependent' identified as the helper doing all of the effort or the assistance of 2 or more helpers required for the activity.A review of the electronic health record revealed a fall risk assessment on March 21, 2022 with a score of 13, indicating that the resident was a low fall risk. A review of the care plan revealed a focus area dated March 21, 2022 noting that the resident was at risk for falls due to recent illness, deconditioning and new environment. Interventions included to attempt and anticipate the resident's needs, ensure that the call light is within reach and encourage use, educate resident/family/ caregivers about safety reminders and what to do if a fall occurs, physical therapy to evaluate and treat as ordered, review information on past falls to attempt to determine cause of falls, record possible root causes of falls, remove potential causes of falls and educate regarding causes of falls, as well as that the resident was a 2-person assist.A review of the facility 5-day report noted an incident on April 29, 2024 at 4:55 AM, which documented that resident #98 had ?rolled' out of bed and started falling while staff #111, CNA (certified nursing assistant,) assisted her to the floor. The documented interview with staff #111 noted that staff #111 was in the process of changing the resident's sheets and that the resident was unable to balance her legs and subsequently dropped both legs to the floor. It was further noted that the CNA held the resident by the shoulders and let her sit on the floor. Staff #111 then reported that he called a nurse and that after a physical ?checkup' the nurse assisted the CNA to put the resident back into bed.The 5-day report documented an interview with staff #52 CNA, who stated that when she observed the resident on April 29, 2024 at 8:30 AM, she was crying. The interview further revealed that the resident stated that she was crying because she had been dropped while a staff member was working with her and that the staff member tried to pick her up but couldn't, so he left to find someone else to assist. She then stated that the initial staff member and another staff member got her up and put her back into bed. Staff #52 stated that she pulled back the sheet and saw that the resident's left leg, from the knee up to the thigh, which looked swollen. Staff #52 stated that she reported this to the charge nurse, staff #84, LPN (licensed practical nurse) and the nurse (staff #84) stated that he would take care of it. The report further noted that staff #52 stated that at 9:30 AM on the same day, she reported to staff #74 ADON (assistant director of nursing) that the resident had not yet been 'checked on.' It was documented that the resident relayed to the ADON that when she fell she heard a crack that sounded like a stick breaking. The report further documented the resident was observed to be wet and staff #52 stated that she was ?afraid' to cause the resident further pain, as she was crying and begged not to be moved, but the CNA was instructed by the ADON to change the resident. Further documentation revealed that staff #52 had a conversation with staff #85, LPN (licensed practical nurse) the following day, April 30, 2024, to check on how the resident was doing and staff #85 reported that the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had fallen out of bed and that no one had reported it. Staff #52 stated that she observed that the resident was still there and had not been treated. The report summary noted that the resident had a fall that resulted in an injury. Follow-up actions noted in the report included education of staff while providing care, proper documentation and communication with providers to ensure prompt care and a written warning to the staff #111, CNA for not following the care plan to ensure safe patient care.A review of the progress notes revealed a health status note dated April 29, 2024 at 7:22 PM noting that resident had complained of left knee pain from recent fall and was awaiting an x-ray which had not been completed yet. The note further revealed that the left knee appeared to be swollen, but no bruising or redness to the area.A review of the Fall Review note dated April 30, 2024 at 12:14 AM revealed that the family, doctor and DON (director of nursing) were notified; however, there was no evidence in the progress notes of prior notifications at the time of the incident.A review of the radiology report dated April 30, 2024 revealed a left femoral view documenting that resident #98 had a fracture of the distal femoral shaft with slight malalignment.A health status note on April 30, 2024 at 12:49 PM documented that an x-ray was conducted at 7:00 AM in the morning, which revealed that the resident had an acute femoral fracture and that an order was given to send the resident to the emergency room. The note further documented that transport arrived around 11:00 AM.An interview was conducted on January 15, 2026 at 2:40 PM with staff #102 LPN. Staff #102 stated that to ensure a resident's safety, transfers and brief changes should always be conducted as outlined in the resident's care plan, but if a fall occurs and the CNA is there or witnesses the fall, a nurse should be called to assess the resident and make sure that they are okay to be moved back into bed. The LPN further stated that if swelling to an extremity were present, she would call