

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055776	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/08/2026
NAME OF PROVIDER OR SUPPLIER Westview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 12225 Shale Ridge Lane Auburn, CA 95602	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store food in accordance with standards for food safety when fresh produce was not labeled or dated correctly to inform staff when the food was safe to use by. This failure had the potential for all residents in the facility who eat food from the kitchen to contract food-borne illness related to consuming food past their use by date. During an observation on 5/5/26, at 8:10 a.m., in the facility walk-in refrigerator, a plastic container of onions were observed without a label to indicate the received date or a use by date. During an interview on 5/5/26, at 8:10 a.m., with the Dietary Director (DD), DD stated there are no labels on the onions. During an observation on 5/5/26, at 8:11 a.m., in the facility walk-in refrigerator, a plastic bag of approximately 8 whole carrots were observed without a label to indicate the received date or a use by date. During an interview on 5/5/26, at 8:11 a.m., with DD, DD stated there were no labels on the carrots and all food needs to be labeled with a use by date. During an observation on 5/5/26, at 8:13 a.m., in the facility walk-in refrigerator, a card box of [NAME] tomatoes were observed without a label to indicate the received date or a use by date. During an interview on 5/5/26, at 8:13 a.m., with DD, DD stated there was no use by date for the [NAME] tomatoes. During an observation on 5/5/26, at 8:14 a.m., in the facility walk-in refrigerator, a plastic bag of cilantro was observed without a use by date. The cilantro appeared wet inside the bag with numerous brown discolored cilantro leaves. During an interview on 5/5/26, at 8:14 a.m., with DD, DD stated there was no use by date for the cilantro. During an observation on 5/5/26, at 8:19 a.m., in the dry food storage room, two plastic tubs were observed with various whole potatoes inside. Neither tub had a use by date. During an interview on 5/5/26, at 8:19 a.m., with DD, DD stated there were no labels on the potatoes. During an observation on 5/5/26, at 8:21 a.m., in the dry food storage room, a plastic bag was observed to be opened with hamburger buns, with no dates labeled on the bag. A sign on the bread rack was noted to direct staff to label bread with the open date and discard after 5 days of being opened. During an interview on 5/5/26, at 8:21 a.m., with DD, DD stated there were no labels on the potatoes. During an observation on 5/5/26, at 8:23 a.m., in the dry food storage room refrigerator, a cardboard box containing 10 apples was observed without a use by date. Another cardboard box containing over a dozen oranges was observed without a use by date. During an interview on 5/5/26, at 8:23 a.m., with DD, DD stated there were no dates on the apples or oranges. A review of the facility's policy and procedure (P&P) titled, Labeling and Dating of Foods dated 2023 indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055776	Facility ID: 055776
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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview and record review, the facility failed to protect and keep secure when not in use, confidential resident health records for a census of 154. This failure had the potential to expose and disclose personal and confidential health information to unauthorized individuals. During a medication pass (med pass) observation on 5/5/26 at 8:08 a.m. with Licensed Nurse 15 (LN 15), LN 15 was observed preparing medications for Resident 122. As LN 15 prepared the medications, she placed the empty bubble packs on their side on top of the medication cart (med cart), positioned with the long thin edge on the cart so that the blisters faced sideways and the pharmacy labels faced outwards. The pharmacy labels contained confidential resident information. LN 15 had placed multiple empty bubble packs in that fashion and stated she did that so she could follow up with the pharmacy to see if they needed to be refilled. LN 15 left the bubble packs on the med cart as she entered Resident 122's room to administer the medications. The bubble packs with their pharmacy labels affixed were left visible to staff and visitors passing by. During an interview on 5/5/26 at 12:04 p.m. LN 15 stated if she had papers on the med cart that contained confidential resident information, she would cover it or flip it over if she walked away from the med cart. LN 15 stated the pharmacy labels on the bubble packs were visible to staff and visitors due to how she positioned them. During a med pass observation on 5/5/26 at 8:41 a.m. with LN 8, LN 8 was observed preparing medications for Resident 134. LN 8 removed an Ozempic (an injectable medication to treat diabetes) 1 milligram (mg, a unit of measurement)/dose pen and an Arnuity Ellipta (a medication to treat asthma) 100 microgram (mcg, a unit of measurement) inhaler from the med cart. LN 8 removed the cap from the Ozempic pen and stated it was empty. LN 8 placed the empty Ozempic pen and empty Arnuity Ellipta box, both with pharmacy labels affixed, on top of the med cart and left them unattended when she went to the medication storage room. The Ozempic pen and Arnuity box were visible and accessible to residents and staff who passed through the hall. During an interview on 5/5/26 at 2:13 p.m. with LN 8, LN 8 stated her practice was to ensure resident information was covered if she walked away from the med cart but could not recall what she had done with the Ozempic pen and Arnuity Ellipta box during the observed med pass. During an interview on 5/6/26 at 3:12 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to keep resident records confidential by turning pharmacy labels over if they were left on the med cart. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 10/2025, the P&P indicated, Policy Interpretation and Implementation. 13. Access to resident personal and medical records will be limited to authorized staff. During a review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, dated 10/2021, the P&P indicated, Policy Interpretation and Implementation: 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his or her. b. medical treatment. 4. Access to resident personal and medical records will be limited to authorized staff and business associates.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure five of 37 sampled residents (Resident 7, Resident 140, Resident 8, Resident 11, and Resident 156) were free from unnecessary psychotropic medications (drugs that affect brain activities associated with mental processes and behaviors) when: Resident 7 received psychotropic medication without behavior monitoring and nursing staff did not implement nonpharmacological (non-drug) interventions; Resident 140's psychotropic medication dosage was increased without documented clinical rationale and nonpharmacological interventions were not implemented; Resident 8's as needed psychotropic medication was extended without documented clinical rationale and nursing staff did not document which nonpharmacological interventions were implemented; Resident 11 received psychotropic medication without side effect or behavior monitoring and nonpharmacological interventions were not implemented and Resident 156's antidepressant (medication used to treat depression - persistent sadness and loss of interest that interfere with daily life) was given without appropriate target behavior monitoring. These failures had the potential to result in the unnecessary use of psychotropic medications and increased risk of exposure to side effects from lack of monitoring and utilization of the lowest effective dose of medication. 1. A review of Resident 7's medical record indicated she was admitted to the facility in December 2021 with diagnoses which included PTSD (post traumatic stress disorder, a mental health condition triggered by experiencing or witnessing a terrifying, life-threatening, or traumatic event), major depressive disorder, and anxiety. A review of Resident 7's physician's orders indicated the following orders: Remeron (brand for mirtazapine, a medication to treat depression and sleep) 15 milligrams (mg, a unit of measurement), give 1 tablet by mouth at bedtime for depression MB (manifested by) inability to fall or stay asleep for 7 days and give 2 tablets by mouth at bedtime for depression MB inability to fall or stay asleep, dated 3/25/25 Wellbutrin (a medication to treat depression) SR (sustained release) 100 mg: Give 100 mg by mouth one time a day for Depression MB tearfulness, dated 4/24/26 Ativan (a medication to treat anxiety) 0.5 mg: Give 1 tablet by mouth at bedtime every Mon, Wed, Fri for anxiety MB inability to sleep, dated 1/16/26 Buspirone (a medication to treat anxiety) 5 mg: Give 5 mg by mouth three times a day for generalized anxiety disorder MB restlessness, dated 3/4/26 During a concurrent interview and record review on 5/7/26 at 11:57 a.m. with the Director of Nursing (DON), Resident 7's monitoring parameters for Remeron were reviewed. The DON confirmed it would be expected that Resident 7 would be monitored for target behaviors related to the use of Remeron and that nursing staff implemented nonpharmacological (treatments or health improvements that do not use medication or drugs) interventions for residents on psychotropic medications. She reviewed Resident 7's medical record and stated nursing staff did not document what interventions were used to help with Resident 7's anxiety and depression. The DON stated she saw check marks for documentation, which made it difficult to see what did and did not work and what (nonpharmacological intervention) they could use next time. The DON confirmed there was no documentation that Resident 7 was monitored for target behaviors related to the use of Remeron. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 140's medical record indicated she was admitted to the facility in May 2015 with diagnoses which included major depressive disorder and anxiety. A review of Resident 140's physician's orders indicated the following orders: Buspirone 10 mg: Give 1 tablet three times daily, ordered 3/4/25 to 5/7/25 Buspirone 10 mg: Give 2 tablets by mouth every 8 hours for anxiety AEB (as evidenced by) restlessness. Administer 20 mg every 8 hours for anxiety MB restlessness, ordered 5/7/25 During a concurrent interview and record review on 5/7/26 at 12:06 p.m. with the Assistant Director of Nursing (ADON), Resident 140's medical record was reviewed for documentation of the clinical rationale for the increase in Resident 140's buspirone dose in May 2025. The ADON was unable to find documentation by the prescriber or nursing staff to justify the increase in Resident 140's dose and stated, There's not a ton of specifics. During a concurrent interview and record review on 5/7/26 at 12:27 p.m. with the DON, Resident 140's medical record was reviewed to identify if and what nonpharmacological interventions were implemented for anxiety in an effort to use the lowest dose of buspirone. The DON reviewed Resident 140's record and stated, No, they are not being implemented. 3. A review of Resident 8's medical record indicated she was admitted to the facility in February 2023 with diagnoses which included anxiety, major depressive disorder, and bipolar disorder (a mental health condition characterized by dramatic, uncontrollable shifts in mood, energy, and activity levels). A review of Resident 8's physician's orders indicated the following orders: Ativan (a medication to treat anxiety) mg: Give 0.5 mg by mouth every 12 hours as needed for anxiety for 14 days, dated 3/25/26 Ativan 0.5 mg: Give 0.5 mg by mouth every 12 hours as needed for Anxiety mb verbal outbursts for 60 days, ordered 4/12/26 to 6/11/26 During a concurrent interview and record review on 5/7/26 at 12:36 p.m. with the DON and ADON, Resident 8's medical record was reviewed. The DON stated there was no documentation that Resident 8 was reevaluated by the physician to determine it was clinically appropriate to extend the as needed Ativan order (dated 3/25/26) beyond 14 days. The ADON reviewed Resident 8's record for monitoring parameters and confirmed Resident 8 was not monitored for side effects or behaviors related to the use of Ativan. The ADON reviewed the record for nonpharmacological interventions to treat Resident 8's anxiety and confirmed nursing staff did not document what they had implemented. During a review of the facility's P&P titled, Psychotropic Medication Use, dated 10/2025, the P&P indicated, Policy Interpretation and Implementation. 6. The need to continue PRN orders for psychotropic medications requires that the practitioner document the rationale for the extended order. 4. A review of Resident 11's medical record indicated she was admitted to the facility in March 2026 with diagnoses which included mood disorder (a mental health condition that causes persistent, intense, and disruptive emotional states). (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 11's physician's orders indicated an order for Seroquel (a type of psychotropic medication) 25 mg, give 1 tablet by mouth in the morning for mood disorder and give 3 tablets by mouth at bedtime for mood disorder, ordered 3/1/26. During a concurrent interview and record review on 5/7/26 at 2:56 p.m. with the DON, Resident 11's monitoring parameters and nonpharmacological interventions related to the use of Seroquel were reviewed. The DON stated there was no documentation that indicated Resident 11 was monitored for side effects or target behaviors related to Seroquel. The DON also confirmed nursing staff did not implement nonpharmacological interventions for Resident 11's mood disorder in an effort to use the lowest effective dose of Seroquel. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 10/2025, the P&P indicated, Policy Interpretation and Implementation. 3. The Physician/Nurse Practitioner will identify, evaluate, and document, with input from other disciplines as needed, symptoms that may warrant the use of psychotropic medications. 6. The need to continue PRN orders for psychotropic medications requires that the practitioner document the rationale for the extended order. 7. The staff will observe, document and report to the Physician/Nurse Practitioner information regarding the effectiveness of any interventions, including psychotropic medications. 8. Nursing staff shall monitor for and report any side effects and adverse consequences of psychotropic medications to the Attending Physician/Nurse Practitioner. 5. During a review of Resident 156's admission records, the records indicated Resident 156 was admitted to the facility in April 2026 and readmitted in May 2026 with diagnoses that included fracture of lower end of left radius (a break in the wrist bone), and depression. Resident 156's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/28/26, indicated Resident 156 had moderate cognitive impairment. A review of Resident 156's physician order, dated 5/2/26, indicated an order for Duloxetine (an antidepressant) 20 mg (milligrams, a unit of measurement) two capsules by mouth one time a day for depression manifested by verbalized sadness. During a review of Resident 156's care plan, initiated on 4/27/26, the care plan indicated, .Duloxetine for Depression M/B [manifested by] verbalization of sadness.At risk for suicidal thinking or abnormal behavior with the use of antidepressant medication.Will exhibit a therapeutic effect related to the use of the medication. During a review of Resident 156's clinical records, there was no documented evidence that Resident 156's target behaviors related to depression were being monitored. During a review on 5/7/26 at 12:56 p.m. with DON, the DON stated behaviors should be monitored for residents on antidepressant. The DON reviewed Resident 156's physician orders and confirmed Resident 156 was receiving Duloxetine 40mg once a day. The DON further confirmed that there was no behavior monitoring for Resident 156's use of antidepressant medication. The DON stated behavior monitoring was important to have so the facility can determine the efficacy of the medication Resident 156 was receiving. During a review of the facility's policy and procedure (P&P) titled Psychotropic Medication Use, revised 10/2025, the P&P indicated, .1. A psychotropic drug is any drug that affects the brain activities associated with mental processes and behavior. These drugs include, but are not limited to, (continued on next page)		

