STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035158	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Prescott Village Nursing & Rehabilitation	1030 Scott Drive Prescott, AZ 86301

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interviews, and review of policies and procedures, the facility failed to ensure informed consents were obtained for psychotropic medications and/or opioids for 3 residents (#42, #8 and #6). The sample size was 4 and the Universe was 50. The deficient practice could lead to residents receiving medications without fully understanding the risks and benefits. This could also increase the likelihood of adverse drug events.Findings include:Regarding Resident #42-Resident #42 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, dysphagia, unspecified Dementia, acute kidney failure, and cognitive communication deficit. Review of the Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she was cognitively intact. The MDS also revealed Resident #42 was taking antidepressant and opioid medications.Review of the physician's orders for Resident #42 revealed the following:Tramadol HCl 50 Milligrams (MG) tablet, 1 tablet, to be administered by mouth every 6 hours as needed for breakthrough pain (4-5 on pain scale). The original order start date was July 1, 2024. The order was updated five times with the most recent start date of November 4, 2025.Oxycodone HCl 5 mg tablet, 1 tablet, to be administered by mouth every 4 hours as needed for pain scale 6-10. The order start date was November 4, 2025.Trazodone HCl oral tablet 50 MG, give 1 tablet by mouth as needed for insomnia at bedtime.Further review of the Resident #42's Electronic Health Record (EHR) did not reveal a signed consent to administer Tramadol and Oxycodone. It also did not reveal a signed psychotropic consent for Trazodone.The Opioid Medication Informed Consent form, submitted by the facility, revealed a signed consent, with an effective date of November 3, 2025. The consent form did not identify the names of the opioid medications Resident #42 was taking.Review of the November 2025 Medication Administration Record (MAR) revealed that Tramadol 50 milligrams (MG) was administered twenty-two times. The same November MAR further revealed that Oxycodone was administered eight times.Review of the December 2025 MAR revealed that Tramadol was administered three times. The same December MAR further revealed that Oxycodone was administered four times.Review of the January 2026 MAR revealed that Tramadol was administered once. The same January MAR further revealed that Oxycodone was administered six times.Regarding Resident #6-Resident #6 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dysphagia, Dementia, and cognitive communication deficit. Review of the quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of 02 which indicated she had severe cognitive impairment. The same MDS also revealed Resident #6 was taking antipsychotic, antianxiety and antidepressant medications.Review of the Order Summary Report revealed physician's orders for the following medications:Alprazolam oral tablet 0.5 MG. Instructions indicated to give two tablets by mouth at bedtime for chronic anxiety. The order start date was noted as February 9, 2024.Paroxetine HCl oral tablet 40 MG. Instructions indicated to give one tablet by mouth one time a day related to depression. The original order start date was noted to be on April 27, 2023. The order was updated two additional times with most current start date of October 8, 2025.Remeron oral tablet 15 MG. Instructions indicated to give one tablet by mouth one time a day for major depressive disorder. The original order start date was noted to be on September 8, 2023. The (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	order was updated eight times with the most current start date of May 30, 2024.Risperdal oral tablet 0.5 MG. Instructions indicated to give half a tablet by mouth one time a day for Dementia related to major depressive disorder. The original order start date was September 19, 2023. The order was updated five times with the most current start date of December 17, 2024.The facility submitted signed consent forms for the following medications:Paxil (Paroxetine) indicating the Medical Power of Attorney (MPOA) verbally consented on August 21, 2025. Remeron was signed by the MPOA on August 21, 2025.Risperidone was signed by the MPOA on December 24, 2024.Regarding Resident #8-Resident #8 was admitted to the facility on [DATE] with diagnoses that include traumatic ischemia of muscle (a condition where severe injury damages blood vessels causing lack of oxygen flow to muscle tissues), opioid dependence with opioid-induced sleep disorder, chronic respiratory failure with hypoxia, and pain in left knee. Review of the Quarterly MDS, dated [DATE], revealed Resident #8 had a BIMS score of 15 which indicated she was cognitively intact. The same MDS also revealed Resident #8 was taking antidepressant and opioid medications.Review of the physician's orders for Resident #8 revealed the following:Dilaudid Oral Tablet 4 MG, 1 tablet, to be administered by mouth three times a day for pain. The order start date was April 16, 2024.Further review of Resident #8's EHR did not reveal a signed consent to administer Dilaudid.Review of Opioid Medication Informed Consent, submitted by the facility, revealed a signed consent, with an effective date of January 5, 2026. The consent form did not identify the name of the opioid medication Resident #8 was taking.An interview was conducted on March 6, 2026 at 8:57 A.M. with Licensed Practical Nurse (LPN/Staff #11). He explained that when a patient is admitted , they would get consents for psychotropic medications and opioids if they come in with the orders. He further explained that if an order is put into place after a resident is admitted , then the nurse who puts the order into the EHR would also obtain the consent from the resident or their responsible party. Staff #11 shared that when he is administering medications to residents, he doesn't look to see if consent has been obtained for opioids and psychotropic medications because there shouldn't be an order in the system (EHR) if consent hasn't been obtained. Staff #11 explained that by not obtaining a signed consent prior to administering the medications could result in residents taking medications that they don't want.An interview was conducted on March 6, 2026 at 9:28 A.M. with the Assistant Director of Nursing (ADON/Staff #1). He shared that residents absolutely need signed consents for their opioid and psychotropic medications. He further shared that the consents were needed so that the resident and/or family are aware of the potential side effects of the medications. Staff #1 explained that once signed consents are obtained, they are then scanned into the EHR if a paper copy is signed or they sign the consents online. He further explained that either way, all signed consents are eventually put into the EHR.An interview was conducted on March 6, 2026 at 10:16 A.M. with the Regional Nurse, Interim Director of Nursing (Staff #101). Staff #101 explained that consents for psychotropic and opioid medications are obtain before the resident is admitted to the facility or upon admission. She further explained that Resident #8 had started taking Cymbalta in August 2024 but it was probably revised. Staff #101 was shown the Opioid Consent form for Resident #8 and she acknowledged that the form did not have the medication name on it. Staff #101 explained that they had created the form in-house and when they created it, they did not leave an area for the name of the medication to be typed up. She also shared that the form was signed on January 5, 2026. She further shared that they did not have an opioid consent form prior to this one so it was created to address that gap. Staff #101 was asked to review Resident #4's opioid consent form, submitted by the facility, and explained that the original form was what was used by the previous facility ownership and it didn't list the name of the medication. Staff #101 explained that the risk of not having signed consents are the residents can't tell them if they don't like the medications or if it didn't work for them in the past.Review of the facility's policy and procedure, titled Psychotherapeutic Drug Management, indicates it was last revised in June of 2020. The policy and procedure described that psychotherapeutic medications will not be administered by the Licensed Nurse until an informed consent by the Resident and/or their responsible party has been obtained and documented by the attending physician.