the doctor to see if the resident could be sent out for further assessment/ treatment. Staff #102 stated that she was familiar with resident #98 but was not on site when the fall occurred. She stated that she had heard that the resident was not sent to the hospital until a day or two later and stated that in her opinion, this was unacceptable. Staff #102 further stated that she had heard that the resident had been complaining of pain for a day or two prior to being sent to the hospital. Staff #102 stated that she knew who the CNA, involved with the fall, was and stated that she did not feel he had the skill set needed to be a CNA and that she didn't think he cared about the residents.A telephone call was placed on January 15, 2026 at 4:30 PM to staff #52, CNA. A message was left on the voicemail; however, no return call was received.A telephone call was placed on January 15, 2026 at 4:41 PM to staff #111, CNA. A message was left on the voicemail but no return call was received. The staff member was observed not to be on schedule during the duration of the survey.A telephone call was placed on January 15, 2026 at 4:43 PM to staff #11, CNA. A message was left on the voicemail requesting a call back. No return call was received.Additional calls were placed on January 16, 2026 to staff #111. Messages were left on the voicemail, but no return calls received.A telephone call was placed on Januray 16, 2026 at 8:50 AM to staff # 45, RN (registered nurse). Message was left on the voicemail; however, the call was not returned.An interview was conducted on January 16, 2026 at 9:03 AM with staff #54 LPN. Staff #54 stated that if a fall occurred, a nurse would need to conduct an assessment to determine if there are any injuries, vitals would be taken and neuro-checks started if the fall was unwitnessed. The LPN stated that a CNA should never lift a resident back into bed, even if it was a witnessed fall, without the resident first being assessed by a nurse. Staff #54 further stated that the doctor would be contacted and notifications to family would take place, post fall. Staff #54 stated if the resident had pain in the arm(s) or leg(s) then range of motion should be established and that at times 911 may need to be called to assist with getting the resident up. Staff #54 stated that if the resident experienced a fall, had pain and needed an x-ray, this would be done the same day. Staff #54 stated that if the x-ray was not done the same day the risk could include increased pain and potential for embolism. Staff #54 stated that he did not recall resident #98.An interview was conducted on January 16, 2026 at 9:13 AM with staff, #98 CNA. Staff #98 stated that if a resident falls, he would first check that they are not injured and then call for help, but not leave the resident unattended in the room. Staff #98 stated that (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he would never attempt to get the resident back into bed until first having clearance from a nurse. He stated that if clearance was not obtained prior to moving the resident, it could result in further injury to the resident. Staff #98 further stated that if conducting a brief or sheet change, he would ensure that the resident is not too close to the edge, would use his body to block the resident, so they would not fall and ask for help if the resident was a 2-person assist.An interview was conducted on January 16, 2026 at 9:26 AM with staff #74 ADON (assistant director of nursing). Staff #74 stated that a resident's care plan is to be followed when providing care or treatment to a resident. She further stated that if a CNA observed a fall that they are expected to get help, and ensure that a nurse has assessed them before they can be moved. She further stated that the expectation would be that the doctor should be notified as well as their representative. Staff #74 further stated that pain or swelling should be relayed to the doctor and orders should be obtained to send the resident out if an injury was suspected. Staff #74 stated that a nurse is the doctor's eyes post fall, to relay if there is pain, swelling, redness, and different limb length, so the doctor can make an informed decision. Staff #74 stated that if some of the aforementioned were present or if there were other indicators of serious injury, a STAT x-ray would be ordered. Staff #74 stated that turn around for a STAT x-ray is generally 2-3 hours and that if it takes longer than that the resident should be sent out for evaluation and treatment. Staff #74 stated that it would never be okay for a resident to wait more than 24 hours to have an x-ray post fall, further more if a resident exhibits extreme pain stating that they do not want to be moved, they should be sent out. The ADON stated that the risk for not conducting a timely x-ray or sending a resident out, could include increased pain and a worsening condition. Staff #74 reviewed the 5-day report and stated that the dates did not seem appropriate and that the x-ray order should have been a STAT, not routine order. Staff #74 stated that the time it took for the resident to obtain an x-ray and be sent out did not meet her expectations. She further stated that the nurse on duty at the time of the incident should have followed up, prior to going off duty and ensured the appropriate notifications transpired. Staff #74 further stated that doctor