

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035151	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Sabino Canyon Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5830 East Pima Street Tucson, AZ 85712	
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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure the advanced directive/code status for 1 resident (#133) out of 135 residents was recorded in the medical record in a timely manner. The deficient practice could result in residents not receiving services according to their wishes. Findings include: Resident #133 was admitted to the facility on [DATE] with diagnoses that included surgical aftercare of the nervous system, diabetes mellitus type-2, post-polio syndrome, and personal history of benign neoplasm. A clinical admission progress note with an effective date of June 20, 2026 at 8:52 p.m. that was authored by a Registered Nurse (RN/staff #26) revealed resident #133 arrived at the facility with her spouse in attendance. The note also revealed resident #133 communicated verbally with clear speech, and was able to understand and be understood when speaking. The admission notes further revealed the resident's mood was pleasant and no unwanted behaviors were witnessed. The admission note and further admissions clinical record revealed no evidence that the resident's advance directive/code status preference had been obtained or documented at the time of admission. A history and physical note with an effective date of June 21, 2026 at 7:05 p.m., revealed the physician spoke with resident #133 regarding end-of-life care. The physician noted the resident wanted to be resuscitated if she developed cardiopulmonary arrest. Review of the advance directive form dated June 21, 2026, completed by RN/staff #26, revealed the resident selected full-code status on June 21, 2026. A physician order dated June 22, 2026 included the resident's advance directive/code status designation of full-code. The Director of Nursing (DON/staff #15) received the order from the physician over the phone and entered the order into the Electronic Health Record (EHR) on June 22, 2026 at 3:32 p.m. A review of progress notes revealed a BIMS (brief interview for mental status) evaluation with an effective date of June 24, 2026 at 8:49 a.m. The evaluation revealed a BIMS score of 14, which indicated the resident's cognitive function was intact. A review of the care plan revealed no evidence of the resident's code status/advanced directive preferences. A formal request of power of attorney documentation for resident #133 was submitted on June 26, 2026 to the DON. The DON stated that the facility did not have either financial or medical power of attorney documentation on file for the resident and that there was no power of attorney in effect for the resident. An interview was conducted on June 25, 2026 at 2:40 p.m. with RN/staff #182, who stated the facility process for securing a resident's advance directive/code status preference is to obtain the status upon admission. She further stated that if the admitting nurse did not have time to secure the advance directive/code status preference upon admission, the night shift would be responsible to complete the task. The RN stated her expectation is that advance directive/code status preferences would be obtained upon admission for all residents; regardless if they arrived in the day, evening, or weekend. She further stated that for a code status to be entered (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	into the system, a physician's order must first be received and entered into the EHR. The RN stated that in the event no advance directive/code status is on file, the resident would be treated as a full-code. The RN further stated that a delay in obtaining a resident's advance directive/code status preferences could result in a resident who wanted to be Do Not Resuscitate (DNR) being treated as a full-code, which would not be in accordance with their choices. The RN reviewed the advance directive/code status timeline and stated resident #133 admitted on [DATE], the advance directive/code status was signed on June 21, 2026, and entered into the EHR on June 22, 2026. She stated that the resident's advance directive/code status should have been obtained upon admission on [DATE] and that the physician order should have been obtained and entered into the system at that time to indicate the resident's preferences. The RN stated that the resident's advance directive/code status preference should be present on the care plan. She reviewed the care plan and did not locate advance directive/code status preferences, which she stated is not compliant with facility policy. She further stated that the delay to obtain and enter the advance directive/code status designation into the EHR was not in compliance with facility policy. An interview was conducted on June 25, 2026 at 3:24 p.m. with the DON. She stated that the facility process for securing a resident's advance directive/code status designation is that the information is secured upon admission by the admission nurse. She further stated that if a resident refused to designate their advance directive preference upon admission, the information would be charted in a progress note. The DON reviewed the clinical record and was unable to locate a progress note that indicated the resident refused to sign the paperwork when she admitted. The DON stated that for an advance