

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of two sampled residents (Resident 69 and Resident 13), who were investigated under the pressure ulcer (PU - damage to an area of the skin caused by prolonged pressure or friction, often over bony areas like the tailbone, heels or elbows) care area, received care consistent with professional standards of practice by failing to: 1. Prevent the worsening of a Stage Two (2) (an open, shallow wound that has damaged the epidermis [top layer of the skin] and the dermis [middle layer of the skin], with the fluid-filled blister appearing as a ruptured or intact blister containing fluid) fluid-filled blister (a painful skin condition where fluid fills a space between layers of skin) on Resident 69's left heel, initially identified on 8/22/2025. The facility failed to: a. Offload (to reduce or remove pressure on the affected area to promote healing and prevent further damage) Resident 69's left heel to relieve pressure and prevent the worsening of an existing Stage Two, fluid-filled blister on the left heel. b. Provide Resident 69 an alternating pressure pad (APP - alternating pressure mattress system used to prevent and treat PU, works by constantly changing the pressure points on a person's body to improve blood circulation and reduce the risk of tissue damage from prolonged, unrelieved pressure) to reduce pressure and friction that contribute to the development and progression of PU. These deficient practices resulted in Resident 69's Stage Two fluid-filled blister on the left heel becoming open, macerated (the skin surrounding the wound becomes soft, soggy, wrinkled due to excessive exposure to moisture - typically the fluid draining from the blister), and enlarged, causing pain and discomfort to Resident 69. Cross reference F656 2. Prevent Resident 13's left hand from skin injuries due to severe range of motion ([ROM] full movement potential of a joint) limitations including the inability to fully extend the left-hand fingers. This deficient practice had the potential for Resident 13's left hand to develop infections and pressure injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). Cross reference F688. Findings: 1. During a review of Resident 69's admission Record, the admission Record indicated the facility initially admitted Resident 69 on 1/15/2025 and re-admitted Resident 69 on 6/26/2025 with diagnoses including type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (paralysis [inability to move] on one side of the body), and hemiparesis (a condition where there is weakness on one side of the body) following cerebral infarction (commonly known a stroke, caused by a blockage in a blood vessel in the brain, leading to brain tissue damage) affecting the right side and dysphagia (difficulty swallowing). During a review of Resident 69's History and Physical (H&P- a comprehensive assessment of a resident's medical condition), dated 6/27/2025, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 6/30/2025, the MDS indicated that Resident 69 was usually understood by others and was also able (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0686 Level of Harm - Actual harm Residents Affected - Few	to promote healing and prevent further damage such as pressure ulcers) for residents identified as high risk for developing pressure ulcers. TN 1 stated he (TN 1) should have obtained an order for APP mattress when Resident 69 had the non-blanchable redness on the sacrum area identified on 6/26/2025 as it may have helped prevent further skin breakdown in other areas such as the development of fluid-filled blister on Resident 69's left heel. During a concurrent observation and interview on 8/28/2025 at 1:37 p.m., with TN 1 and Treatment Nurse 2 (TN 2), in Resident 69's room, observed TN 1 and TN 2 providing wound care to Resident 69's left heel. TN 1 removed the dressing on Resident 69's heel and stated that there was a light-yellow tinge on the dressing. TN 1 stated that the light-yellow tinge may have been caused by the betadine solution. While TN 1 repositioned Resident 69 to assess the left heel, a tear was observed rolling down Resident 69's right cheek. TN 2 asked Resident 69 if she (Resident 69) was experiencing pain in her (Resident 69) left heel, to which Resident 69 responded "Yes, it hurts a lot." TN 1 stated that the heel now appeared worse and described the left heel as a partial-thickness skin lesion (any abnormal lump, discoloration [any change in the normal color of the skin], sore [refers to pressure ulcer] or other change or on or in the skin that differs from the surrounding skin's normal appearance) with a shallow open area and a pink wound bed (surface at the base of a wound), measuring three (3) cm x 3.8 cm x UTD, with the open lesion measuring 0.6 cm x 0.7 cm x UTD. TN 2 stated that when she (TN 2) last changed the dressing on 8/27/2025, the blister had been intact. TN 1 further stated that the use of an APP mattress, and consistent heel-floating could have prevented Resident 69's pain and the worsening of the blister on Resident 69's left heel. During an interview on 8/28/2025 at 4:37 p.m., with the Director of Nursing (DON), the DON stated that Resident 69's pressure ulcer on her (Resident 69) left heel was avoidable. The DON stated that the licensed nurses should have obtained a physician's order for an APP mattress, especially given that Resident 69 had a history of a pressure ulcer, mobility limitations and pain related to osteoarthritis. The DON stated that Resident 69's heels should never have been resting flat on the bed. During a review of the facility provided APP Owner's Manual, undated, the manual indicated that the APP is a flotation therapy device that provides pressure management to assist in the prevention and treatment of pressure injuries. During a review of the facility's Policy and Procedure (P&P) titled "Skin and Wound Monitoring and Management" last reviewed on 4/2025, the P&P indicated a resident who enters the facility without a pressure injury does not develop a pressure injury unless the individual's clinical condition demonstrates it was unavoidable. The P&P defines stage 2 pressure injury as partial thickness skin loss with exposed dermis. The P&P further indicates to prevent pressure ulcers by repositioning and using pressure mattresses, wedges and pillows. 2. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 3/11/2025 with diagnoses including atherosclerotic heart disease (fatty deposits [plaque] build up inside the blood vessels that supply the heart making the vessels stiff and narrow), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), age-related cognitive (ability to think, understand, learn, and remember) decline, and anxiety disorder (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 13's Physician's Certification for Hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) Benefit, dated 3/11/2025, the Physician's Certification indicated Resident 13's primary hospice diagnosis was atherosclerotic heart disease. During a review of Resident 13's Minimum Data Set ([MDS] a resident assessment tool), dated 3/13/2025, the MDS indicated Resident 13 had clear speech, had limited ability to express ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition. The MDS indicated Resident 13 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in both arms and legs. The MDS indicated Resident 13 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, partial/moderate assistance (helper does less than half the effort) for rolling to either side in bed, and substantial/maximal assistance (helper does more than half the effort) for toileting, upper and lower body dressing, and toilet transfers. The MDS indicated Resident 13 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for transferring from lying to sitting on the side of the bed and chair/bed-to-chair transfers. The MDS indicated Resident 13 was at risk of developing pressure injuries. During a review of Resident 13's initial JME, dated 3/18/2025, completed by Occupational Therapist (OT - profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) 2 (OT 2), the JME indicated Resident 13 had moderate ROM limitation (50% to 75% range intact &dash; means the joint is restricted to between half and three-quarters of its normal, full ROM) in the right hip and minimum ROM limitation (75 to 100% range intact &dash; means the joint or body part has a minimum of 75% of its normal, healthy ROM to 100% no limitation at all) in both shoulders, the right elbow, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitations in the left elbow, both wrists, both fingers (hands), and both ankles. During a review of Resident 13's Hospice Updated Assessment, dated 4/3/2025, 4/17/2025, 5/1/2025, 5/15/2025, and 5/29/2025, the Hospice Updated Assessment indicated Resident 13 had ROM loss (unspecified location). During a review of Resident 13's quarterly JME, dated 6/2/2025 and completed by Occupational Therapist 1 (OT 1), the JME indicated Resident 13 had severe ROM limitation (0-25% range intact) in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitations in the left shoulder, the left hip, and both knees. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had clear speech, had limited ability to express ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition. The MDS indicated Resident 13 had functional limitations in ROM in one arm and both legs. The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for eating and substantial/maximal assistance for upper body dressing, rolling to either side in bed, and transferring from lying to sitting on the side of the bed. The MDS indicated Resident 13 was dependent for toileting and lower body dressing. The MDS indicated Resident 13 was at risk of developing pressure injuries. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	increase range of motion) or any other device to place in the left hand. During an interview on 8/28/2025 at 9:38 a.m. with CNA 1, CNA 1 stated Resident 13 did not have any device to place in the left-hand palm. CNA 1 stated a towel was sometimes placed in the left hand but Resident 13 could remove the towel. During a telephone interview on 8/28/2025 at 9:56 a.m. with Treatment Nurse 3 (TN 3), TN 3 stated Resident 13's CIC Evaluation for the left-hand finger cut was written on 8/25/2025 but occurred on 8/24/2025. TN 3 stated someone else (unknown) had already cut Resident 13's left-hand fingernails on 8/24/2025 but they were still too long. TN 3 stated Resident 13's left-hand fingers were in a bent position and could be extended enough to trim the nails. TN 3 stated TN 3 was present in Resident 13's room while a LVN (unknown name) trimmed Resident 13's nails and cut the left ring finger too much causing it to bleed. TN 3 stated Resident 13's physician was contacted and agreed to the application of Betadine for the cut. During a telephone interview on 8/28/2025 at 10:24 a.m. with Resident 13's Hospice RN, the Hospice RN stated Resident 13 had a left-hand contracture and a left-hand skin cut. The Hospice RN stated Resident 13's left-hand contracture had developed "a few weeks if not a few months" ago (from the date of the interview). The Hospice RN stated the biggest concern would be to prevent Resident 13 from developing any skin issues from the contractures since the left hand was in a closed position, which could cause fungal issues in the palm and skin tears wherever Resident 13's nails make contact. The Hospice RN stated Resident 13 did not have any skin issues prior to the left-hand skin cut. During an interview on 8/28/2025 at 12:35 p.m. with OT 1 and the DON, Resident 13's JME, dated 3/18/2025 and 6/2/2025, was reviewed. The DON and OT 1 reviewed Resident 13's JME, dated 3/18/2025, and stated Resident 13 did not have any ROM limitations in the left-hand fingers. The DON and OT 1 reviewed Resident 13's JME, dated 6/2/2025, and stated Resident 13 had severe ROM limitations in the left-hand fingers. OT 1 stated nursing was not notified regarding Resident 13's "substantial decline" of ROM in the left hand because of OT 1's misinformation that intervention was not supposed to be provided to residents under hospice care. During an interview on 8/28/2025 at 2:01 p.m. with the DON, the DON stated residents were not supposed to develop contractures because it would affect their quality of life and activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The DON stated the development contractures placed residents at higher risk for pressure injury. During an interview on 8/28/2025 at 2:45 p.m. with the DON, the DON stated cutting Resident 13's fingernails prevented the nails from digging into the palm which could cut the skin. The DON stated the rings worn on Resident 13's left ring finger could get stuck, cause pressure, and cause swelling since the fingers were in a bent position. The DON stated Resident 13's left hand ROM limitations increased the resident's potential for skin injuries. During a telephone interview on 8/28/2025 at 3:09 p.m. with Resident 13's primary physician (Hospice MD), the Hospice MD stated the hospice goal included to maintain Resident 13's comfort. The Hospice MD stated the hospice team had an internal discussion a few weeks or one month ago (from the interview date) about Resident 13's closed fist position on the left hand. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
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F 0686 Level of Harm - Actual harm Residents Affected - Few	The Hospice MD was unaware of Resident 13's JME, dated 6/2/2025, which identified Resident 13's severe ROM loss in the left-hand. Hospice MD stated, "I would have appreciated if this was reported to me at least." The Hospice MD stated a one-time OT evaluation could have been ordered for recommendations, including braces (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion), towel rolls, or any conservative measures to prevent Resident 13's ROM in the left hand from worsening and to prevent the development of any wounds from the closed fist position. During a review of the facility's policy and procedure (P&P) titled, "Skin and Wound Monitoring and Man		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to maintain range of motion (ROM- full movement potential of a joint) and mobility (ability to move) for two of four sampled residents (Resident 13 and Resident 69) reviewed under the Position/Mobility care area by failing to: 1. Provide Resident 13 with ROM exercises to both arms and legs following the identification of ROM limitations on the initial Joint Mobility Evaluation (JME- brief assessment of a resident's ROM in each joint of both arms and legs), dated 3/18/2025. 2. Implement interventions including ROM exercises and the use of devices to prevent further ROM loss and ensure skin protection after worsening ROM was identified in Resident 13's left-hand fingers progressing from no ROM limitation (means 100 percent [%] range intact) to severe ROM limitation (zero [0] to 25% - means the joint can only move through a minimal portion of its normal, healthy range - a measurement of zero would mean the joint has no movement at all [full stiffness], 25% means the joint can only move a quarter of the way) on the quarterly JME, dated 6/2/2025. 3. Report and address Resident 13's ROM decline in the left hand, observed during daily care from 6/12/2025 to 8/28/2025, to the primary care physician, in accordance with Resident 13's care plan titled, Risk for Alteration (changes) in Episodes of Comfort. 4. Follow the facility's policy and procedures (P&P) titled, ROM and Contracture (a stiffening or shortening at any joint that reduces the joint's range of motion) Prevention to ensure that Resident 13, who was receiving hospice care (compassionate care for people who are near the end of life provided at the person's home or within a health care facility), maintained and/or improved their ROM. 5. Follow the facility's P&P titled, Restorative Program (focuses on implementing nursing interventions to improve or maintain a resident's ability to perform Activities of Daily Living [ADL, basic tasks that individuals perform to maintain their daily lives and independence]) to restore or maintain Resident 13's mobility skills and ROM. These deficient practices resulted in Resident 13, who was admitted to the facility on hospice care, not receiving any interventions to prevent ROM decline from 3/18/2025 to 8/21/2025 (a period of five months), leading to the development of contractures in the fingers of the left hand and placed Resident 13 at increased risk for infection and pressure injury (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) in the left-hand. 6. Provide Resident 69 with the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) program for sit-to-stand transfers on 8/26/2025 in accordance with the physician's orders, dated 8/22/2025. These failures also had the potential for Resident 69 to experience a decline in mobility. Cross reference F580, F656, and F686. Findings: a. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 3/11/2025 with diagnoses including atherosclerotic heart disease (fatty deposits [plaque] build up inside the blood vessels that supply the heart making the vessels stiff and narrow), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), age-related cognitive (ability to think, understand, learn, and remember) decline, and anxiety disorder (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). During a review of Resident 13's Physician's Certification for Hospice Benefit, dated 3/11/2025, the Physician's Certification indicated Resident 13's primary hospice diagnosis was atherosclerotic heart disease. During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 3/13/2025, the MDS indicated Resident 13 had clear speech, had limited ability to express ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 13 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in both arms and legs. The MDS indicated Resident 13 required setup or clean-up assistance (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	(helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, partial/moderate assistance (helper does less than half the effort) for rolling to either side in bed, and substantial/maximal assistance (helper does more than half the effort) from staff with toileting, upper and lower body dressing, and toilet transfers. The MDS indicated Resident 13 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for transferring from a lying to a sitting position on the side of the bed as well as for bed-to-chair and chair-to-bed transfers. During a review of Resident 13's Care Plan titled, Risk for Alteration in Episodes of Comfort due to admission under hospice care, dated 3/12/2025, the care plan interventions included to observe and report changes including decreased functional abilities, decreased ROM, and withdrawal or resistance to care. During a review of Resident 13's initial JME, dated 3/18/2025, completed by Occupational Therapist (OT - professional aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) 2 (OT 2), the JME indicated Resident 13 had moderate ROM limitation (50% to 75% range intact - means the joint is restricted to between half and three-quarters of its normal, full ROM) in the right hip and minimum ROM limitation (75 to 100% range intact - means the joint or body part has a minimum of 75% of its normal, healthy ROM to 100% no limitation at all) in both shoulders, the right elbow, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitations in the left elbow, both wrists, both fingers (hands), and both ankles. During a review of Resident 13's Hospice Updated Assessment, dated 4/3/2025, 4/17/2025, 5/1/2025, 5/15/2025, and 5/29/2025, the Hospice Updated Assessment indicated Resident 13 had a loss of ROM (unspecified location). During a review of Resident 13's Hospice Health Aide (HA - a person who provides personal care and basic health-related services to individuals in their homes) Visit Notes, dated 5/5/2025, 5/8/2025, 5/12/2025, 5/15/2025, 5/22/2025, and 5/26/2025, the Hospice HA Visit Notes indicated Resident 13 