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interview, and review of policies and procedures, the facility failed to ensure that medications were administered within the parameters established by physician's orders for three (#4, #42, and #52) out of five residents. The universe was 50. The deficient practice could cause over or under dosing of residents, altered mental status, or other health complications.Findings include:Regarding resident #42-Resident #42 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes, dysphagia, unspecified Dementia, acute kidney failure, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #42 had a Brief Interview for Mental Status (BIMS) score of 13 which indicated she was cognitively intact. The same MDS also revealed Resident #42 was taking antidepressant and opioid medications.Review of the Pharmacy Review for Resident #42, dated December 2025 revealed a note, written by the pharmacist to the facility. The note asked the facility to review, with the nursing staff, that pain medications need to be given within parameters.Review of the physician's orders for Resident #42 revealed the following physician's orders:Acetaminophen 325 milligrams (MG) tablet, two tablets, to be administered by mouth every 6 hours as needed for mild pain (1-2 on pain scale) or a fever. Tramadol HCl 50 MG tablet, 1 tablet, to be administered by mouth every 6 hours as needed for breakthrough pain (4-5 on pain scale). Oxycodone HCl 5 mg tablet, 1 tablet, to be administered by mouth every 4 hours as needed for pain scale 6-10. A random sample of the Medication Administration Record (MAR) for the following months were reviewed:Acetaminophen was administered 4 times outside of the established parameters during June 2025. Tramadol was administered 5 times outside of the established pain parameters during November 2025.Tramadol was administered 3 times outside of the established pain parameters during December 2025.Acetaminophen was administered 2 times outside of parameters in January 2026Acetaminophen was administered 3 times outside of parameters in February 2026. Regarding Resident #4-Resident #4 was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery, dysphagia, cognitive communication deficit, and acute kidney failure. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated she was cognitively intact. The same MDS also revealed Resident #4 was taking antidepressant, opioid, and anticonvulsant medications. The physician's orders for Resident #42 revealed an active physician's order for Acetaminophen 325 MG tablet and to give two tablets by mouth every 6 hours as needed for generalized or breakthrough pain rated 1-4.The February 2026 MAR revealed that Acetaminophen was administered outside of parameters on the following dates:February 5, 2026February 6, 2026February 19, 2026The care plan revealed that it was initiated on September 17, 2025. The care plan identified that Resident #4 required pain management due to acute/chronic pain related to the right hip. Identified interventions include administering analgesia per physician's orders. Regarding Resident #52- Resident #52 was admitted to the facility on [DATE] with diagnoses that included encephalopathy unspecified, acute and chronic respiratory failure, and acute kidney failure.The admission MDS, dated [DATE] revealed Resident #52 had a BIMS score of 14 which indicated she was cognitively intact. The same MDS also revealed Resident #52 was taking an Opioid.The physician's orders for Resident #52 revealed an order, dated February 20, 2026, for Oxycodone HCl Oral Tablet 10 MG and to give the medication by mouth every 4 hours as needed for pain rated 6-10. The February 2026 MAR revealed that Oxycodone was administered outside of parameters on February 26, 2026. The MAR further revealed that Resident #52 rated her pain as a 3. An interview was conducted on March 6, 2026 with Licensed Practical Nurse (LPN/Staff #11) at 8:57 A.M. Staff #11 explained that when a resident is having pain, he would then do a pain assessment for the resident and have them rate their pain level. He further explained that the physician's orders for the pain medications have parameters that explain which pain medications are to be given according (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to the pain level identified by the resident. When asked to review the MAR for Resident #4, Staff #11 identified that there were three days where Acetaminophen was administered outside of parameters during the month of February. When asked to review the MAR for Resident #52, Staff #11 identified that Oxycodone was administered once outside of parameters during the month of February. When asked what the risk, to the residents, would be when medication is not administered according to the Physician's orders, Staff #11 explained there would be a risk of overdose or unnecessary sedation of the residents.An interview was conducted on March 6, 2026 with the Assistant Director of Nursing (ADON/Staff #1) at 9:28 A.M. Staff #1 explained that when residents are experiencing pain, there are pain parameters with the as needed (PRN) medications such as opioids or Tylenol. He further explained that the parameters are in place so Nurses know which medication is appropriate to administer to residents. Staff #1 shared that the risk of not following the identified parameters would be residents experiencing over sedation, lethargy, respiratory distress, or constipation. When asked to review the MAR for Resident #4, Staff #1 identified that during the month of February, Acetaminophen was not administered within parameters. He also shared that the Nurse should have administered Tramadol for the higher pain rating. When asked to review the MAR for Resident #52, Staff #1 identified that during the month of February, Oxycodone was administered outside of parameters one time. He shared that administering Oxycodone for pain rated as a 3 was an overkill.An interview was conducted with the interim Director of Nursing (DON/Staff #101) on March 6, 2026 at 10:16 A.M. Staff #101 shared that staff should ask residents if they are having pain and have the resident rate their pain using the pain scale. Staff are to first offer a non-pharmacological intervention and if that doesn't work then they offer medications. She further shared that some residents don't want to take controlled medications even if they have extreme pain so options are provided to the residents and then staff are to monitor for side effects of the medications. Staff #101 was asked to review the February MAR for Resident #4 and she identified Acetaminophen was administered twice outside of parameters. When asked to review the February MAR for Resident #52, Staff #101 shared that Oxycodone was administered once outside of parameters. When asked to review the February MAR for Resident #42, Staff #101 shared that for Acetaminophen was administered once outside of pain parameters. When asked to review the December 2025 MAR for the same resident, Staff #101 shared that Tramadol was administered three times outside of pain parameters. When asked what were the pain parameters identified on the MAR for Tramadol, Staff #101 shared that it was to be given for pain rated 4-5 but instead was given for pain rated at 7 and 8. Staff #101 shared that based on her review of the MAR, just now, she sees that staff are not following Physician's orders. She further shared that the risk of not following the orders was the residents not being able to get ahead of the pain. She added that staff know residents will say yes to Oxycodone but they still need to follow the physician's orders and have supporting documentation if they plan on going a different route for the pain medications than what is ordered.Review of the facility's undated Policy and Procedure, titled Medication Administration, did not have language referencing administering medications according to pain parameters established by a Physician. Further review of the policy and procedure revealed that that resident's MAR will be reviewed for special considerations for administration including acceptable professional standards and principles. It also explains that prior to administering medications, three checks must be conducted. The three checks consist of comparing the physician's order, pharmacy label, and the MAR to ensure the accuracy of the medications.