directive/code status to be valid, there must be a physician order on file. The DON reviewed the advance directive/code status timeline and indicated the resident admitted on [DATE], the advance directive/code status paperwork was signed on June 21, 2026, and the code status order was uploaded into the EHR on June 22, 2026. The DON stated a resident's advance directive/code status is not always updated on their care plan. The DON stated the care plan not indicating a resident's advance directive/code status preference is compliant with facility policy. The DON stated that the delay to obtain and upload the resident's advance directive/code status preference was compliant with facility policy. The DON identified a risk of not having a resident's advance directive/code status documented is that their advance directive is not followed. Review of the facility policy titled, Advance Directives - revised May 2023, revealed it is the policy of the facility that a resident's choice about what advance directives will be recognized and respected. The policy further stated the facility will recognize and respect the resident's right to choose his/her treatment and make decisions about care to be received at the end of his/her life. Advance directive policy review further revealed at the time of admission, social services, clinical, or admission will ask residents and/or their families about the existence of any advance directives. The Advance Directives Policy further revealed that once advance directive or information regarding resident preferences regarding treatment options is received by the facility, it will be confirmed in the medical record and documented in the plan of care (care plan). The facility will also notify the attending physician of advance directives so that, if necessary, appropriate orders can be documented in the resident's medical record and plan of care. The policy further revealed it is the responsibility of the care plan team to periodically review the advance directive preferences regarding treatment options with the resident or their representative to ensure the preferences on file are accurate. Review of the facility policy titled, Baseline Care Plan - reviewed February 2024, revealed within 48 hours, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care. The policy further revealed the baseline care plan will include minimum healthcare necessary to properly care for a resident (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to execute and document the transfer/discharge process in accordance with the regulation and facility policy for 1 of 21 sampled residents (#3). The deficient practice could result in incomplete and inaccurate medical records for residents. Findings include: Resident #3 was admitted to the facility on [DATE], with diagnoses that included displaced fracture of the base of the neck of the left femur, muscle weakness, displaced simple supracondylar fracture, hypertension, hyperlipidemia, obstructive and reflux uropathy, cognitive communication deficit, polyneuropathy, and muscle weakness. An admission Minimum Data Set (MDS) dated [DATE], revealed that a Brief Interview for Mental Status (BIMS) was conducted with a score of 7, which indicated severe cognitive impairment. Resident #3's face sheet revealed that she had a discharge date of February 22, 2026, and that she was discharged to an acute care hospital. Resident #3's census list revealed that she had a discharge date of February 22, 2026. A nursing progress note dated February 22, 2026, at 6:03 a.m. revealed that the resident was transferred to the hospital due to an altered mental status and being non-responsive to verbal stimuli, only to tactile stimuli. The note also revealed that the family and son were notified via phone and that attending answering service was updated on the patient's condition with two calls. A progress note dated February 23, 2026, at 11:09 a.m. revealed that the resident's son and his wife picked up all of the resident's belongings left in the facility. Review of Resident #3's clinical record on June 26, 2026, at 9:34 a.m. revealed no evidence that a discharge MDS was initiated or completed. A follow-up review of Resident #3's clinical record on June 26, 2026, at 11:01 a.m. revealed that a discharge MDS dated [DATE], was initiated and in progress with sections A, B,C, D, E, GG, H, I, J, K, M, N, O, P, and Q being completed on June 26, 2026, after an interview with the MDS assistant (MDS assistant/Staff#58). There was no evidence in Resident #3's clinical record of a physician's order to transfer to the hospital. An interview was conducted on June 26, 2026, at 9:38 a.m. with a registered nurse (RN/Staff#182), who stated that the process for transferring a resident to the hospital included a physician's order for the transfer, a diagnosis list, medication list, contacting the provider and family, complete the e-interact transfer assessment, and documenting in a progress note where the resident went. The RN stated that there was never an instance where the facility would not complete a transfer assessment because it was required. The RN stated that a discharge MDS needed to be completed for the resident transferring to the hospital, and that the risk of failing to complete the transfer assessment and discharge MDS would be that if something happened to the resident during the transfer and documentation was absent, then there could be a negative outcome for the resident, and their