and family were not notified at the time of the incident and notifications had not occurred until April 30, 2024 at 12:14 PM. She further stated that a lapse in notifying the doctor or family timely, as well as not following the care plan did not meet professional standards nor quality of care for the resident. She stated that if professional standards are not followed then the resident is at risk for injury or a delay in treatment.A follow-up interview was conducted on January 16, 2026 at 1:25 PM with staff #74 (ADON). The ADON stated that staff #111, CNA was 'written-up' for not following the care plan for resident #98, as the resident should have been a 2-person assist.A review of the policy titled Compliance Risks-Resident Quality of Care and Quality of Life with a revision date of January 2025 revealed that residents are to be provided a safe, clean and comfortable environment that is free from accident hazards and adequately supervised and that nursing staff have the appropriate training and levels of competency to ensure resident safety.A review of the policy titled Care Plans-Baseline with a revision date of March 2022, revealed that the care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality of care.A review of the policy titled Care Plans, Comprehensive Person-Centered with a review date of March 2022, revealed that the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Furthermore, the policy documented that the care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem area and their causes and relevant clinical decision making.A review of the policy titled Change in a Resident's Condition or Status revised February 2021 revealed that the facility is to promptly notify the resident, his or her attending physician and the resident representative of changes in the resident's medical/ mental condition and/ or status. The policy further documented that unless otherwise instructed by the resident, a nurse will notify the resident's representative when the resident is involved in any accident or incident that results in injury.

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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** Based on observations, staff interviews, and the facility policy and procedures, the facility failed to ensure a resident (#48) did not have medications at bedside without the presence of an assessment and orders and failed to ensure treatment cart with prescriptions treatments was locked. The deficient practice could lead to medication interactions, inaccurate dosing and others having unrestricted access to medications. The universe was 81. The sample size was 22. Findings include: -Regarding Resident #48 Resident #48 was admitted on [DATE] with diagnosis including the presence of a right artificial hip joint, atrial fibrillation, hypertension, need for assistance with personal care, encephalopathy, urinary tract infection and hypertensive heart disease. An observation was conducted on January 13, 2026 at 8:57 AM in the room of resident #48. The observation revealed Equate Nasal Spray and Dermal Wound Cleanser on the bedside table. A review of the MDS (minimum data set) dated November 30, 2025 revealed a BIMS (brief interview of mental status) score of 11, indicating that the resident had moderate cognitive impairment. A review of the physician orders revealed an order for Fluticasone Furoate nasal suspension, 1 spray in each nostril every 24 hours as needed for allergies. However, there was no evidence in the physician orders for Equate Nasal Spray or it's equivalent or for the dermal wound cleanser. Furthermore, physician's orders revealed no evidence of an order for medication self-administration. A review of the electronic health record revealed no evidence that the resident was assessed for self-administration of medications. A review of the care plan revealed that the resident was at risk for impaired skin integrity and had a documented right lateral skin tear. The documented interventions included that medications are to be administered as ordered and to monitor/ document for side effects and effectiveness. The care plan further noted that the resident had impaired cognitive function/ dementia or impaired thought processes. An interview was conducted on January 13, 2026 at 9:05 AM with staff #61, CNA (certified nursing assistant). Staff #61 stated that a medication is any prescribed or over the counter treatment. Staff #61 stated that nasal spray would be a medication but was unsure if dermal wound cleanser would be classified as a medication. Staff #61 stated that medications should not be at the resident's bedside and that the risk could include a resident using the medication inappropriately. An interview was conducted on January 13, 2026 at 9:08 AM with staff #84, LPN (licensed practical nurse). Staff #84 stated that both equate nasal spray and dermal wound cleaners would be considered medications and these should not be at bedside. Staff #84 removed both medications from the resident's bedside table. Staff #84 stated that the risk could include another resident picking the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications up and using them. A follow-up interview with staff #84, LPN was conducted on January 13, 2026 at 10:08 AM. The LPN stated that a resident would have to be assessed for the ability to self-administer medications and an