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on closed record review, staff interview, and review of policies and procedures, the facility failed to ensure that a licensed pharmacist performed a medication regimen review (MRR) for four (#4, #6, #8, and #42) out of five residents. The census was 50. The deficient practice could result in residents having preventable harm, functional decline, hospitalizations, or death.Findings include:Regarding Resident #4-Resident #4 was admitted to the facility on [DATE] with diagnoses that included aftercare following joint replacement surgery, dysphagia, cognitive communication deficit, and acute kidney failure. The Quarterly Minimum Data Set (MDS), dated [DATE], revealed Resident #4 had a Brief Interview for Mental Status (BIMS) score of 14 which indicated she was cognitively intact. The same MDS also revealed Resident #4 was taking antidepressant, opioid, and anticonvulsant medications.The Pharmacy Review documents, provided by the facility, revealed there were no Pharmacy Reviews for Resident #4 conducted by a licensed pharmacist for the following months:October 2025November 2025January 2026February 2026There was a pharmacy review conducted during December 2025 which indicated there were no recommendations. Related to Resident #6-Resident #6 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dysphagia, Dementia, and cognitive communication deficit. The quarterly MDS, dated [DATE], revealed Resident #6 had a BIMS score of 02 which indicated she had severe cognitive impairment. The same MDS also revealed Resident #6 was taking antipsychotic, antianxiety, antidepressant, antibiotic, diuretic and hypoglycemic medications. The Pharmacy Review documents, provided by the facility, revealed there were no pharmacy reviews for Resident #6 conducted by a licensed pharmacist for the following months:September 2025October 2025November 2025January 2026February 2026. There was a pharmacy review conducted during December 2025 which indicated there were no recommendations. Related to Resident #8-Resident #8 was admitted to the facility on [DATE] with diagnoses that include traumatic ischemia of muscle (a condition where severe injury damages blood vessels causing lack of oxygen flow to muscle tissues), opioid dependence with opioid-induced sleep disorder, chronic respiratory failure with hypoxia, and pain in left knee. The Quarterly MDS, dated [DATE], revealed Resident #8 had a BIMS score of 15 which indicated she was cognitively intact. The same MDS also revealed Resident #8 was taking antidepressant and opioid medications.The Pharmacy Review documents, provided by the facility, revealed there were no pharmacy reviews for Resident #8 conducted by a licensed pharmacist for the following months:August 2025September 2025October 2025November 2025January 2026February 2026Related to resident #42-Resident #42 was admitted to the facility on [DATE] with diagnoses that include type 2 diabetes, dysphagia, unspecified Dementia, acute kidney failure, and cognitive communication deficit. The Quarterly MDS, dated [DATE], revealed Resident #42 had a BIMS score of 13 which indicated she was cognitively intact. The same MDS also revealed Resident #42 was taking antidepressant and opioid medications.The Pharmacy Review documents, provided by the facility, revealed there were no pharmacy reviews for Resident #42 conducted by a licensed pharmacist for the following months:September 2025October 2025November 2025December 2025January 2026February 2026An interview was conducted on March 6, 2026 at 9:28 A.M. with the Assistant Director of Nursing (ADON/Staff #1). He explained that the medication review, for all residents, is conducted upon admission with the facility's provider. He further explained that the facility receives a monthly packet from the pharmacist which is reviewed by him and the facility provider. He added that sometimes the pharmacist will make suggestions related to medications which the provider will either agree with or not. The Pharmacy Review document is then sent to medical records. Staff #1 was asked if he could provide the Pharmacy Review records for Resident #42. He confirmed that after reviewing the Pharmacy Review binder, he was not able to locate pharmacy reviews for Resident #42 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for October 2025, November 2025, December 2025, January 2026 and February 2026. When asked for the Pharmacy Review records for Resident #8, he confirmed that he was not able to locate the records for Resident #8 for October 2025, November 2025, January 2026, and February 2026. He did share that the December 2025 review was done with no recommendations. Related to Resident #6, Staff #1 verified that he was not able to locate a Pharmacy Review record for Resident #6 for October 2025, November 2025, January 2026, and February 2026. He also verified that the December 2025 review was conducted with no recommendations. Staff #1 explained that he was not able to share if the reviews were conducted for the missing months due to not having the information at hand. He also explained that not having the pharmacy reviews done on a monthly basis was not acceptable because they want to make sure that everyone is looked at. He further stated that there might be some changes that are made to resident medications that do not conform to pharmacy standards. An interview was conducted with the Interim Director of Nursing (DON/Staff #101) on March 6, 2026 at 10:16 A.M. She explained that the pharmacist is at the facility on a monthly basis, but she stated that she believed that the Pharmacy Reviews only needed to be conducted on a quarterly basis. Review of the facility's policy and procedure titled, Drug Regimen Review indicated it was last revised in January 2025. The policy documented that the pharmacist will review each resident's medication regimen at least monthly to detect irregularities, as well as clinically significant risks and any actual or potential adverse outcomes associated with medication use. The policy further documented that the consulting pharmacist will document in the resident's medical record that the pharmacy medication review has been completed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and review of facility policies and procedures, the facility failed to ensure food is stored in accordance to food safety standards and sanitation measures are followed regarding hairnets. The facility census was 50. The deficient practice could lead to residents contracting foodborne illnesses. Findings include:An initial observation of the kitchen was conducted on March 3, 2026 at 10:37 A.M. Cook/Staff #68 was observed preparing vegetables at the food preparation counter and did not have a beard net covering his beard. During the same initial observation a container of pickled beets with a use by date of February 27, 2026 was observed on