received assistance with toileting, dressing, and feeding but refused bed baths. The Hospice HA Visit Note included a section for exercises, including active range of motion (AROM - performance of an exercise to move a joint without any assistance or effort of another person) and passive range of motion (PROM - movement of a joint through the range of motion with no effort from person), which was blank. During a review of Resident 13's Nursing Progress Notes from 3/11/2025 to 6/2/2025, the Nursing Progress Notes did not indicate any reported changes in ROM for Resident 13. During a review of Resident 13's quarterly JME, dated 6/2/2025, completed by Occupational Therapist 1 (OT 1), the JME indicated Resident 13 had severe ROM limitation in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitations in the left shoulder, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitation in the right shoulder, both elbows, both wrists, right-hand fingers, and both ankles. The JME indicated Resident 13 was on hospice care. During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had clear speech, had limited ability to express ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition. The MDS indicated Resident 13 had functional limitations in ROM in one arm and both legs. The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for eating and substantial/maximal assistance for upper body dressing, rolling to either side in bed, and transferring from a lying to a sitting position on the side of the bed. The MDS indicated Resident 13 was dependent on staff for toileting and lower body dressing. During a review of Resident 13's Census List (record of hospitalizations, room changes, and payer source changes), the Census List indicated Resident 13 had a room change on 6/12/2025. During a review of Resident 13's Hospice HA Visit Notes, dated 7/3/2025, 7/7/2025, and 7/10/2025, the Hospice HA Visit Notes section for exercise, including AROM and PROM exercises, was blank. During a review of Resident 13's Hospice Updated Assessment, dated 7/10/2025, the Hospice Updated Assessment indicated Resident 13 had a loss of ROM (unspecified location) and contractures (unspecified location). During a review of (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	Resident 13's Hospice HA Visit Notes, dated 7/14/2025, 7/17/2025, 7/21/2025, 7/24/2025, the Hospice HA Visit Notes section for exercise, including AROM and PROM exercises, was blank. During a review of Resident 13's Hospice Updated Assessment, dated 7/24/2025, the Hospice Updated Assessment indicated Resident 13 had had a loss of ROM (unspecified location) and contractures (unspecified location). During a review of Resident 13's Hospice HA Visit Notes, dated 7/28/2025 and 7/31/2025, the Hospice HA Visit Notes included a section for exercises, including AROM and PROM exercises, was blank. During a review of Resident 13's Physician's Orders, dated 8/19/2025, the Physician's Orders indicated to start the Restorative Nursing Assistant Program (RNA Program-nursing aide program that helps residents to maintain their function and joint mobility) on 8/20/2025 for PROM to both arms and legs, five times per week as tolerated. During a review of Resident 13's quarterly JME, dated 8/21/2025, the JME indicated Resident 13 had severe ROM limitation in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitation in the left shoulder, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitations in the right shoulder, both elbows, both wrists, right-hand fingers, and both ankles. During a review of Resident 13's Documentation Survey Report (record of nursing assistant tasks) for 8/2025, the Documentation Survey Report indicated that the Restorative Nursing Assistant (RNA - a specialized role for Certified Nursing Assistants [CNA] who receive additional training to help residents regain or maintain physical function and mobility) began providing PROM exercises to both arms and legs on 8/25/2025. During a review of Resident 13's Change in Condition (CIC - when there is a sudden change in a resident's condition) Evaluation, dated 8/25/2025, the CIC Evaluation indicated Resident 13 had a small cut with scant (little) bleeding from the nails being trimmed on the left ring finger. The CIC Evaluation indicated Resident 13's physician was notified with orders to cleanse the left ring finger with normal saline (a mixture of water and salt), pat dry, apply Betadine external solution (brand name for povidone-iodine, a topical [applied directly to skin] antiseptic solution [substance that keeps the broken skin from getting infected] used to clean and disinfect the skin to prevent an infection from developing, thus promoting healing), and cover with a dry dressing (wound covering that keeps the wound surface dry). During an interview on 8/26/2025 at 9:36 a.m., with the Director of Rehabilitation (DOR), the DOR stated the JME was completed upon admission and quarterly by the either the Physical Therapist (PT - professional aimed in the restoration, maintenance, and promotion of optimal physical function) or OT to monitor residents' ROM and mobility. The DOR stated the purpose of the JME was to ensure residents maintained their ROM, prevent the development of contractures, and prevent the worsening of existing contractures. The DOR stated the therapy staff (PT or OT) collaborated with nursing to determine appropriate interventions, including requesting physician orders for a therapy evaluation when changes were identified on the JME. The DOR stated that ROM limitations and contractures can lead to skin injuries and could affect the residents' comfort and quality of life. During a concurrent observation and interview on 8/26/2025 at 11:10 a.m., in Resident 13's room, observed Resident 13 lying in bed and had oxygen running through the nasal cannula (a small plastic tube that is inserted into the person's nostrils to deliver supplemental oxygen). Resident 13 was observed moving at the right shoulder, elbow, wrist, and hand joints. Resident 13's left arm, body, and both legs were covered with a blanket. During a concurrent observation and interview on 8/27/2025 at 11:13 a.m., with Restorative Nursing Assistant 2 (RNA 2), in Resident 13's room, Resident 13's RNA program was observed. Resident 13 spoke clearly but expressed disorganized thoughts while lying in bed. RNA 2 stated Resident 13 had behaviors of not complying with ROM exercises. Resident 13 was observed bending and extending both legs and raising both arms overhead without any assistance. Resident 13's left hand was observed in a closed fist position, with the left-hand fingernails, including an adhesive bandage (known as Band-Aid, a medical dressing that consists of adhesive strip [a strip of material coated with an adhesive that sticks to the skin] to protect would from infection and dirt) on the tip of the left ring finger, slightly touching the palm. Resident 13's left hand did not have any device applied to the palm to prevent the (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	fingerprints from touching the palm. Resident 13 stated, We are not doing any exercises today, but agreed to an observation of the skin on the left palm. Resident 13 used the right hand to extend the left-hand fingers but could not completely straighten the fingers, which remained in bent positions at all joints. During a concurrent interview and record review on 8/27/2025 at 12:49 p.m., with OT 1, Resident 13's JME dated 3/18/2025, 6/2/2025, and 8/21/2025, and Physician's Orders for RNA dated 8/19/2025 were reviewed. OT 1 stated Resident 13 was admitted to the facility under hospice care on 3/11/2025 and had never received any therapy (PT, OT, and Speech Language and Pathology (SLP-profession aimed in the prevention, assessment, and treatment of speech, language, communicative, and swallowing disorders) services. OT 1 reviewed Resident 13's JME, dated 3/18/2025, and stated the JME indicated Resident 13 had moderate ROM limitation in the right hip and minimum ROM limitation in both shoulders, the right elbow, the left hip, and both knees. OT 1 stated the JME did not indicate any recommendations to address Resident 13's ROM limitations. OT 1 reviewed Resident 13's JME, dated 6/2/2025, and stated the JME indicated Resident 13 had severe ROM limitation in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitation in the left shoulder, the left hip, and both knees. OT 1, who performed Resident 13's JME on 6/2/2025, stated there were no recommendations to address Resident 13's ROM limitations since Resident 13 was under hospice care. OT 1 stated residents under hospice care, from OT 1's experience, did not receive any therapy and RNA services. OT 1 stated the DOR (unavailable for further interview) placed the physician's order, dated 8/19/2025, for RNA to provide PROM to both arm and legs. OT 1 reviewed Resident 13's JME, dated 8/21/2025, and stated the JME indicated Resident 13 had severe ROM limitation in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitation in the left shoulder, the left hip, and both knees. During a concurrent observation and interview on 8/27/2025 at 2:31 p.m., with Certified Nursing Assistant 1 (CNA 1), in Resident 13's room, Resident 13's left hand was observed. Resident 13's left-hand fingers were in a closed fist position without any device placed between the fingerprints and the palm. During a follow-up interview on 8/27/2025 at 2:39 p.m., with CNA 1, CNA 1 stated Resident 13 had been assigned to CNA 1 during the day shift for the past three months after Resident 13 moved from another room to Resident 13's current room. CNA 1 stated Resident 13's left hand did not have a closed fist when Resident 13 moved to the current room. CNA 1 stated Resident 13 started developing a closed fist to the left hand approximately one month ago (unknown date) and reported it (unknown date) to the charge nurse (unknown). During a telephone interview on 8/27/2025 at 3:42 p.m., with Resident 13's responsible Family Member 1 (FM 1) and Family Member 2 (FM 2), FM 1 stated Resident 13 hid the left hand during family visits. FM 1 described Resident 13's left hand as curled up, stiff, and unable to open. FM 1 stated Resident 13's left hand did not have a closed fist position upon admission to the facility and developed it shortly after (unknown date) Resident 13's admission. FM 1 stated FM 1 contacted (unable to recall when) Resident 13's Hospice Registered Nurse (Hospice RN) and the facility's nurse (unknown) about Resident 13's left hand. FM 1 stated the Hospice RN looked at Resident 13's left hand, informed FM 1 that the left hand was contracted, and stated to FM 1 that nothing could be done. FM 1 stated the family was not aware that the facility provided RNA services for ROM exercises and was never offered any RNA services for Resident 13. During a review of Resident 13's Nursing Progress Notes from 6/3/2025 to 8/28/2025, the Nursing Progress Notes did not indicate any reported changes in ROM for Resident 13. During an interview on 8/28/2025 at 9:06 a.m., with CNA 1, CNA 1 stated Resident 13 developed the closed fist on the left hand within the month (8/2025). CNA 1 stated Resident 13's inability to open the left-hand fingers was reported (unknown date and time) to Licensed Vocational Nurse 1 (LVN 1). During an interview on 8/28/2025 at 9:12 a.m., with LVN 1, LVN 1 stated a CNA, possibly CNA 1, reported (unable to recall specific date) discoloration (a change in the normal color of the skin) to Resident 13's left hand, which was reported to Resident 13's hospice care. LVN 1 stated no one informed LVN 1 that Resident 13's left hand was positioned in a closed fist and unable to extend the fingers. LVN 1 stated Resident 13 often refused (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	care and had not noticed the left hand since Resident 13 covered the left arm. During a concurrent observation and interview on 8/28/2025 at 9:18 a.m., with Treatment Nurse 2 (TN 2), in Resident 13's room, Resident 13's left-hand fingers were observed. TN 2 stated Resident 13 was unable to fully open the left-hand fingers. TN 2 stated Resident 13's left hand had a skin cut on the tip of the ring finger near the nail bed and another skin cut on the side of the nail bed (area of the nail on which the nail rests). TN 2 stated the nails were cut to prevent them from digging into the skin of Resident 13's left-hand palm since the fingers were bent. During a telephone interview on 8/28/2025 at 9:56 a.m., with Treatment Nurse 3 (TN 3), TN 3 stated Resident 13's CIC Evaluation for the left-hand fingernail cut was documented on 8/25/2025 but occurred on 8/24/2025. TN 3 stated TN 3 was present in Resident 13's room while an LVN (unknown name) trimmed Resident 13's nails on 8/24/2025. TN 3 stated Resident 13's left-hand fingers were in a bent position and could be extended enough to trim the nails. During a telephone interview on 8/28/2025 at 10:24 a.m., with Resident 13's Hospice RN, the Hospice RN stated Resident 13 had a left-hand contracture and a left-hand skin cut. The Hospice RN stated Resident 13's left-hand contracture had developed a few weeks if not a few months ago (from the date of the interview). The Hospice RN stated the biggest concern would be to prevent Resident 13 from developing any skin issues from the contractures since the left hand was in a closed position, which could cause fungal issues in the palm and skin tears wherever Resident 13's nails make contact. The Hospice RN stated providing basic ROM to Resident 13 during care was encouraged during the Hospice HA visits and was not aware the facility had a program to provide ROM exercises. During an interview on 8/28/2025 at 12:35 p.m., with OT 1 and the Director of Nursing (DON), Resident 13's JME dated 3/18/2025 and 6/2/2025, the Nursing Progress Notes dated 3/11/2025 to 8/28/2025, the Care Plan titled, Risk for Alteration in Episodes of Comfort, dated 3/12/2025, and Physician's Order for RNA dated 8/20/2025 were reviewed. The DON and OT 1 stated Resident 13 had ROM limitations on Resident 13's JME, dated 3/18/2025, on multiple joints of both arms and legs. OT 1 stated RNA services were not provided to Resident 13 after the JME, dated 3/18/2025, since it was OT 1's experience and misunderstanding that residents under hospice care did not receive RNA services for ROM exercises. The DON and OT 1 reviewed Resident 13's JME, dated 6/2/2025, and stated Resident 13 had severe ROM limitations in the left-hand fingers. OT 1 stated OT 1 did not notify a licensed nurse regarding Resident 13's substantial decline in ROM in the left hand after the JME on 6/2/2025. OT 1 stated the facility did not provide any ROM following the JME on 6/2/2025 because of OT 1's misinformation that RNA services should not be offered to residents receiving hospice care. The DON reviewed all of Resident 13's Nursing Progress Notes since admission to the facility on 3/11/2025 and did not locate any Nursing Progress Notes documenting Resident 13's severe ROM limitation in left hand. The DON reviewed Resident 13's care plan titled, Risk for Alteration in Episodes of Comfort, and stated the facility did not follow the care plan intervention to observe and report changes including Resident 13's decline in ROM after the JME on 6/2/2025 and during daily care since the Nursing Progress Notes did not indicate any decline in Resident 13's left hand ROM. The DON stated Resident 13 had physician's orders, dated 8/19/2025, to start RNA for PROM exercises on 8/20/2025. Both the DON and OT 1 stated that Resident 13 did not receive any ROM exercises for five months from the initial JME on 3/18/2025 to 8/20/2025. OT 1 stated the facility should have provided RNA for ROM exercises upon admission since Resident 13 had ROM limitations and was at risk of developing further ROM limitations. Both the DON and OT 1 stated that Resident 13's significant ROM loss in the left hand was preventable. During a concurrent interview and record review on 8/28/2025 at 2:01 p.m., with the DON, Resident 13's JME dated 3/18/2025, and the facility's P&P titled, ROM and Contracture Prevention, dated as reviewed on 1/2025 and 3/2025, were reviewed. The DON reviewed Resident 13's JME, dated 3/18/2025, and stated ROM limitations were identified in both arms and legs. The DON reviewed the facility's P&P titled, ROM and Contracture Prevention and stated that all of the facility's residents, including Resident 13 receiving hospice care, should maintain and/or improve their ROM and prevent further (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	ROM limitations. The DON stated that the facility's RNA program provides ROM exercises to prevent ROM decline. The DON stated that the facility should have implemented the RNA Program for Resident 13 to prevent ROM decline but failed to do so. During a concurrent interview and record review on 8/28/2025 at 2:29 p.m., with the DON, Resident 13's Hospice HA Visit Notes (located in the hospice care binder), dated 5/5/2025, 5/8/2025, 5/12/2025, 5/15/2025, 5/22/2025, 5/26/2025, 7/3/2025, 7/7/2025, 7/10/2025, 7/14/2025, 7/17/2025, 7/21/2025, and 7/24/2025, were reviewed. The DON stated that the Hospice HA Visit Notes did not indicate that Resident 13 received any exercises, including PROM and AROM exercises. The DON further stated Resident 13 was at increased risk for developing ROM limitations and contractures since the facility and the Hospice HA did not provide ROM exercises. During an interview on 8/28/2025 at 2:45 p.m., with the DON, the DON stated the facility staff, including the CNAs, should have reported Resident 13's loss of ROM in the left hand, as the facility provided daily care to Resident 13. During a telephone interview on 8/28/2025 at 3:09 p.m., with Resident 13's primary physician (Hospice MD), the Hospice MD stated the hospice goal included maintaining Resident 13's comfort. The Hospice MD stated that the loss of ROM in Resident 13's left hand could have been slowed down with daily ROM exercises. The Hospice MD stated that hospice staff were unaware the facility had an RNA program that provided ROM exercises at least five times per week. The Hospice MD stated that the facility could have provided ROM exercises to Resident 13, as tolerated, and if the resident was not in any pain. The Hospice MD stated that the hospice team had discussed the closed fist position of Resident 13's left hand during an internal meeting a few weeks or one month prior (from the interview date, unable to recall specific date). The Hospice MD was unaware of Resident 13's JME, dated 6/2/2025, which identified Resident 13's severe ROM loss in the left-hand. Hospice MD stated, I would have appreciated if this was reported to me at least. The Hospice MD further stated that a one-time OT evaluation could have been ordered to provide recommendations such as braces (material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase ROM), towel rolls, or other conservative measures to prevent further ROM decline in Resident 13's left hand and minimize the risk of wound development from the closed fist position. During a review of the facility's P&P titled, ROM and Contracture Prevention, reviewed on 1/2025 and 3/2025, the P&P indicated the facility ensured residents receive services, care, and equipment to assure Every resident maintains, and/or improves their highest level of ROM and mobility, unless a reduction is clinically unavoidable. The P&P also indicated Every resident with limited range of motion and mobility maintains or improves function unless reduced ROM and mobility is unavoidable based on the resident's clinical condition. During a review of the facility's P&P titled, Restorative Program, last revised on 1/2025, the P&P indicated the facility provided a Restorative Program to restore or maintain a resident's mobility skills and ROM to maximum independence and safety. b. During a review of Resident 69's admission Record, the admission Record indicated the facility admitted Resident 69 on 6/26/2025 with diagnoses including Type 2 diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified fall, abnormalities of gait (manner of walking) and mobility, and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side. During a review of Resident 69 Physical Therapy ([PT] profession aimed in restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 6/27/2025, the PT Evaluation indicated Resident 69's range of motion ([ROM] full movement potential of a joint) in both legs were within functional limits ([WFL] sufficient joint movement without significant limitation). The PT Evaluation indicated Resident 69 required substantial/maximal assistance (helper does more than half the effort) for rolling, transferring from lying to sitting on the side of the bed, chair/bed-to-chair transfers, and sit-to-stand transfers. During a review of Resident 69's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 6/30/2025, the MDS indicated Resident 69 had clear speech, had difficulty expressing ideas and wants, understood verbal (continued on next page)		