last status would not be shown in the documentation. The RN opened the record of Resident #3 and stated that she was admitted on [DATE], and was discharged on February 22, 2026, to the hospital. The RN stated that there wasn't a transfer assessment completed for the resident's transfer to the hospital and that the E-interact assessment should have been completed. The RN also stated that there was no discharge MDS completed for Resident #3 and that this transfer did not meet the facility's policy expectations for transfers/discharges. An interview was conducted on June 26, 2026, at 9:49 a.m. with the MDS assistant, Staff #58, who was filling in for the MDS coordinator for the day, and stated that when transferring a resident to the hospital, they were required to complete a discharge MDS. The MDS assistant stated that if the transfer was unplanned, they would indicate it in the discharge MDS and document where the resident was going. The MDS assistant also stated that (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they would only know what to mark on the discharge MDS through the documentation, so if there wasn't any, she would have to dig for the information. The MDS assistant further stated that if the resident was transferred and out of the facility for less than 24 hours, she believed they would not need to complete a discharge MDS. The MDS assistant stated that when a resident transferred to the hospital, an E-transfer assessment needed to be completed with a progress note that explained what happened to them. The MDS assistant also stated that the risk of failing to complete a transfer assessment and discharge MDS for a resident going out to the hospital was that the facility would not be fully keeping track of their residents, there was insurance risks, and that if the resident was in the facility's care last and something happened to them, the lack of completed assessments and documentation could result in harm to the resident if they were not ?on top of it.' The MDS assistant opened the clinical record for Resident #3 and stated that she was admitted to the facility on [DATE], and discharged on February 22, 2026, but the MDS assistant could not find a reason for the discharge. The MDS assistant found a progress note that showed the resident went to the hospital and stated that the facility did not complete a transfer assessment. The MDS assistant further stated that the facility also did not complete a discharge MDS, and that they needed to complete a discharge MDS because she did not return to the facility. The MDS assistant stated that they did not follow their process correctly for transferring the resident, and that the risk of failing to complete the transfer assessment and discharge MDS in this case was that it took her forever to figure out what happened to the resident during the interview, because they failed to track her status, and they still did not know what happened to her. An interview was conducted on June 26, 2026, at 10:14 a.m. with the Director of Nursing (DON/Staff#15), who stated that she expected that when transferring a resident to the hospital, staff would complete a progress note about the transfer. The DON further stated that they would have to complete the E-interact transfer assessment. The DON amended her statement and stated that she would expect the transfer assessment or a progress note that met the sections of the E-interact transfer assessment, and that the progress note needed to include when, where, and why the resident was transferred, and who was notified. The DON stated that a discharge MDS should have been completed for a resident going out to the hospital, and that there was no instance in which it should not have been completed. The DON stated that the risk of failing to complete the transfer assessment was that a needed party might not get all of the information it needed, and that the risk of failing to complete the discharge MDS was that the Centers for Medicare & Medicaid Services (CMS) would not get information regarding the resident's status, and that the patient's information would be inaccurate. The DON opened Resident #3's clinical record and stated that she was admitted on [DATE], and that she was not an active resident because she was discharged on February 22, 2026. The DON stated that the resident was discharged to the hospital for altered mental status, that the resident's son was notified, and that the facility failed to open and complete a discharge MDS for the resident. The DON stated that the facility did not complete a transfer form for the resident and did not obtain a physician's order for the transfer, and she further stated that there should have been an order. The DON stated that the handling of Resident #3's transfer did not meet her expectations, and the failure to complete a discharge MDS also did not meet her expectations. A review of a policy titled, Accuracy of Assessment (MDS 3.0), dated July 2025, revealed that it was the policy of the facility to verify that the assessment accurately reflected the resident's status. The policy revealed that the RN assessment coordinator was responsible for certifying the overall completion of the MDS, and that backdating a completion would not be acceptable. A review of a policy titled Criteria for Transfer and Discharge, dated May 2022, revealed that when the facility transferred or discharged a resident, the facility would ensure that the transfer or discharge was documented