the 3rd shelf in the refrigerator. A second kitchen observation was conducted, in the refrigerator, on March 4, 2026 at 2:36 P.M. A gallon sized ziplock bag containing several partial blocks of pasteurized processed white Swiss cheese was observed. The bag had a received by date of February 23, 2026 and a use by date of March 3, 2026. On March 4, 2026 at 2:41 P.M., in passing, Director of Nutritional Services/Staff #89 shared that she and the cooks are responsible to ensure that food does not expire. They go through their food supply twice a week to check the dates on the food packages. On March 4, 2026 at 2:51 P.M., an interview was conducted with the Cook/Staff #2. He explained that the first date on the food container is the open date and the 2nd date would be the use by date. When shown the gallon ziplock bag containing cheese, he shared that the food should have been tossed. He further shared that they don't typically use Swiss cheese unless it is on the menu and the last time it was on the menu was the week before. However, he couldn't tell with 100% certainty that anyone had requested Swiss cheese for a sandwich. Staff #2 explained that having expired food and serving it to the residents could lead to residents getting sick. An interview was conducted was Cook/Staff #86 on March 3, 2026 at 8:22 A.M. When asked when do hairnets need to be used in the kitchen, she stated that every time a staff member is in the kitchen, they are to use it to prevent hair from falling into the food or onto plates. Staff #86 also explained that when food is brought in, by a vendor, they will put the received date and the use by date on the food packages. She further explained that they cannot serve food past the use by date and at that point, the food should be tossed. Staff #86 also added that they toss the food by the use by date as a precaution because they don't know how long the food item has been out if the use by date is not identified. This could lead to residents getting sick due to a bacterial disease or some type of foodborne illness. An interview was conducted on March 6, 2026 at 8:28 A.M. with Staff #89. Staff #89 explained that hairnets have to be worn upon entering the kitchen and the same applies for the beard guards. She also shared that if food is not discarded by the discard date, it could cause a potential outbreak and residents could get a foodborne illness. Staff #89 further shared that both of these situations did not meet her expectations. Review of the facility's policy and procedure titled, Kitchen Sanitation - Operating and Cleaning indicated that it was last revised January 1, 2025. The policy explained that all kitchen staff must wear hairnets while in the kitchen and a beard guard when needed. It further explained that for food storage, all food items must be clearly labeled and dated upon delivery. It also indicated that when a food item is opened, it must be dated with an expiration date or discard date.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on resident and staff interviews, record review, facility documentation and policy review, the facility failed to ensure staffing information submitted was accurate. The census was 50. The deficient practice could result in residents receiving inadequate care due to potential lack of staffing.Findings include:The Payroll-Based Journal (PBJ) Staffing Data Report revealed that the facility consistently triggered for excessively low weekend staffing for three quarters and triggered for one star rating for two of the fiscal year 2025 quarters. Per the report, submitted weekend staffing data was excessively low and had a one star rating.The facility assessment reviewed on October 30, 2025 revealed that the facility was licensed for 58 residents; the current number of residents for the center was 50. Total admissions and discharges in the last year: 290 and 271. The facility had documented on the Daily Nursing Staffing with three nurses on day shift and two on the night shift. Per review of the daily nursing staffing. The facility had a registered nurse (RN) for at least 8 consecutive hours each day. Night shift had 3 certified nursing assistants (CNA) and day shift had four.During resident interviews conducted during the initial pool on March 3, 2026, revealed multiple residents, who were alert and oriented, who reported having to wait long periods of time before receiving assistance they needed. Resident #55 revealed that a nurse worked six days in a row due to open shifts. Resident #47 revealed that the call lights are not answered quickly and it takes forever. Resident #12 stated it can take 30-60 minutes for a call light to be answered. Resident #2 stated the facility was short handed one time and had to wait an hour 30 minutes for someone to answer the call light a couple days ago. Resident #13 felt the facility was under-staffed with CNAs, mostly on day shift.A request was made on March 4, 2026 at 2:55 p.m. for the data submission for staffing, including date, time and what was submitted. On March 5, 2026 at 9:11 a.m. the information was still not available. On the original 807 request for the information, a note was written by administrator Staff #30: timeclock inputs to Xchieve, Xchieve to CMS. At the same time, Staff #30 stated the information is in California and should be getting it any minute. A review was conducted of the PBJ submitter final file validation report obtained from the facility. The Total Employee Link Records portion failed to be submitted.An interview was conducted on March 5, 2026 at 1:05 p.m. with certified nursing assistant (CNA) staff #60 and revealed that the facility just started using agency staff and it has helped with getting daily tasks done. Staff #60 stated that he has had to work with only one other CNA in the building when other staff members have called off from work.An interview was conducted on March 5, 2026 at 1:10 p.m. with licensed vocational nurse (LVN) Staff #11 and revealed that most days (90%) there is enough time to get nursing duties completed on time. Staffing is an issue, especially when someone calls out. If someone calls out, you have to wait until someone comes in before you can leave. Finding replacements can be hard. There has been a lot of turnovers with staff in the past 6 months.An interview was conducted on March 6, 2026 at 10:33 a.m. with administrator Staff #30 and revealed that the expectations for staffing the clinical area of the facility is that they are meeting the state minimum and residents are receiving the care that they need. Staff #30 works with the staffing coordinator and the director of nursing to create the schedules. If the schedule cannot be filled with the facility staff, then agency will be brought in. If staff cannot be found to work, then the management staff will have to come in and cover. For nursing it is the nurse on call or the assistant director of nursing. Direct care staff include, CNAs, LPNs, RNs and therapy. Staff #30 was unable to tell what the turnover rate for nursing was and stated would need to look that up. All staff will swipe in to clock in, when starting to work and ending their shift. That data goes to Xchieve which is a company that sends the data to the Centers for Medicare & Medicaid Services (CMS). Staff #30 does not review the data after submission, someone in payroll reviews. The payroll team is in Texas. Staff #30 was unaware of any triggers with staffing or low star/one star staffing. The PBJ submitter final file validation report (that was obtained from the facility) was then shown to Staff #30. (continued on next page)

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the policy Staffing, Version 1.1 Revised October 2025, revealed that direct care staffing information per day (including agency and contract staff) is submitted to the CMS payroll-based journal system. All inquiries or concerns relative to our facility's staffing should be directed to the administrator or his/her designee.