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F 0688 Level of Harm - Actual harm Residents Affected - Few	content, and had severely impaired cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 69 did not have any functional limitations in ROM (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) on both arms and legs. The MDS also indicated Resident 69 required partial/moderate assistance (helper does less than half the effort) for hygiene and substantial/maximal assistance for transferring from lying to sitting on the bed, chair/bed-to-chair transfers, and sit-to-stand transfers. During a review of Resident 69's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 69 required substantial/maximal assistance for sit-to-stand transfers and chair/bed-to-chair transfers. The PT Discharge Summary indicated recommendations for the RNA program for passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both legs and sit-to-stand mobility using side rails, five times per week as tolerated. During a review of Resident 69's physician's orders, dated 8/22/2025, the physician's orders indicated for the RNA program to provide PROM to both legs and sit-to-stand mobility using side rails, five times per week as tolerated. During an observation on 8/26/2025 at 1:14 p.m. in the bedroom, Resident 69 was fully dressed and sleeping while sitting up in a wheelchair next to the bed. During an observation on 8/27/2025 at 9:11 a.m. in the bedroom, Resident 69 was fully dressed and sleeping while sitting up in a wheelchair next to the bed. Resident 69 was observed wearing socks without any grip on the sole. During an observation on 8/27/2025 at 9:14 a.m. in the bedroom with Restorative Nursing Assistant 1 (RNA 1), Resident 69's RNA program was observed. Resident 69 was sitting up in the wheelchair with Resident 69's body leaning against the wheelchair's right armrest. Resident 69 woke up to RNA 1's voice and agreeable to the leg exercises. RNA 1 sat directly in front of Resident 69's wheelchair and performed ROM exercises to both legs while Resident 69 kept both eyes closed. During an observation on 8/27/2025 at 10:40 a.m. in the bedroom with RNA 1, RNA 1 removed Resident 69's socks and replaced them with non-skid socks. Resident 69's left heel was observed wrapped in dressing. During a concurrent observation and interview on 8/27/2025 at 10:54 a.m., RNA 1 and Restorative Nursing Assistant 2 (RNA 2) wheeled Resident 69 into the hallway and positioned the wheelchair facing the hallway's handrail. RNA 1 stood on Resident 69's right side while RNA 2 stood on the left side. Resident 69 reached both arms forward and held onto the hallway handrail as RNA 1 and RNA 2 physically assisted Resident 69 to stand. Resident 69's hips were approximately six inches above the wheelchair seat and unable to stand fully with RNA 1 and RNA 2's physical assistance. RNA 1 stated Resident 69 had pain while attempting to stand. Licensed Vocational Nurse 7 (LVN 7) observed Resident 69's second attempt to perform sit-to-stand transfers. Resident 69 attempted to stand with RNA 1 and RNA 2's physical assistance, started to moan, and did not place any weight on the left heel. LVN 7 stated RNA 1 and RNA 2 cannot even lift Resident 69 to stand. RNA 1 stated Resident 69 could place weight through the right leg but only put weight on the left toes. RNA 1 stated Resident 69 required the assistance of two-persons for sit-to-stand transfers and could not remember the last time Resident 69 received RNA for sit-to-stand transfers. RNA 1 stated Resident 69 did not receive RNA for sit-to-stand transfers yesterday (8/26/2025) and assisted Certified Nursing Assistant 5 (CNA 5) with transferring Resident 69 from the wheelchair to the bed. During an interview on 8/28/2025 at 11:09 a.m. with RNA 1, RNA 1 stated RNA 1 forgot to provide Resident 69 with the RNA program for sit-to-[TRUNCATED]		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to report a change of condition to the physician and/or the resident representative for three of 28 sampled residents (Resident 10, 63, and 13) by failing to: a. Notify the physician when Resident 10's blood sugar was greater than 200 milligrams per deciliter (mg/dL, a unit of measure for blood sugars, normal reference range 80 - 130 mg/dL) as indicated in the physician's order. This deficient practice placed Resident 10 at risk of becoming hyperglycemic (high blood sugar levels) which could lead to increased thirst, headaches, blurred vision and diabetes-related ketoacidosis (DKA- a lack of insulin and a high amount of ketones causes the blood to become acidic). b. Notify the physician when Resident 63's blood sugars were consistently elevated for a period of approximately seven weeks for one (Resident 63) of 28 sampled residents. c. This had the potential for Resident 63 to suffer from complications related to hyperglycemia. d. Notify Resident 13's primary physician of Resident 13's decline in range of motion ([ROM] full movement potential of a joint) on the left hand, including after a significant loss of motion of the left-hand fingers was identified during the Joint Mobility Evaluation ([JME] brief assessment of a resident's range of motion in each joint of both arms and legs) on 6/2/2025. e. These failures resulted in the development of Resident 13's left-hand contracture (a stiffening/shortening at any joint that reduces the joint's range of motion), placing Resident 13 at risk for the development of skin injuries. f. Cross Reference F688. g. Notify Resident 13's family of Resident 13's cut on the left ring finger on 8/24/2025. h. This failure resulted in Resident 13's family being unaware of Resident 13's cut and treatment on the left-hand ring finger. Findings: a. During a review of Resident 10's admission Record (or Face sheet- front page of the chart that contains a summary of basic information about the resident) the admission Record indicated the facility originally admitted Resident 10 on 11/11/2024 and re-admitted resident on 12/9/2024, with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and retention of urine. During a record review of Resident 10's History and Physical (H & P) dated 11/12/2024, the H&P indicated Resident 10 does not have the capacity to understand and make decisions on her own. During a record review of Resident 10's physician order dated 1/30/2025, the physician order indicated the following orders: -Accuchecks (blood glucose [simple sugar] monitoring tests to measure blood sugar levels) BID (two times a day) for diabetes and to call the medical doctor if less than (<) 60 milligrams per deciliter ([mg]/dL, a metric unit of measure for blood sugars) or greater than (>) 200 mg/dL. - Insulin Glargine Subcutaneous Solution (diabetes medication) 100 u/ml (units/milliliter - units of measurement) Inject 20 unit subcutaneously (injection into the fat tissue) every 12 hours for diabetes mellitus (DM -a disorder characterized by difficulty in blood sugar control and poor wound healing). During a record review of Resident 10's Medication Administration Record (MAR) dated 7/2025, the MAR indicated the following blood sugar results: (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/2/2025 219 mg/dL^ 7/3/2025 226 mg/dL^ 7/4/2025 220 mg/dL^ 7/5/2025 203 mg/dL^ 7/6/2025 281 mg/dL^ 7/11/2025 200 mg/dL^ 7/13/2025 230 mg/dL^ 7/25/2025 229 mg/dL^ 7/27/2025 200 mg/dL^ During a record review of Resident 10's MAR dated 8/2025, the MAR indicated the following blood sugar results: 8/3/2025 216 mg/dL^ 8/07/2025 248 mg/dL^ 8/10/2025 227 mg/dL^ 8/12/2025 208 mg/dL^ 8/15/2025 233 mg/dL^ 8/16/2025 209 mg/dL^ 8/20/2025 268 mg/dL^ 8/21/2025 244 mg/dL^ 8/22/2025 244 mg/dL^ 8/23/2025 235 mg/dL^ During a concurrent interview and record review on 8/27/2025 at 8:34 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 10's physician orders and MAR for 7/2025 and 8/2025 were reviewed. LVN 1 stated the physician order for accuchecks indicated to call the physician if accuchecks are <60 or >200 mg/dL. LVN 1 stated that anytime an accucheck is outside these ordered parameters, the physician should have been notified. LVN 1 stated that when the physician is notified, the nurse who made the notification must document the communication in the nurse's progress notes. LVN 1 stated there were no progress notes that indicated the physician had been notified of the high blood sugar levels for the month of 7/2025 and 8/2025 in Resident 10's medical (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	record. LVN 1 stated that not following the physician order placed Resident 10 at risk for developing side effects associated with hyperglycemia (high blood sugar levels). LVN 1 stated that it was important to notify the physician of elevated blood sugar results so the physician could adjust Resident 10's insulin orders as needed to prevent hyperglycemic episodes and reduce Resident 10's risk of developing DKA. During a concurrent interview and record review on 8/27/2025 at 8:56 a.m. with Registered Nurse (RN) 6, Resident 10's physician orders and MAR for 7/2025 and 8/2025 were reviewed. RN 6 stated it was important to follow the physician's orders to reduce Resident 10's risk of developing elevated blood sugar levels. RN 6 stated that the high blood sugar results 7/2025 and 8/2025 should have been reported to the physician. RN 6 stated that failure to follow a physician's order could have caused Resident 10 to experience an increased thirst, headaches, blurred vision and DKA.^^ During a concurrent interview and record review on 8/27/2025 at 1:47 p.m. with the Director of Nursing (DON), Resident 10's physician orders and MAR for 7/2025 and 8/2025 were reviewed. The DON stated the physician order for accuchecks indicated to call the physician if the blood sugars are <60 or >200 mg/dL. The DON stated that there were no progress notes indicating communication with the physician regarding the high blood sugar levels for the months of 7/2025 and 8/2025. The DON stated that the failure to report the high blood sugar levels to the physician placed Resident 10 at an increased risk for developing health complications due to high blood sugar levels which could have potentially led to kidney failure, vision problems and other sever medical conditions.^^ During a telephone interview on 8/28/2025 at 9:47 a.m., with LVN 5, LVN 5 stated it was important to follow the physician orders to avoid causing potential harm to residents. LVN 5 stated that he checked Resident 10's blood sugar levels at 06:30 a.m., on the following dates with these results: 8/20/2025 268 mg/dL^ 8/21/2025 244 mg/dL^ 8/22/2025 244 mg/dL^ 8/23/2025 235 mg/dL^ LVN 5 stated that he did not notify the physician of the high blood sugar levels because he did not understand the accucheck order and he "thought" the order read to call MD if "twice a day" the accuchecks are <60 or >200 mg/dL. LVN 5 stated that if a physician order is not clear, that order needs to be clarified with the ordering physician and not just ignored. LVN 5 stated that this failure placed Resident 10 at an increased risk of developing side effects related to increasing blood sugar levels in the body. LVN 5 stated that he should have notified the physician of the high blood sugar levels to avoid potential harm to Resident 10.^^ During a review of the facility's policy and procedure (P&P) titled "Nursing Administration- Nursing Care of the Resident with Diabetes Mellitus," dated 1/2025, the P&P indicated "Glucose monitoring; 1. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. 2. The physician will order the frequency of glucose (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitoring. Prevent recurrent hyperglycemia/ hypoglycemia. Notify Physician.&rdquo;^ During a review of the facility&rsquo;s P&P titled &ldquo;Prescriber Medication Orders,&rdquo; dated 1/2025, the P&P indicated &ldquo;The prescriber is contacted to verify or clarify an order.&rdquo;^^ During a review of the facility&rsquo;s policy and procedure (P&P) titled, &ldquo;Change in Condition&rdquo; dated April/2025, the P&P indicated &ldquo;The nurse will perform and document communication with the resident&rsquo;s provider to obtain new orders or interventions.&rdquo;^ b. During a review of Resident 63&rsquo;s admission Record, the admission Record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including diabetes mellitus and stroke (is when part of the brain does not get enough blood, causing weakness, trouble speaking, or other problems). During a review of Resident 63&rsquo;s Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/21/2025, the MDS indicated Resident 63 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 63 was dependent on staff for personal hygiene. During a review of Resident 63&rsquo;s Physician&rsquo;s Orders, the orders indicated the following: &middot; Fasting blood sugar check every Monday, Wednesday, Friday, in the morning for DM, dated 4/24/2025. &middot; Pioglitazone oral tablet (brand name is Actos, a medication to treat hyperglycemia), 15 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth one time a day for DM, dated 5/09/2025. &middot; Semaglutide oral tablet (a medication to treat hyperglycemia),14 mg, give one tablet by mouth one time a day for DM, dated 5/09/2025. During a review of Resident 63&rsquo;s Care Plan for Hypoglycemia (low blood sugar)/Hyperglycemia related to DM, initiated on 4/26/2025, the care plan indicated a goal that Resident 63 will be free from any signs or symptoms of hyperglycemia through the review date. The care plan indicated the following interventions: &middot; DM medication as ordered by doctor. Monitor/document for side effects and effectiveness. &middot; Fasting blood sugar checks every Monday, Wednesday, and Friday. &middot; If infection is present, consult the doctor regarding any changes in diabetic medications. During a review of Resident 63&rsquo;s Facsimile (long version of the word Fax, a document transmitted to another person by telecommunication lines) to Physician, dated 8/07/2025, the fax indicated the following: Januvia tablet (an oral medication to treat hyperglycemia) was discontinued&hellip;Per Resident 63, she is requesting to have this medication reinitiated as her blood sugar levels are still high. Please call and clarify with facility please, authored by LVN 1. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 63's Fax to Physician, dated 8/18/2025, the fax indicated the following: Resident 63 is requesting to get Januvia prescribed once again as her blood sugar levels remain high even though she is already on Semaglutide and Actos, authored by LVN 1. During a review of Resident 63's MAR for the month of 7/2025, covering the dates 7/01/2025 through 7/31/2025, the MAR indicated the following blood sugar values for the 6:30 a.m. fasting blood sugar check: &middledot; 7/02/2025 221 mg/dL &middledot; 7/04/2025 222 mg/dL &middledot; 7/07/2025 206 mg/dL &middledot; 7/09/2025 237 mg/dL &middledot; 7/11/2025 249 mg/dL &middledot; 7/14/2025 196 mg/dL &middledot; 7/16/2025 247 mg/dL &middledot; 7/18/2025 255 mg/dL &middledot; 7/21/2025 290 mg/dL &middledot; 7/23/2025 251 mg/dL &middledot; 7/25/2025 270 mg/dL &middledot; 7/28/2025 242 mg/dL &middledot; 7/30/2025 346 mg/dL During a review of Resident 63's MAR for the month of 8/2025, covering the dates 8/01/2025 through 8/25/2025, the MAR indicated the following blood sugar values for the 6:30 a.m. fasting blood sugar check: &middledot; 8/1/2025 375 mg/dL &middledot; 8/4/2025 346 mg/dL &middledot; 8/6/2025 216 mg/dL &middledot; 8/8/2025 361 mg/dL &middledot; 8/11/2025 350 mg/dL &middledot; 8/13/2025 381 mg/dL (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	&middledot; 8/15/2025 454 mg/dL &middledot; 8/18/2025 459 mg/dL &middledot; 8/20/2025 425 mg/dL &middledot; 8/22/2025 484 mg/dL During a review of Resident 63's Change in Condition Form (COC, a change in a resident's medical condition that requires doctor notification and possible medical intervention), dated 8/22/2025 at 6:43 a.m., the COC indicated the following: Resident 63 noted with elevated blood sugar this morning 484 mg/dL. Physician on call notified, however (Physician on call) stated Resident 63's primary physician, medical doctor (MD 1), will follow up once the office is open. Will endorse to next shift. During a review of Resident 63's Nursing Progress Notes, the notes indicated the following entries: &middledot; Placed a call to MD 1's office today and spoke to receptionist regarding a follow up with MD 1 regarding hyperglycemic episode on 8/22/2025 and for orders. Confirmed with receptionist that facility did notify office on 8/22/2025, however messages were received by MD 1 today (8/25/2025). Requested for a follow-up phone call from MD 1, dated 8/25/2025 at 4:05 p.m., authored by LVN 8. During an observation and interview with Resident 63 in their room on 8/25/2025 at 3:07 p.m., Resident 63 stated their blood sugars were elevated for the month of 8/2025. During a concurrent interview and record review with RN 4 on 8/25/2025 at 3:41 p.m., reviewed Resident 63's 8/2025 MAR and COC and RN 4 stated that Resident 63's blood sugars had been in the 300's and 400's on 8/2025. RN 4 reviewed Resident 63's COC that indicated Resident 63's blood sugar on 8/22/2025 was 484 mg/dL and Resident 63 physician, MD 1 had been contacted. During a concurrent interview and record review with LVN 1 on 8/25/2025 at 3:50 p.m., reviewed faxes sent to the physician related to Resident 63's blood sugars. LVN 1 stated Resident 63 complained her blood sugar was high. LVN 1 stated that she followed up with MD 1 by calling but spoke to a receptionist and left a message. Reviewed Resident 63's Fax to Physician, dated 8/7/2025, that LVN 1 faxed to MD 1 which indicated Resident 63's blood sugars "are still high"; and Resident 63 requested a diabetic medication to be prescribed which she used to take. Reviewed Resident 63's Fax to Physician, dated 8/18/2025, which indicated the same resident request and indicated Resident 63's blood sugars remain high. LVN 1 stated she did not hear back from MD 1 after sending these faxes. During an interview with Registered Nurse 5 (RN 5) on 8/27/2025 at 6:57 a.m., he stated LVN 3 notified him on 8/22/2025 of Resident 63's blood sugar of 484 mg/dL RN 5 stated he called the on-call doctor who did not want to give an order but to wait for the primary physician, MD 1, to respond. RN 5 stated he called MD 1's office after 8 a.m. before leaving his shift. During an interview and concurrent record review with LVN 3 on 8/27/2025 at 7:18 a.m. LVN 3 stated (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Resident 63's 6:30 a.m. blood sugar was 484 mg/dL and could be at risk for DKA. Reviewed Resident 63's 8/2025 MAR and noted that LVN 3 took Resident 63's 6:30 a.m. blood sugars on 8/15/2025 (454 mg/dl) and 8/20/2025 (425 mg/dl). LVN 3 stated he did not notify the RN Supervisor on duty or Resident 63's physician that Resident 63's blood sugars were high but should have done so. LVN 3 did not have a reason why he did not notify the RN Supervisor or Resident 63's physician. During a concurrent interview and record review with LVN 4 on 8/27/2025 at 7:20 a.m., reviewed Resident 63's 8/2025 MAR. LVN 4 confirmed she took Resident 63's blood sugar on 8/11/2025 which was 350 mg/dL, and on 8/13/2025 which was 381 mg/dL and on 8/18/2025 which was 459 mg/dL. LVN 4 stated Resident 63 was upset because her blood sugars were high. LVN 4 stated there were no parameters for Resident 63's blood sugar order in which to notify the physician if the blood sugar was over a certain value. LVN 4 stated she should have notified Resident 63's physician when the blood sugar was over 300 mg/dL. LVN 4 stated she endorsed to the 7 a.m. to 3 p.m. licensed nurses when the blood sugar was elevated but she could not remember to whom she reported to or give a description of the licensed nurse who she reported to. LVN 4 was unable to show documentation of the notification. LVN 4 stated she should have documented she (LVN 4) notified oncoming shift licensed nurses to ensure there is continuity of care for Resident 63. During a concurrent interview and record review with the DON on 8/27/2025 at 4:33 p.m., reviewed Resident 63's 6/2025, 7/2025, and 8/2025 MARS. The DON noted that Resident 63's blood sugars were in the 150's in the month of 6/2025. The DON stated this was Resident 63's normal range. The DON noted that Resident 63's blood sugars from the 7/2025 MAR were in the 200's and 8/2025 the blood sugars were consistently in the 300's and 400's. The DON stated Resident 63's physician should have been notified when Resident 63's blood sugars remained in the 200's in the month of 7/2025 but was not. During a review of the facility's policy and procedure titled, "Diabetic Protocol," last reviewed 1/2025, the policy indicated licensed nurses should notify the physician for two or more blood glucose values above 250 mg/dL and there is a new or markedly different clinical situation that is accompanied by a change in condition or functional status. During a review of the facility's policy and procedure titled, "Change in Condition," last reviewed 4/2025, the policy indicated the following: • If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the licensed nurse or Nurse Supervisor should be made aware: Examples would be the following (but not limited to): Change in medical condition including but not limited to low/high blood sugar, hypoglycemic episodes, or fever of unknown origin. • There will be certain circumstances where immediate attention will be warranted, and nursing will be responsible for notifying the appropriate department for evaluation. The nurse shall use his/her clinical judgment and shall contact the physician based on the urgency of the situation. The Medical Director shall be notified, in the event that the Attending Physician or on-call Physician cannot be reached. c. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 3/11/2025 with diagnoses including atherosclerotic heart disease (fatty deposits [plaque] build up inside the blood vessels that supply the heart making the vessels stiff and narrow), Major Depressive Disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), age-related cognitive (ability to think, understand, learn, and remember) decline, and anxiety disorder (mental health disorder characterized by feelings of worry or fear that (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	are strong enough to interfere with one's daily activities).^^ ^ During a review of Resident 13's Physician's Certification for Hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) Benefit, dated 3/11/2025, the Physician's Certification indicated Resident 13's primary hospice diagnosis was atherosclerotic heart disease.^^ ^ During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had clear speech, had limited ability to express ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 13 had functional limitations in ROM (range of motion- limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in both arms and legs.^ The MDS indicated Resident 13 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists only prior to or following the activity) for eating, partial/moderate assistance (helper does less than half the effort) for rolling to either side in bed, and substantial/maximal assistance (helper does more than half the effort) for toileting, upper and lower body dressing, and toilet transfers.^ The MDS indicated Resident 13 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for transferring from lying to sitting on the side of the bed and chair/bed-to-chair transfers.^^ ^ During a review of Resident 13's care plan titled, "Risk for Alteration in Episodes of Comfort" due to admission under hospice care, dated 3/12/2025, the care plan interventions included to observe and report changes including decreased functional abilities, decreased ROM, and withdrawal or resistance to care.^^ ^ During a review of Resident 13's initial Joint Mobility Evaluation ([JME] brief assessment of a resident's range of motion in each joint of both arms and legs), dated 3/18/2025 and completed by Occupational Therapist 2 ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]), the JME indicated Resident 13 had moderate ROM limitation (50-75 percent [%] range intact) in the right hip and minimum ROM limitation (75-100% range intact) in both shoulders, the right elbow, the left hip, and both knees.^ The JME indicated Resident 13 had no ROM limitations in the left elbow, both wrists, both fingers (hands), and both ankles.^^ ^ During a review of Resident 13's Hospice Updated Assessment, dated 4/3/2025, 4/17/2025, 5/1/2025, 5/15/2025, and 5/29/2025, the Hospice Updated Assessment indicated Resident 13 had ROM loss (unspecified location).^^ (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During a review of Resident 13's quarterly JME, dated 6/2/2025 and completed by Occupational Therapist 1 (OT 1), the JME indicated Resident 13 had severe ROM limitation (0-25% range intact) in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitations in the left shoulder, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitation in the right shoulder, both elbows, both wrists, the right-hand fingers, and both ankles. The JME indicated Resident 13 was "on hospice care." ^ During a review of Resident 13's MDS, dated [DATE], the MDS indicated Resident 13 had clear speech, had limited ability to express ideas and wants, responded adequately to simple and direct communication only, and had severely impaired cognition. The MDS indicated Resident 13 had functional limitations in ROM in one arm and both legs. The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for eating and substantial/maximal assistance for upper body dressing, rolling to either side in bed, and transferring from lying to sitting on the side of the bed. The MDS indicated Resident 13 was dependent for toileting and lower body dressing. ^ During a review of Resident 13's Census List (record of hospitalizations, room changes, and payer source changes), the Census List indicated Resident 13 had a room change on 6/12/2025. ^ During a review of Resident 13's Hospice Updated Assessment, dated 7/10/2025 and 7/24/2025, the Hospice Updated Assessment indicated Resident 13 had ROM loss (unspecified location) and contractures (unspecified location). ^ During a review of Resident 13's physician's orders, dated 8/19/2025, the physician's orders indicated to start the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) program on 8/20/2025 for passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both arms and legs, five times per week as tolerated. ^ During a review of Resident 13's Change in Condition (CIC) Evaluation, dated 8/25/2025, the CIC Evaluation indicated Resident 13 had a small cut with scant (little) bleeding from nails being trimmed on the left ring finger. The CIC Evaluation indicated Resident 13's physician was notified to cleanse the left ring finger with normal saline (sterile solution of salt water), pat dry, apply Betadine external solution (topical chemical substance used to prevent and treat skin infections), and cover with a dry dressing. The CIC Evaluation also indicated Resident 13's Family Member 1 (FM 1) was notified of the small cut on the left ring finger. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	^ During an interview on 8/26/2025 at 9:36 a.m. with the Director of Rehabilitation (DOR), the DOR stated the JME (in general) was completed upon admission and quarterly by the therapy staff to monitor the residents' ROM and mobility. The DOR stated the purpose of the JME was to ensure the residents (in general) maintained their ROM, prevent the development of contractures, and prevent the worsening of contractures. The DOR stated the therapy staff collaborated with nursing to determine the intervention, including requesting physician's orders for a therapy evaluation, if a change was detected on the JME. The DOR stated ROM limitations and contractures could cause skin injuries and could affect the residents' comfort and quality of life. ^ During a concurrent observation and interview on 8/26/2025 at 11:10 a.m. in the resident's room, Resident 13 was lying in bed and had oxygen running through the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 13 was observed using the right hand to hold a towel over Resident 13's nose and mouth. Resident 13 stated the towel was over the nose and mouth to protect Resident 13 from germs. Resident 13's left arm, body, and both legs were covered with a blanket. ^ During a concurrent observation and interview on 8/27/2025 at 11:13 a.m. with Restorative Nursing Aide 2 (RNA 2) in the resident's room, Resident 13's RNA program was observed. Resident 13 spoke clearly but expressed disorganized thoughts while lying in bed. RNA 2 stated Resident 13 had behaviors of not complying with ROM exercises. Resident 13 was observed bending and extending both legs and raising both arms overhead without any assistance. Resident 13's left hand was observed in a closed fist position. Resident 13's left-hand fingernails, including an adhesive bandage on the tip of the left ring finger, slightly touched the palm. Resident 13's left hand did not have any equipment applied to the palm to prevent the fingernails from touching the palm. Resident 13 stated, "We are not doing any exercises today," but agreed to an observation of the skin on the left palm. Resident 13 used the right hand to extend the left-hand fingers but could not completely straighten the fingers, which remained in bent positions at all joints. Resident 13's left-hand palm was observed with intact skin. ^ During a concurrent interview and record review on 8/27/2025 at 12:49 p.m. with OT 1, Resident 13's JME, dated 3/18/2025, 6/2/2025, and 8/21/2025, and physician's orders for RNA, dated 8/19/2025, were reviewed. OT 1 stated Resident 13 was admitted to the facility under hospice care on 3/11/2025 and had never received any therapy services. OT 1 reviewed Resident 13's JME, dated 3/18/2025, and stated the JME indicated Resident 13 had moderate ROM limitation in the right hip and minimum ROM limitation in both shoulders, the right elbow, the left hip, and both knees. OT 1 stated the JME did not indicate any recommendations to address Resident 13's ROM limitations. OT 1 reviewed Resident 13's JME, dated 6/2/2025, and stated the JME indicated Resident 13 had severe ROM limitation in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitation in the left shoulder, the left hip, and both knees. OT 1 stated there were no recommendations to address Resident 13's ROM limitations since Resident 13 was under hospice care. OT 1 stated residents under hospice care, from OT 1's experience, did not receive any the [TRUNCATED]		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a document that summarizes a resident's needs, goals, and care/treatment) for four of 28 sampled residents (Resident 13, 38, 86, and 154) by failing to: 1. Develop interventions for Resident 13 to prevent further range of motion ([ROM] full movement potential of a joint) limitations upon admission on [DATE], develop interventions upon identification of severe ROM limitation (0-25 percent [%] range intact) in the left hand on 6/2/2025, and include the provision of the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) program in Resident 13's care plan. These failures resulted in Resident 13's left-hand contracture (a stiffening/shortening at any joint that reduces the joint's range of motion) in a closed fist position. 2. Develop and implement care plan interventions for Resident 38's Sign-In Sheet for each Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) treatment session. 3. Develop a care plan addressing Resident 86's urinary tract infection (UTI- an infection in any part of the urinary system). 4. Develop a care plan addressing Resident 13's and Resident 154's refusal for vaccinations. These deficient practices had the potential to result in failure to deliver the necessary care and services. Findings: 1. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted Resident 13 on 3/11/2025 with diagnoses including atherosclerotic heart disease (fatty deposits [plaque] build up inside the blood vessels that supply the heart making the vessels stiff and narrow), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), age-related cognitive (ability to think, understand, learn, and remember) decline, and anxiety disorder (mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities). During a review of Resident 13's Physician's Certification for Hospice (compassionate care for people who are near the end of life provided at the person's home or within a health care facility) Benefit, dated 3/11/2025, the Physician's Certification indicated Resident 13's primary hospice diagnosis was atherosclerotic heart disease. During a review of Resident 13's care plan titled, "ADL (Activities of Daily Living, routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) Self Care Performance Deficit," initiated 3/12/2025 and updated 8/21/2025, the care plan included interventions to converse with the resident while providing care, promote dignity by ensuring privacy, and monitor/document/report to the physician as needed for any changes. During a review of Resident 13's Minimum Data Set (MDS- a resident assessment tool) dated 3/13/2025, the MDS indicated Resident 13 had clear speech and had severely impaired cognition (ability to think, understand, learn, and remember). The MDS indicated Resident 13 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) in both arms and legs. The MDS indicated Resident 13 required setup or clean-up assistance (helper sets up or cleans up while resident completes the activity, helper assists (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	only prior to or following the activity) for eating, partial/moderate assistance (helper does less than half the effort) for rolling to either side in bed, and substantial/maximal assistance (helper does more than half the effort) for toileting, upper and lower body dressing, and toilet transfers. The MDS indicated Resident 13 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for transferring from lying to sitting on the side of the bed and chair/bed-to-chair transfers. During a review of Resident 13's initial Joint Mobility Evaluation ([JME] brief assessment of a resident's range of motion in each joint of both arms and legs), dated 3/18/2025 and completed by Occupational Therapist 2 ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]), the JME indicated Resident 13 had moderate ROM limitation (50-75% range intact) in the right hip and minimum ROM limitation (75-100% range intact) in both shoulders, the right elbow, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitations in the left elbow, both wrists, both fingers (hands), and both ankles. During a review of the initial Interdisciplinary Team ([IDT] group of professionals from different disciplines who collaborate to provide comprehensive and coordinated care to residents) Care Plan Review, dated 3/14/2025, the IDT Care Plan Review indicated Resident 13's Family Member (FM 1) was notified of the medications, diet, activities, social services, and the monitoring of Resident 13's skin changes in both breasts and both legs. The IDT Care Plan Review did not indicate FM 1 was notified regarding Resident 13's ROM limitations in both arms and legs. During a review of Resident 13's Hospice Updated Assessment, dated 4/3/2025, 4/17/2025, 5/1/2025, 5/15/2025, and 5/29/2025, the Hospice Updated Assessment indicated Resident 13 had ROM loss (unspecified location). During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had clear speech and had severely impaired cognition. The MDS indicated Resident 13 had functional limitations in ROM in one arm and both legs. The MDS indicated Resident 13 required supervision or touching assistance (helper provides verbal cues and/or touching and/or steadying assistance as resident completes the activity) for eating and substantial/maximal assistance for upper body dressing, rolling to either side in bed, and transferring from lying to sitting on the side of the bed. The MDS indicated Resident 13 was dependent for toileting and lower body dressing. During a review of Resident 13's quarterly JME, dated 6/2/2025 and completed by Occupational Therapist 1 (OT 1), the JME indicated Resident 13 had severe ROM limitation (0-25% range intact) in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitations in the left shoulder, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitation in the right shoulder, both elbows, both wrists, the right-hand fingers, and both ankles. The JME indicated Resident 13 was "on hospice care." During a review of the quarterly IDT Care Plan Review, dated 6/8/2025, the IDT Care Plan Review indicated FM 1 was notified of Resident 13's medications, refusal of vaccines, diet with weight loss, activities, and social services. The IDT Care Plan Review did not indicate FM 1 was notified regarding Resident 13's ROM limitations in both arms and leg, including the severe ROM limitation on the left hand. During a review of Resident 13's Census List (record of hospitalizations, room changes, and payer source changes), the Census List indicated Resident 13 moved rooms on 6/12/2025. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 13's Hospice Updated Assessment, dated 7/10/2025 and 7/24/2025, the Hospice Updated Assessment indicated Resident 13 had ROM loss (unspecified location) and contractures (unspecified location). During a review of Resident 13's physician's orders, dated 8/19/2025, the physician's orders indicated to start the Restorative Nursing Aide ([RNA] nursing aide program that helps residents to maintain their function and joint mobility) program on 8/20/2025 for passive range of motion ([PROM] movement of a joint through the range of motion with no effort from person) to both arms and legs, five times per week as tolerated. During a review of Resident 13's quarterly JME, dated 8/21/2025, the JME indicated Resident 13 had severe ROM limitation in the left-hand fingers, moderate ROM limitation in the right hip, and minimum ROM limitation in the left shoulder, the left hip, and both knees. The JME indicated Resident 13 had no ROM limitations in the right shoulder, both elbows, both wrists, the right-hand fingers, and both ankles. During a concurrent observation and interview on 8/26/2025 at 11:10 a.m., in the resident's room, Resident 13 was lying in bed and had oxygen running through the nasal cannula (a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). Resident 13 was observed using the right hand to hold a towel over Resident 13's nose and mouth. Resident 13 stated the towel was over the nose and mouth to protect Resident 13 from germs. Resident 13's left arm, body, and both legs were covered with a blanket. During a concurrent observation and interview on 8/27/2025 at 11:13 a.m., with Restorative Nursing Assistant 2 (RNA 2) in the resident's room, Resident 13's RNA program was observed. Resident 13 spoke clearly but expressed disorganized thoughts while lying in bed. RNA 2 stated Resident 13 had behaviors of not complying with ROM exercises. Resident 13 was observed bending and extending both legs and raising both arms overhead without any assistance. Resident 13's left hand was observed in a closed fist position. Resident 13 used the right hand to extend the left-hand fingers but could not completely straighten the fingers, which remained in bent positions at all joints. During a concurrent observation and interview on 8/27/2025 at 2:31 p.m., with Certified Nursing Assistant 1 (CNA 1) in the resident's room, Resident 13's left hand was observed. Resident 13's left-hand fingers were observed in a closed fist position. During a follow-up interview on 8/27/2025 at 2:39 p.m. with CNA 1, CNA 1 stated Resident 13 had been assigned to CNA 1 for the past three months after Resident 13 moved from another bedroom to Resident 13's current room. CNA 1 stated Resident 13's left hand did not have a closed fist when Resident 13 moved to the current room. CNA 1 stated Resident 13 started developing a closed fist to the left hand approximately one month ago (unknown date) and reported it to the charge nurse (unknown). During a telephone interview on 8/27/2025 at 3:42 p.m. with FM 1 and Family Member 2 (FM 2), FM 1 stated Resident 13 hid the left hand during family visits. FM 1 described Resident 13's left hand as curled up, stiff, and unable to open. FM 1 stated Resident 13's left hand did not have a closed fist position upon admission to the facility and developed it shortly after (unknown date) Resident 13's admission. FM 1 stated FM 1 contacted Resident 13's Hospice Registered Nurse (Hospice RN) and the facility's nurse (unknown) about Resident 13's left hand. FM (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1 stated the Hospice RN looked at Resident 13's left hand, informed FM 1 that the left hand was contracted, and stated to FM 1 that nothing could be done. During a telephone interview on 8/28/2025 at 10:24 a.m. with Resident 13's Hospice RN, the Hospice RN stated Resident 13 had a left-hand contracture. The Hospice RN stated Resident 13's left-hand contracture had developed "a few weeks if not a few months" ago (from the date of the interview). During an interview on 8/28/2025 at 12:35 p.m. with OT 1 and the Director of Nursing (DON), Resident 13's JME dated 3/18/2025, 6/2/2025, and 8/21/2025, IDT Care Plan Review dated 3/14/2025 and 6/8/2025, and care plans were reviewed. The DON and OT 1 reviewed Resident 13's JME, dated 3/18/2025, and stated Resident 13 had ROM limitations on multiple joints of both arms and legs. OT 1 stated interventions were not provided to Resident 13 since it was OT 1's experience and misunderstanding that residents under hospice care did not receive any interventions, including RNA services. The DON and OT 1 reviewed Resident 13's JME, dated 6/2/2025, and stated Resident 13 had severe ROM limitations in the left-hand fingers. OT 1 stated nursing was not notified regarding Resident 13's "substantial decline" of ROM in the left hand. OT 1 stated the facility did not provide any intervention after the JME, dated 6/2/2025, because of OT 1's misinformation that RNA services were not supposed to be offered to residents under hospice care. The DON and OT 1 reviewed the JME, dated 8/21/2025, and stated RNA services were started on 8/20/2025. The DON reviewed the IDT Care Plan Review, dated 3/14/2025 and 6/9/2025, and stated Resident 13's ROM limitations were not discussed with FM 1. The DON stated the care plans (in general) indicated the facility's plan for the provision of care to the residents. The DON reviewed Resident 13's care plans and stated Resident 13 did not have any care plans to address Resident 13's significant ROM decline in the left hand on 6/2/2025. During a concurrent interview and review on 8/28/2025 at 4:21 p.m., with MDS Coordinator 1 (MDSN 1), Resident 13's MDS dated [DATE] and 6/2/2025, and care plans were reviewed. MDSN 1 stated Resident 13's ROM limitations from the MDS assessments were addressed in the care plan titled, "ADL Self Care Performance." The MDSN 1 stated Resident 13's care plan did not include specific interventions to address ROM limitation. The MDSN stated the care plan for refusal with RNA was added on 8/27/2025 but stated Resident 13 did not have any other RNA care plans. During a review of the facility's policy and procedure (P&P) titled, "Comprehensive Person-Centered Care Planning," dated 11/2016 and reviewed 4/2025, the P&P indicated the IDT "shall develop a comprehensive person-centered care plan for each resident that includes objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment." Cross reference F688. 2. During a review of Resident 38's admission Record, the admission Record indicated the facility admitted Resident 38 on 7/24/2025 with diagnoses including cervical spinal stenosis (condition where the spinal canal in the neck because narrowed, putting pressure on the spinal cord and nerves), type two (2) diabetes mellitus ([DM] disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, monoplegia (paralysis restrict to one limb or region of the body) affecting the right dominant side, and difficulty walking. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 38's OT Evaluation and Plan of Care, dated 7/25/2025, the OT Evaluation indicated Resident 38's prior level of function (ability prior to admission) was independent with activities of daily living ([ADLs] routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), including eating, hygiene, toileting, bathing, and upper and lower body dressing. The OT Evaluation indicated Resident 38 required substantial/maximal assistance for eating, personal hygiene, and upper body dressing. The OT Evaluation indicated Resident 38 was dependent for toileting, showering, and lower body dressing. The OT Plan of Care included providing Resident 38 with therapeutic exercises (movement prescribed to correct impairments and restore muscle function), manual therapy (hands-on treatment involving techniques to treat muscles and joints), therapeutic activity (tasks that improve the ability to perform ADLs), self-care management, and neuromuscular reeducation (technique used to restore movement patterns through repetitive motion to retrain the brain), three times per week for four weeks. During a review of Resident 38's PT Evaluation and Plan of Care, dated 7/25/2025, the PT Evaluation indicated Resident 38's prior level of function was independent with ambulation (the act of walking) and transfers. The PT Evaluation indicated Resident 38 required substantial/maximal assistance for rolling to either side in bed, transferring from lying to sitting on the side of the bed, sit-to-stand transfers, and chair/bed-to-chair transfers. The PT Evaluation indicated ambulation (the act of walking) was not attempted due to medical conditions (unspecified) or safety concerns (unspecified). The PT Plan of Care included therapeutic exercises, neuromuscular reeducation, manual therapy, therapeutic activities, gait (manner of walking) training. During a review of Resident 38's Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 7/26/2025, the MDS indicated Resident 38 had clear speech, had difficulty expressing ideas and wants, usually understood verbal content, and had severely impaired cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 38 required substantial/maximal assistance (helper does more than half the effort) for eating, personal hygiene, upper body dressing, rolling to either side in bed, transferring from lying to sitting on the side of the bed, sit-to-stand transfers, and chair/bed-to-char transfers. The MDS also indicated Resident 38 was dependent (helper does all the effort, resident does none of the effort to complete the activity, or the assistance of two or more helpers is required to complete the activity) for lower body dressing, toileting, and bathing. During a review of Resident 38's care plan, titled "Limited Physical Mobility," initiated 7/25/2025, the care plan interventions included PT services, five times per week for four weeks, for therapeutic exercises, therapeutic activities, neuromuscular reeducation, manual therapy, and gait training. During a review of Resident 38's care plan, titled "ADL Self Care Performance Deficit," initiated 7/26/2025, the care plan interventions included OT services, three times per week for four weeks, for therapeutic exercises, manual therapy, self-care management, therapeutic activity, and neuromuscular reeducation to improve toilet commode transfers and lower body dressing to minimum assistance (requires less than 25 percent [%] physical assistance to perform task). During a review of Resident 38's Interdisciplinary Team ([IDT] group of professionals from different disciplines who collaborate to provide comprehensive and coordinated care to residents) Care Plan Review, dated 7/28/2025, the IDT Care Plan Review indicated Resident 38 stated the therapists provided treatment only twice during the week (of the IDT). The IDT Care Plan Review indicated that the therapists were presented to Resident 38, who recognized the therapists. The IDT (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care Plan Review indicated the therapists would implement a Sign-in Sheet during therapy sessions. During a review of Resident 38's OT Sign-In Sheet, the OT Sign-In Sheet included Resident 38's signature on 7/28/2025, 7/31/2025, and 8/1/2025. During a review of Resident 38's OT Treatment Encounter Notes, the OT Treatment Encounter Notes indicated Resident 38 received OT sessions on 7/28/2025, 7/31/2025, 8/1/2025, 8/2/2025, 8/6/2025, 8/12/2025, 8/13/2025, 8/14/2025, 8/16/2025, 8/19/2025, 8/20/2025, 8/22/2025, and 8/23/2025. During a review of Resident 38's PT Sign-In Sheet, the PT Sign-In Sheet included Resident 38's signature on 7/31/2025, 8/1/2025, 8/4/2025, 8/5/2025, 8/6/2025, 8/7/2025, 8/8/2025, 8/18/2025, and 8/20/2025. During a review of Resident 38's PT Treatment Encounter Notes, the PT Treatment Encounter Notes indicated Resident 38 received PT session on 7/29/2025, 7/30/2025, 7/31/2025, 8/1/2025, 8/3/2025, 8/5/2025, 8/6/2025, 8/7/2025, 8/8/2025, 8/10/2025, 8/11/2025, 8/12/2025, 8/15/2025, 8/16/2025, 8/18/2025, 8/19/2025, 8/20/2025, and 8/22/2025. During an interview on 8/25/2025 at 10:40 a.m. in the resident's room, Resident 38 stated the PT treatments were not provided five times a week. During a concurrent observation and interview on 8/26/2025 at 2:13 p.m. in the resident's room, Resident 38 was sitting up in wheelchair and stated today (8/26/2026) was the first time since last week that the therapists provided treatment to Resident 38. Resident 38 stated the therapists were supposed to provide therapy every weekday. Resident 38 stated the facility was informed during Resident 38's conference (IDT Care Plan Review) that the therapists were not providing any treatment but the facility stated the therapists did provide the treatment. Resident 38 stated the therapists were supposed to provide Resident 38 with a Sign-in Sheet during therapy to keep track of the treatment sessions and stated the therapists stopped offering the Sign-in Sheet last week. Resident 38 stated therapy was necessary to improve the strength in both hands to maneuver the wheelchair and to grab onto a walker (an assistive device used for stability when walking) to start walking again. During a concurrent interview and record review on 8/26/2025 at 8/26/2025 with the Director of Rehabilitation (DOR), Resident 38's PT and OT Evaluations, dated 7/25/2025, IDT Care Plan Review, dated 7/28/2025, and Sign-in Sheets for PT and OT were reviewed. The DOR stated Resident 38 was admitted to the facility on [DATE] and received PT and OT Evaluations on 7/25/2025. The DOR stated the PT Plan of Care included providing Resident 38 with treatment five times per week for four weeks and the OT Plan of Care included treatment three times per week for four weeks. The DOR stated the therapists started providing Resident 38 with a Sign-in Sheet for PT and OT sessions in response to Resident 38's claims during the IDT Care Plan Review that the therapists were not providing treatment. The DOR provided Resident 38's Sign-in Sheet for PT and OT. The DOR stated Resident 38 signed the PT Sign-in Sheet on 7/31/2025, 8/1/2025, 8/4/2025, 8/5/2025, 8/6/2025, 8/7/2025, 8/8/2025, 8/18/2025, and 8/20/2025 and the OT Sign-in Sheet on 7/28/2025, 7/31/2025, and 8/1/2025. During an interview on 8/27/2025 at 4:47 p.m. with Occupational Therapist 1 (OT 1), OT 1 stated the Sign-in Sheet was provided to a resident (in general) in the event the resident forgets or if the family (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	claims the therapists did not provide treatments. OT 1 stated the full-time therapists verbally communicated with the part-time therapists and the therapy assistants if a resident had a Sign-in Sheet. During an interview on 8/27/2025 at 4:56 p.m. with Occupational Therapist 2 (OT 2), OT 2 stated the PT and OT were informed of Resident 38's Sign-in Sheet during the therapy meeting (unknown date) which occurs on Wednesdays. OT 2 did not know how Resident 38's Sign-in Sheet was communicated to the per diem therapists (therapists who work on an as-needed basis). OT 2 stated the DOR may have informed the per diem therapists. During an interview on 8/27/2025 at 5:14 p.m. with per diem Physical Therapist Assistant 1 (PTA 1), PTA 1 stated the DOR would either inform PTA 1 via text or in-person if a resident had a Sign-in Sheet for therapy. PTA 1 stated Resident 13 did have a Sign-in Sheet and forgot to provide Resident 13 with the Sign-in Sheet during PT treatment (unspecified dates). PTA 1 stated the Sign-in Sheet was supposed to record the therapy treatment provided to Resident 13. During a concurrent interview and record review on 8/28/2025 at 11:48 a.m., with OT 2 and the Director of Nursing (DON), reviewed Resident 38's IDT Care Plan Review dated 7/28/2025, PT Treatment Encounter Notes from 7/28/2025 to 8/25/2025, OT Treatment Encounter Notes from 7/28/2025 to 8/25/2025, PT Sign-in Sheet, OT Sign-in Sheet, and care plans. OT 2 reviewed Resident 38's IDT Care Plan Review and stated Resident 38's Sign-in Sheets were implemented due to Resident 38's concerns of not receiving therapy. OT 2 compared the PT Sign-in Sheet with the PT Treatment Encounter Notes and stated Resident 38 did not sign for PT treatment on 8/10/2025, 8/11/2025, 8/12/2025, 8/15/2025, 8/16/2025, 8/19/2025, 8/22/2025, and 8/25/2025. OT 2 compared the OT Sign-in Sheet with the OT Treatment Encounter Notes and stated Resident 38 did not sign for OT treatment on 8/2/2025, 8/6/2025, 8/12/2025, 8/13/2025, 8/14/2025, 8/16/2025, 8/19/2025, 8/20/2025, 8/22/2025, and 8/23/2025. OT 2 did not know the reason Resident 38's Sign-in Sheets were not implemented during each PT and OT treatment. OT 2 stated the therapists may have stopped keeping track of the treatment sessions due to Resident 38's improved cognition. OT 2 stated the therapists could have also documented treatment sessions without the provision of services to Resident 38. The DON stated the implementation of Resident 38's Sign-in Sheet was an intervention that should have been included in the comprehensive care plan. The DON reviewed Resident 38's care plans and stated the Sign-in Sheets were not but should have been included in Resident 38's care for PT care plan titled, "Limited Physical Mobility," and OT care plan titled, "ADL Self Care Performance Deficit." During a review of the facility's policy and procedure (P&P) titled, "Comprehensive Person-Centered Care Planning," dated 11/2016 and reviewed 4/2025, the P&P indicated the IDT "shall develop a comprehensive person-centered care plan for each resident that includes objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment." 3. During a review of Resident 86's admission Record, the admission Record indicated the facility admitted the resident on 6/26/2025 with diagnoses including muscle weakness and end stage renal disease (a condition where the kidneys have permanently lost most of their function and can no longer adequately filter waste products and excess fluid from the blood).^ During a review of Resident 86's Minimum Data Set (MDS - a resident assessment tool) dated 6/30/2025, the MDS indicated the resident's cognitive (the mental action or process of acquiring (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	knowledge and understanding through thought, experience, and the senses) skills for daily decision making was intact and the resident required staff assistance for toileting hygiene, lower body dressing, putting on and taking off footwear and supervision or touching assistance with eating, oral hygiene, shower, and upper body dressing. ^ During a concurrent interview and record review on 8/26/2025 at 2:19 p.m., with the Director of Nursing (DON), reviewed Resident 86's Change of Condition (COC- a sudden clinically important deviation from a resident's baseline in physical, cognitive, behavioral, or functional domains) dated 7/10/2025 and Resident 86's physician orders. The COC indicated that Resident 86 had blood in his urine and Resident 86's physician order dated 7/11/2025 indicated for an order to administer Levaquin oral tablet 250 milligram (mg- unit of measurement) two tablet by mouth one time a day for UTI for four (4) days until finished. The DON stated that for any change of condition, including a new diagnosis of UTI, a care plan should have been developed for Resident 86 to ensure the goals of treatment are established and care plan interventions are identified. The DON stated that without a care plan, Resident 86 may not be provided with the necessary care and services in resolving his UTI diagnosis. ^ During a review of the facility's policy and procedure titled, "Comprehensive Person-Centered Care Planning," last reviewed on 3/10/2025, the policy indicated, "It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive-person centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment." ^ During a review of the facility's policy and procedures titled, "Change in Condition," last reviewed on 3/10/2025, the policy indicated, "It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical, mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care." ^ 4. During a review of Resident 13's admission Record, the admission Record indicated the facility admitted the resident on 3/11/2025 with diagnoses including, but not limited to, atherosclerotic heart disease (plaque buildup in the heart's major blood vessels) and age-related cognitive (relating to or involving the processes of thinking and reasoning) decline. ^ ^ During a review of Resident 13's MDS dated [DATE], the MDS indicated Resident 13 had severe cognitive impairment and was completely dependent on staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). ^ During a review of Resident 154's admission Record, the admission Record indicated the facility admitted the resident on 8/18/2025 with diagnoses including, but not limited to, end stage renal disease (ESRD- irreversible kidney failure) and dependence on renal dialysis (a medical procedure to remove waste from the body when the kidneys are unable to). ^ During a review of Resident 154's MDS dated [DATE], the MDS indicated Resident 154 was cognitively intact. ^ ^ (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/28/2025 on 11:08 a.m., with the Infection Preventionist (IP), reviewed Resident 13's and Resident 15's Immunization Report. Resident 13's Immunization Report indicated the resident refused the influenza, pneumococcal, and COVID vaccines on 3/20/2025. Resident 15's Immunization Report indicated the resident refused the influenza and pneumococcal vaccines on 12/18/2024 and refused again on 3/20/2025. The IP stated there were no care plans developed regarding Resident 13's and Resident 15's refusal of these vaccines. The IP stated Resident 13 is an older adult and Resident 15 is on dialysis which		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to update a resident's care plan to include pain interventions for one of two sampled residents (Resident 69) reviewed under the pressure ulcer care area after Resident 69 developed Stage Two (2) (an open, shallow wound that has