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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. Based on interview and record review, the facility failed to ensure patient safety for medication use for six of 37 sampled residents (Residents 7, 8, 11, 76, 116 and 153) when: Nursing staff administered the incorrect probiotic to Resident 153; Nursing staff did not educate and assist Resident 76 to ensure he correctly administered his inhaler; Multiple incomplete and unclear PRN (as needed) pain medication orders were not clarified for indication for use (e.g. mild, moderate, or severe pain) prior to administration. Medication orders were not scheduled for administration according to the physician's orders to avoid drug interactions for Resident 7; and Nursing staff did not notify the physician in accordance with the order when Resident 11's blood sugar (BS) was greater than 200. These failures had the potential to result in inappropriate medication administration, preventable medication errors, increased risk of adverse drug events, oversedation, and resident harm or death. 1. During a medication pass (med pass) observation on 5/5/26 at 9:06 a.m. with Licensed Nurse (LN 5), LN 5 was observed preparing medications for Resident 153, including saccharomyces boulardii (a probiotic yeast, not bacteria, used to treat and prevent diarrhea, especially when caused by antibiotics or travel) 10 billion CFU (colony forming units, a unit of measurement), 1 capsule. LN 5 stated she would not administer Resident 153's senna (a medication to treat constipation) because the resident had another loose stool that morning. A review of Resident 153's physician's orders indicated an order for lactobacillus (a probiotic bacteria that naturally lives in the digestive tract that protects the gut from harmful bacteria), give 1 capsule by mouth three times a day for supplement, dated 4/27/26. During a concurrent observation, interview and record review on 5/5/26 at 12:28 p.m. with LN 5, Resident 153's probiotic order was reviewed. LN 5 opened the medication cart (med cart) and pulled out the saccharomyces boulardii and confirmed that was what she had administered to Resident 153 during the morning med pass. LN 5 stated she should have administered Culturelle (a brand of probiotic that contains lactobacillus) instead. During an interview on 5/6/26 at 3:27 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to correctly identify which over the counter (OTC) medication a resident was ordered by reviewing the order in the MAR and selecting the medication from the med cart. The DON stated nursing staff should be able to identify which OTC was the appropriate medication. 2. During a med pass observation on 5/5/26 at 8:21 a.m. with LN 15, LN 15 was observed preparing medications for Resident 76 which included Breztri Aerosphere (a medication to treat chronic obstructive pulmonary disease, a long-term, progressive lung disease that makes it hard to breathe due to damaged, inflamed, or blocked airways) 160/9/4.8 microgram/actuation (mcg, a unit of measurement). LN 15 removed a new Breztri Aerosphere inhaler from a sealed manufacturer's box, shook it, and stated the reason for shaking it was to ensure the medication was not settled. A review of Resident 76's physician's orders indicated an order for Breztri Aerosphere 160/9/4.8 mcg, 1 puff inhale orally two times a day for COPD rinse mouth after administration, dated 6/17/25. During the same med pass observation with LN 15, LN 15 entered Resident 76's room and handed the resident the inhaler. Resident 76 pressed down on the inhaler and stated, Nothing is coming out. Resident 76 then pressed the inhaler down a second time, then a third, and inhaled the medication each time. During a concurrent interview and record review on 5/5/26 at 12:15 p.m. with LN 15, Resident 76's order for Breztri was reviewed. LN 15 confirmed the order indicated one puff and Resident 76 had administered more than prescribed. LN 15 stated she was not aware of any special handling or preparation required prior to the use of a new Breztri inhaler because it was a new medication to her. A review of the manufacturer's labeling for Breztri Aerosphere, dated 4/2026 indicated, 2.1 Preparation and Administration Information. Priming Before Use: Priming BREZTRI AEROSPHERE is essential to ensure appropriate drug content in each actuation. Prime BREZTRI AEROSPHERE before using for the first time. Prime BREZTRI AEROSPHERE by releasing 4 sprays into the air away from the face, shaking well before each spray. Re-prime BREZTRI AEROSPHERE if the inhaler has not been used for more than 7 days, is dropped, or after weekly (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as needed for fever do not exceed 4 g/day from all sources, dated 9/17/25Tramadol (a potent medication to treat pain) 50 mg: Take 1 tab every 8 hours as needed for pain, dated 9/21/25 During a concurrent interview and record review on 5/6/26 at 3:34 p.m. with the DON, Resident 116's Tylenol and tramadol orders were reviewed. The DON stated the tramadol order did not indicate when to administer it in relation to the Tylenol. She stated the tramadol order should have been clarified to indicate a specific time and pain level to administer it. 4. A review of Resident 7's physician's orders indicated the following:Ferrous sulfate (an iron supplement) 325 mg: Give 1 tablet by mouth two times a day for anemia DO NOT CRUSH****Iron can affect absorption of levothyroxine and thus administration of dose should be separated by at least 4 hours****, ordered 5/17/24Levothyroxine (a medication to treat the thyroid) 150 mcg (microgram, a unit of measurement): Give 150 mcg by mouth one time a day for hypothyroidism (underactive thyroid, a condition where the small, butterfly-shaped gland in your neck (the thyroid) doesn't produce enough of the hormones that control how the body uses energy) Administer on an empty stomach with a full glass of water at least 30-60 minutes prior to breakfast apart from other medications known to decrease absorption (e.g. Calcium), dated 1/31/26 A review of the scheduling details for the two orders indicated the ferrous sulfate was scheduled to be administered at 8 a.m. and 8 p.m. and the levothyroxine was scheduled for 6 a.m., daily. This was a separation of only 2 hours (not four, as indicated by the orders) between the two medications. During a concurrent interview and record review on 5/7/26 at 11:42 a.m. with the DON, the DON reviewed the ferrous sulfate and levothyroxine orders and their respective scheduling details and confirmed they were not separated by at least four hours. The DON stated the ferrous sulfate should have been scheduled for administration later in the morning at 10 or 11 a.m., to avoid it affecting the absorption of levothyroxine. 5. A review of Resident 11's physician's orders indicated an order for insulin glargine (a long acting insulin to treat diabetes, a condition where the body's blood sugar is too high because the body cannot properly move sugar from the blood into the cells for energy) 100 unit/ml, inject 13 unit subcutaneously (under the skin) at bedtime for diabetes mellitus Do not mix with other insulins or solutions. Notify MD if BS (blood sugar) <70 or >200, dated 3/1/26. During a concurrent interview and record review on 5/7/26 at 3 p.m. with the DON, Resident 11's insulin glargine order, BS values and physician communications were reviewed. The DON stated if a resident continuously experienced BS values over 200 there should have been communication to the physician to decide what to do for the resident. The DON reviewed Resident 11's record and stated the resident's BS was consistently over 200 at bedtime and there was no documentation that indicated nursing staff were notifying the physician. The DON stated, I'm not seeing it. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 10/2025, the P&P indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 2. Medications are administered in accordance with prescriber orders. 5. If a dosage is believed to be inappropriate or excessive for a resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the resident's Attending Physician/Nurse Practitioner or the facility's Medical Director to discuss the concerns.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents receive treatment and care in accordance with professional standards of practice for six residents (Resident 13, Resident 146, Resident 85, Resident 159, Resident 94, and Resident 151), for a census of 154, when: 1a. Resident 13's intravenous antibiotic (IV ATB- medications used to treat infections delivered directly into the bloodstream through a vein for immediate action) was initialed as given by a Licensed Vocational Nurse (LVN- healthcare professional providing basic nursing care under the supervision of a Registered Nurse or RN); 1b. Resident 146's IV ATB medication was initialed as given by an LVN; 1c. Resident 85's IV ATB treatments were initialed as given by LVN; 1d. Resident 159's IV ATB medication was initialed as given by an LVN; 1e. Resident 94's IV ATB medication was initialed as given by an LVN; and, 1f. Resident 151's IV medications were initialed as given by LVNs. These failures had the potential for residents to experience adverse consequences due to unsafe nursing practice and can potentially cause a delay in care. 1a. A review of the admission Record indicated Resident 13 was admitted to the facility February 2023 with diagnoses including type 1 diabetes mellitus (DM- a chronic disorder wherein sugar builds up in the blood requiring daily insulin replacement) with mild nonproliferative diabetic retinopathy (complication of DM affecting the eye due to damage to the retina or the light sensitive tissue at the back of the eye) and paroxysmal atrial fibrillation (irregular, rapid heart rhythm). During a review of Resident 13's Medication Administration Record (MAR) for April and May, the order indicated Meropenem Intravenous Solution [antibiotic given directly into a vein to treat severe infections] Reconstituted [turning a white powder into a liquid solution] 500 MG [milligram- unit of measurement] (Meropenem) Use 500 mg intravenously every 8 hours for UTI [urinary tract infection- an infection in the bladder/urinary tract causing burning or pain during urination] for 7 Days. Resident 13's IV medication was started on 4/29/26. Further review of Resident 13's IV ATB administration indicated the following information: -on 4/29/26 at 2000 [8 p.m.], Licensed Nurse 11 (LN 11/LVN) initialed the MAR and the Medication Administration Note indicated administered by RN; -on 4/30/26 at 0400 [4 a.m.], LN 9 (LVN) initialed the MAR and the Medication Administration Note indicated Done by RN; -on 4/30/26 at 12 noon, LN 10 (LVN) initialed the MAR and the Medication Administration Note indicated Administered by RN; -on 5/1/26, three LVNs (LN 9, LN 10, and LN 12) initialed the MAR at 4 a.m., 12 noon, and 8 p.m., and the Medication Administration Note by LN 12 (for 8 p.m.) indicated Administered by RN supervisor. There was no Administration note by LN 9 and LN 10. -on 5/2/26, two LVNs (LN 3 and LN 10 [2x]) initialed the MAR. LN 10 made two Administration Notes at 12 noon and for 8 p.m. The LN 10's Medication Administration Note for 8 p.m. indicated Administered by RN; -on 5/3/26, three LVNs (LN 3, LN 10, and LN 12) initialed the MAR. LN 12's Medication Administration (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Note indicated Administered by RN; -on 5/4/26, two LVNs (LN 3 and LN 11) initialed the MAR. LN 3 and LN 11's Medication Administration Note indicated the IV ATB was administered by RN; -on 5/5/26, two LVNs (LN 9 and LN 13) initialed the MAR. LN 13 indicated in the Medication Administration Note Administered by rn [sic]; and, -on 5/6/26, two LVNs (LN 9 and LN 10) initialed the MAR. LN 9 and LN 10 indicated in the Medication Administration Note the IV ATB was administered by RN. During an interview on 5/7/26 at 8:03 a.m. with LN 10, LN 10 stated she was not IV certified (LN cannot legally perform tasks such as starting IV or administering IV medications). The LN 10 further stated only the RN can administer IV medications. LN 10 added she never administered IV medications for Resident 13. The LN 10 further added she signed the MAR for the IV ATB for Resident 13 and wrote a note the RN administered the medication. During a follow up interview on 5/7/26 at 8:35 a.m. with LN 10, LN 10 was asked the name of the RN who administered the IV ATB for Resident 13 when she wrote Administered by RN. LN 10 was unable to recall the name of the RN. The LN 10 confirmed the RN who administered the IV medication did not sign the MAR and the name of the RN was not indicated in the progress notes. LN 10 was asked to describe the process of administering IV medication, LN 10 stated the RN working that day will administer the IV medication and the LVN will initial the IV medication in the MAR. LN 10 further stated the RN who will prepare and administer the IV medication will write the initial in the IV bag/administration set and once the medication was administered, the IV administration set with the RNs initial will be discarded. During a concurrent interview and record review on 5/8/26 starting at 8:03 a.m. with the Director of Nursing (DON), Resident 13's antibiotic order, MAR for April and May, and the Medication Administration Notes were reviewed. The DON stated Resident 13 was on IV ATB from 4/29 to 5/6/26. The DON further stated it has been the practice for RNs to prepare and administer the IV medication and the LVNs will sign the MAR for the administration of IV medication. The DON added, the LVNs were told to sign the MAR and put a note saying the RN administered the IV medication. The DON stated her expectation was for the LVNs to sign the MAR for administration of IV medication and for the LVNs to indicate the RN administered the medication in the progress note. 1b. A review of the admission Record indicated Resident 146 was admitted March of 2026 with diagnoses including acute respiratory failure (lungs unable to get enough oxygen into the blood or remove carbon dioxide causing severe shortness of breath) and benign prostatic hyperplasia (BPH-enlarged prostate gland restricting urine flow and difficulty emptying the bladder). During a review of Resident 146's MAR for May 2026, the order indicated, Meropenem Intravenous Solution Reconstituted (Meropenem) Use 500 mg intravenously every 8 hours for UTI for 7 Days. Resident 146's IV medication was started on 5/3/16. Further review of Resident 146's MAR indicated on 5/5/26 at 4 a.m., LN 3 (LVN) initialed the MAR for the IV medication. The LN 3 made a note on 5/5/26 indicating Resident 146 was on charting for IV ATB for UTI. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/8/26 at 8:18 a.m. with the DON, Resident 146's IV ATB order, MAR and Medication Administration Notes were reviewed. The DON stated Resident 146 was started on IV ATB on 5/3/26. The DON further stated LN 3 signed the MAR on 5/5/26 at 4 a.m. and the Nurse's note did not indicate the IV medication was administered by an RN. 1c. A review of the admission record indicated the facility admitted Resident 85 in March of 2026 with multiple diagnoses which included osteomyelitis of vertebra (an infection in the bones of the spine that causes pain and inflammation). During an observation and interview on 5/7/26 at 8:05 a.m., Resident 85 was observed in his bed. Resident 85 was pleasant and answered all questions appropriately. Resident 85 explained that he was admitted to the facility to continue treatment for infected bones in his spine. Resident 85 pointed to his right upper arm and explained that he had picc line (peripherally inserted central catheter, a long thin tube placed into a vein; used to give medications for a longer time without needing repeated needle sticks) and received antibiotics to treat the infection. A review of Resident 85's clinical records indicated that he was prescribed two different antibiotics (ABXs) to treat bones infection, including Daptomycin 500 mg IV once a day and Teflaro 600 mg every 8 hours from 3/24/26 to 4/12/26. A review of Resident 85's MARs from 3/24 through 4/12/26 indicated that Daptomycin was administered daily at 10 a.m., and Teflaro was administered at 00 a.m. (midnight), 8 a.m., and 5 p.m. A review of Resident 85's MARs from 3/24/26 through 3/31/26 indicated that the resident received 8 doses of Daptomycin 500 mg IV and 24 doses of Teflaro 600 mg IV. Out of 8 doses of Daptomycin 500 mg administered to Resident 85 in March, one dose was initialed/documented as administered by RN and out of 24 doses of Teflaro 600 mg administered to Resident 85 for the same period, indicated that none was initialed/documented as administered by RN. Resident 85's MARs revealed multiple instances where licensed vocational nurses placed their initials indicating the administration of antibiotics. A review of Resident 85's MARs from 4/1 through 4/12/26 indicated that out of 12 doses of Daptomycin, RNs initialed/documented the administration of medication twice and out of 36 doses of Teflaro, RNs initialed the documentation of medication administration three times. Resident 85's MARs indicated licensed vocational nurses placed their initials on multiple days indicating the administration of the antibiotics. A further review of Resident 85's progress notes titled, Medication Administration Note [MAN] from 3/24/26 through 4/12/26 revealed there were multiple instances when the administration of Daptomycin was administered by an RN. A further review of Resident 85's progress notes, including MAN from 4/1 through 4/12/26 revealed 16 antibiotic doses lacked documentation indicating the Teflaro medication was administered by an RN. A review of Resident 85's clinical records from 3/24/26 through 4/12/26 revealed multiple instances where licensed vocational nurses initialed IV ABXs administration in the MARs and documented in medication administration notes Administered by RN or Done by RN without identifying Registered Nurse's name who performed the IV medications administration. During an interview on 5/7/26 at 12:18 p.m., with LN 1, LN 1 stated he was not certified to administer (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV medications, and all IV medications were administered by RNs. LN 1 stated, If I have a resident with scheduled antibiotic, I'd notify RN supervisor about ABX due. I wouldn't touch it. If I did not administer IV ABX, I'd not initial the MARs. LN 1 explained the process of IV medications administration further, RN that administered ABX has to place her initials which indicate that she/he was the one that administered the medication. During a continued interview on 5/7/26 at 12:18 p.m., Resident 85's administration of IV antibiotics was discussed with LN 1. LN 1 stated he was familiar with Resident 85 and with the resident's treatments and care. LN 1 explained, Sometimes I am in resident's room with [resident's electronic chart] open, I would click on the MAR with the name of ABX, but document in progress notes that it was administered by RN. LN 1 validated that by clicking on medications in the MARs indicated the administration of medication. LN 1 acknowledged that he might have initialed Resident 85's antibiotics administration but could not identify which RNs administered resident's antibiotics and added, whichever RN worked that day. During an interview with Registered Nurse (RN 1) on 5/7/26 commencing at 12:30 p.m., RN 1 stated she was asked to administer antibiotics for other residents not assigned to her in the past. RN 1 explained the process of IV medication administration as follows, Verify there is an order for medication.pull up MARs, confirm the medication name, dose, resident's name.all 5 rights, verify set up, prime tubing, flush the access, hang ABX, connect to IV site and start [infusion]. When RN 1 was asked about documentation, RN 1 stated, I try to sign off [ABX administration] . under my log in when I am verifying the medication. RN 1 further stated she would occasionally administer IV antibiotics while logged into LVNs opened chart and added, Occasionally LVN assigned to resident had resident's chart opened [under her log in] and she would click [on the medication]. RN 1 acknowledged that selecting/clicking the medication entry indicated the medication had been administered by the individual whose name appeared in the documentation. RN 1 validated this process resulted in documentation reflecting the medication was administered under the name of the LVN logged into the resident's chart. During a concurrent interview and record review on 5/7/26 commencing at 10:58 a.m., with DON and ADON, DON stated, Only RNs can administer IV antibiotics. Upon discussing LVNs initialing on the Resident 85's Daptomycin and Teflaro administration, the DON stated, They initial that it was given, but document in progress notes that it was administered by RN. This is our process that LVNs get medications ready, and RNs hang them, then LVN initials and documents in progress notes that it was administered by RN. The DON validated that RNs administer but do not sign the administration of ABX in resident's chart. During a continued interview with DON and ADON on 5/7/26 at 10:58 a.m., the DON confirmed that in accordance with professional standards of practice, the nurse who administers the medication is responsible for documenting/signing the MAR for that specific medication. The DON added, It's ok if they add note indicating it was administered by RN. The DON stated her expectation was that every dose administered by RN and initialed by LVN, should have a note indicating that RN administered the medication. 