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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** Based on resident and staff interviews, review of the clinical record, facility documentation and policy, the facility failed to ensure that a code status was accurate and consistent in the medical record for one resident #13 out of 14 sampled residents. The universe was 50. The deficient practice could result in a resident not receiving care consistent with the signed advance directive.Findings include:Resident #13 was admitted on [DATE] and discharged on [DATE] with diagnosis including essential primary hypertension, other acute osteomyelitis of the right ankle and foot, anemia, methicillin resistant staphylococcus aureus infection, rheumatoid arthritis, chronic kidney disease, type 2 diabetes mellitus with diabetic neuropathy, muscle wasting and atrophy, muscle weakness and other abnormalities of gait and mobility.The admission MDS (minimum data set) dated February 20, 2026 revealed that the resident had a BIMS (brief interview of mental status) score of 14, indicating that the resident was cognitively intact.The landing page of the electronic health record (EHR) revealed that the resident had been documented as a full-code.Additional documentation in the electronic health record revealed that the resident had signed a Prehospital Medical Care Directive effective February 19, 2026 which noted that in the event of cardiac or respiratory arrest, the resident opted to refuse any resuscitation measures to include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of advanced cardiac life support drugs and related emergency medical procedures.The physician orders revealed no evidence of a DNR order; however, a review of the progress notes did reveal a medical practitioner note dated February 19, 2026 noting the code status as a DNR.The care plan revealed a focus area noting that a full code CPR (cardiopulmonary resuscitation) was in place effective February 24, 2026. The goal noted that the request for CPR was to be initiated and followed. Interventions documented that the medical record was to be reviewed and ensured that proper documents were signed, that nursing staff were to be consulted regarding any changes in health and that the resident and family were to be counseled regarding any emotional concerns arising from the decision.The Advanced Directives Book on the unit revealed a cover sheet noting resident names and indicated that resident #13 was documented as a full-code.An interview was conducted on [DATE] at 11:18 AM with staff #52, RN (registered nurse). The RN stated that if someone was ?coding' she would utilize the Advanced Directives Book on the unit to confirm whether a resident had a full-code status or DNR in place. Staff #52 stated that it was important to respect the resident's wishes regarding their advanced directives. Staff #52 reviewed the resident's EHR and stated that the landing page did show the resident to be a full-code. She then reviewed additional documents housed under the miscellaneous tab and stated that the resident did have a DNR form which was dated February 19, 2026 and stated that this form should also be in the Advanced Directives Book on the unit. Staff #52 reviewed the documentation on the unit and indicated that the orange DNR form was in the book; however, the RN confirmed that the first page of the book listing all resident names indicated that resident #52 was a full-code. Staff #52 stated that the risk for inconsistent documentation regarding advanced directives could include the resident not getting proper care.An interview was conducted on [DATE] at 12:03 PM with staff #101, interim DON (director of nursing). Staff #101 stated that the expectation regarding advanced directives was that staff should ensure that the order matches if someone is designated as a DNR and to make sure that the documentation is filled out correctly. Staff #101 stated that the information regarding advanced directives could be found in the resident's EHR. She further stated that there should be an order in place indicating that the resident is either a full-code or a DNR and that the resident's choice should be care-planned. Staff #101 stated that documentation needs to match, needs to be appropriate and everyone needs to be on the same page. The DON reviewed the resident's EHR and stated that the resident was a full-code, based on the (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation on the landing page. She then reviewed the miscellaneous tab and located the DNR form that was uploaded on February 19, 2026. She further stated that an order for a DNR was not in place as the information on the landing page in the EHR pulls directly from the orders. Staff #101 further stated that the DNR was also not care planned based on her review. Staff #101 stated that the risk could include having to get clarification to know what to do in an emergency and that takes time. She further stated that this could potential delay CPR, if indicated. An interview was conducted on [DATE] at 8:22 AM with staff #10 CNA (certified nursing assistant). Staff #10 stated that advanced directives were always documented in the EHR, but can also be found on the unit in a binder, if the resident is a DNR. Staff #10 stated that all documentation must be accurate in all areas or staff would not know what to do. He stated that the risk could include staff not acting on the resident's wishes.A review of the policy titled Advanced Directives, with a revision date of August, 2020 revealed that the facility will honor the resident's advanced directives.A review of the policy titled Physician Orders, with a revision date of February 2025 revealed that the purpose of the policy was to ensure that all physician orders are complete and accurate and that the medical records department will verify that physician orders are complete, accurate and clarified as necessary.