damaged the epidermis [top layer of the skin] and the dermis [middle layer of the skin], with the fluid-filled blister appearing as a ruptured or intact blister containing fluid) fluid-filled blister (a painful skin condition where fluid fills a space between layers of skin) on the left heel. This deficient practice had the potential to result in inadequate management of Resident 69's pain resulting in decreased quality of life. Findings: During a review of Resident 69's admission Record, the admission Record indicated the facility initially admitted Resident 69 on 1/15/2025 and re-admitted Resident 69 on 6/26/2025 with diagnoses including type two (2) diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), hemiplegia (paralysis [inability to move] on one side of the body, and hemiparesis (a condition where there is weakness on one side of the body) following cerebral infarction (commonly known a stroke, caused by a blockage in a blood vessel in the brain, leading to brain tissue damage) affecting the right side and dysphagia (difficulty swallowing). During a review of Resident 69's History and Physical (H&P- a comprehensive assessment of a resident's medical condition), dated 6/27/2025, the H&P indicated Resident 69 had the capacity to understand and make decisions. During a review of Resident 69's Minimum Data Set (MDS - a resident assessment tool) dated 6/30/2025, the MDS indicated that Resident 69 was usually understood by others and was also able to usually understand others. The MDS indicated Resident 69 was dependent on facility staff for Activities of Daily Living (ADLs- essential, basic self-care tasks required to live independently) including toileting, bathing, and lower body dressing and required maximal assistance from staff with mobility (movement) such as rolling from side to side, transitioning from lying to sitting on the side of the bed, sit-to-stand transfers, and toilet transfers. The MDS indicated Resident 69 did not have any PU at the time of assessment but was identified as being at risk for developing PU. The MDS further indicated Resident 69 did not have pain in the last five days prior to the assessment date. During a review of Resident 69's Change of Condition (COC- when there is a sudden change in a resident's condition) Evaluation form completed by Treatment Nurse 1 (TN 1), dated 8/22/2025, timed at 2:54 p.m., the COC form indicated that Resident 69 had a fluid filled blister on the left heel measuring 3.2 centimeters (cm - unit of measure) in length x (by) 3.4 cm in width x unable to determine (UTD) depth. The COC further indicated a pain assessment was not clinically applicable to the change of condition being reported. During a review of Resident 69's Physician Order, dated 8/22/2025, the Physician Order indicated treatment for Resident 69's fluid filled blister to the left heel. The physician's order did not include an order to address possible pain from the fluid filled blister on Resident 69's left heel. During a review of Resident 69's Has Actual Impairment to Skin Integrity, CP initiated on 8/22/2025, the CP did not include any interventions to address pain. During a concurrent observation and interview on 8/28/2025 at 1:37 p.m., with Treatment Nurse 1 (TN 1) and Treatment Nurse 2 (TN 2), in Resident 69's room, observed TN 1 and TN 2 providing wound care to Resident 69's left heel. TN 1 removed the dressing on Resident 69's heel and stated that there was a light-yellow tinge on the dressing. TN 1 stated that the light-yellow tinge may have been caused by the betadine solution. While TN 1 repositioned Resident 69 to assess the left heel, a tear was observed rolling down Resident 69's right cheek. TN 2 asked Resident 69 if she (Resident 69) was experiencing pain in her (Resident 69) left heel, to which Resident 69 responded Yes, it hurts a lot. During a concurrent interview and record review on 8/28/2025 at 2:33 pm with TN 1, reviewed Resident 69's Has Actual Impairment to Skin Integrity CP. TN 1 stated the CP did not have interventions to address pain. TN 1 stated he or another licensed nurse should have updated the CP to include a pain intervention when the fluid filled blister was identified on 8/22/2025 (continued on next page)		

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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: 056337	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2025
NAME OF PROVIDER OR SUPPLIER Panorama Gardens Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9541 Van Nuys Blvd. Panorama City, CA 91402	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to anticipate and prevent Resident 69's pain.^ ^During an interview on 8/28/2025 at 4:37 p.m., with the Director of Nursing (DON), the DON stated that the licensed nurses should have obtained a physician's order for pain medication and update the care plan especially given that Resident 69 had a history of a pressure ulcer, mobility limitations and pain related to osteoarthritis. During a review of the facility's P&P titled Comprehensive Person-Centered Care Planning last reviewed 4/2025, the P&P indicated the facility must develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.^ ^ During a review of the facility's P&P titled Pain Recognition and Management last reviewed 4/2025, the P&P indicated the facility ensure that pain management is provided to residents who require such services consistent with professional standards of practice.^		

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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 observation, interview and record review, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice by failing to: a. Implement the listed care plan intervention to raise the head of one of the sampled resident's (Resident 5) bed, while in bed, during 2 random observations. This deficient practice had the potential to result in Resident 5 having shortness of breath (difficulty breathing) and complications of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently sometimes resulting in leg swelling).b. Follow the physician's order to notify the physician when the accucheck (blood sugar result) result was greater than (>) 200 milligrams per deciliter (mg/dL, a unit of measure for blood sugars) for one of three residents reviewed under the care area of insulin.This deficient practice had the potential to result in Resident 10 being at risk of suffering from hyperglycemia (high blood sugar levels) including increased thirst, headaches, blurred vision and diabetes-related ketoacidosis (DKA- a lack of insulin and a high amount of ketones causes the blood to become acidic). c. Provide treatment to control the blood sugar of one of 28 sampled (Resident 63), which was consistently elevated for approximately seven weeks. This had the potential to result in Resident 63 suffering from complications related to hyperglycemia.Findings: a. During a review of Resident 5's admission Record, the admission Record indicated the facility initially admitted Resident 5 on 8/5/2017 and re-admitted Resident 5 on 7/4/2025 with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), CHF, and acute pyelonephritis (an infection of the kidneys, [organ that filter waste from the blood]). During a review of Resident 5's History and Physical (H&P) dated 7/5/2025, the H&P indicates Resident 5 had the capacity to understand and make decisions. During a review of Resident 5's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/7/2025, the MDS indicated Resident 5 could understand others and make herself understood and was dependent on facility staff for activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) such as toileting, bathing, lower body dressing and putting on and removing shoes. During a review of Resident 5's Care Plan (CP) dated 7/6/2025 with a focus of being at risk for episodes of cardiac (heart) decompensation (decline in function), the CP included an intervention for the "head of bed to be elevated." During an observation on 8/27/2025 at 8:17 am while in Resident 5's room, Resident 5 was sleeping in her bed on her left side with the head of the bed flat. During a concurrent observation and interview on 8/27/2025 at 8:22 am while in resident 5's room with Certified Nursing Assistant (CNA 5), CNA 5 stated the resident usually always sleeps in this position. CNA 5 stated she was unaware if Resident 5 had issues with her heart but stated it could possibly be harder for the resident to breathe when the bed is completely flat. During a concurrent observation and interview on 8/28/2025 at 8:17 am while in Resident 5's room with Licensed Vocational Nurse (LVN 6), LVN 6 stated Resident 5 was sleeping flat on her back. (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 of Resident 5's CHF CP with LVN 6, LVN 6 reviewed the CHF CP. LVN 6 stated there is a listed intervention to raise the head of Resident 5's bed. LVN 5 stated Resident 5's head of the bed must be elevated, or she might have trouble breathing but that sometimes Resident 5 refuses or lowers the bed herself. During an interview 8/28/2025 at 4:14 pm with the Director of Nursing (DON), the DON stated her staff must follow care plan interventions to provide the necessary and consistent care. The DON stated Resident 5 has a history of CHF and must have the head of her bed elevated to make it easier for her to breathe. The DON stated if Resident 5 is refusing to have the head of her bed elevated, the licensed nurses must notify the doctor to update the CP to reflect her refusals. During a review of the facility's Policy and Procedure (P&P) titled "Quality of Care"; last reviewed 4/2025, the P&P indicated the facility must give residents appropriate treatment and services to maintain or improve his or her abilities. During a review of the facility's P&P titled "Comprehensive Person-Centered Care Planning"; last reviewed 4/2025, the P&P indicated the facility must develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet each resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. b. During a record review of Resident 10's admission Record (front page of the chart that contains a summary of basic information about the resident) the admission Record indicated the facility originally admitted Resident 10 on 11/11/2024 and re-admitted Resident 10 on 12/9/2024, with diagnoses including type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (high blood pressure), and retention of urine. During a record review on 8/26/2025 at 9:05 a.m. of Resident 10's History and Physical (H & P) dated 11/12/2024, the H&P indicated Resident 10 does not have the capacity to understand and make decisions on her own. During a record review Resident 10's care plan, titled, Resident has risk for alteration in episode of hyperglycemia/hypoglycemia (low blood sugar level) related to diabetes mellitus, created on 11/12/2024, the care plan indicated an intervention to monitor/document/report to physician as needed the signs/symptoms of hyperglycemia/hypoglycemia. During an interview and record review on 8/27/2025 at 8:34 a.m. with Licensed Vocational Nurse (LVN) 1 of Resident 10's physician order dated 1/30/2025, the physician order indicated an order for accuchecks (blood sugar checks) BID (two times a day) for diabetes, call MD (Medical Doctor) if less than (&lt;) 60 milligrams per deciliter (mg/dL, a unit of measure for blood sugars) or greater than (&gt;) 200 mg/dL. During an interview and record review on 8/27/2025 at 8:34 a.m. with LVN 1 of Resident 10's medication administration record (MAR) dated July 2025 and August 2025, the MAR indicated the following blood sugar results: &middot; 7/02/2025 219 mg/dL &middot; 7/03/2025 226 mg/dL (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	&middledot; 7/04/2025 220 mg/dL &middledot; 7/05/2025 203 mg/dL &middledot; 7/06/2025 281 mg/dL &middledot; 7/11/2025 200 mg/dL &middledot; 7/13/2025 230 mg/dL &middledot; 7/25/2025 229 mg/dL &middledot; 7/27/2025 200 mg/dL August 2025: &middledot; 8/03/2025 216 mg/dL &middledot; 8/07/2025 248 mg/dL &middledot; 8/10/2025 227 mg/dL &middledot; 8/12/2025 208 mg/dL &middledot; 8/15/2025 233 mg/dL &middledot; 8/16/2025 209 mg/dL &middledot; 8/20/2025 268 mg/dL &middledot; 8/21/2025 244 mg/dL &middledot; 8/22/2025 244 mg/dL &middledot; 8/23/2025 235 mg/dL LVN 1 stated that the accuchecks that were >200 mg/dL blood sugars should have been reported to the physician, per the physician order. LVN 1 stated the reporting nurse should have documented the physician communication in the nursing progress notes. During an interview and record review on 8/27/2025 at 8:34 a.m. with LVN 1, the nursing progress notes date July and August 2025 were reviewed. LVN 1 indicated there was no documentation in the nursing progress notes that the high accuchecks, for July and August had been reported to the physician, as indicated in the physician order. LVN 1 stated that this failure placed Resident 10 at risk of experiencing hyperglycemic side effects and prevented Resident 10 from potentially receiving appropriate treatment and quality of care. LVN 1 stated that the accuchecks order was not followed by Resident 10's nurses. During a concurrent interview and record review on 8/27/2025 at 1:47 p.m. with the Director of (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nursing (DON) Resident 10's physician orders and MAR for July and August 2025 were reviewed. The DON stated the physician order for accuchecks indicated to call the MD if accuchecks are <60 OR >200. The DON stated there was no documentation in the nursing progress notes that the high sugar levels for July and August had been reported to the physician as the physician order stated. The DON stated that this failure to report the high accuchecks to the doctor placed Resident 10 at an increased risk of developing diabetes complications due to high sugar levels in the blood which can potentially lead to kidney failure, vision problems and other severe medication conditions. The DON stated not following physician orders potentially prevented Resident 10's physician from adjusting Resident 10's diabetes medication. The DON stated this failure prevented Resident 10 from receiving quality care in the facility due to the accuchecks order not being followed by the nurses. During a review on 8/28/2025 at 10:30 a.m., of the facility's policy and procedure (P&P) titled, "Change in Condition", dated April/2025, the P&P indicated "It is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychological well-being in accordance with the plan of care. Change in medical condition including but not limited to low/high blood sugar"; 2. The nurse will perform and document communication with the resident's provider to obtain new orders or interventions. During a review on 8/28/2025 at 10:30 a.m., of the facility's policy and procedure (P&P) titled "Nursing Administration- Nursing Care of the Resident with Diabetes Mellitus," dated January/2025, the P&P indicated "Glucose monitoring; 1. The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. 2. The physician will order the frequency of glucose monitoring. Prevent recurrent hyperglycemia/ hypoglycemia. Notify Physician." c. During a review of Resident 63's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and stroke. During a review of Resident 63's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/21/2025, the MDS indicated Resident 63 was severely impaired in cognition (the process of acquiring knowledge and understanding through thought, experience, and the senses) with skills required for daily decision making. The MDS indicated Resident 63 was dependent on staff for personal hygiene. During a review of Resident 63's Physician's Orders, the orders indicated the following: • Fasting blood sugar check every Monday, Wednesday, Friday, in the morning for DM, dated 4/24/2025. • Pioglitazone oral tablet (brand name is Actos, a medication to treat hyperglycemia [high blood sugar]), 15 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth one time a day for DM, dated 5/09/2025. • Semaglutide oral tablet (a medication to treat hyperglycemia), 14 mg, give one tablet by mouth one time a day for DM, dated 5/09/2025. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	&middledot; Fasting blood sugar check before breakfast and before dinner daily and call the physician if blood sugar is less than (&lt;) 80 milligrams per deciliter (mg/dL, a unit of measure for blood sugars) or greater than (&gt;) 250 mg/dL two times a day for DM, dated 8/26/2025 During a review of Resident 63's Care Plan for Hypo/Hyperglycemia (low/high blood sugar) related to DM dated 4/26/2025 the care plan indicated a goal that Resident 63 would be free from any signs or symptoms of hyperglycemia through the review date. The care plan indicated the following interventions: &middledot; DM medication as ordered by doctor. Monitor and document for side effects and effectiveness. &middledot; Fasting blood sugar checks every Monday, Wednesday, and Friday. &middledot; If an infection is present, consult the doctor regarding any changes in diabetic medications. During a review of Resident 63's Nursing Progress Notes, the notes indicated the following: &middledot; Resident 63 returned from urology appointment with new order for Cefdinir (oral medication for treating UTI) 300 mg for five days for UTI, dated 8/18/2025 at 4:37 p.m. &middledot; Cefdinir oral capsule (an oral antibiotic to treat a urinary tract infection [UTI- an infection in the bladder/urinary tract]) 300 mg, first dose taken from Emergency Kit (E-kit, a box that contains medications to be given to residents in an emergency situation or if a medication needs to be started but will be a long pharmacy delivery time), dated 8/18/2025 at 5:46 p.m. During a review of Resident 63's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 8/2025, covering the dates 8/18/2025 through 8/23/2025, the MAR indicated Resident 63 received Cefdinir from 8/18/2025 until 8/23/2025. During a review of Resident 63's Facsimile (long version of the word Fax, a document transmitted to another person by telecommunication lines) to the Physician, dated 8/07/2025, the fax indicated the following: Januvia tablet (an oral medication to treat hyperglycemia) was discontinued&hellip;Per Resident 63, she is requesting to have this medication reinitiated as her blood sugar levels are still high. Please call and clarify with facility please, authored by Licensed Vocational Nurse 1 (LVN 1). During a review of Resident 63's Fax to the Physician, dated 8/18/2025, the fax indicated the following: Resident 63 is requesting to get Januvia prescribed once again as her blood sugar levels remain high even though she is already on Semaglutide and Actos, authored by LVN 1. During a review of Resident 63's MAR for the month of 7/2025, covering the dates 7/01/2025 through 7/31/2025, the MAR indicated the following blood sugar values: &middledot; 7/02/2025 221 mg/dL &middledot; 7/04/2025 222 mg/dL (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	intervention), dated 8/22/2025 at 6:43 a.m., the COC indicated the following: Resident 63 noted with elevated blood sugar this morning 484 mg/dL. Physician on call notified, however (Physician on call) stated Resident 63's primary physician, MD 1, will follow up once the office is open. Will endorse to next shift. During a review of Resident 63's Licensed Nurse Condition Monitoring Form, dated 8/22/2025 at 4:13 p.m., the form indicated Resident 63 continued to be monitored for taking antibiotics for a UTI. Resident 63 was also on monitoring for hyperglycemia episodes. Charge Nurse (LVN 1) followed up with MD 1, spoke with receptionist, regarding Resident 63's new change of condition, stated MD 1 has not responded back with any new orders, will endorse to next shift to follow up. During a review of Resident 63's Nursing Progress Notes, the notes indicated the following: • Placed a call to MD 1's office today and spoke to receptionist regarding a follow up with MD 1 regarding hyperglycemic episode on 8/22/2025 and for orders. Confirmed with receptionist that facility did notify office on 8/22/2025, however messages were received by MD 1 today (8/25/2025). Requested for a follow-up phone call from MD 1, dated 8/25/2025 at 4:05 p.m. • Received a call from MD 1's office and spoke with the assistant to MD 1 and said that MD 1 wants to see the resident. The assistant said that MD 1 wants to see the resident tomorrow (8/26/2025) at 1:15 p.m., dated 8/25/2025 at 4:28 p.m. • Resident 63 returned from MD 1's office with new orders, dated 8/26/2025 at 5 p.m. During an observation and interview with Resident 63 while in Resident 63's room on 8/25/2025 at 3:07 p.m., Resident 63 stated her blood sugars were elevated for the month of 8/2025. During a concurrent interview and record review with Registered Nurse 4 (RN 4) on 8/25/2025 at 3:41 p.m., Resident 63's 8/2025 MAR was reviewed, and it was determined that Resident 63's blood sugars had been in the 300's and 400's that month. RN 4 reviewed Resident 63's COC, and the COC indicated Resident 63's blood sugar for 8/22/2025 was 484 mg/dL and Resident 63's physician, MD 1 had been contacted. RN 4 reviewed Resident 63's Nursing Progress Notes and determined that MD 1 had not returned the licensed nurses phone call. RN 4 stated she was going to call MD 1 again and if she could not reach them, then she would notify the facility's Medical Director (MDir). During a concurrent interview and record review with LVN 1 on 8/25/2025 at 3:50 p.m., LVN 1 stated she followed up, calling MD 1 but spoke to a receptionist and left a message. LVN 1 stated Resident 63 complained her blood sugar was high. Reviewed Resident 63's Fax to the Physician, dated 8/07/2025, that LVN 1 faxed to MD 1 which indicated Resident 63's blood sugars "are still high" and Resident 63 requested a diabetic medication to be prescribed which she used to take. Resident 63's Fax to the Physician, dated 8/18/2025, was reviewed, which indicated the same resident request and indicated Resident 63's blood sugars remain high. LVN 1 stated she did not hear back from MD 1 after sending these faxes. During an interview with RN 4 on 8/25/2025 at 4:30 p.m., she stated Resident 63's physician called back, and she is obtaining an appointment for 8/26/2025. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 63 left the facility to see MD 1 on 8/26/2025. During an interview with Registered Nurse 5 (RN 5) on 8/27/2025 at 6:57 a.m., he stated LVN 3 notified him on 8/22/2025 of Resident 63's blood sugar of 484 mg/dL. RN 5 stated he called the on-call doctor who did not want to give an order but to wait for the primary physician, MD 1, to respond. RN 5 stated he called MD 1's office after 8 a.m. before leaving his shift and was told by the medical assistant to fax the blood sugar value to MD 1 and the doctor is busy seeing other patients. RN 5 stated he endorsed to LVN 1 to follow up with MD 1 later in the day. During an interview and concurrent record review with LVN 3 on 8/27/2025 at 7:18 a.m. LVN 3 stated Resident 63 does not have a parameter for notifying the physician when the blood sugar is over a certain value. LVN 3 stated he saw that Resident 63's blood sugar was 484 mg/dL and could be at risk for diabetic ketoacidosis (a serious condition that can happen in people with DM, in which a lack of insulin causes harmful substances called ketones to build up in the blood causing vomiting and can be life threatening). Resident 63's 8/2025 MAR was reviewed and noted Resident 63's blood sugar on 8/15/2025 was 454 mg/dl, on 8/15/2025 Resident 63's blood sugar was 454 mg/dl and on 8/20/2025 it was 425 mg/dl, on the days he took Resident 63's blood sugars. LVN 3 stated he did not notify the RN supervisor on duty or Resident 63's physician but should have done so. LVN 3 did not have a reason why he did not take these interventions. During a concurrent interview and record review with LVN 4 on 8/27/2025 at 7:20 a.m., Resident 63's 8/2025 MAR was reviewed. LVN 4 confirmed she took Resident 63's blood sugar on 8/11/2025 which was 350 mg/dL, and on 8/13/2025 which was 381 mg/dL and on 8/18/2025 which was 459 mg/dL. LVN 4 stated Resident 63 was upset because her blood sugars were high. LVN 4 stated there were no parameters for Resident 63's blood sugar order in which to notify the physician if the blood sugar was over a certain value. LVN 4 stated she should have notified Resident 63's physician when the blood sugar was over 300 mg/dL. LVN 4 stated she endorsed the 7 a.m. to 3 p.m. licensed nurses when the blood sugar was elevated but she could not remember to whom she reported to or give a description of the licensed nurse who she reported to. LVN 4 was unable to show documentation of the notification. LVN 4 stated she should have documented that she notified the oncoming shift licensed nurses to ensure there is continuity of care for Resident 63. During an interview with the Director of Nursing (DON) on 8/27/2025 at 7:38 a.m., she stated Resident 63's blood glucose order should have had parameters in which to notify the physician if the blood sugar was under or over a certain value. The DON stated the licensed nurses should have notified the Medical Director before he was notified on the third day of not being able to reach Resident 63's physician. During an interview with the Medical Director (MDir) on 8/27/2025 at 8:24 a.m., he stated he was notified of Resident 63's doctor not returning the licensed nurses phone call to MD 1. The MDir stated Resident 63 used to be his patient but has not been her physician or involved in any way in the last two years. When asked what his role as a medical director to mitigate the issue of MD 1 not responding, he stated he has not tried to call Resident 63's physician in the last two years. The MDir stated Resident 63 does not want him to be involved in any way in her care. The MDir stated he would have to ask permission to document in Resident 63's chart. The MDir stated if the licensed nurse does not see a parameter for the blood sugar on a blood sugar check order, then the prescribing doctor should be notified for clarification. The MDir stated complications from high blood sugar are organ damage to the heart, kidneys, and brain. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Assistant Director of Nursing (ADON) on 8/27/2025 at 2 p.m., she stated she called MD 1's office and left a message that the survey team wanted to speak with the physician. The ADON stated MD 1 has not returned the phone call. MD 1 was not available for phone interview during the recertification survey. During a concurrent interview and record review with the DON on 8/27/2025 at 4:33 p.m., the DON reviewed Resident 63's 6/2025, 7/2025, and 8/2025 MARS. The DON noted that Resident 63's blood sugars were in the 150's in the month of 6/2025. The DON stated this was Resident 63's normal range. The DON noted that Resident 63's blood sugars from the 7/2025 MAR were in the 200's and 8/2025 the blood sugars were consistently in the 300's and 400's. The DON stated Resident 63's physician should have been notified when Resident 63's blood sugars remained in the 200's in the month of 7/2025 but was not. The DON stated the licensed nurses should have seen that the blood sugar order had no parameter and notified MD 1 to clarify the order. The DON stated if the blood sugar is controlled then the medications are considered effective. The DON stated the Medical Director should have been contacted prior to 8/25/2025 because Resident 63's physician was not able to be contacted on 8/22/2025. The DON stated a resident can have high blood sugar if there is an infection, such as urinary tract infection. The DON stated Resident 63's primary care physician, MD 1, should have been contacted when it was known that the resident had a UTI and prescribed an antibiotic by Resident 63's urologist in the case they may have wanted to order further intervention. During a review of the facility's policy and procedure titled, "Nursing Care of the Resident with Diabetes Mellitus," last reviewed 1/2025, the policy indicated the following: • The management of individuals with diabetes mellitus should follow relevant protocols and guidelines. • Residents whose blood sugar is poorly controlled or those taking insulin may require more frequent monitoring, depending on the situation. • "Finger sticks (capillary blood samples, or finger pricks) measure current blood glucose levels. • Normal ranges are defined as 80 – 130 mg/dL before meals and < 180 mg/dL after meals. • Hyperglycemia is considered anything above target reference ranges. During a review of the facility's policy and procedure titled, "Diabetic Protocol," last reviewed 1/2025, the policy indicated licensed nurses should notify the physician for two or more blood glucose values above 250 mg/dL and there is a new or markedly different clinical situation that is accompanied by a change in condition or functional status. During a review of the facility's policy and procedure titled, "Prescriber Medication Orders," last reviewed 3/10/2025, the policy indicated the following steps are initiated to complete documentation and receive the medications starting with clarifying the order as necessary.		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 28 sampled residents (Resident 63) investigated for frequency of visits, was evaluated by a physician at the required intervals by failing to: 1. Ensure Resident 63 was seen by the physician at least once every 60 days between the dates of 11/15/2024 and 3/01/2025. 2. Ensure Resident 63 was seen by the physician within the first 30 days after readmission, and then at 30-day intervals up until 90 days after readmission from a general acute care hospital (or simply hospital) on 4/25/2025. This had the potential for Resident 63's physician to miss addressing the beginning of Resident 63's elevated blood sugars. Findings: During a review of Resident 63's admission Record (or Face Sheet, the front page of the chart that contains a summary of basic information about the resident) the admission Record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and stroke. During a review of Resident 63's Census, current as of 8/28/2025, the census indicated Resident 63 was admitted to the hospital on [DATE] and returned to the facility on 4/24/2025. During a review of Resident 63's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/21/2025, the MDS indicated Resident 63 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 63 was dependent on staff for personal hygiene. During a review of Resident 63's Clinical Summary Report, dated 3/07/2025, the report indicated the following: - Resident 63 went for an in-person office visit with their primary care physician, MD 1, on 11/15/2024. - Resident 63 had a telephone visit with MD 1 on 1/30/2025. - Resident 63 had a telephone visit with MD 1 on 2/26/2025. - Resident 63 had a telephone visit with MD 1 on 3/05/2025. During a review of Resident 63's Encounter Summary, dated 3/01/2025, the summary indicated Resident 63 had an in-person office with MD 1, on 3/01/2025. During a review of Resident 63's Encounter Summary, dated 3/25/2025, the summary indicated Resident 63 had a telephone visit with MD 1 on 3/25/2025. During a review of Resident 63's Office Visit Document, dated 6/25/2025, the document indicated Resident 63 had an in-person office visit with MD 2 (who provided Resident 63 care when MD 1 was not available) on 6/25/2025. During a review of Resident 63's Office Visit Document, dated 7/03/2025, the document indicated Resident 63 had an in-person office visit with MD 2 on 7/03/2025. During a review of Resident 63's Office Visit Document, dated 8/26/2025, the document indicated Resident 63 had an in-person office visit with MD 2 on 8/26/2025. During a concurrent interview and record review with the Director of Medical Records (DMR) on 8/28/2025 at 2:46 p.m., reviewed Resident 63's Doctor Visit Log. The above- referenced physician visits were confirmed with the DMR. During a concurrent interview with the Administrator (ADM) on 8/28/2025 at 3:54 p.m., the ADM reviewed the policy and procedure titled, Physician Visits, last reviewed 1/2025. The ADM stated the policy should be more specific to include the requirement for physician visits after the first 90 days to be 60 days. The ADM stated this is important to ensure a resident's physician is aware of a resident's condition, mental status, including any change in condition. During a concurrent interview with the Director of Nursing on 8/28/2025 at 4:27 p.m., the DON reviewed the policy and procedure titled, Physician Visits, last reviewed 1/2025. The DON stated a resident after should be seen by their physician every 30 days for 90 days and then every 60 days after that. The DON stated the Physician Visits policy should be more specific regarding the physician visit requirements after the first 90 days. The DON stated there should be wording that the physician visits should be every 60 days for a resident who has been in the facility greater than 90 days. The DON stated the licensed nurses should have ensured Resident 63 was seen by their physician as required by the Department of Public Health's regulation. The DON stated this is important to ensure a resident's physician is aware of what is happening medically with a resident. During a review of the (continued on next page)		

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility's policy and procedure titled, Physician Visits, last reviewed 1/2025, the policy indicated the following:- The resident must be seen by his/her attending physician at least once every thirty (30) days for the first ninety (90) days following the resident's admission.- Once the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established.		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to establish and implement policies with clear guidance in treating a resident with elevated blood sugar levels in the months of 7/2025 and 8/2025 for one (Resident 63) of 28 sample residents. Additionally, although attempts were made to contact Resident 63's primary care physician since 8/07/2025, the licensed nurses did not speak to the doctor by phone until 8/25/2025 after the survey team inquired regarding Resident 63's elevated blood sugars for the month of 8/2025. This had the potential for Resident 63 to suffer from complications related to hyperglycemia. Findings: During a review of Resident 63's admission Record, the admission record indicated the resident was admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses that included diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and stroke. During a review of Resident 63's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 8/21/2025, the MDS indicated Resident 63 was cognitively (the process of acquiring knowledge and understanding through thought, experience, and the senses) intact with skills required for daily decision making. The MDS indicated Resident 63 was dependent on staff for personal hygiene. During a review of Resident 63's Physician's Orders, the orders indicated the following:- Fasting blood sugar checks every Monday, Wednesday, Friday, in the morning for DM, dated 4/24/2025. - Pioglitazone oral tablet (brand name is Actos, a medication to treat hyperglycemia [high blood sugar]), 15 milligrams (mg, metric unit of measurement, used for medication dosage and/or amount), give one tablet by mouth one time a day for DM, dated 5/09/2025. - Fasting blood sugar check before breakfast and before dinner daily and call the physician if blood sugar is less than (&lt;) 80 milligrams per deciliter (mg/dL, a unit of measure for blood sugars) or greater than (&gt;) 250 mg/dL two times a day for DM, dated 8/26/2025. During a concurrent interview and record review with the Director of Nursing (DON) on 8/25/2025 at 4:50 p.m., the DON reviewed the policy and procedure titled, Change in Condition, last reviewed 4/2025. The policy indicated the following: If, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following (but not limited to): change in medical condition including but not limited to low/high blood sugar, hypoglycemic episodes (episodes of low blood sugar), or fever of unknown origin. When asked what the blood sugar would warrant physician notification, the DON stated the licensed nurses should follow the parameters of the usual sliding scale insulin order such as if the blood sugar is less than 70 mg/dL or greater than 400 mg/dL. The DON reviewed Resident 63's Medication Administration Record (MAR, a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of 8/2025, covering the dates 8/18/2025 through 8/23/2025. The DON verified that the 8/2025 MAR indicated the following blood sugar levels:- 8/15/2025 454 mg/dL- 8/18/2025 459 mg/dL- 8/20/2025 425 mg/dL- 8/22/2025 484 mg/dL- 8/25/2025 310 mg/dL The DON stated Resident 63's physician should have been notified when the resident's first blood glucose was 454 mg/dL on 8/15/2025. During a concurrent interview and record review with the Director of Nursing (DON) on 8/27/2025 at 7:38 a.m., the DON reviewed the policy and procedure titled, Nursing Care of the Resident with Diabetes Mellitus, last reviewed 1/2025. The DON stated the policy does not specify that blood sugar check orders are required to have a parameter of when to notify the physician of an elevated blood sugar value. The DON stated Resident 63's blood sugar check order does not have a parameter for doctor notification but that there should be one. During an interview with the Medical Director (MDir) on 8/27/2025 at 8:24 a.m., when asked about parameters of when to notify the physician for low or high blood sugars, he stated there should be a parameter. The MDir stated if there (continued on next page)		