1d. A review of Resident 159's admission Record, indicated Resident 159 was admitted to the facility in May 2026 with diagnoses including neuromuscular dysfunction of bladder (nerve damage that disrupts the signals between the brain, spinal cord, and bladder muscles) and sepsis (a serious condition in which the body responds improperly to an infection). (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 159's Order Summary, dated 5/7/26, indicated Resident 159 had an order for ceftriaxone sodium injection solution (IV ATB, antibiotic given directly into a vein to treat severe infections) 2 grams (g, a unit of measurement) every 24 hours for UTI/sepsis. A review of Resident 159's MAR for May 2026 indicated LN 7 (LVN) initialed the order for the IV ATB on 5/4/26 that it was administered and there was no note indicating that the IV ATB was administered by RN. During a concurrent interview and record review on 5/7/26 at 3:32 p.m. with LN 7, Resident 159's MAR was reviewed. LN 7 confirmed Resident 159's order for IV ATB on 5/4/26 was administered with her initials and confirmed there was no note indicating the IV ATB was administered by RN. LN 7 stated she was not supposed to initial the MAR because she did not administer the medication and LVNs are not supposed to administer IV medications. During an interview on 5/8/26 at 9:16 a.m. with DON, DON stated LVNs do not administer IV medications and LVNs should put a note indicating the IV medication was administered by the RN. DON further stated not putting a note could look like the LVN administered the IV medication. 1e. During a review of Resident 94's admission records, the records indicated Resident 94 was admitted to the facility in April 2026 with diagnoses that included acute osteomyelitis of left femur (infection of the thigh bone), and cervical cancer. Resident 94's MDS, dated [DATE], indicated Resident 94 had intact cognition. A review of Resident 94's physician order, dated 4/17/26, indicated an order for Ertapenem (an antibiotic) 1 g (gram, a unit of measurement) intravenously one time a day for osteomyelitis. During a review of Resident 94's care plan, initiated on 4/17/26, the care plan indicated, .Resident is at risk for complications and side effects of antibiotic use.Administer medication as ordered. During a review of Resident 94's MAR for April 2026 for Ertapenem, the MAR indicated Resident 94's Ertapenem was signed as administered by LN 3, a LVN, on 4/19/26, 4/24/26, 4/29/26, 4/30/26, and 5/5/26. During a review of Resident 94's progress notes, the notes indicated Resident 94's Ertapenem doses administered on 4/19/26, 4/24/26, and 5/5/26 were administered by an RN, but did not specify the name of the RN who administered the doses. There was also no documented evidence that an RN administered Resident 94's antibiotic on 4/29/26 and 4/30/26. During a concurrent interview and record review on 5/7/26 at 12:56 p.m. with the DON, the DON stated LVNs are not allowed to administer IV medications and RNs always administer IV medications. The DON reviewed Resident 94's MAR and confirmed that Resident 94's Ertapenem doses were signed by LN 3 on 4/19/26, 4/24/26, 4/29/26, 4/30/26, and 5/5/26. The DON also reviewed Resident 94's progress notes and confirmed that the notes for 4/19/26, 4/24/26, and 5/5/26 indicated Resident 94's was administered by an RN and no specific RN name was mentioned on the notes. The DON also confirmed that there were no progress notes regarding the IV ATB administration on 4/29/26 and 4/30/26 to indicate that an RN administered the antibiotic doses and stated that LN 3 should have documented it. The DON stated that LN 3 signed the MAR and documented that the antibiotic doses were administered by an RN to indicate that the RNs were doing the administrations. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1f. During a review of Resident 151's admission records, the records indicated Resident 151 was admitted to the facility in February 2022 an readmitted in December 2025 with diagnoses that included senile degeneration of brain (age-related cognitive decline), hypotension (low blood pressure), and adult failure to thrive (physical and psychological decline associated with advanced age). Resident 151's MDS, dated [DATE], indicated Resident 151 had intact cognition. A review of Resident 151's physician orders indicated the following: - Sodium Chloride (water and salt solution) IV solution 0/9%, use 75 ml/hr (milliliters per hour, a unit of measurement) IV one time only for hydration for 1 day, ordered 3/12/26 - Sodium Chloride IV solution 0.9 %, use 1 liter IV one time for hydration for 1 day to run at 75ml/hr, ordered 3/14/26 - Dextrose-Sodium Chloride (a solution combining sugar and salt in water) IV solution 5-0.45%, use 50 ml (milliliters, a unit of measurement) intravenously one time only for hypernatremia (high sodium levels in the blood) for 1 day 50mL/hr, ordered 3/16/26 - Dextrose-Sodium Chloride IV solution 5-0.45%, use 1000 ml one time only for hypernatremia for one day 50mL/hr, ordered 3/17/26 During a review of Resident 151's MAR for March 2026, the MAR indicated Resident 151's Dextrose-Sodium Chloride was signed as administered by LN 9, an LVN, on 3/18/26. Furthermore, Resident 151's Sodium Chloride IV doses were signed as administered by LN 8 on 3/9/26, by LN 1 on 3/12/26, and by LN 2 on 3/14/26. LN 8, LN 1, and LN 2 were LVNs. During a review of Resident 151's progress note, dated 3/18/26, the note indicated Resident 151's Dextrose-Sodium Chloride was given by RN. The note did not specify which RN administered Resident 151's IV medication. Furthermore, there were no progress notes on 3/9/26, 3/12/26, and 3/14/26 to indicate Resident 151's Sodium Chloride solutions were administered by an RN. During an interview on 5/8/26 at 10:43 a.m. with LN 1, LN 1 stated LVNs are not allowed to administer IV mediations and LN 1 confirmed that he did not have IV therapy certification. LN 1 stated upon administration of IV medications, he signed off on the MAR and the RN administered the medication. LN 1 added he put a comment in the progress note to indicate that the RN administered the IV medication. During an interview on 5/8/26 at 10:48 a.m. with LN 2, LN 2 confirmed that he did not have IV therapy certification and stated the RNs administer IV medications. LN 2 further stated nurses should sign if they administer a medication. Ln 2 stated, .Sign what you do.Be very careful with something you sign and you didn't do. During a concurrent interview and record review on 5/8/26 at 10:57 a.m. with the ADON, the ADON stated LVNs are allowed to give hydration fluids as long as they are certified. The ADON reviewed Resident 151's physician orders and MARs and confirmed LN 9 signed on Resident 151's Dextrose-Sodium Chloride on 3/18/26, and Resident 151's Sodium Chloride IV doses were signed as administered by LN 8 on 3/9/26, by LN 1 on 3/12/26, and by LN 2 on 3/14/26. The ADON also reviewed Resident 151's progress notes and confirmed that Resident 151's Dextrose-Sodium Chloride was given by RN but did not specify which RN administered the medication. The ADON further (continued on next page)		

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

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to provide restorative nursing assistant (RNA: is a certified nursing assistant (CNA) with specialized training who helps residents in skilled nursing facilities maintain or regain functional independence, mobility, and strength) services to two of 37 sampled residents (Resident 72 and Resident 143) according to professional standards when: Facility staff did not have documented evidence Resident 72 had his arm brace/splint applied daily according to physician orders, 2. It was not documented that Resident 143's hand splint was put on and removed according to the physician order. These failures had the potential for Resident 72 and Resident 143 to have a decline in mobility or range of motion (ROM: the full movement potential of a joint). 1. A review of Resident 72's facesheet dated 5/6/26 indicated, Resident 72 had a diagnosis of Hemiplegia [one-sided paralysis caused by brain damage] and Hemiparesis [partial weakness or reduced mobility on one side of the body including the arm, leg, and face caused by brain injury] following nontraumatic intracerebral hemorrhage [brain bleed] affecting right dominant side. A review of Resident 72's Order Summary Report dated 5/6/26 indicated, an order for RNA for R [right] resting splint 2 hours daily start date 2/10/26. During an observation on 5/5/26, at 8:43 a.m., in Resident 72's room, Resident 72's right hand did not have a brace on. A sign was noted to be posted behind Resident 72's bed and read Please apply resting hand splint to R hand at Breakfast and remove at shift change (2:30 pm) Daily Resident 72 was observed to be finished eating breakfast and his food tray was removed from the room already. During an observation on 5/6/26, at 8:13 a.m., in Resident 72's room, Resident 72's right hand did not have a brace on. Resident 72 was observed to be finished eating breakfast and his food tray was removed from the room already. During an interview on 5/6/26, at 8:50 a.m., with Restorative Nurse Assistant (RNA), RNA stated she was the only RNA working for AM shift currently. RNA stated, she is given a printout of the residents who are assigned to her and the RNA services she is supposed to perform. RNA stated, there are currently no daily RNA services for any residents in the facility, there are only three times weekly services ordered. During a concurrent interview and record review on 5/6/26, at 8:56 a.m., with RNA, the RNA assignment scheduled for all residents was reviewed. The RNA schedule for Resident 72 indicated, SPLT [splint- medical device used to stabilize, support, and protect injured bones, joints, or soft tissues by keeping them still. Often called half-casts or braces] 3 indicating to RNA staff to perform this task 3 times per week. RNA stated Resident 72 has RNA order for a splint three times weekly per the schedule. A review of Resident 72's Task for RNA Splinting and Bracing Program Task on donning [applying] R resting splint every day 2 hours dated 4/9/26-5/6/26, indicated, the splint was charted as applied only 12 days during this date range. Task indicated, the splint was not applied for 16 days in the date range 4/9/26-5/6/26. During an interview on 5/7/26, at 1p.m, with Certified Occupational Therapy Assistant (COTA), COTA stated, the purpose of ordering the splint for Resident 72 was to keep his arm in an open position. (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	COTA further stated because Resident 72 has weakness and paralysis on his right side, he needs the brace to prevent his R hand from clinching and staying closed. COTA stated if the brace is not used Resident 72 is at a risk of developing a contracture (permanent or long-term tightening and shortening of muscles, tendons, skin, or other tissues, causing joints to become stiff and limiting range of motion). During an interview on 5/7/26, at 11:14 p.m., with the director of staff development (DSD), DSD stated there is no documentation the RNA staff was applying the brace daily according to the order in the last 30 days for more than half of the days. DSD stated Resident 72 has an order for daily splinting and it should be completed and charted it was done daily which it has not been. DSD stated she was the staff member who is responsible for ensuring RNAs are completing their tasks. 2. A review of Resident 143's admission Record indicated Resident 143 was admitted to the facility in August 2021 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (disrupted blood flow to the brain causing brain cell death), dysphagia (difficulty swallowing) and dementia (loss of cognitive functioning including thinking and memory). A review of Resident 143's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 3/24/26, indicated Resident 143 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 8 out of 15 that indicated Resident 143 was moderately cognitive impaired. A review of Resident 143' Order Audit Report indicated order dated 4/24/26 CNA [Certified Nursing Assistant] for donning [putting on] and doffing [removing] LUE [left upper extremity] resting hand splint for 6 hours or as tolerated monitoring skin integrity one time a day Monitor skin integrity prior to donning and after doffing splint and remove per schedule . A review of Resident 143's Task Documentation for 4/26/26 to 5/7/26 indicated splint was applied 4/24/26, 4/27/26, 4/28/26, 4/29/26, 5/1/26, 5/3/26, 5/4/26, 5/5/26, 5/7/26, but did not indicate when it was removed. The Task Documentation indicated splint was removed on 4/26/26 and 5/2/26 but did not indicate when it had been put on. The Task Documentation did not indicate splint had been applied and removed after 6 hours on any days. A review of a sign posted on the wall of Resident 143's room indicated Please DON Pts [Patients] L [Left] Resting Hand Splint at Breakfast and Remove at Shift Change (2:30) DAILY A review of Resident 143's Care Plan, initiated 4/24/26, .CNA for donning and doffing of left hand splint . indicated .Interventions/Tasks . CNA for donning and doffing LUE resting hand splint for 6 hours or as tolerated . During a concurrent observation and interview on 5/6/26 at 1:25 p.m. with Resident 143, observed Resident 143 in bed and black hand splint was on the nightstand. Observed sign posted on wall that indicated hand splint to be applied for 6 hours and removed at 2:30 p.m. daily. Resident 143 stated brace was taken off today and staff only puts it on sometimes. During a concurrent observation and interview on 5/6/26 at 1:27 p.m. with Licensed Nurse (LN) 6, observed sign in Resident 143's room indicating splint to be applied for 6 hours and removed at 2:30 p.m. LN 6 confirmed that Resident 143's splint had been removed prior to 2:30 p.m. LN 6 stated she (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had not been aware there was a sign in Resident 143's room that indicated it was to be removed at 2:30 p.m. LN 6 stated the splint is usually applied about 6:30 a.m. and removed after lunch. LN 6 stated CNAs usually apply the splint, but the RNA applied it today. LN 6 stated it is charted by the CNAs when it is applied and when it is removed. During a concurrent interview and record review on 5/6/26 at 1:48 p.m. with the RNA, reviewed Resident 143's order for left hand splint to be applied for 6 hours daily. The RNA stated she applied it today at approximately 8:30 a.m. per the nurse's request. When asked when it should have been removed, the RNA stated at 2:30 p.m. The RNA acknowledged it had not been applied for 6 hours today. Reviewed Resident 143's Task Documentation with the RNA. The RNA acknowledged that charting of donning and doffing of the hand splint was not done consistently but should be charted accurately. During a concurrent interview and record on 5/7/26 at 3:22 p.m. with the Director of Nursing (DON), the DON stated Resident 143's splint order indicated it should be applied for 6 hours a day unless she asks for it to be removed. The DON stated the donning and doffing should be documented in the Task Documentation. The DON acknowledged that the charting was not done accurately. The DON stated the CNAs apply the brace and if the resident does not want it or wants it removed it should be documented what time it was removed. A review of the facility's Policy and Procedure (P&P) titled Resident Mobility and Range of Motion, revised 8/25, indicated ' .Residents will have decreased risk for reduction in range of motion (ROM) .Residents with limited mobility will receive appropriate services, equipment and assistance to maintain or improve mobility unless reduction in mobility is unavoidable .The care plan will include specific interventions, exercises, and therapies to decrease the risk of decline in, and/or in improve mobility and range of motion .Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice .The care plan will include interventions, as well as goals . A review of the facility's policy and procedure (P&P) titled, RNA Program dated 2025, the P&P indicated, The facility should have designated certified and trained RNA staff to fully provide the RNA treatment as recommended for each resident.