in the resident's (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record and that appropriate information was communicated to the receiving health care institution or provider. The policy further revealed that when the facility discharged or transferred a resident, their medical record should have included documentation of the basis for the transfer. The policy also revealed that the information provided to the receiving provider must include the following information at a minimum: contact information of the practitioner responsible for the care of the resident, the resident representative information including contact information, advance directive information, all special instructions or precautions for ongoing care, comprehensive care plan goals, and all other necessary information including a copy of the resident's discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care. The policy also revealed that a copy of the form for the physician to complete when a person was discharged or transferred should have been attached as Attachment A. The facility was cited for this deficient practice February 4, 2026 and was in the process of correcting this deficiency during the dates Identified. The facility did not allege compliance until March 6, 2026 and this deficiency occurred on February 22, 2026.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that the discharge Minimum Data Set (MDS) assessment was completed and accurate for 1 of 21 sampled residents (#3). The deficient practice could result in incomplete and inaccurate medical records for residents. Findings include: Resident #3 was admitted to the facility on [DATE], with diagnoses that included displaced fracture of the base of the neck of the left femur, muscle weakness, displaced simple supracondylar fracture, hypertension, hyperlipidemia, obstructive and reflux uropathy, cognitive communication deficit, polyneuropathy, and muscle weakness. An admission MDS dated [DATE], revealed that a Brief Interview for Mental Status (BIMS) was conducted with a score of 7, which indicated severe cognitive impairment. Resident #3's face sheet revealed that she had a discharge date of February 22, 2026, and that she was discharged to an acute care hospital. Resident #3's census list revealed that she had a discharge date of February 22, 2026. A nursing progress note dated February 22, 2026, at 6:03 a.m. revealed that the resident was transferred to the hospital due to an altered mental status and being non-responsive to verbal stimuli, only to tactile stimuli. The note also revealed that the family and son were notified via phone and that attending answering service was updated on the patient's condition with two calls. A progress note dated February 23, 2026, at 11:09 a.m. revealed that the resident's son and his wife picked up all of the resident's belongings left in the facility. Review of Resident #3's clinical record on June 26, 2026, at 9:34 a.m. revealed no evidence that a discharge MDS was initiated or completed. A follow-up review of Resident #3's clinical record on June 26, 2026, at 11:01 a.m. revealed that a discharge MDS dated [DATE], was initiated and in progress with sections A, B, C, D, E, GG, H, I, J, K, M, N, O, P, and Q being completed on June 26, 2026, after an interview with the MDS assistant (MDS assistant/Staff#58). An interview was conducted on June 26, 2026, at 9:38 a.m. with a registered nurse (RN/Staff#182), who stated that the process for transferring a resident to the hospital included a discharge MDS that needed to be completed for the resident transferring to the hospital, and that the risk of failing to complete the discharge MDS would be that if something happened to the resident during the transfer and documentation was absent, then there could be a negative outcome for the resident, and their last status would not be shown in the documentation. The RN opened the record of Resident #3 and stated that she was admitted on [DATE], and was discharged on February 22, 2026, to the hospital. The RN stated that there was no discharge MDS completed for Resident #3 and that they did not meet the facility's policy expectations for the completion of the MDS. An interview was conducted on June 26, 2026, at 9:49 a.m. with the MDS assistant, Staff #58, who was filling in for the MDS coordinator for the day, and stated that when transferring a resident to the hospital, they were required to complete a discharge MDS. The MDS assistant stated that if the transfer was unplanned, they would indicate it in the discharge MDS and document where the resident was going. The MDS assistant also stated that they would only know what to mark on the discharge MDS through the documentation, so if there wasn't any, she would have to dig for the information. The MDS assistant further stated that if the resident was transferred and out of the facility for less than 24 hours, she believed they would not need to complete a discharge MDS. The MDS assistant stated that the risk of failing to complete a discharge MDS for a resident going out to the hospital was that the facility would not be fully keeping track of their residents, including insurance risks, and that if the resident was in the facility's care last and something happened to them, the lack of completed assessments and documentation could result in harm to the resident if they were not on top of it. The MDS assistant opened the clinical (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure that resident medical records were completed accurately for two of two residents (#19 & #42) regarding Minimum Data Set (MDS) assessment and pain medication administration record. The universe was 104. The deficient practice could result in incomplete documentation in resident medical records. Findings include: - Regarding Resident #42: Resident #42 was admitted on [DATE] with the diagnoses that included concussion without loss of consciousness , cognitive communication deficit and other symbolic dysfunction. Review of the resident medical record admission Minimum Data Set (MDS) that was submitted to the Centers for Medicare & Medicaid Services (CMS) and accepted on June 22, 2025, revealed that Resident #42 was admitted to the facility on [DATE]. The MDS also revealed that a Brief Interview for Mental Status (BIMS) was conducted with a score of 15, which indicated no cognitive impairment. The MDS further revealed the resident exhibited rejection of care and evaluations that are necessary to achieve the resident's goals for health and well-being at a frequency of one to three days. The MDS revealed that Resident #42 had active diagnoses of coronary artery disease, hemiplegia, traumatic brain injury, disc degeneration, dysphagia, muscle weakness, and scoliosis. No diagnosis of depression was identified on MDS dated [DATE]. Subsequent review of the resident medical record MDS for resident #42 submitted to CMS and accepted for dates September 22, 2025, December 23, 2025, and March 24, 2026 for resident #42 revealed no diagnosis of depression. Review of the Medication Administration Record (MAR) revealed Sertraline HCL 50 milligram (mg) one tablet by mouth one time a day for depression as evidenced by negative statements was ordered by the physician on July 29, 2025. Resident #42 remained on Sertraline 50 mg one tablet by mouth one time a day for depression until physician order dated October 24, 2025, changed the dose of Sertraline HCL to 100mg one tablet by mouth one time a day for depression as exhibited by negative statements. The MAR did not have depression listed as a diagnosis until the Director of Nursing (DON/RN/#15) entered the diagnosis on June 25, 2026 to the resident electronic health record. A review of the medical records for resident #42 on June 26, 2026 noted the DON #15 entered the diagnosis of depression for resident #42 under the active diagnosis list in the electronic health record . An interview with resident #42 on June 25, 2026 at 1:24 P.M. revealed the resident was aware she was taking Sertraline 100mg one tablet a day for depression and negativity. She stated she was unaware of how long she had been taking the medication. She stated she does not have any negative (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Sabino Canyon Rehabilitation & Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 5830 East Pima Street Tucson, AZ 85712	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	symptoms and does believe that it does decrease her symptoms of being negative to others. Resident #42 does participate in the care plan meetings and they review her medications at that time. An interview was conducted on June 25, 2025 at 1:13 P.M. with DON/staff #15 who stated the resident was taking Sertraline for negative thoughts and does not talk nice at times. She reviewed resident #42 chart under medical diagnosis and she stated that depression was not listed, but should be. An interview was conducted on June 26, 2026 at 9:20 A.M. with MDS Assistant (RN/staff #58) stated that she is the primary person responsible to complete and submit the resident MDS. The Staff #58 stated that she completes the MDS with a seven day look back period by reviewing the resident electronic health record and if the information is not correct the MDS could be inaccurate. Staff #58 stated that if a resident is taking Sertraline HCL for depression the diagnosis should be in the resident electronic medical record under medical diagnosis and should be on the MAR. She stated that the March 24, 2026 MDS was submitted to CMS with no indication of depression listed under active diagnosis. Staff #58 stated the risk of the MDS not being accurate could be flagged by CMS for not accurately submitting MDS and could cause an insurance issue. Also, it could possibly harm the resident if the resident does not have a diagnosis for the medication they are receiving. -Regarding Resident #19: Resident #19 was readmitted on [DATE], with a diagnosis that included cerebrovascular disease, dementia, severe protein-calorie malnutrition, obstructive pulmonary disease, type 2 diabetes mellitus, chronic respiratory failure, senile degeneration of the brain, insomnia, hyperlipidemia, hypertension, depression, and mood disorder. A care plan initiated on September 04, 2025, had a focused area that Resident #19 was prescribed an opioid for chronic pain; the potential for adverse outcome from opioid use was low risk. A physician order dated September 04, 2025, had an order for Hydromorphone Hydrochloride(HCL) 2 milligrams (MG) Tablets. Give 1 tablet by mouth every 8 hours for pain. A Quarterly Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 04, indicating Resident #19 was severely cognitively impaired. Review of the Narcotics sheet for Resident #19 dated April 03, 2026, for Hydromorphon 2 mg tablet revealed that on May 01, 2026, one tablet was taken out of the medication cart at 2:00 PM; however, it was not documented in the