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and facility policy and procedures, the facility failed to ensure that a complete and accurate level I PASARR was assessed on admission for one resident (#10). The universe was 50. The deficient practice could result in specialized services not being identified and provided to residents.Findings include:Resident #10 was admitted to the facility on [DATE] with diagnoses that included: generalized anxiety disorder, bipolar disorder, major depressive disorder, bariatric surgery status, post-traumatic stress disorder (PTSD), muscle weakness and morbid obesity.Resident #10's minimum data set (MDS) revealed a brief interview mental status (BIMS) score of 15, meaning the resident was cognitively intact.A care plan focus for Resident #10 revealed the resident was receiving psychotropic medication, Aripiprazole related to diagnosis of (PTSD)/bipolar disorder (behavior management. The date of initiation was January 25, 2026 with a revision on January 26, 2026. The preadmission screening and resident review (PASRR) from the hospital, revealed null for serious mental illness and mental illness.An interview was conducted on March 5, 2026 at 09:46 a.m. with social services clerk Staff #44 and regional licensed masters social worker Staff #102, revealed Staff #44 works on discharge planning from the beginning of admission and does not do anything with the PASRR. Staff #102 continued with giving information regarding PASRRs and that the facility just recently received the information to be able to submit PASRRs electronically. If a hospital inputs incorrect data on the PASRR, the expectation is to correct it immediately. A review of Resident #10's PASRR was conducted during the interview with the null answers and revealed that it meant there were no psychiatric diagnoses while at the hospital. Resident #10's diagnoses were reviewed and had diagnosis of anxiety, bipolar and depression. Staff #102 stated those should have been caught, a review should have been done to make sure a level II did not trigger. Staff #102 continued that Resident #10 had many diagnoses and Staff #49 could catch those when doing the MDS (minimum data set). The first catch is with admissions, MDS and with auditing.An interview was conducted on March 5, 2026 at 12:59 p.m. with MDS nurse Staff #49 and revealed that he was told that social services reviewed the PASRR and does not look to see if they are a level II. Staff #49 has never seen a level II from the hospital. The risk for not having an accurate level I on admission is that the resident would not get the services needed. There are certain facilities that provide that level of care needed.An interview was conducted on March 6, 2026 at 11:06 a.m. with admissions coordinator Staff #3 and revealed that the PASRR is reviewed prior to accepting a resident. A review is conducted by Staff #3 and the central intake team. The Level I PASRR is usually the last thing that is sent over prior to admission and a corporate auditor looks over the PASSR and all the information in the admission agreement.Review of the policy Pre-admission Screening Resident Review (PASRR) Version No. 1.0 Date Revised: 06/2020, all first-time applicants to the facility, regardless of Medicaid status or payer, must undergo a Level I PASRR screening before being admitted to the facility, or on the first day in which Medicaid reimbursement is requested.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and facility policy and procedures, the facility failed to ensure that a new level I PASARR was completed when a resident was in the facility for more than 30 days for one resident (#10) out of 13. The universe was 50. The deficient practice could result in specialized services not being identified and provided to residents.Findings include:Resident #10 was admitted to the facility on [DATE] with diagnoses that included: generalized anxiety disorder, bipolar disorder, major depressive disorder, bariatric surgery status, post-traumatic stress disorder (PTSD), muscle weakness and morbid obesity.Resident #10's minimum data set (MDS) revealed a brief interview mental status (BIMS) score of 15, meaning the resident was cognitively intact.A care plan focus for Resident #10 revealed the resident was receiving psychotropic medication, Aripiprazole related to diagnosis of (PTSD)/bipolar disorder (behavior management. The date of initiation was January 25, 2026 with a revision on January 26, 2026. Review of the preadmission screening and resident review (PASRR) from the hospital, null for serious mental illness and mental illness. A second level I PASRR was not found after Resident #10 had been at the facility for more than 30 days.An interview was conducted on March 5, 2026 at 09:46 a.m. with social services clerk Staff #44 and regional licensed masters social worker Staff #102, revealed Staff #44 works on discharge planning from the beginning of admission and does not do anything with the PASRR. Staff #102 continued with giving information regarding PASRRs and that the facility just recently received the information to be able to submit a PASRR. If a hospital inputs incorrect data on the PASRR, the expectation is to correct it immediately. Resident #10's diagnoses were reviewed. Anxiety, bipolar and depression. No corrected PASRR and the only PASRR that could be reviewed was the PASRR from the hospital during the interview.An interview was conducted on March 5, 2026 at 12:59 p.m. with MDS nurse Staff #49 and revealed that he was told that social services reviewed the PASRR and does not look to see if they are a level II and has never seen a level II from the hospital. The risk for not having an accurate level I on admission is that the resident would not get the services needed. There are certain facilities that provide that level of care needed.An interview was conducted on March 6, 2026 at 11:06 a.m. with admissions coordinator Staff #3 and revealed that the PASRR is reviewed prior to accepting a resident. A review is conducted by the Staff #3 and the central intake team. The Level I PASRR is usually the last thing that is sent over prior to admission and a corporate auditor looks over the PASSR and all the information in the admission agreement.Review of the policy Pre-admission Screening Resident Review (PASRR) Version No. 1.0 Date Revised: 06/2020, (in bold print) If the facility stay is longer than thirty days, a Level I screening must be performed within 40 days of admission.