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure: Nursing staff disposed of medication that was prepared but not administered in accordance with facility policy and procedure (P&P); Emergency kits (e-kit; a kit/box containing medications and supplies for immediate use during a medical emergency) were replaced timely after use and removal of medications documented for a census of 154; Medications with discontinued orders were securely stored in a designated area until time of destruction; Ensure the availability of routine medications for one of 37 sampled residents (Residents 134). These failures resulted in the facility not safely and securely storing medications for destruction and the potential for diversion (the illegal transfer, theft, or misuse of medications) from medications not being disposed of, the potential for emergency medications to not be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions. 1. During a medication pass (med pass) observation on 5/5/26 at 8:21 a.m. with LN 15, LN 15 was observed preparing medications for Resident 76 including clopidogrel (a medication to prevent blood clots) 75 milligrams (mg, a unit of measurement), 1 tablet. LN 15 counted the number of tablets she had in the medicine cup and dropped the clopidogrel tablet onto the medication cart (med cart). LN 15 picked up the tablet and threw it into the small trash receptacle attached to the outside of the med cart. The trash receptacle was open, and the contents were easily accessible to staff and residents in the hall. During an interview on 5/5/26 at 12:12 p.m. with LN 15, LN 15 stated that dropped doses of medication were to be destructured in a designated container (a drug disposal system designed to safely deactivate and dispose of unwanted medications) located in the med cart. LN 15 confirmed earlier that morning she had disposed of the dropped clopidogrel tablet in the trash receptacle on the med cart and should not have. During an interview on 5/6/26 at 3:16 p.m. with the Director of Nursing (DON), the DON stated nursing staff were to dispose of dropped or refused doses of medication in the designated container inside the med cart. The DON stated the concern for disposing in the trash receptacle affixed to the med cart was that it could potentially be picked out of the trash and used by staff or residents. A review of the facility's P&P titled, Discarding and Destroying Medications, dated 10/2025, the P&P indicated, Policy Statement: Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. Policy Interpretation and Implementation. 2. Non-controlled and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. 2. During a concurrent interview and inspection on 5/5/26 at 9:33 a.m. of Medication Storage Room Nursing Station 2 with LN 15, one Injectable/Sublingual/Nasal/Oral Suspension E-Kit was identified with a red plastic tie indicating it had been opened by nursing staff. LN 15 opened the E-Kit and the emergency kit log (a document completed by nursing staff whenever a medication is removed from the emergency supply) was dated 4/22/26, 13 days prior. LN 15 stated as soon as nursing staff opened an E-Kit it should be reordered and replaced by the supplier pharmacy. LN 15 confirmed the E-Kit should have already been ordered and replaced. During a concurrent inspection and interview on 5/5/26 at 9:42 a.m. with LN 2 at Nursing Station 2, multiple E-Kits were identified with red plastic ties. One opened First Dose Oral E-Kit was identified with four E-Kit logs dated 5/1/26, 5/2/26, 5/2/26, and 5/3/26. A second First Dose Oral E-Kit was identified with an E-Kit log dated 5/1/26. A third opened Injectable/Sublingual/Nasal/Oral Suspension E-Kit was identified but did not have a log inside to indicate which medication was removed. A review of the contents list compared to the contents contained inside the kit indicated one lidocaine (an anesthetic medication) 1% MDV (multidose vial) had been removed. LN 2 confirmed the findings and stated the expectation was when nursing staff removed medication from an E-Kit, the removal was documented on a log. LN 2 stated the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation was important because it allowed the facility to keep track of what was removed and the count to be correct. During an interview on 5/6/26 at 3:32 p.m. with the DON, the DON stated nursing staff were expected to document what medication was removed from an E-Kit and to request a replacement of the kit from the supplier pharmacy. She stated it was important to replace E-Kits timely so emergency medications were available when needed. During a review of the facility's P&P titled, Emergency Medications, dated 8/2025, the P&P indicated, Policy Interpretation and Implementation. 7. Any medication that is removed from the emergency kit must be documented on the emergency medication administration log. 8. Medications and supplies used from the emergency medication kit must be replaced within 72 hours. 3. During a concurrent interview and inspection on 5/5/26 at 12:59 p.m. of the Medication Storage Room Nursing Station 4 with LN 4, six bubble packs containing medication were identified in an unlocked cabinet. Katisia reviewed the pharmacy label and stated the resident had been discharged and the medications should have been destroyed. LN 4 stated discontinued medications and medications for discharged residents were to be given to a nurse supervisor or the DON for destruction, not stored in the unlocked cabinet. During a review of the facility's P&P titled, Storage of Medication, dated 3/2025, the P&P indicated, Policy Statement: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Policy Interpretation and Implementation. 4. Discontinued, outdated, or deteriorated drugs or biologicals are placed on designated appropriated bins for destruction. 4. During a med pass observation on 5/5/26 at 8:41 a.m. with LN 8, LN 8 was observed preparing medications for Resident 134 including Ozempic (a medication to treat diabetes and obesity) 1 milligram/dose pen. LN 8 removed the Ozempic pen from the medication cart (med cart), removed the cap, and stated it was done. LN 8 stated she would need to see if there was another pen available for Resident 134 in the medication storage room and left to go check. A review of Resident 134's physician's orders indicated an order for Ozempic (1 mg/dose) subcutaneous (under the skin) pen injector 4 mg/3 milliliter (ml, a unit of measurement): Inject 1 mg subcutaneously one time a day every Tuesday for weight loss hold for blood glucose <90, dated 3/2/26. During the same medication pass observation on 5/5/25 at 8:47 a.m. with LN 8, LN 8 returned to the med cart from the medication storage room and stated the Ozempic was not available. LN 8 stated she had just called the supplier pharmacy on her way back to the med cart and requested a refill for Resident 134's medication. During an interview on 5/5/26 at 1:21 p.m. with LN 8, LN 8 stated she normally checked if an injectable medication was due to be refilled by the pharmacy when she checked expiration dates in the med cart. LN 8 stated she must not have realized the Ozempic was due for refill because the medication was clear and difficult to see. During an interview on 5/6/26 at 3:24 p.m. with the DON, the DON stated nursing staff were knowledgeable about reordering resident medications so that they did not run out. The DON stated nursing staff needed to pay attention to the medication amount to see when it was low and reorder on time for the next dose. A review of the manufacturer's labeling for Ozempic, dated 9/2023 indicated, Instructions for Use. How much OZEMPIC is left? To see how much OZEMPIC is left in your pen, use the dose counter: Turn the dose selector until the dose counter stops. If it shows 1, at least 1 mg is left in your pen. If the dose counter stops before 1 mg, there is not enough Ozempic left for a full dose of 1 mg. If the dose counter stops before 1 mg, there is not enough Ozempic left for a full dose of 1 mg. If there is not enough Ozempic left in your pen for a full dose, do not use it. Use a new Ozempic pen. During a review of the facility's P&P titled, Pharmacy Services, dated 10/2025, the P&P indicated, Policy: Regular and reliable pharmaceutical service is available to provide residents with prescription and non-prescription medications, services, and related equipment and supplies. Procedures. D. The pharmacy provider agrees to perform the following pharmaceutical services, including: 1. Assisting the facility, as necessary, in determining the appropriate equipment and packaging to meet the medication needs of the residents and the facility.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a 14.29% error rate when five medication errors out of 35 opportunities were observed during a medication pass for three of six Residents (Residents 76, 134, and 158). This failure resulted in medications not given in accordance with the prescriber's order and the potential to affect residents' clinical conditions, and unwanted exposure to hazardous (medications that can cause serious effects including cancer, organ toxicity, fertility problems, genetic damage, and birth defects if not handled appropriately) drugs from not following special handling requirements potentially leading to health complications. 1. During a medication pass (med pass) observation on 5/5/26 at 8:21 a.m. with Licensed Nurse 15 (LN 15), LN 15 was observed preparing medications for Resident 76 which included Breztri Aerosphere (a medication to treat chronic obstructive pulmonary disease, a long-term, progressive lung disease that makes it hard to breathe due to damaged, inflamed, or blocked airways) 160/9/4.8 microgram/actuation (mcg, a unit of measurement). LN 15 removed a new Breztri Aerosphere inhaler from a sealed manufacturer's box, shook it, and stated the reason for shaking was to ensure the medication was not settled. A review of Resident 76's physician's orders indicated an order for Breztri Aerosphere 160/9/4.8 mcg/actuation, 1 puff inhale orally two times a day for COPD rinse mouth after administration, dated 6/17/25. During the same med pass observation with LN 15, LN 15 entered Resident 76's room and handed the resident the inhaler. Resident 76 pressed down on the inhaler and stated, Nothing is coming out. Resident 76 then pressed the inhaler down a second time, then a third, and inhaled the medication each time. During an interview on 5/5/26 at 12:14 p.m. with LN 15, LN 15 stated she was not aware of any special handling or preparation required prior to the use of a new Breztri inhaler because it was a new medication to her. During an interview on 5/6/26 at 3:19 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to review physician's orders for administration instructions as well as the manufacturer's labeling on the box if a medication came in one. The DON stated if a medication was supplied in a box, the box would have the instructions on how to prepare it. The DON stated if the inhaler was not prepared for administration correctly, the concern would be that the resident would not receive the dose they were prescribed. A review of the manufacturer's labeling for Breztri Aerosphere, dated 4/2026 indicated, 2.1 Preparation and Administration Information. Priming Before Use: Priming BREZTRI AEROSPHERE is essential to ensure appropriate drug content in each actuation. Prime BREZTRI AEROSPHERE before using for the first time. Prime BREZTRI AEROSPHERE by releasing 4 sprays into the air away from the face, shaking well before each spray. Re-prime BREZTRI AEROSPHERE if the inhaler has not been used for more than 7 days, is dropped, or after weekly rinsing. Prime BREZTRI AEROSPHERE by releasing 2 sprays into the air away from the face, shaking well before each spray. 2. During a med pass observation on 5/5/26 at 9:11 a.m. with LN 5, LN 5 was observed preparing medications for Resident 158 which included aspirin (a medication to prevent blood clots) 81 milligrams (mg, a unit of measurement) chewable, one tablet, finasteride (a medication to treat enlarged prostate in men) 5 mg, one tablet, and diclofenac (a medication to treat inflammation and pain) 1% gel. The finasteride bubble pack had a pharmacy label on it that indicated it was a hazardous medication. LN 5 was not observed wearing gloves during the handling and preparation of the medication. LN 5 then prepared Resident 158's diclofenac 1% gel. LN 5 used an opaque medicine cup with markings to measure liquid medications, to squeeze out and measure the gel. LN 5 stated she used the lines on the medicine cup that indicated dram (a measurement of volume that describes how many pills or how much liquid a bottle can hold) to measure the gel. LN 5 confirmed the gel was below the 1-dram line. A review of Resident 158's physician's orders indicated the following orders: Ecotrin (brand name for enteric coated (a coating that delays absorption) aspirin) low strength delayed release 81 mg: Give one tablet by mouth one time a day for clot prevention. Do not crush, dated 4/18/26. Finasteride 5 mg: Give one tablet by mouth one time a day for BPH (benign prostatic hyperplasia, a condition where the prostate (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is enlarged) do not crush, break, or chew. Wear gloves when handling medication. Women who are pregnant or may become pregnant should not handle crushed or broken tablets, dated 4/18/26 Diclofenac 1% gel: Apply to affected area topically four times a day for pain 2 grams to affected area, dated 4/18/26. During the same med pass observation on 5/5/26 at 9:15 a.m. with LN 5, LN 5 administered all oral medications to Resident 158 and applied the diclofenac gel to the back of Resident 158's neck. During a concurrent observation, interview and record review on 5/5/26 at 12:29 p.m. with LN 5, Resident 158's physician's orders and medications were reviewed. LN 5 stated the physician's order for aspirin was for the enteric coated formulation, but she had mistakenly given the chewable form. LN 5 stated the difference was that the enteric coated formulation was slow release. LN 5 removed the finasteride bubble pack from the medication cart and reviewed the pharmacy labeling on it. LN 5 confirmed the labeling indicating it was a hazardous medication. LN 5 stated the labeling meant that it was important to wear gloves to protect oneself and others. She stated the medication could affect the fetus of a woman who was pregnant or the child of woman who was breastfeeding. LN 5 stated she did not wear gloves during the medication preparation earlier that morning because she thought it was only necessary to wear them during medication administration. LN 5 stated nursing staff had a measurement strip available to use when measuring diclofenac gel, but she used the medicine cup. LN 5 stated she used the line on the medicine cup that indicated 2.5 milliliters (ml, a unit of measurement) to measure the diclofenac gel for Resident 158. LN 5 stated 2.5 ml was not equivalent to 2 grams of gel. During an interview on 5/6/26 at 3:27 p.m. with the DON, the DON stated nursing staff were expected to correctly identify which over the counter (OTC) medication a resident was ordered by reviewing the order in the Medication Administration Record (MAR) and selecting the medication from the med cart. The DON stated nursing staff were expected to correctly identify which OTC was the appropriate medication according to the physician's order. The DON stated nursing staff were expected to wear gloves when handling hazardous medication because it was protection for the nurse. The DON stated nursing staff were expected to measure diclofenac gel using a ruler that showed where 2 grams were on it and that one milliliter was not equivalent to 1 gram. She stated it was important for nursing staff to correctly measure the medication, so the resident received the correct dose. A review of the manufacturer's labeling for diclofenac 1% gel, dated 4/2026 indicated, Instructions for Use. Step 1. Remove the dosing card that is attached inside the diclofenac sodium topical gel carton. Use the dosing card to correctly measure each dose of diclofenac sodium topical gel. To measure the correct amount of diclofenac sodium topical gel, place the dosing card on a flat surface so that you can read the print. If the print is backwards, flip dosing card over. Step 2. Squeeze diclofenac sodium topical gel onto the dosing card evenly, up to the 2 g line (a 2.25 inch length of gel). Make sure that the gel covers the 2 g area of the dosing card. 3. During a med pass observation on 5/5/26 at 8:41 a.m. with LN 8, LN 8 was observed preparing medications for Resident 134 including Ozempic (a medication to treat diabetes and obesity) 1 mg/dose pen. LN 8 removed the Ozempic pen from the med cart, removed the cap, and stated it was done. LN 8 stated she would need to see if there was another pen available for Resident 134 in the medication storage room and left to go check. A review of Resident 134's physician's orders indicated an order for Ozempic (1 mg/dose) subcutaneous (under the skin) pen injector 4 mg/3 ml: Inject 1 mg subcutaneously one time a day every Tuesday for weight loss hold for blood glucose <90, dated 3/2/26. During the same medication pass observation on 5/5/25 at 8:47 a.m. with LN 8, LN 8 returned to the med cart from the medication storage room and stated the Ozempic was not available. LN 8 stated she had just called the supplier pharmacy on her way back to the med cart and requested the refill for Resident 134's medication. During an interview on 5/5/26 at 1:21 p.m. with LN 8, LN 8 stated she normally checked if an injectable medication was due to be refilled by the pharmacy when she checked expiration dates in the med cart. LN 8 stated she must not have realized the Ozempic was at the end because the medication level in the pen was difficult to see since it was clear. A review of the Administration Record dated 5/5/26 indicated Resident 134's weekly Ozempic injection was (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered late, at 9:39 a.m. During an interview on 5/6/26 at 3:24 p.m. with the DON, the DON stated nursing staff were knowledgeable about reordering resident medications so that they did not run out. The DON stated nursing staff needed to pay attention to the medication amount to see when it was low and reorder on time for the next dose. A review of the manufacturer's labeling for Ozempic, dated 9/2023 indicated, Instructions for Use. How much OZEMPIC is left? To see how much OZEMPIC is left in your pen, use the dose counter: Turn the dose selector until the dose counter stops. If it shows 1, at least 1 mg is left in your pen. If the dose counter stops before 1 mg, there is not enough Ozempic left for a full dose of 1 mg. If the dose counter stops before 1 mg, there is not enough Ozempic left for a full dose of 1 mg. If there is not enough Ozempic left in your pen for a full dose, do not use it. Use a new Ozempic pen. During a review of the facility's P&P titled, Pharmacy Services, dated 10/2025, the P&P indicated, Policy: Regular and reliable pharmaceutical service is available to provide residents with prescription and non-prescription medications, services, and related equipment and supplies. Procedures. D. The pharmacy provider agrees to perform the following pharmaceutical services, including: 1. Assisting the facility, as necessary, in determining the appropriate equipment and packaging to meet the medication needs of the residents and the facility. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 10/2025, the P&P indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 2. Medications are administered in accordance with prescriber orders, including any required time frame.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to ensure medications were safely stored for five of 37 sampled residents (Resident 145, Resident 155, Resident 46, Resident 156 and Resident 67) when: A medicine cup containing three medicine tablets was found on top of the nightstand in Resident 145's room; A box of eyedrop (liquid medication applied to the eye surface to treat dryness, allergies, or infections) was observed on top of Resident 155's nightstand; Four pink plastic ampoules were observed on top of Resident 46's nightstand; An unlabeled medication cup containing white powder was observed on top of Resident 156's bedside table; and Three syringes of normal saline (NS, mixture of water and salt) were observed on top of Resident 67's nightstand. These failures decreased the facility's potential to safely store medications for residents. Findings: 1. A review of Resident 145's admission Record, indicated Resident 145 was admitted to the facility in September 2024 with multiple diagnoses including ulcer of esophagus (open, inflamed sores in the lining of the food pipe). During an observation on 5/5/26 at 8:53 a.m. in Resident 145's room, a medicine cup containing three medicine tablets was on top of the nightstand. During a concurrent observation and interview on 5/5/26 at 8:55 a.m. with Licensed Nurse (LN) 2, in Resident 145's room, the medicine cup containing three medicine tablets was observed on top of the nightstand. LN 2 stated the tablets in the medicine cup were Resident 145's scheduled morning medications and Resident 145 would get up and take the medications later. During an interview on 5/5/26 at 9:11 a.m. with Director of Staff Development (DSD), DSD stated leaving medications at the bedside are not allowed, if a resident did not want to take the medication, the LN should have taken the medication with them and not leave it at bedside. DSD further stated the LN should not have prepared the medication without making sure the resident was ready to take them. During an interview on 5/8/26 at 9:16 a.m. with Director of Nursing (DON), DON stated LNs are expected to never leave medications at the bedside due to the risk of another resident could pick up the medication that was left at bedside and the risk of resident not getting the medications as ordered. 2. During a review of Resident 155's admission records, the records indicated Resident 155 was admitted to the facility in May 2026 with diagnoses that included traumatic subcutaneous emphysema (a condition where air becomes trapped under the skin following injury to the airway). Resident 155's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/8/26, indicated Resident 155 had intact cognition. A review of Resident 155's physician order, dated 5/1/26, indicated an order for Dextran70-Hypromellose Ophthalmic Solution (used for temporary relief of dry, irritated eyes) instill one drop in both eyes every 6 hours as needed for dry eyes. During a concurrent observation and interview on 5/5/26 at 9:27 a.m. with Resident 155 in his room, Resident 155 was observed alert and calm, sitting in a wheelchair. A box of Dextran eyedrop was (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed on top of Resident 155's nightstand. Resident 155 stated he uses eye drops and apply it to himself. During a concurrent observation and interview on 5/5/26 at 11:38 a.m. with Licensed Nurse 4 (LN 4), LN 4 stated Resident 155 was not allowed to administer his own medication. When asked if Resident 155 was receiving Dextran eyedrop, LN 4 checked the medication cart and there were no eyedrops observed for Resident 155 inside the cart. During a concurrent observation and interview on 5/5/26 at 11:41 a.m. with Resident 155 and LN 4 in Resident 155's room, Resident 155 stated he brought the eyedrops from the hospital and stated the eyedrop was on his nightstand. LN 4 asked permission from Resident 155 to open the top drawer of the nightstand and Resident 155 agreed. LN 4 found the box of eyedrop inside the drawer of the nightstand. LN 4 stated medications at bedside could lead to over usage, and LN 4 stated it was important that the staff know what the resident was taking. LN 4 stated Resident 155 could have overused the eyedrops or somebody else could use them. 3. During a review of Resident 46's admission records, the records indicated Resident 46 was admitted to the facility in April 2026 with diagnoses that included diffuse large B-cell lymphoma (fast-growing blood cancer that affects a type of white blood cell), and pneumonitis (inflammation of the lung tissue) due to inhalation of food and vomit. Resident 46's MDS indicated Resident 46 had moderate cognitive impairment. During an observation on 5/5/26 at 9:37 a.m. in Resident 46's room, Resident was observed lying in bed and did not respond to questions. Four pink plastic ampoules were observed on top of Resident 46's nightstand. During a concurrent observation and interview on 5/5/26 at 9:43 a.m. with LN 5, LN 5 confirmed the four pink ampoules on top of Resident 46's nightstand and stated they were ampoules of normal saline and were used for wound care. LN 5 the four ampoules were not supposed to be at bedside and stated someone, or Resident 46 might use or ingest them. 4. During a review of Resident 156's admission records, the records indicated Resident 156 was admitted to the facility in April 2026 and readmitted in May 2026 with diagnoses that included fracture of lower end of left radius (a break in the wrist bone), depression persistent sadness and loss of interest that interfere with daily life), and muscle weakness. Resident 156's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/28/26, indicated Resident 156 had moderate cognitive impairment. During an observation on 5/6/26 at 10 a.m. in Resident 156's room, an unlabeled medication cup containing white powder was observed beside a cup of water on top of Resident 156's bedside table. During a concurrent observation and interview on 5/6/26 at 10:04 a.m. with LN 4, LN 4 confirmed that there was a medication cup with white powder on top of the bedside table. LN 4 stated she did not know what it was and threw it because it was not supposed to be at bedside. During an interview on 5/7/26 at 12:56 p.m. with the DON, the DON stated that it was the expectation for staff to not leave medications at bedside. The DON further stated medications should be administered at bedside and staff needed to make sure the residents took them. The DON stated if medications were left at bedside, staff would not be able to confirm if the resident took the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication. 5. A review of Resident 67's clinical record indicated the facility admitted the resident in 2025 with multiple diagnoses, including dementia (a progressive state of decline in mental abilities) and depression. A review of Minimum Data Set (MDS, a federally required assessment) dated 4/23/26 indicated Resident 67's had severe cognitive impairment. A review of cognitive impairment care plan dated 7/25/25 indicated that Resident 67 had altered recall and cognitive function, was at risk for progressive decline in skills for daily decision making and was at risk for injuries. The care plan interventions directed staff to anticipate resident's needs and provide education regarding safety measurement. During an observation on 5/6/26 at 4:14 p.m., Resident 67 was observed sitting in wheelchair in his room. Three (3) syringes prefilled with 10 milliliters (ml, unit of measurement) of normal saline (NS) were observed on top of Resident 67's nightstand. All 3 syringes were observed with the protective outer cellophane removed and one syringe was observed with tip cap removed. The syringes were accessible to Resident 67. Resident 67 replied when his name was called, but was observed to be confused and unable to answer questions regarding the syringes or their intended use. During a follow up observation of Resident 67's room on 5/7/26 at 9:58 a.m., the 3 syringes containing NS were observed on the resident's nightstand. Resident 67 was observed sleeping in his bed. During a concurrent observation and interview with Assistant Director of Nursing (ADON) in Resident 67's room on 5/7/26 at 10:15 a.m., the ADON validated the 3 syringes with NS were observed accessible to Resident 67. The ADON stated she was not sure why the syringes with NS were stored at Resident 67's nightstand unsecured. The ADON stated, I don't know why it [syringes] there. Should not be stored there. Not safe. The DON acknowledged that one of the syringes had tip cap removed and when asked if Resident 67 might have ingested the saline, the ADON replied, If its opened, everything is possible. During an interview on 5/7/26 at 12:30 p.m., Licensed Nurse (LN 1) stated he was familiar with Resident 67 care and needs. LN 1 described Resident 67 as pleasantly confused and requiring lots of supervision. LN 1 stated that Resident 67 did not have any wounds or skin issues requiring the use of NS. When discussing syringes found at Resident 67's bedside, LN 1 stated, His roommate has wounds .Maybe resident had taken it from his bedside, not sure. LN 1 added that syringes with NS should not be stored on the resident's bedside because the resident might attempt to swallow them. During an interview on 5/7/26 at 3:45 p.m., a Certified Nursing Assistant (CNA 5) stated, Resident [67] is very confused, unable to turn on his call light and call for assistance. We have to supervise him all the time and anticipate needs. A review of the P & P titled, Storage of Medications, dated 3/2025 indicated, The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments. The nursing staff is responsible for maintaining medication storage. A review of the facility's policy and procedure (P & P) titled, Safety and Supervision of Residents, (continued on next page)		

Department of Health & Human Services
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revised 10/2025 indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident supervision is a core component of the system's approach to safety.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program was effective when the facility had not identified and developed corrective action plans for issues related to administration of IV (Intravenous-administering medications through a needle or tube inserted into a vein) medication documentation and RNA (Restorative Nurse Assistant) services being performed daily per physician's order for a census of 154. This failure increased the risk for residents residing in the facility to have poor quality of care outcomes. During an interview on 5/8/26 at 1:54 p.m. with the Administrator (ADM), the ADM stated the facility conducts quarterly QAPI meetings. The ADM stated the committee members review Performance Improvement Projects (PIP), quality measures, and grievances. The ADM stated he is informed of issues to be reviewed during QAPI by staff, visitors, and departments who can bring their concerns to the QAPI committee. The ADM stated issues to be worked on by the QAPI committee are system issues, not individual problems. The ADM stated they work on one PIP annually, currently it is falls reduction. The ADM stated they collect data and monitor trends to determine effectiveness of the PIP. The ADM stated the QAPI did not identify any issues with IV medication administration documentation or RNA services during last QAPI meeting on 4/15/26. The ADM stated he was not aware that IV medication administration documentation and daily RNA services were an issue. A review of the facility's 2026 Quality Assurance & Performance Improvement (QAPI) Plan indicated .Purpose Our purpose of QAPI in our organization is to take a proactive approach to continually improve the way we care for and engage with our residents, caregivers, and other partners so that we may realize our vision to be the premier skilled nursing facility by perfecting our core competencies. To do this, all employees will participate in ongoing QAPI efforts which support our mission by providing exceptional care and quality .The QAPI team at [Name of Facility] will decide what data to monitor routinely .Areas to consider may include .Clinical care areas .State survey results and deficiencies .Performance Improvement Projects The QAPI team .will review our sources of information to determine if gaps or patterns exist in our systems of care that could result in quality problems .Systemic Analysis and Systemic Action [Name of Facility] uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of a change. [Name of Facility] applies a thorough and highly organized structured approach to determine whether and how identified problems may be caused or exacerbated care and services are organized and delivered. [Name of Facility] 's approach comprehensively assesses all involved systems to prevent future events and promote sustained improvement . Refer to F-tags F 684 (IV medication administration documentation) and F688 (RNA services not provided daily).		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program for a census of 154 when: Staff did not perform hand hygiene in between glove use and did not maintain clean work environment during wound care for Resident 24; Certified Nursing Assistant (CNA) 2 did not wear required personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) while providing care to a resident on enhanced barrier precaution (EBP, an infection control method); Staff did not perform hand hygiene prior to assisting Resident 121 during a meal; Laundry Aide (LA) used the same apron while loading residents' dirty laundry into the washer and when moving clean linens from the washer to the dryer; Staff did not wear required PPE while applying back brace to Resident 119 who was on EBP and Licensed Nurse (LN 15) failed to sanitize blood pressure cuff between residents. These failures decreased the facility's potential to prevent infection spread among residents, staff and visitors for a census of 154. Findings: 1. A review of the admission Record indicated Resident 24 was admitted [DATE] with diagnoses including paraplegia (partial or complete paralysis of the lower half of the body including both legs) and pressure ulcer of sacral region, stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone). During a wound care observation on 5/6/26 starting at 1:38 p.m. with the Treatment Nurse (TN) and Certified Nursing Assistant 6 (CNA 6) in Resident 24's room, infection control practices were observed during wound care as follows: -the TN did not perform hand hygiene in between glove use both times when the old dressing was removed from the left hip and the right lower back; and, -the TN placed the pair of scissors on top of the air mattress after cutting a portion of the foam dressing and then TN used the same scissors to cut the remaining foam dressing for the wound on the right lower back. During an interview on 5/6/26 at 2:05 p.m. with the TN outside Resident 24's room, the TN stated she might have forgotten when she was asked if she performed hand hygiene in between glove use. The TN further stated the top of the air mattress was not a clean area. During an interview on 5/7/26 at 12:43 p.m. with the IP, the IP stated anytime a staff remove the gloves, hand hygiene should be performed prior to putting a new glove on. The IP further stated if there was no barrier to keep the scissors clean then the top of the air mattress is not clean. The IP added if the TN placed the scissors on top of the air mattress without a barrier, then the scissors should have been sanitized prior to use. The CDC (Centers for Disease Control and Prevention) guidelines for skilled nursing facilities (SNFs) emphasize that hand hygiene is the primary, most effective measure to prevent the transmission of infections, recommending alcohol-based hand sanitizer (ABHS) as the preferred method when the hands are not visibly soiled. Staff must perform hand hygiene before and after all patient contact. Key CDC hand hygiene recommendations for SNFs include: before touching a resident, immediately after (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removing gloves, after touching a resident's immediate environment. (https://www.cdc.gov) The CDC guidelines for wound care in SNFs emphasize using clean technique for chronic wound care to prevent infection, relying on strict hand hygiene, appropriate PPE (gloves and gown), and maintaining a clean field. Key CDC- aligned recommendations for wound care in SNFs include: perform hand hygiene before and after all wound care, and before putting on and after taking off gloves, prepare a clean work surface and separate clean supplies from contaminated items, bring only necessary supplies into the resident's room and set up a clean field. (https://www.cdc.gov) 2. A review of the admission Record indicated Resident 121 was admitted [DATE] with diagnoses including type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control) with diabetic neuropathy (nerve damage) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of right hand. During the dining observation on 5/5/26 at 12:17 p.m. Resident 121 stated she needed help with opening the small carton of milk included in the lunch tray. During a follow up observation on 5/5/26 at 12:19 p.m. Certified Nursing Assistant 3 (CNA 3) was holding the back of a wheelchair prior to helping Resident 121 open the small carton of milk. Further observed CNA 3 stuck her finger on the inside of the carton while opening it. The CNA 3 did not perform hand hygiene prior to opening the carton of milk for Resident 121. During an interview on 5/5/26 at 12:21 p.m. with CNA 3 outside the dining room, CNA 3 stated she did not perform hand hygiene prior to opening the carton of milk for Resident 121. The CNA 3 further stated she put her finger inside the carton of milk because it would not open. The CNA 3 said no when she was asked if she was supposed to touch the opening of the carton of milk. During an interview on 5/7/26 at 12:43 p.m. with the Infection Preventionist (IP), the IP stated her expectation was for staff to perform hand hygiene prior to opening the milk and in between tasks. A review of the facility's policy and procedure reviewed July 2025 and titled, Dining Room Infection Prevention indicated, The purpose of these procedures is to reduce risks of infection in the Dining areas .Staff must perform hand hygiene before and after handling food .and resident care 3. A review of Resident 111's admission Record, indicated Resident 111 was admitted to the facility in October 2024, with diagnoses including traumatic brain injury without loss of consciousness and dysphagia (difficulty swallowing). A review of Resident 111's Order Summary Report, dated 5/8/26, indicated Resident 111 had an order for EBP for wound with a start date of 4/6/26. During an observation on 5/5/26 at 9:59 a.m. outside Resident 111's room, CNA 2 entered Resident 111's room wearing gloves. CNA 2 assisted Resident 111 with teeth brushing, wiped Resident 111's face, repositioned Resident 111 in the wheelchair, and brushed Resident 111's hair. During an interview on 5/5/26 at 10:05 a.m. with CNA 2, CNA 2 stated he assisted Resident 111 with activities of daily living. CNA 2 confirmed he was only wearing gloves and stated he was supposed to wear gown and gloves. CNA 2 added it was important to wear proper PPE to prevent the spread of bacteria or infection to other residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/5/26 at 9:32 a.m. with Infection Preventionist (IP), IP stated staff are expected to wear a gown and gloves when caring for residents on EBP to prevent other residents from getting infections. A review of the facility's policy titled, Multidrug-Resistant Organisms; Infection Precaution & Enhanced Standard Precautions, reviewed 9/2025, indicated, . Enhanced Barrier Precaution will be integrated in the care of residents with chronic wounds . EBP is used in conjunction with standard precautions and expand the use of PPE to donning of gowns and gloves during high-contact resident care activities . 