Medication Administration Record (MAR). Review of the Narcotics sheet for Resident #19 dated April 03, 2026, for Hydromorphon 2 mg tablet revealed that on May 13, 2026, one tablet was taken out of the medication cart at 06:20 AM; however, it was not documented in the MAR. Review of the Narcotics sheet for Resident #19 dated May 28, 2026, for Hydromorphon 2 mg tablet revealed that on June 06, 2026, one tablet was taken out of the medication cart at 09:00 PM; however, (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it was not documented in the MAR. Review of the Narcotics sheet for Resident #19 dated May 28, 2026, for Hydromorphon 2 mg tablet revealed that on June 14, 2026, one tablet was taken out of the medication cart at 10:00 PM; however, it was not documented in the Medication MAR. Review of the Narcotics sheet for Resident #19 dated June 16, 2026, for Hydromorphon 2 mg tablet revealed that on June 22, 2026, one tablet was taken out of the medication cart at 10:00 PM; however, it was not documented in the Medication MAR. An interview was conducted on June 26, 2026, at 09:26 AM with Licensed Practical Nurse (LPN/staff #51), who stated that the facility process for administering scheduled pain medications is to first look over the order, get the medication, check the name of the medication and resident, double-check the dosage, give it to the resident, log in to the narcotics book and check it on the MAR, must be in both places. She stated that Resident #19 should have had Hydromorphone HCL 2 mg tablet checked off in the MAR. She stated that if it is not marked in only one place, then it could risk issues such as Resident #19, where his medication time frame could be missed or a staff member could miss medication, or give the medication too soon. An interview was conducted on June 26, 2026, at 10:03 AM with the Director of Nursing (DON/staff #15), who stated that the facility process for administering scheduled pain medication is that the nurse will verify the order and the resident, then they will administer the medication and document in the Medication Administration Record. She stated that the narcotics sheet will help verify if the medication was given to the resident or not. She stated that for Resident #19, his MAR was not documented for Hydromorphone when reviewing the chart. The DON did not offer any risks or possible harm for the resident. Reviewed the policy Medication Administration-Oral Revised date May 2025, revealed that it is the policy of the facility to accurately prepare, administer, and document oral medication. When administering unit doses, document administration of medication Facility policy titled: Documentation and Charting, revised 10/2025 states a complete account of the resident care, treatment, and response to the care, signs and symptoms, etc. as well as the progress of resident's care. Facility policy titled Accuracy of Assessment (MDS 3.0), reviewed 7/2025 states it is the policy of this facility to verify that the assessment accurately reflects the resident's status. To verify that each resident receives an accurate assessment by staff that are qualified to assess relevant care areas and are knowledgeable about the resident's status, needs, strengths, and areas of decline. The physical, mental and psychosocial condition of the resident determines the appropriate level of involvement of physicians, nurses, rehabilitation therapists, activities professionals, medical social workers, dietitians, and other professionals in assessing the resident and in correcting resident assessments. Involvement of other disciplines is dependent upon resident status and needs. On an assessment or correction request, the RN Assessment Coordinator is responsible for certifying overall completion once all individual assessors have completed and signed their portion(s) of the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	MDS. When MDS records are completed directly on the facility's computer (e.g., no paper form has been manually completed) the RN Coordinator signs and dates the computer-generated hard copy or provides an electronic signature. Backdating a completion is not acceptable. A registered nurse (RN) must sign and certify that the assessment is completed. Review of a facility policy titled Psychoactive Medication, revised 10/2025 states it is the policy of the facility to maintain every resident's right to be free from use of psychoactive medication. A physician's order is necessary for the use of psychoactive medication. No psychoactive medication will be utilized without a specific physician's order or without a diagnoses specific condition and will include the target behavior.