order would be put in place. Staff #84 stated that the resident would then be reassessed every 6 months, or sooner if warranted such as a change in condition, to ensure that they are still safely able to self-administer medications. Staff #84 stated that he checks the resident rooms for medications during medication administration. An interview was conducted January 16, 2026 at 10:00 AM with staff #74 ADON (assistant director of nursing). The ADON stated that medications are to be administered as ordered and that a resident would need to be assessed to be able to self-administer medications. She stated that risk for medications at bedside without an assessment could include inaccurate dosing, use of a medication outside of the intended use, and someone else accessing the medication. Regarding unlocked treatment cart: An observation was conducted on January 15, 2026 at 8:13 a.m. and revealed that a cart was unlocked, facing away from the nurses' station. Staff, residents and visitors were walking past the cart. An interview was conducted with licensed practical nurse (LPN) Staff #38 on January 15, 2026 at 8:14 a.m. and revealed the cart was a treatment cart with supplies. Staff #38 opened the treatment cart and prescription treatments were in the cart. The cart is supposed to be locked. A resident could get in the cart. An interview was conducted with assistant director of nursing (ADON) Staff #74 on January 15, 2026 at 10:31 a.m. and revealed that nurses have a key to the medication cart they are assigned to. There are 4 medication carts and 2 treatment carts. One of the treatment carts has a code that is needed to open and access the contents of the cart. The other treatment cart is opened by a key. The wound nurse has the key for the cart. When the wound nurse is not at the facility the key is kept in the wound office and the staff can get the key from the wound office. The residents could get into the cart and the medications in it. An observation was conducted on January 16, 2026 at 3:06 p.m. and revealed a nurse standing at a medication cart and a resident sitting in a wheel chair behind the nurse. The nurse secured the computer screen and walked around the outside of the nurse's station, into a room and the door closed after the nurse. The medication cart was not secured. The nurse opened the door and came out of the room, around the nurse's station and back to the medication cart. An interview was conducted with LPN Staff #102 on January 16, 2026 at 3:07 p.m. and revealed that the cart was left unsecured but that the staff went over there, pointing to the other side of the station. The risk for not having the medication cart secured is that someone could grab something. Review of the facility policy titled, Storage of Medications version 1.3 revealed that in section 6.0, compartments (including carts) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended. A review of the policy titled Administering Medications, revised April 2019 noted that medications are (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to be administered in a safe and timely manner, and as prescribed. The policy further noted that residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision-making capacity to do so safely.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observations, staff interviews, and policy, the facility failed to ensure that garbage and refuse were maintained properly.Findings include:During a walkthrough of the kitchen conducted on January 14, 2026, at 12:04 PM with Diet Technician/staff # 40, an observation was conducted of the facility dumpster area. Observed were two soiled gloves under the garbage receptacle, and trash debris was observed surrounding the outside perimeter. The lid to the garbage receptacle was open with a large number of flies. The lower left exterior of the receptacle had a rusted area approximately 6-7 inches in length that was dripping a liquid substance, milky in color that had formed a small puddle beneath the garbage receptacle with flies. The substance had a strong rancid odor. Also observed a Home Depot bucket filled with empty soda cans, empty food bags, and other garbage. There were multiple flies observed inside the bucket. An interview was immediately conducted on January 14, 2026, at 12:22 PM with Diet Technician/staff # 40, who stated the refuse area is maintained by the maintenance department, but it is expected that anyone disposing of garbage ensure that the lid is closed at all times. Staff #40 stated she was unaware of what the substance was leaking from the garbage receptacle. Staff #40 stated the risk of having the garbage receptacle lid open and having an unclean area surrounding it as it can attract vermin and pests. An interview was conducted on January 16, 2026, at 12:39 PM with Dietary Supervisor (Staff # 101). Staff # 101 stated that the cleaning of the garbage receptacle area is a collaborative effort of keeping the area clean, but is unaware of who is responsible for maintaining the area. Staff # 101 stated that the risks of not maintaining a clean perimeter, having an open garbage receptacle lid, and leakage from the garbage receptacle are the attraction of pests to the area. Review of the facility policy titled Waste Disposal revised January 2012 states all infectious and regulated waste shall be handled and disposed of in its appropriate manner.