4. During a concurrent observation and interview on 5/6/26 at 3:10 p.m. with Housekeeper Supervisor (HS) in the laundry room, LA was wearing gloves and apron while loading laundry into the washing machine. HS stated LA was loading residents' personal clothing and slings into the washer. During an observation on 5/6/26 at 3:23 p.m. in the laundry room, LA was wearing the same apron, unloaded linens from one of the washing machines, transferred the linens to a basket, then loaded them into the dryer. The linens touched the apron during this process. During an interview on 5/6/26 at 3:25 p.m. with HS, HS agreed that wearing the same apron while handling both dirty and clean laundry could cause contamination. HS stated it had been their practice to use the same apron when rinsing dirty laundry, loading the washer, unloading the washer, and transferring laundry to the dryer. HS further stated the only time they would not wear an apron was when they are folding laundry. During an interview on 5/7/26 at 9:32 a.m. with IP, IP stated using the same apron for both dirty and clean laundry could cause contamination of the clean laundry. A review of the facility's policy titled, Departmental (Environmental Services) & Laundry and Linen, revised 6/2025, indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen . Separate soiled and clean linen at all times . Consider all soiled linen to be potentially infectious and handle with standard precaution . Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination . 5. During a review of Resident 119's admission records, the records indicated Resident 119 was admitted to the facility in April 2026 with diagnoses that included wedge compression fracture of T11-T12 vertebra (occurs when the front part of the mid-back bones breaks and collapses), and resistance to multiple antimicrobial drugs. Resident 119's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 119 had intact cognition. During an observation on 5/5/26 at 9:56 a.m. in Resident 119's room, a signage indicating EBP was observed posted by the door of the door. The door was closed, knocked several times, and upon opening the door, Resident 119 was observed sitting on a wheelchair and a staff member was observed inside the room wearing gloves but without a gown. During an interview on 5/5/26 at 9:58 a.m. with the Occupational Therapy Assistant (OTA), the OTA confirmed he was inside Resident 119's room and stated that he found Resident 119 sitting on wheelchair without the back brace and stated, I put on her brace for her. The OTA confirmed he was wearing gloves but not wearing a gown while inside Resident 119's room and applying the back brace. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The OTA stated, If not doing any kind of changing, no need to wear gown. During an interview on 5/7/26 at 12:36 p.m. with the IP, the IP stated EBPs were required for residents that have MDRO, invasive, procedures, and wounds. The IP further stated if a resident is on EBP, staff are expected to wear appropriate PPEs including gloves, and gown when they provide direct patient care, physically touching and caring for the resident. When asked if staff were supposed to wear PPE during application of back brace for a resident on EBP, the IP stated I would assume I would wear PPE. The IP stated it was important to wear proper PPE to mitigate the spread of MDRO and to prevent going either way from clean to dirty, and to prevent the spread of infection. During an interview on 5/7/26 at 12:56 p.m. with the DON, the DON stated staff need to wear gowns and gloves for residents on EBP when providing direct patient care, and applying back brace is direct patient care. During a review of the facility's policy and procedure (P&P) titled Multidrug-Resistant Organisms; Infection Precaution & Enhanced Standard Precautions, dated 9/2025, the P&P indicated, .Appropriate precautions are taken when caring for individuals known to or suspected to have infection with a multidrug-resistant organism.a. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities.e. For residents for whom EBP are indicated, EBP is employed when performing high-contact resident care activities. 6. During a medication pass (med pass) observation on 5/5/26 at 8:10 a.m. with LN 15, LN 15 stated she needed to take Resident 122's blood pressure. LN 15 entered Resident 122's room with the vitals cart and wrapped the smaller of the two available blood pressure cuffs around Resident 122's arm. LN 15 took the resident's blood pressure and pulse and stated it was high and that she would need to take it again with the larger sized cuff. LN 15 removed the blood pressure cuff off Resident 122, placed it in the vitals cart without sanitizing and disinfecting it, and removed the larger sized cuff. LN 15 took Resident 122's blood pressure with the larger cuff then removed it and placed it onto the vitals cart without sanitizing or disinfecting it. During an interview on 5/5/26 at 12:08 p.m. with LN 15, LN 15 stated the blood pressure cuff was to be sanitized and disinfected after each use with a bleach wipe. LN 15 stated she did not clean the blood pressure cuff during the med pass observation earlier that morning because she did not have any wipes available to use on her medication cart. During an interview on 5/5/26 at 1:45 p.m. with the Infection Preventionist (IP), the IP stated nursing staff were expected to sanitize and disinfect a blood pressure cuff after each use with a bleach wipe and ensure it was dry before using it again on another resident. During an interview on 5/6/26 at 3:15 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to clean blood pressure cuffs between resident use with a sanitizing wipe and follow the kill time (the amount of time a cleaning product must sit and stay wet on a surface to actually kill germs) for the specific wipe. During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items, Surfaces and Equipment, dated 9/2023, the P&P indicated, Policy Interpretation and Implementation. 2. d. Reusable items, including environmental surfaces will be cleaned and/or disinfected between residents and surfaces are visibly soiled. 3. Durable medical equipment (DME) (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	must be cleaned and disinfected before reuse by another resident. 4. Reusable resident care equipment will be cleaned and disinfected between residents according to manufacturers' instructions.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to maintain dignity for one of 37 sampled residents (Resident 50) when Certified Nursing Assistant 1 (CNA 1) was observed standing while assisting Resident 50 during the lunch meal in the dining room. This failure decreased the facility's potential to protect Resident 50's dignity. Findings: During a review of Resident 50's admission records, the records indicated Resident 50 was admitted to the facility in February 2023 with diagnoses that included dementia (a progressive state of decline in mental abilities), and abnormalities of gait and mobility. Resident 50's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/4/26, indicated Resident 50 had severe cognitive impairment. During a review of Resident 50's care plan, revised 3/18/26, indicated, [Resident 50] has ADL [activities of daily living - routine tasks/activities a person performs daily to care for themselves] self-care performance deficits related to cognitive and physical deficits related to Dementia. Assist with ADLs - (eating/meals.). During a concurrent dining observation and interview on 5/5/26 at 12:10 p.m. with the Director of Staff Development (DSD) in the social dining hall, CNA 1 was observed standing while assisting Resident 50 with eating. CNA 1 was observed holding a spoon and serving melon to Resident 50. The DSD confirmed the observation and stated, [Staff] generally do sit with residents. During an interview on 5/5/26 at 12:16 p.m. with CNA 1, CNA 1 confirmed standing while assisting Resident 50 with eating. CNA 1 stated, When I walked in, I didn't see a chair and I didn't want [Resident 50] to wait. CNA 1 further stated staff were supposed to be sitting while assisting residents during dining to communicate better with residents and for safety. CNA 1 added, We are providing dignity if we are sitting beside the resident when we assist them. During an interview on 5/7/26 at 12:56 p.m. with the Director of Nursing (DON), the DON stated that the expectation was for staff to be sitting with the residents while they are assisting residents with eating to maintain dignity. During a review of the facility's policy and procedure (P&P) titled Dignity, revised 10/2025, the P&P indicated, .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, preferences and individuality .1. Residents shall be treated with dignity and respect at all times .During a review of the facility's P&P titled Assistance with Meals, dated 10/2025, the P&P indicated, .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Dining Room Residents: .3. Residents who cannot feed themselves will be assisted with attention to safety, comfort, and dignity.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to ensure two of 37 sampled residents (Resident 128 & Resident 156) were given showers according to the shower schedule and personal preferences when: Resident 128 did not receive her scheduled shower for seven days; and, Resident 156 did not receive shower as scheduled. These failures contributed to Resident 128 & Resident 156 not receiving scheduled shower(s), and had a potential for negative health outcomes related to hygiene. Findings: 1. During an interview on 5/5/26, at 8:57 a.m., with Resident 128, in Resident 128's room located in station 2, Resident 128 stated she was not assisted with a shower yesterday and it was her scheduled day to shower, she further stated she has not had a shower in over 5 days. Resident 128 stated she needed assistance to shower and cannot get out of bed without using the lift device. Resident 128 further stated one of the nurses told her she needed to take her showers to prevent skin issues related to her lack of mobility. Resident 128 stated she did not refuse any showers in the last week, and the facility staff are short on CNAs which is why she was not bathed. A review of Station 2's Shower Schedule indicated, Resident 128 was scheduled to shower on Monday and Thursday. A review of Resident 128's Bathing Task, dated 4/30/26-5/7/26, the task charting indicated the last shower Resident 128 had charted was 4/30/26 (7 days ago). A review of Resident 128's Progress notes dated 4/30/26-5/7/26 indicated, no notes regarding any refusal of showers by Resident 128. A review of the Station 2 shower binder indicated no shower sheets for Resident 128. A review of the Station 2 whiteboard on the wall opposite the nurses' station indicated, shower sheets are to be filled out and signed before end of both day and pm (evening shift) shifts. During an interview on 5/7/26, at 3:12 p.m., with Resident 128 in her room, Resident 128 stated, she had not received a shower and stated, It's not my fault there [are] not enough CNAs to help. Resident 128 further stated it is important to her to get her showers as scheduled. During an interview on 5/8/26, at 1:01 p.m., with Director of Staff Development (DSD), DSD stated, the CNAs are supposed to chart in the task section when they shower a resident. DSD stated, Resident 128 was last showered on 4/30/26, and then on 5/7/26 during PM shift. DSD stated, Resident 128 is on the schedule to be showered Monday and Thursday, and the shower was not done on 5/4/26. A review of the facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting dated 2025, the P&P indicated, Resident will be provided with care, treatment, and services appropriate to enable them to carry out Activities of Daily Living (ADLs). 2. Care and services will be provided for resident who re unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Hygiene (bathing. 2. During a review of Resident 156's admission records, the records indicated Resident 156 was admitted to the facility in April 2026 and readmitted in May 2026 with diagnoses that included fracture of lower end of left radius (a break in the wrist bone), depression (persistent sadness and loss of interest that interfere with daily life), and muscle weakness. Resident 156's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/28/26, indicated Resident 156 had moderate cognitive impairment. During a review of Resident 156's MDS Section GG & Functional Abilities, dated 4/28/26, the MDS indicated Resident 156 required substantial assistance with showers. During an interview on 5/5/26 at 9:11 a.m. with Resident 156, Resident 156 stated she has not had showers yet since readmission and had no idea about her shower schedule. During a review of the shower schedule posted in the nurses' station, Resident 156 was scheduled to receive showers every Wednesday and Saturday. During a review of Resident 156's bathing task, dated 4/24/26 - 5/7/26, the task indicated Resident 156 did not receive shower on 5/5/26 and indicated Resident 156 was not scheduled for shower on that day. The task also did not indicate that showers were provided for Resident 156 since her readmission to 5/7/26. During a follow-up interview on 05/07/2026 at 9:05 a.m. with Resident 156, Resident 156 stated she had not received showers and was not sure about her shower schedule. Resident 156 stated she did not receive shower on 5/6/26 (Wednesday) because staff said .it wasn't a shower day. Resident 156 confirmed not receiving showers since readmission and stated, I wanted to have showers. During a concurrent interview and record review on 05/07/2026 at 10:43 a.m. with the Director of Staff Development (DSD), the DSD stated all residents have schedule for showers and staff are expected to follow the shower schedule for hygiene, infection control and dignity. The DSD further stated that if resident is not available for showers, staff offer showers for a different time or different shift and try to accommodate certain days that a resident wants. The DSD added that if showers were missed, it should be documented on the tasks and on the progress notes. The DSD reviewed Resident 156's bathing task and confirmed that Resident 156 did not receive showers since readmission. The DSD further confirmed that there was no documented evidence or progress notes indicating if Resident 156's showers were missed or refused. The DSD also confirmed Resident 156 was scheduled to receive showers every Wednesday and Friday and stated Resident 156 should have received shower on 5/6/26. During an interview on 5/7/26 at 12:56 p.m. with the Director of Nursing (DON), the DON stated that the expectation for staff was to provide showers as scheduled unless the resident refused. The DON stated the refusals can be seen under the bathing task and it should be documented in the clinical record if the resident declined. The DON stated providing showers as scheduled was important for dignity, cleanliness, and hygiene. During a review of the facility's policy and procedure (P&P) titled Shower and Bathing Policy, revised 8/2025, the P&P indicated, .The purpose of this policy is to ensure cleanliness, provide comfort, and observe the overall condition of the resident and skin integrity.1. Observe facility shower (continued on next page)		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	schedule. The following information should be recorded on the resident's ADL [activities of daily living - routine tasks/activities a person performs daily to care for themselves] record and/or in the resident's medical record: 1. The staff will document the date the shower or bathing was performed. 2. The name and title of the person recording the data.		