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, resident and staff interviews, facility documentation and policy and procedures, the facility failed to ensure nail care was provided for one resident #7 out of 14 sampled. The universe was 50. The deficient practice could result in the resident not having their personal grooming needs met, potential injury or infection.Findings include: Resident #7 was admitted on [DATE] with diagnosis including gastrointestinal hemorrhage, sequelae of cerebral infarction, systolic (congestive) heart failure, anemia, acute kidney failure, acute respiratory failure with hypoxia, age-related osteoporosis, major muscle wasting and atrophy, muscle weakness, dysphagia-oropharyngeal phase, abnormalities of gait and mobility, cognitive communication deficit, need for assistance with personal care and neuromuscular dysfunction of the bladder. The 5-day MDS (minimum data set) dated February 9, 2026 revealed a BIMS (brief interview of mental status) score of 14, indicating that the resident was cognitively intact. The MDS further revealed no indicators of psychosis or noted behaviors. It was further documented in the MDS that the resident had upper extremity impairment on both sides and lower extremity impairment on one side. The care plan revealed that the resident had significant ADL (activities of daily living) deficits as related to health diagnosis, including impairment to both upper and lower extremities, dated February 10, 2026. Noted interventions included that the resident required caregiver assistance with personal hygiene/ oral care and that the resident required extensive assistance to reposition and turn in bed. The electronic medical record (EHR) revealed no documented evidence that issues regarding the resident's finger and toenails had been identified nor that either had been trimmed or cleaned. An observation conducted on March 3, 2026 at 12:01 PM revealed the resident laying elevated in her hospital bed. It was observed that the resident's left toenails were discolored with a yellowish tinge, brittle in appearance and extending a few centimeters above the tip of the toe. The right foot was observed to have an orthopedic-like boot in place. A wound dressing was also observed on the top of the left foot. A subsequent interview with the resident was conducted and she stated that the toenails had not been cut for several months. A secondary observation was conducted on March 4, 2026 at 11:05 AM revealing the resident again laying in an elevated hospital bed with her fingernails visible. One jagged fingernail (thumb) on the left hand was visible and the right hand revealed noted contractures. There was no evidence that the toenails had been trimmed. An interview was conducted on March 4, 2026 at 11:07 AM with staff #88, CNA (certified nursing assistant). Staff #88 stated that nail care is conducted during showers and then documented on the shower sheets. The CNA stated that nails that are jagged or above 1/4 of inch over the top of the nail would need to be trimmed by the CNA's. Staff #88 stated that some residents, if diabetic, would receive toenail care from the podiatrist, but otherwise the CNA would be able to trim the toenails. Staff #88 further stated that the shower sheets are located at each unit and that the nurses review them. The CNA stated that the risk of not trimming the nails could include the resident scratching themselves. An interview was conducted on March 4, 2026 at 11:22 AM with staff #11, LVN (licensed vocational nurse). Staff #11 stated that nail care for fingernails is conducted by CNA's as long as the resident was not ?diabetic'. Staff #11 stated that the documentation regarding nail care would be located in the EHR. Staff #11 stated that the podiatrist would be involved regarding toenail care. On March 4, 2026 at 11:31 AM staff #11 went into the room of resident #7 and stated that the left-hand thumb was jagged and should be clipped. He further stated that the left toenails are much too long and needed to be clipped. He stated that the risk to the resident could include scratches or infection. On March 4, 2026 at 11:33 AM the resident's assigned nurse, staff #52 RN (registered nurse) entered the room of resident #7 and observed the resident's nails. Staff #52 stated that both thumbs were too long and should have been clipped. Staff #52 further stated that the left thumb was jagged and that the toenails appeared to be a couple of centimeters above the top of the toe. Staff #52 explained that issues with nail care should be identified during (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weekly skin checks and that the issues with this resident's nails should have been caught, especially since the resident was also receiving wound care on the same foot. The RN stated that the CNA's are responsible for providing nail care when they conduct the showers, but stated it ultimately is the nurse's responsibility to identify the issue during skin checks and this had not been identified by either CNA's or the nurse. Staff #52 reviewed the shower-sheets for this resident and stated that nothing had been documented regarding the resident's ?excessively' long nails. Staff #52 further reviewed the skin checks for this resident and stated that a ?scab' had been documented but stated that there was no documentation regarding either the finger or toenails on any skin checks. An interview was conducted on March 4, 2026 at 12:14 PM with staff #101, interim DON (director of nursing). Staff #101 stated that the expectation regarding nail care is that all nails should be trimmed and cleaned underneath. She stated that this was work in progress in the facility. She further stated that nails should be looked at each time the resident is given a shower. Staff #101 stated that those responsible for nail care could include the CAN's, nurses, activities staff or podiatrist. Staff #101 stated that fingernail care would generally be conducted by CNA's unless the resident was diabetic. She further stated that toenail care for diabetics is generally conducted by scheduled podiatry visits. Staff #101 reviewed that resident's EHR for any documentation of podiatry notes or scheduling and stated that she did not see any evidence thereof. Staff #101 stated that the risk for not cleaning and clipping the nails could include germs under the nail bed which could result in infection and if nails are too long the risk of a self-inflicted skin tear. A review of the policy titled Grooming Care of the Fingernails and Toenails with no documented date, revealed that finger and toenails are to be trimmed by CNA's unless the resident exhibits the following conditions: diabetes or circulatory impairments, ingrown/ infected/ or painful nails and nails that are too hard or thick to cut. The policy further noted that the procedure is to be documented in the resident's medical record.