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, staff interviews, and a review of facility policy and procedures, the facility failed to ensure that infection control standards were maintained when using reusable medical equipment to obtain resident vital signs and that enhanced barrier precautions were followed. The deficient practices could result in the spread of infection to residents. Findings include: During a vital sign documentation observation conducted on June 25, 2026, at approximately 2:47 p.m., a Certified Nursing Assistant (CNA/staff #33) was observed entering a resident room occupied by resident #28 and resident #2 to obtain blood pressure and pulse oximeter readings for both residents. The observation revealed that the CNA knocked on the resident's door and did not perform hand hygiene before entering the room. Observation of a sign posted outside of the resident's room revealed that both residents were on Enhanced Barrier Protections (EBP). Observation of the CNA revealed that she greeted resident #28 in bed A and placed the blood pressure cuff on the resident's arm and the pulse oximeter on his finger. Observation revealed that the CNA removed the blood pressure cuff from the resident's arm and hung it on the cart without sanitizing the equipment after use. Observation further revealed that the CNA also removed the pulse oximeter from the resident's finger and placed it in her pocket without sanitizing the equipment after use. Observations revealed that the CNA did not perform hand hygiene after she assessed the resident's vital signs. The CNA was observed moving the blood pressure cart to resident #2 bed B. Hand hygiene was not performed by the CNA as she moved from the resident #28 in bed A to resident #2 in bed B. Observations revealed that the CNA placed the same blood pressure cuff on the resident's arm and same the pulse oximeter on his finger. Observations further revealed that the CNA removed the blood pressure cuff from the resident's arm and hung it on the cart without sanitizing the equipment after use. Observations revealed that the CNA removed the pulse oximeter from the resident's finger and placed it in her pocket without sanitizing the equipment after use. Observations revealed the CNA retrieved lip balm from her pocket and applied it on her lips in the resident's room. Observations revealed that the CNA exited the resident's room with the blood pressure cart and did not perform hand hygiene or sanitize the equipment after use on both resident #28 and resident #2. The CNA/staff #33 entered the room of resident #8 on June 25, 2026 at approximately 2:54 p.m. to assess the vital signs of the resident. A sign posted outside the resident's room revealed that the resident was on EBP. The CNA did not perform hand hygiene, did not put on a gown and gloves, and did not sanitize the blood pressure cuff or pulse oximeter before she entered the resident's room. The CNA placed the blood pressure cuff on the resident's arm and the pulse oximeter on his finger. The CNA removed the blood pressure cuff from the resident's arm and hung it on the cart without sanitizing the equipment after use. The CNA removed the pulse oximeter from the resident's finger and placed it in her pocket without sanitizing the equipment after use. CNA/staff #33 exited the resident room and did not perform hand hygiene. An interview was conducted on June 25, 2026, at 2:57 p.m. with CNA/staff #33. CNA/staff #33 confirmed that she did not sanitize either the blood pressure cuff or the pulse oximeter between resident uses. She stated that facility policy is for the blood pressure cuff and pulse oximeter to be sanitized between each use and that the devices are sanitized using the bleach wipes observed to be present and full on the blood pressure equipment cart. She stated potential outcomes that could result from medical equipment not being sanitized between resident use, which included bacteria and germs could travel from resident to resident. CNA/staff #33 confirmed she was not wearing a gown or gloves in an EBP room. She stated that the facility policy was to wear a gown and gloves in EBP rooms when providing care. She further stated that her actions were not compliant with facility policy and could (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	result in germs being spread between residents. An interview was conducted on June 25, 2026, at approximately 3:33 p.m. with the Director of Nursing (DON/staff #15). The DON stated that facility policy was for reusable medical devices, such as blood pressure cuffs and pulse oximeters, to be sanitized after each resident use and that bleach wipes are used to sanitize them. She stated potential outcomes that could result from not sanitizing reusable medical devices between resident use included the spread of infection. The DON stated that CNA/staff #33's observed failure to sanitize reusable medical devices between resident uses did not meet facility expectations. The DON stated that gowns and gloves must be worn by team members in an EBP room when providing direct care to a resident in a close contact environment. She stated that CNA/staff #33's observed failure to wear a gown and gloves in resident rooms with EBP while using reusable medical devices to obtain a resident's vital signs did not meet facility expectations. The facility's policy titled, Infection Prevention and Control Program (IPCP) Standard and Transmission-Based Precautions, dated April 2025, revealed that it was the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Procedures included proper use of Personal Protective Equipment (PPE) when applicable, hand hygiene, environmental cleaning and disinfection, and reprocessing of reusable medical equipment. The facility policy further revealed that a gown and gloves must be used during high-contact resident care activities for residents on EBP. The policy further revealed that for residents on EBP, frequent cleaning/disinfection of shared equipment and environmental surfaces, changing PPE, and performing hand hygiene between residents may be implemented. Facility policy review revealed Standard Precaution Procedures that included proper selection and use of PPE, hand hygiene, and reprocessing of reusable medical equipment.		