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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. Based on interview and record review, the facility failed to ensure that information regarding a hospital transfer was effectively communicated to 1 of 37 sampled residents (Resident 14)'s Responsible Party (RP) when Resident 14's Notice of Proposed Transfer/ Discharge was not completed. This failure had the potential to result in Resident 14's RP to not be informed of reason for transfer and right to return to facility. A review of Resident 14's admission Record indicated Resident 14 was admitted to the facility in November 2015 with multiple diagnoses including anoxic brain damage (lack of oxygen to the brain causing brain cell death), dysphagia (difficulty swallowing), and moderate protein calorie malnutrition (does not take in enough calories or protein to meet nutritional needs). A review of Resident 14's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 3/16/26, indicated Resident 14 was rarely or never understood and had long and short-term memory problems. A review of Resident 14's SBAR [Situation Background Assessment Recommendation] Communication Form, dated 8/12/25, indicated .Seems different than usual. Tired, Weak, Confused, or Drowsy .Temp [temperature] 102.2 [temperature >102 may cause discomfort and often requires treatment] .Send resident to acute care hospital for further evaluation . A review of Resident 14's SBAR Communication Form, dated 12/4/25, indicated .Abnormal vital signs .Fever, Pain .Decrease in meal consumption, increasing pain noted through body language, abnormal lab values and vital signs .BP [Blood Pressure]: 80/53 Pulse143 .RR [Respiratory Rate]: 38 Temp 101.3 .NP [Nurse Practitioner] orders to send pt [patient] out to acute care hospital . A review of Resident 14's Notice of Proposed Transfer/Discharge, dated 12/4/25, indicated .Type of Assessment .Transfer .Reason for transfer/discharge: .The transfer is necessary for the resident's welfare and the resident's needs cannot be met at the facility .Notifications .My/our signature confirms that 1/we have received a written copy of the Notice of Proposed Transfer/Discharge, and if applicable, the State Bed Hold Notice (including the facility's bed hold policy.) I/we understand my/our rights, and this information has been provided to me/us in a language and manner that I/we can understand .Resident Notification and verification of notice .Long-term Care Ombudsman .was notified of transfer/discharge .Appeal Rights and Contact Information . During a concurrent interview and record review on 5/7/26 at 3:22 p.m. with the Director of Nursing (DON), upon record review, the DON acknowledged that a Notice of Proposed Transfer/Discharge was not provided for Resident 14's transfer to the hospital on 8/12/25. The DON stated the Notice of Proposed Transfer/Discharge is usually done by herself or sometimes the nurse supervisor. The DON stated the Notice of Proposed Transfer/ Discharge should have been completed on 8/12/25 but was missed. The DON stated the purpose of the notice is notify every one of the transfer and the change in location. The DON stated the resident, or the RP is notified of the bed hold policy by phone. The DON stated the Notice of Proposed Transfer/Discharge is to be done for transfers to the hospital according to the regulations. During a concurrent interview and record review on 5/7/26 at 3:46 p.m. with Licensed Nurse (LN 6), LN 6 acknowledged that the Notice of Proposed Transfer/Discharge was completed for Resident 14 on 12/4/25 but not on 8/12/25. LN 6 stated the DON completes the Notice of Proposed Transfer/Discharge. A review of the facility's Policy and Procedure (P&P) titled Transfer or Discharge, revised 6/25, indicated .Once admitted to the facility, residents have the right to remain in the facility. Transfers and discharges must meet specific criteria and requires resident/representative notification, orientation, and documentation in the medical record . When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care provider The basis for the transfer or discharge .That an appropriate notice was provided to the resident and/or legal representative .the new location of the resident .A summary of the resident's overall medical, physical, and mental condition .Residents have the right to appeal a transfer or discharge through the state agency that (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handles appeals . Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge, including .the name, address, email, and the telephone number of the entity that receives such requests .information about how to obtain, complete, and submit and appeal form .the facility bed -hold policy		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure a comprehensive, person-centered care plan (a detailed approach outlining individual resident's concerns and needs, and the care and services needed to meet their needs) addressing resident's non-compliance (refusals) of showers was developed for one of 37 sampled residents (Resident 106). This failure resulted in Resident 106 not having clear care guidelines to the desired health outcomes of the identified issues and had the potential to impact Resident 106's health. A review of Resident 106's clinical record indicated the facility admitted the resident in 2023 with multiple diagnoses, which included absence of right leg below knee, history of falling, and depression. A review of the most recent Minimum Data Set (MDS, a federally required assessment) dated 4/18/26 indicated Resident 106 was cognitively intact. The functional abilities assessment for self-care activities indicated that Resident 106 required setup assistance from staff with personal hygiene. A review of activities of daily living (ADL, routine tasks/activities, including bathing and personal hygiene) care plan dated 4/20/23 indicated Resident 106 required assistance with ADL's. The care plan goal indicated that staff would ensure that Resident 106's needs were met and the resident was bathed and groomed daily. The care plan interventions directed nursing staff to assist with personal hygiene and grooming as needed. The care plan did not indicate that Resident 106 refused showers, bathing, and personal hygiene. A review of Resident 106's documentation of showers or bathing from 4/8/26 through 5/7/26 indicated that the resident did not receive any showers or bed baths. During an observation on 5/7/26 and 5/8/26 Resident 106 was observed leaving his room in wheelchair. Resident 106 was dressed in street clothes and was noted to have strong body odor. Resident 106 stated he was in a hurry to go outside and declined the interview. A review of the facility's undated shower schedule indicated Resident 106 was scheduled to receive showers every Monday and Thursday on the evening shift. A review of Resident 106's documentation of showers or baths from 4/8/26 through 5/7/26 indicated that the resident did not receive any showers or bed baths. The shower task documentation indicated that Resident 106 refused showers/bath on 4/13, 4/27, 4/30, and 5/7/26. During an interview on 5/7/26 at 10:05 a.m., Certified Nursing assistant (CNA 4) stated she was familiar with Resident 106 and his care needs. CNA 4 stated it was a while since she offered showers for Resident 106 because he had them scheduled for pm (evening) shifts. CNA 4 explained that if resident refused shower/bath, the staff would offer again, ask another staff, and after the 3rd refusal, document the refusal, notify nurse, and get nursing supervisors involved. During a joint interview and record review with Director of Nursing (DON) and Assistant Director of Nursing (ADON) on 5/6/26 at 4:40 p.m., the ADON validated that Resident 106 did not have documented showers in the last 30 days, but had the refusals documented. The DON explained, If resident refusing showers - talk [to him], offer [shower] at different times, [and] if the resident [is] continuing to refuse, initiate a care plan for shower refusals. The DON added that physician should be notified about resident's refusals as well. Upon reviewing Resident 106's care plans, the DON stated that Resident 106 had lots of care plans addressing his refusals, but there was no care addressing refusals of showers or bathing. A review of the facility's policy and procedure (P & P) titled, Care Plans, Comprehensive, revised 10/2025, indicated, A comprehensive care plan .to meet the resident's physical .needs is developed and implemented for each resident .Each resident's .care plan will be consistent with the resident's rights to participate .in his or her treatment .The resident has the right to refuse to participate in the .medical and nursing treatments .The comprehensive care plan will .Describe services that would otherwise be provided .but are not provided due to the resident exercising his or her rights, including the rights to refuse treatment. The P & P indicated that care plans were to be revised and updated as information about the resident's condition change.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review the facility failed to ensure nutritional needs and interventions were identified to mitigate weight loss for 2 of 37 sampled residents (Resident 7 and Resident 14) when quarterly nutritional risk assessments by a Registered Dietitian (RD) were not completed. This failure had the potential for Resident 7 and Resident 14's nutritional needs to be unmet resulting in further weight loss. A review of Resident 7's admission Record indicated Resident 7 was admitted to the facility in December 2021 with multiple diagnoses including left leg above knee amputation (AKA), right knee below knee amputation (BKA), lymphoma (blood cancer that affects the immune system), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health condition that cause fear and dread out of proportion to the situation), agoraphobia (fear of places or situations that may cause feelings of being trapped, helpless, or embarrassed) and PTSD. A review of Resident 7's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 3/17/26, indicated Resident 7 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 7 was cognitively intact. A review of Resident 7's Weight Summary for 2/1/26 to 5/1/26, indicated Resident 7 weighed 119 pounds on 2/1/26 and 110 pounds on 5/1/26. A weight loss of 9 pounds in three months, a 7.6 % weight loss. A review of Resident 7's Nutritional Risk Review (Quarterly), dated 9/18/25, indicated .Most Recent Weight .125.0 .No Significant Weight Changes .Wt hx [weight history]: 9/5/25 125#, 8/2/25 124 #, 6/8/25 123#, 3/1/25 117# .Goals: Will eat @ least 50 % of meals and maintain weight 121# +/- 4# through next review . A review of Resident 7's IDT [Interdisciplinary Team]- Weight Variance Assessment, dated 10/16/25, indicated .Significant wt loss -4#/3.4% x 1 wk [week] . Average % intake .75% .Previous Weight 118 .Current Weight 114 .[Resident 7] reports weight loss r/t [related to] being depressed .Resident expressed concern for weight gain 9/22/25 . A review of Resident 7's Nutritional Risk Assessment (Admission/Annual), dated 12/22/25, indicated .Comments BMI [Body Mass Index-measure of body fat] 27.8 (adjusted for AKA and BKA) Wt hx: 12/6/25 118# [pounds], 11/14/25 116#, 9/5/25 125#, 6/8/25 123#. Noted with non-significant wt loss -7#/5.6% x 3 mo [month] acceptable per resident preference and in setting prior overweight BMI status .Intake 51%-75 % of Meals . A review of Resident 7's IDT-Weight Variance Assessment, dated 5/7/26, .Weight -9 .Weight loss/gain (%) -7.6 % .In number of months? 3 .Previous Weight 119 .Current Weight 110 .Interventions .Recommend 1) add fortification by way of gravy sauce w/ meals 2) Ensure Plus 4 oz [ounces] BID [two times a day] . A review of Resident 7's Care Plan Nutrition, revised 12/22/25, indicated .Interventions/Tasks .RD to reassess as indicated . A review of Resident 7's Care Plan Weight Loss, revised 3/25/26, Interventions/Tasks .RD to evaluate as needed . A review of Resident 14's admission Record indicated Resident 14 was admitted to the facility in November 2015 with multiple diagnoses including anoxic brain damage (lack of oxygen to the brain causing brain cell death), dysphagia (difficulty swallowing), and moderate protein calorie malnutrition (does not take in enough calories or protein to meet nutritional needs). A review of Resident 14's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 3/16/26, indicated Resident 14 was rarely or never understood and had long and short-term memory problems. A review of Resident 14's Weight Summary, from 11/1/25 to 5/1/26, indicated Resident 14 weighed 101 pounds on 11/1/25 and 88 pounds on 5/1/26. A weight loss of 13 pounds in six months, 12.9 % weight loss. A review of Resident 14's Nutritional Risk Review (Quarterly), dated 10/8/25, .Most Recent Weight 101.0 .wt stable x 2 months but wt gain is desired .intakes increased since last RD note now average 76-100% .pt meeting /exceeding est [estimated] needs w/ diet and supplementation but wt gain not noted .new goal: maintain 100 lbs w/ gradual wt gain 1-2 lbs per week to .112-120lbs . A review of Resident 14's Nutritional Risk Assessment (Admission/Annual), dated 12/16/25, indicated .readmission .Started on Hospice .Most Recent Weight 103.0 .Wt hx: 12/14/25 103#, 12/10/25 104#, 11/1/25 101#, 9/21/25 99#, 6/13/25 104# . Intake 26%-50% of Meals (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.decreased from typical 75-100% most .increased needs r/t meeting criteria for malnutrition .Will continue to monitor po [oral] intake .wt . A review of Resident 14's Progress Note Nutrition Narrative Note, dated 2/27/26, indicated .RD note: Monthly Review for <100 [less than 100 pounds] #wt 2/1/26 96# .Wt hx 1/4/26 96 #, 11/1/25 101 #. Noted with 5# wt loss x ~ 1.5 mo [month] . A review of Resident 14's IDT-Weight Variance Assessment, dated 5/6/26, indicated .Previous Weight 96 .Current Weight 88 .Resident was on hospice care and was discharged from hospice 3/13/26 .BMI [Body Mass Index- measure of body fat] 18.4 .Underwt [underweight] . A review of Resident 14's Care Plan Weight Loss, revised 1/7/26, indicated .Interventions/Tasks .RD to evaluate as indicated . A review of Resident 14's Care Plan Nutrition, revised 4/15/26, indicated .Interventions/Tasks .Observe for signs or symptoms of malnutrition AEB [as evidenced by] emaciation, refusing meals, significant weight loss .RD