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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, record review, staff interviews and policy review, the facility failed to ensure that medications/treatments are stored properly and not left at the bedside for one resident (#46). The facility census was 50. The deficient practice could result in harm to the residents, and/or visitors who have access to medications.Findings include:Resident #46 was admitted to the facility on [DATE] with the diagnosis that included left hand contracture, dysphagia, major depressive disorder and muscle weakness.The minimum data set (MDS), revealed a brief interview of mental status (BIMS) score of 10 which revealed resident with moderate cognition impairment.The care plan revealed no documentation for medications at the bedside.An observation was conducted on March 03, 2026 at 10:53 a.m. in Resident #46 ?s room and revealed an overbed table with a disposable bed pad covering the top of the overbed table. Items included a clear resealable bag with gauze, an abdominal pad package and band aids. An opened package of 200 count 4x4 gauze sponges, three individually wrapped blue sponge oral swabs, a silver package containing a wound dressing, a small black tube with a white cap, an opened 0.18 oz skin protectant individual package, a spray bottle of Skintegrity wound cleanser and a nearly full 16-ounce bottle of mineral oil with Lubricant Laxative written in smaller script below the larger printed Mineral Oil.An interview was attempted on March 3, 2026 at 10:55 a.m. with Resident #46 and was unsuccessful.An interview was conducted on March 03, 2026 at 11:03 a.m. in Resident #46 ?s room with registered nurse (RN) Staff #27 and revealed that the black tube on the overbed table was a tube of Medihoney that is used to treat wounds and staff stated that should not be kept at the bedside, the skin protectant is also a treatment and should not be at the bedside, the wound cleanser is just a cleanser and was not sure if that could be left in the room. Staff #27 did not know if mineral oil is considered a medication. Staff #27 concluded the interview by stating that patients are walking around and could come in and get to those items.An interview was conducted on March 03, 2026 at 11:46 a.m. with certified nursing assistant (CNA) Staff #77 and revealed that no medications or stuff for treatments are allowed to be left at the bedside.An interview was conducted on March 6, 2026 at 09:06 a.m. with regional nurse interim director of nursing (RN DON) Staff #101 and revealed that medications are not left at the bedside. Residents can have medications at the bedside if an assessment has been done, the doctor has been contacted, the self-administration form completed and signed by the resident and someone in the building. Medications are anything that is administered to the residents. Mineral oil is. Staff #101 only was aware of the wound cleanser being at the bedside, not the bottle of mineral oil, the Medihoney, or the skin protectant. The risk for leaving medications at the bedside or in the room is that somebody else could come in there and unintentionally take the meds.Review of the policy Medication Storage, date revised 01/2026 revealed, medications must be stored securely to prevent unauthorized access, diversion, loss, contamination or misuse.Review of the policy Medication-Administration Nursing Manual- Nursing Care VIII. Policy No. -NP-301 Employees Nursing staff, Version No. 1.0 revealed, medications will not be left at the bedside. Review of the policy Self-Administration of Medications revision date 08-2020 revealed that results from the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record on the care plan.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, observations, and review of facility policies and procedures, the facility failed to follow infection control standards related to catheters for one resident (#27) out of 14 sampled. The deficient practice could lead to a high risk of CAUTI (catheter-associated urinary tract infections), contamination transfer or tube obstruction.Findings include:Resident # 27 was re-admitted on [DATE] with diagnosis including chronic kidney disease, mild cognitive impairment, weakness, acute kidney failure, urinary tract infection, muscle wasting and atrophy, infection and inflammatory reaction due to other urinary catheter, cognitive communication deficit, obstructive and reflux uropathy, and pneumonia.The 5-day MDS (minimum data set) revealed a BIMS (brief interview of mental status) score of 7, indicating severe cognitive impairment. The MDS further revealed that the resident had an indwelling catheter.The physician's orders revealed an order summary dated February 5, 2026 noting enhanced barrier precautions due to Foley catheter. Another order summary dated February 5, 2026 revealed that catheter care was to be conducted every shift and as needed. An order summary dated February 6, 2026 noted to change the catheter securement device every week.The care plan revealed a focus area dated March 3, 2026 which documented that the resident had an indwelling catheter related to urinary retention/ obstruction with noted interventions including to position the catheter bad and tubing below the level of the bladder and away from the entrance room door and to check tubing for kinks and maintain the drainage bag off the floor.An observation was conducted on March 5, 2026 at 7:39 AM in the 200 hallway. Resident #27 was observed seated in the wheelchair assisted with ambulation by staff #56 PTA (physical therapy assistant). The resident's catheter bag was observed below the wheelchair dragging on the floor. During the observation, staff #56 assisted resident #27 to a standing position and then walking through the hallway with the wheelchair behind the resident and the catheter bag still dragging on the floor.On March 5, 2026 at 7:41 an interview was conducted with staff #52, RN (registered nurse) regarding catheter bag placement. Attention was brought to the catheter bag trailing on the floor behind the resident and staff #52 stated that the bag should never be touching the floor under any circumstances and stated that the risk was an infection control issue. Staff #52 followed the resident to the dinning area where he was now seated and adjusted the catheter bag.An interview was conducted on March 5, 2026 at 7:45 AM with staff #56. Staff #56 stated that he had been assisting resident #27 from his room to the dining area. He stated that the privacy bag cover had been in place but observed the nurse adjusting the resident's catheter bag and stated that the bag was touching the floor and should not have been. Staff #56 stated that risk for the catheter bag touching the floor could include a rupture, pulling on the site and infection.An interview was conducted on March 5, 2026 at 12:53 PM with staff #101, interim DON (director of nursing). Staff #101 stated that the expectation regarding catheter bags is that they are secured, hanging either from the bed or wheelchair and that they should not be on the ground. Staff #101 stated that risk to the resident if the bag is touching the ground is one of infection control.An interview was conducted on March 6, 2026 at 8:22 AM with staff #10, CNA (certified nursing assistant). Staff #10 stated that catheter bags should be covered with a privacy cover, situated on the inside or and between the legs of the resident and properly anchored. Staff #10 stated that a catheter bag should never be allowed to touch the floor and stated that if it did touch the floor, the risk could include infection control or it could ?pop' open.A review of the policy titled Catheter-Care of, with a review date of January 2025, revealed the purpose of the policy was to prevent catheter-associated urinary tract infections (CAUTI) and ensure indwelling catheters are only used when medically necessary. The policy further noted that the catheter is to be anchored with a leg strap to prevent excessive tension on the catheter, which could lead to urethral tears or dislodging of the catheter. Regarding the collection bag, the policy noted to take care to ensure that the collection bag does not touch the floor at any time.