to reassess as indicated . During an interview on 5/7/26 at 8:46 a.m. with Licensed Nurse (LN) 6, LN 6 indicated Resident 7 is not fond of food, has a decreased appetite and may be eating less. LN 6 stated residents are weighed by the Restorative Nurse Assistant (RNA) and notifies the nurse of any weight loss. LN 6 stated the nurse notifies the physician of weight loss but is not sure who notifies the RD of weight loss. During an interview on 5/7/26 at 9:02 a.m. with Resident 7, Resident 7 stated her current weight is 110 pounds and she would like to lose more. During an interview on 5/7/26 at 3:22 p.m. with the Director of Nursing (DON), the DON stated Resident 7 's weight fluctuates. The DON stated her mental health issues affect her eating because she self-limits her intake. The DON stated Resident 14 was discharged from hospice in March 2026 and is eating about 69 % of meals. DON stated RD is following these residents. During a concurrent interview and record review on 5/8/26 at 9:27 a.m. with the RD, the RD stated she has worked at the facility three weeks and works part time. The RD stated she is notified of residents' weight loss by receiving a written weight watch notification or verbal notification from staff. The RD stated Resident 14 lost 8 pounds in 3 months from 2/1/26 to 5/1/26 for 8.3 % weight loss. The RD stated Resident 14 was on hospice until March 2026 and then was discharged from hospice. The RD confirmed there was no nutritional risk assessment done for Resident 14 since 12/16/25. The RD stated the nutritional risk assessment should be done at least quarterly. The RD stated there was no quarterly nutritional risk assessment done in March 2026 and Resident 14 continued to lose weight. Reviewed with the RD Resident 14's Progress Note Nutrition Narrative Note, dated 2/27/26, with monthly weight review for residents less than 100 pounds. The RD acknowledged that in March when Resident 14 was discharged from hospice she still weighed less than 100 pounds, but no new RD follow-up or interventions were done for continued weight loss. The RD stated if a resident is on hospice a nutritional risk assessment should still be done. Reviewed with the RD Resident 7's weight loss. The RD stated Resident 7 lost 9 pounds in 3 months from 2/1/26 to 5/1/26, 7.6 % weight loss. The RD acknowledged that a weight variance note was done 10/16/25 but not again until 5/7/26. The RD acknowledged that a nutritional risk assessment for Resident 14 was done 12/22/25, but there was no quarterly risk assessment done in March 2026 and there was no RD progress note done in March 2026. The RD stated it is a requirement to have annual and quarterly nutritional risk assessments. The RD stated the assessments were not done in March 2026 due to gap of RD coverage at the facility. The RD stated if the quarterly and annual nutritional risk assessments are not done, there is the potential for residents to continue to lose weight. During an interview on 5/8/26 at 10:25 a.m. with the Administrator (ADM), the ADM stated the facility had full time RD coverage until the end of February 2026 when the RD left. The ADM stated there was a part time RD who also left. The ADM acknowledged there was a gap in RD coverage at the facility and quarterly and annual nutritional risk assessments were missed during that time. A review of the facility's Policy and Procedure (P&P) titled Nutritional Screening/Assessment Care Planning, revised 8/25, indicated .The residents' nutritional status and nutritional needs will be assessed .Residents will be reviewed quarterly and annually .Changes in eating habits, eating patterns, weight or other nutritional problems will be evaluated .All documentation will be completed in the electronic record . A review of the facility's P&P (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Weight Assessment and Intervention, revised 10/25, indicated .The multidisciplinary team will strive to decrease the risk, monitor, and intervene for undesirable weight loss for out residents . The Dietitian will review residents with significant weight change and follow individual weight trends over time . A review of the facility's Job Description: Registered Dietitian, indicated .Complete nutritional initial, quarterly, annual and significant change reviews on residents according to federal and state guidelines .Complete nutritional reviews on high-risk patients .Assess nutritional needs, diet restrictions and current health plans in order to develop and implement dietary care plans and provide nutritional counseling as needed .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to accurately document oxygen saturation levels (amount of oxygen in the blood) for 1 of 37 sampled residents (Resident 1) when Resident 1's documented oxygen saturation level did not indicate Resident 1 was using supplemental oxygen (oxygen therapy that provides extra oxygen to breathe to maintain oxygen saturation levels). This failure resulted in documentation that was not accurate and did not reflect Resident 1's treatment needs. A review of Resident 1's admission Record indicated that Resident 1 was initially admitted to the facility in June 2024 and readmitted to the facility in March 2026 with multiple diagnoses including congestive heart failure (heart does not pump blood as efficiently as it should), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a cerebral infarction (disrupted blood flow to the brain causing brain cell death), chronic respiratory failure (lungs do not deliver enough oxygen to the blood) with hypoxia (low level of oxygen in the body's tissues), diabetes (too much sugar in the blood), and chronic kidney disease (kidneys do not filter the blood the way they should). A review of Resident 1's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 3/23/26, indicated Resident 1 had Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 2 out of 15 that indicated Resident 1 was severely cognitively impaired. A review of Resident 1's Order Audit Report indicated order dated 6/10/25, .Oxygen-@ 1.5 Liters/Min [amount of oxygen delivered by supplemental oxygen] Via Nasal Cannula [thin flexible tube that delivers supplemental oxygen to your nose to breathe in] . (Medical DX [Diagnosis]: SOB [Shortness of Breath] Goal To Maintain O2 Sats [oxygen saturation] Greater Than 90 % [the percentage of oxygen in the blood, normal is 95% to 99 %] . A review of Resident 1's O2 sats summary, for 4/22/26 to 5/6/26, indicated 14 out of 26 oxygen saturation measurements were on room air with no supplemental oxygen used. A review of Resident 1's Care Plan .Oxygen . revised 1/9/25, indicated .Interventions/Tasks .Monitor oxygen saturation via pulse oximetry [a device clipped on end of finger to measure blood oxygen level] every shift . During an observation on 5/7/26 at 10:30 a.m., observed Resident 1 wearing oxygen via nasal cannula with oxygen concentrator (machine that separates nitrogen from the air to produce pure oxygen) set at 1.5 liters/ minute. During a concurrent observation and interview on 5/7/26 at 10:38 a.m. with Licensed Nurse (LN) 11, LN 11 stated Resident 1 is always on oxygen at1.5 liters/ minute. Observed with LN 11 that Resident 1 was using oxygen at 1.5 liters/ minute. Reviewed with LN 11 oxygen saturation documentation that reflected oxygen saturation levels were taken on room air. LN 11 stated the CNAs (Certified Nursing Assistants) chart the oxygen saturation levels and if it indicated it was on room air that is incorrect because Resident 1 is always using oxygen via nasal cannula. During an interview on 5/7/26 at 12:28 p.m. with CNA 3, CNA 3 stated she charts oxygen saturations in the vital signs section. CNA 3 stated she charts if resident is on oxygen via nasal cannula. Reviewed with CNA 3 that there were multiple entries for Resident 1 that indicated she was on room air instead of using oxygen via nasal cannula. CNA 3 stated if in a hurry that may be overlooked and will just document room air, but Resident 1 is always on oxygen via nasal cannula. During a concurrent interview and record review with the Director of Nursing (DON), the DON acknowledged charting that indicated Resident 1 oxygen saturations documented taken on room air were incorrect. The DON stated that Resident 1 has order for continuous oxygen and is always wearing 1.5 liters/ minute. The DON stated her expectation is that charting will be accurate. A review of the facility's Policy and Procedure (P&P) titled Oxygen Administration, revised 10/25, indicated .After completing the oxygen set up or adjustment, the following information should be recorded in the resident's medical record .The rate of oxygen flow, route . A review of the facility's P&P titled Documenting Vital Signs, revised 9/25, indicated .The purpose of this procedure is to document the resident's vital signs .in the medical record .		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on interview and record review, the facility failed to identify trauma triggers for 1 out of 37 sampled residents (Resident 7) with post-traumatic stress disorder (PTSD- a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event). This failure had the potential for Resident 7 to experience re-traumatization (re-experience/relives a traumatic event or experiences causing similar stress reactions to a new event), and possible increased symptoms such as restlessness, irritability, and social withdrawal. A review of Resident 7's admission Record indicated Resident 7 was admitted to the facility in December 2021 with multiple diagnoses including left leg above knee amputation, right knee below knee amputation, lymphoma (blood cancer that affects the immune system), major depressive disorder (mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (mental health condition that cause fear and dread out of proportion to the situation), agoraphobia (fear of places or situations that may cause feelings of being trapped, helpless, or embarrassed) and PTSD. A review of Resident 7's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 3/17/26, indicated Resident 7 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 7 was cognitively intact. A review of Resident 7's Care Plan Depression/Post Traumatic Stress Disorder (PTSD) [Resident 7] is at risk for ineffective coping mechanisms r/t [related to] D/x [diagnosis] of Depression .with underlying Post Traumatic Stress Disorder (PTSD), initiated 12/28/22. Resident 7's Care Plan did not reflect Resident 7's triggers for PTSD or interventions to mitigate triggers. A review of Resident 7's Progress Note Type Nurse Practitioner Note, dated 4/6/23, indicated .Posttraumatic stress disorder- Onset : 01/24/2023 . A review of Resident 7's Social History Assessment (Admission/Annual), dated 10/31/24, indicated .Significant Life Events .Sexual Assault (rape, attempted rape, made to perform any type of sexual act through force or threat of them) .Happened to me . PTSD triggers were not identified. A review of Resident 7's Social History Assessment (Admission/Annual), dated 12/27/24, indicated .Significant Life Events .Sexual Assault (rape, attempted rape, made to perform any type of sexual act through force or threat of them) .Happened to me . PTSD triggers were not identified. A review of Resident 7's Progress Notes Type: Nurse Practitioner Note, dated 4/7/26, indicated .Assessment . Stress disorder, post traumatic . During an interview on 5/7/26 at 8:46 a.m. with Licensed Nurse (LN) 6, LN 6 stated she was aware that Resident 7 has a history of PTSD and is followed by psych nurse. LN 6 stated she was not aware of Resident 7's PTSD triggers. During an interview on 5/7/26 at 9:03 a.m. with Resident 7, Resident 7 stated she does have a history of PTSD and counselor talks to her about it. Resident 7 stated had no concerns and did not want to talk further regarding PTSD. During a concurrent interview and record review on 5/7/26 at 12:08 p.m. with the Social Services Director (SSD), the SSD stated she was not aware that Resident 7 had a diagnosis of PTSD. During a record review with the SSD the SSD then acknowledged that Resident 7 had a diagnosis of PTSD. The SSD stated there was not an assessment done to identify Resident 7's PTSD triggers. The SSD stated the facility had not been conducting trauma informed care assessments and she was not aware they needed to be done for residents with diagnosis of PTSD. The SSD stated there was no PTSD assessment done to identify Resident 7's PTSD triggers. The SSD stated, If no assessment to identify triggers staff wouldn't know what her triggers are. During a concurrent interview and record review on 5/7/26 at 3:22 p.m. with the Director of Nursing (DON), the DON acknowledged that Resident 7 did not have a trauma informed care assessment completed for a diagnosis of PTSD. Reviewed Resident 7's Social History Assessments (Admission/Annual) dated 10/31/24 and 12/27/24 with the DON. The DON stated the assessments indicated a traumatic event but did not identify the triggers. The DON stated if the triggers were not identified, then the triggers cannot be mitigated. The DON stated the triggers should be indicated in the care plan. The DON acknowledged that Resident 7's PTSD care plan did not indicate triggers. The DON stated, If staff don't know what (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the triggers are, then someone could trigger something we don't know about. A review of the facility's Policy and Procedure (P&P) titled Post Traumatic Stress Disorder, revised 10/25, indicated .PTSD Involves the development of symptoms following exposure to one or more traumatic, life-threatening events; Symptoms may include, but are not limited to, the re-experiencing or re-living of the stressful event .emotional and behavioral expressions of distress .extreme discontentment or inability to experience pleasure, as well as dissociation .hyperarousal .As part of the initial assessment, staff will review available information . to identify individuals who have a history of post traumatic stress disorder (PTSD) .Staff will interview the resident and/or family member to confirm diagnosis and trigger .Staff will observe patient for possible signs and symptoms of PTSD, Trauma, and/or adjustment difficulty and potential triggers and coordinate with IDT [Interdisciplinary Team] for interventions .Examples of potential triggers may include .loud noises .unfamiliar faces .sights, sounds, smells, actual physical surroundings, and situations that are similar .		