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is no parameter, the licensed nurse should call the physician to obtain a parameter. The MDir stated complications of diabetes include organ damage to heart, kidney, and brain. During an interview with the Administrator (ADM) and DON on 8/28/2025 at 9:39 a.m., the ADM and DON reviewed the facility's policy and procedure titled, Nursing Care of the Resident with Diabetes Mellitus and Diabetic Protocol, last reviewed 1/2025. The Diabetic Protocol policy indicated the following: - Call the physician if [assuming blood sugar, only blank space on policy] below 70 OR above 400- Call the physician for two or more blood glucose values above 250 AND there is a new or markedly different clinical situation that is accompanied by a change in condition that is accompanied by a change in condition or functional status.- Call the physician when a diabetic patient has not eaten 50% of meal for two (2) days.- Call the physician when the diabetic resident has one or more of the following: fever, hypotension, lethargy or confusion, abdominal or chest pain, respiratory distress, or functional and/or mental decline. When asked what factors determine a resident's target blood sugar range specific to the resident, the DON stated Yes, based on a resident's A1C, blood sugar finger sticks, and compliance with eating. When asked if these factors should be in the language of either policy, the DON and ADM did not have an answer to the question. The DON was asked what markedly different clinical situation is accompanied by a change in condition that is accompanied by a change in condition or functional status meant. The DON was reminded that Resident 63 had no documented clinical signs or symptoms of high blood sugar, the DON replied stating the phrase referred to there being a blood sugar greater than 250 mg/dL for two or more days. During a concurrent interview with the Administrator (ADM) on 8/28/2025 at 3:54 p.m., the ADM reviewed the policy and procedure titled, Physician Visits, last reviewed 1/2025. The policy indicated the following:- The resident must be seen by his/her attending physician at least once every thirty (30) days for the first ninety (90) days following the resident's admission.- Once the attending physician determines that a resident need not be seen by him/her every thirty (30) days, an alternate schedule of visits may be established. The ADM stated the policy should be more specific to include the requirement for physician visits after the first 90 days to be 60 days. The ADM stated this is important to ensure a resident's physician is aware of a resident's condition, mental status, including any change in condition. During a concurrent interview with the Director of Nursing on 8/28/2025 at 4:27 p.m., the DON reviewed the policy and procedure titled, Physician Visits, last reviewed 1/2025. The DON stated a resident after should be seen by their physician every 30 days for 90 days and then every 60 days after that. The DON stated the Physician Visits policy should be more specific regarding the physician visit requirements after the first 90 days. The DON stated there should be wording that the physician visits should be every 60 days for a resident who has been in the facility for greater than 90 days. The DON stated the licensed nurses should have ensured Resident 63 was seen by their physician as required by the Department of Public Health's regulation. The DON stated this is important to ensure a resident's physician is aware of what is happening medically with a resident. During a review of the facility's Facility Assessment, last reviewed 1/2025, indicated the following: Our facility utilizes the data collected in the review of our resident profile/resident population to evaluate what policies and procedures may be required in the provision of care and to ensure the policies and procedures meet current professional standards of practice. Policies required by statute or regulation are included in our policy portfolio. Policies are reviewed and revised, as needed, at least every 12-18 months or more frequently. If standards, regulations, or new evidence comes available to require a revision sooner. In lieu of a policy, we may use guidelines, manufacturer guidance/recommendation, or evidence-based competency skills to identify steps of a procedure or process for the delivery of care.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interviews and record review, the facility failed to ensure there was evidence to support the initiation of a psychotropic (drug that affects brain activities associated with mental processes and behavior, which includes but not limited to medications used to treat anxiety [a feeling of fear, dread, and uneasiness that is more intense and persistent than normal and can interfere with daily life]) for one of five sampled residents reviewed under the unnecessary medication, chemical restraints/psychotropic medications care area (Resident 12). This failure had the potential of unnecessary chemical restraint. Findings: During a review of Resident 12's admission Record, the record indicated the facility originally admitted Resident 12 to the facility on 4/14/2025 with diagnoses including psychosis (a state where a person experiences a loss of contact with reality) and post-traumatic stress disorder (PTSD, a mental health condition that can develop after experiencing or witnessing a traumatic event). During a review of Resident 12's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 7/25/2025, the MDS indicated the resident's cognitive skills (the mental abilities the brain uses to think, learn, remember, and solve problems) for daily living were intact. During a review of Resident 12's physician orders, the physician orders indicated Resident 12 had an active order dated 8/1/2025 for buspirone (a psychotropic drug that treats anxiety disorder) 5 milligrams (mg, a unit to measure mass) twice a day for anxiety manifested by constant worrying causing panic. During a concurrent record review and interview on 8/27/2025 at 3:55 PM, with the Director of Nursing (DON), reviewed Resident 12's buspirone order and progress notes. The DON stated that Resident 12's physician ordered the medication on 7/31/2025, with a start date of 8/21/2025. The DON further stated that the physician's progress notes indicated the physician last saw Resident 12 on 6/30/2025. During a review of Resident 12's physician progress note dated 7/23/2025 at 8 AM), the note did not document an assessment for Resident 12's anxiety disorder, nor the clinical rationale for the use of buspirone. During a concurrent interview and record review on 8/27/2025 at 3:58 PM with the DON, reviewed Resident 12's psychiatric progress notes, dated 7/15/25. The DON stated that the psychiatric nurse practitioner documented No psychiatric medications at this time. During a review of Resident 12's Behavior/Psychoactive IDT Review (an interdisciplinary team meeting where a team of healthcare professionals of different disciplines collaborates to assess, plan, and manage a patient's care), dated 7/11/2025, the IDT review did not document any discussion of anxiety. The review also did not document any specific non-pharmacological interventions for Resident 12's anxiety or worries. During an interview on 8/27/2025 at 4:08 PM, with the DON, the DON stated that the most recent IDT meeting for Resident 12 was done before the start of Resident 12's buspirone order and did not discuss what led to the start of Resident 12's use of buspirone. The DON confirmed there was no documented evidence that individualized non-pharmacological interventions were developed to manage Resident 12's anxiety before initiating buspirone. During an interview on 8/27/2025 at 4:15 PM, with the DON, the DON stated there was a lack of evidence to support starting Resident 12 on buspirone. During a review of the facility's policy and procedures (P&P), Chemical Restraints and Psychotropic Medication Management, dated 4/2025, the P&P indicated . Psychotropic Medication: Any drug that affects brain activities associated with mental processes and behavior. This category includes medications in the categories of . anti-anxiety. They are to be administered only when required to treat the resident's medical symptoms and will be considered only after nonpharmacological interventions have been attempted and failed. The decision to prescribe . based on a comprehensive assessment of the resident. The specific condition requiring the use of psychotropic medication is diagnosed and documented in the clinical record. The medical record must show documentation of the diagnosed condition .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure a resident who required assistance with nail trimming was provided care and services to maintain good personal hygiene for one of four sampled residents (Resident 11). This deficient practice had the potential to result in a negative impact on the resident's self-esteem due to an unkempt appearance. Findings: During a review of Resident 11's admission Record, the admission Record indicated the facility originally admitted the resident on 12/17/2012 and readmitted the resident on 5/16/2024 with diagnoses that included but not limited to, hypertension (high blood pressure [the force of the blood pushing on the blood vessel walls is too high]) and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 11's Minimum Data Set (MDS - a resident assessment tool) dated 7/01/2025, the MDS indicated that the resident's cognitive (the mental action or process of acquiring knowledge and understanding through thought, experience, and the senses) skills for daily decision making was impaired and required partial/moderate assistance from staff for shower, dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 11's Care Plan (CP- a written document that summarizes a resident's needs, goals, and care/treatment) for Activities of Daily Living (ADLs - activities related to personal care) revised on 7/1/2025, the CP indicated that the resident has ADL self-care performance deficit related to the resident's medical comorbidities (medical conditions that coexist alongside a primary diagnosis) including muscle weakness. The CP indicated that the resident required moderate assistance with personal hygiene care. During a concurrent observation and interview on 8/27/2025 at 8:17 a.m., with the Director of Nursing (DON), observed Resident 11's fingernails. Observed that Resident 11's fingernails in both hands were long and had black substances under the nails. The DON stated that Resident 11's nails need cleaning and trimming. The DON stated that a dirty appearance can affect a person's self-esteem. Upon review by the DON of Resident 11's ADL personal hygiene documentation by the Certified Nurse Assistants (CNAs), the documentation indicated that Resident 11 had not refused care at any time from 8/1/2025 to 8/26/2025. During a review of the facility's policy and procedure titled, Resident Rights-Dignity and Respect, last reviewed on 3/10/2025, the policy and procedure indicated that residents will be appropriately dressed in clean clothes and be well groomed.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide an environment free from accident hazards for two of seven residents (Resident 9 and 40) investigated under the Accidents care area by failing to:1. Ensure bedside rails were not used for a resident (Resident 9) that does not require such use to prevent risk of limb entrapment which could lead to injury.2. Ensure Resident 40's bedside rails were fully covered by padding per the physician's orders. These deficient practices had the potential to place Residents 9 and 40 at an increased risk of injury and harm. Findings: 1. During review of Resident 9's admission Record, the admission Record indicated the facility originally admitted the resident on 5/09/2025 and readmitted the resident on 7/19/2025, with diagnoses including unspecified dementia (a condition where a person experiences cognitive [the mental processes involved in gaining knowledge and comprehension] decline that cannot be definitively diagnosed as a specific type of dementia) and gastroesophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During a review of Resident 9's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/23/2025, the MDS indicated the resident's cognitive skills for daily living are severely impaired and the resident was totally dependent on staff for eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on and taking off footwear and personal hygiene. During an observation on 8/26/2025 at 8:05 a.m., Resident 9 was observed in bed eating with quarter bedside rails up on both sides of the bed. The bedside rails had gaps between the bars. During an interview and record review of Resident 9's Care Plan on 8/27/2025 at 10:17 a.m., with the Director of Nursing (DON), the Care Plan indicated Resident 9's Care Plan (a comprehensive document that outlines the individualized healthcare goals, interventions, and evaluation for a patient) for bedside rails use was not initiated or developed. The DON stated that there is no CP for the use of bedside rails. The DON stated that the use of bedside rails poses a risk of limb entrapment which could lead to strangulation and injury. The DON stated that there is no identified need or benefit for Resident 9 to have bedside rails. The DON stated that when a bedside rail is used, there must be a care plan to ensure interventions are in place for monitoring the resident thereby preventing injury. During an interview on 8/27/2025 at 10:28 a.m., Certified Nurse Assistant 4 (CNA 4) stated that she is assigned to Resident 9, and she took her to the activity room. CNA 4 stated that after Resident 9 is done with the activity, she will bring her back to her bed and put the bedside rails up. During a review of the facility's policy and procedures titled Care and Treatment- Accident Intervention, last reviewed on 3/10/2025, the facility indicated that "It is the policy of this facility that the resident environment remains free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents...the purpose is to ensure that the facility provides an environment that is free from hazards over which the facility has control and provides appropriate supervision to each resident to prevent avoidable accidents. This includes systems and processes designed to identify hazard(s) and (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk(s)&hellip;&rdquo;. 2. During a review of Resident 40&rsquo;s admission Record, the admission Record indicated the facility originally admitted the resident on 8/17/2018 and readmitted the resident on 8/20/2020 with diagnoses including, but not limited to, hypertension (HTN-high blood pressure) and seizures (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 40&rsquo;s History and Physical (H&P), dated 9/14/2024, the H&P indicated Resident 40 did not have the capacity to understand and make decisions. During a review of Resident 40&rsquo;s Minimum Data Set (MDS &ndash; a resident assessment tool), dated 5/30/2025, the MDS indicated Resident 40 had severely impaired cognition (the ability to think, learn, and remember clearly) and was dependent on staff for most activities of daily living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 40&rsquo;s Physicians Orders, the Physicians Orders indicated the following order dated 1/29/2024: &ldquo;2 half upper rails up and padded for seizure precautions.&rdquo; During a review of Resident 40&rsquo;s care plan titled, &ldquo;Side rails used as a seizure precaution&hellip;&rdquo; dated 1/16/2024, the care plan goal indicated that the resident will &ldquo;have safe use of bed rails&hellip;&rdquo; and the intervention indicated 2&rdquo; half upper rails up and padded for seizure precautions. During observations on 8/25/2026 at 12:26 p.m. and 8/26/2026 at 7:35 a.m., Resident 40 was in bed with both upper side rails up with padding on. The padding on the left upper side rail had slipped down exposing the hard side rail to the resident on both observations. During a concurrent observation and interview on 8/27/2025 at 9:26 a.m. with the Assistant Director of Nursing (ADON) while at Resident 40&rsquo;s bedside, Resident 40 was in bed with both upper side rails up. The padding on both upper side rails had slipped down exposing the hard side rails to the resident. The ADON stated the padding slips down easily and should be readjusted after care. The ADON stated the resident has fragile thin skin and risks becoming bruised from hitting the hard side rails if the padding isn&rsquo;t there. During an interview on 8/28/2025 at 3:43 p.m. with the Director of Nursing (DON), the DON stated if the padding for seizure precautions is not fully covering the bed rail, if the resident has a seizure, then the padding can&rsquo;t protect the resident. During a review of the facility&rsquo;s policy and procedure (P&P) titled, &ldquo;Seizure Management,&rdquo; last reviewed 3/10/2025, the P&P indicated it is the policy of the facility to prevent injury during a seizure and to provide safety and protection. The P&P indicated to provide a safe environment including to pad side rails.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide trauma-informed care (an approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma) to one of two residents (Resident 12) investigated under the Behavioral-Emotional care area when the resident's triggers (a psychological stimulus that prompts recall of a previous traumatic event, even if the stimulus itself is not traumatic or frightening) for his diagnosed Post-Traumatic Stress Disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing or witnessing a traumatic event) were not adequately assessed and the resident's care plan (a document that outlines a patient's healthcare needs, goals, and the interventions and treatments planned to achieve those goals, serving as a roadmap for their care and facilitating communication among the healthcare team) did not include person-centered specific interventions to address the resident's PTSD. These deficient practices placed Resident 12 at an increased risk of experiencing triggering events and becoming retraumatized. ^ Findings: ^ During a review of Resident 12's admission Record, the admission Record indicated the facility originally admitted the resident on 4/14/2025 and readmitted the resident on 4/21/2025 with diagnoses including, but not limited to, chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), PTSD, anxiety disorder (a condition in which a person has excessive worry and feelings of fear, dread, and uneasiness), dementia (a progressive state of decline in mental abilities), and psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 12's History and Physical (H&P), dated 4/17/2025, the H&P indicated the resident did not have the capacity to make decisions. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 7/11/2025, the MDS indicated Resident 12 was able to make himself understood and can understand others. The MDS further indicated Resident 12 was cognitively intact (can think, learn, and remember clearly) and required partial assistance or supervision for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 12's Order Summary Report, the Order Summary Report indicated an order dated 8/26/2025 to transfer the resident to the nearest hospital emergency room via paramedics due to chest discomfort and uncontrolled anxiety behaviors. During an observation on 8/26/25 at 10:26 a.m., Resident 12 was in his bed shouting I can't breathe and wailing. Staff administered a breathing treatment then called 911. The resident was taken to the hospital via paramedics. During an interview on 8/26/2025 at 2:25 p.m. with Housekeeping Supervisor (HKS) 1, HKS 1 stated she is also a certified nursing assistant and will help residents when needed. HKS 1 stated she has talked to and helped Resident 12 before. HKS 1 stated Resident 12 is usually calm but has outbursts once in a while. HKS 1 stated his outbursts seem random without any reason for them happening. During a concurrent observation and interview on 8/27/2024 at 8:24 a.m. with Resident 12 at his bedside, Resident 12 stated he has PTSD but has not discussed with any staff members what his reactions are or what causes episodes for him. Resident 12 stated he will start to feel angry and worked up when a lot of people come into his room and walk past his bed or stand in his room. Observed Resident 12's bed is the first bed next to the door and people must walk past his bed to get to his two roommates. Resident 12 stated seeing the policemen in the hats (the paramedics) when he was transferred to the hospital yesterday also caused these feelings for him. During a concurrent interview and record review on 8/27/2026 at 11:21 a.m. with the Special Care Unit Director (SCD), Resident 12's Social Services Assessments, dated 4/15/2025 and 7/13/2025, and Resident 12's care plan titled At Risk for Re-traumatization r/t (related to): history of trauma Post-Traumatic Stress Disorder., created on 8/21/2025, were reviewed. The SCD stated she is the social services director for the locked unit (a secured area with locked doors or other means to prevent residents from leaving at will, often used in memory care (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	units to ensure patient safety and prevent wandering) and other residents in the facility in certain rooms including Resident 12. The SCD stated she completed Resident 12's Social Services assessment dated [DATE] on his admission. The Social Services Assessments indicated the resident had PTSD, is a veteran, and recently lost his mother. The Social Services Assessments did not indicate any identified triggering events that may cause re-traumatization. Resident 12's care plan did not identify any triggers for Resident 12's PTSD. The SCD stated Resident 12 did not want to discuss the trauma or triggers. The SCD stated within the last two weeks Resident 12 told her hearing people talk in different languages really upset him. The SCD stated Resident 12 becomes paranoid and thinks people might be talking about him. The SCD stated the care plan does address that the resident has PTSD but is not specific about what should be done if the resident starts having behaviors. The SCD stated it should be care-planned that he does not like hearing people speak in different languages. The SCD stated she thinks his triggers should be care-planned so staff can identify what his triggers and behaviors. During an interview on 8/27/2025 at 2:25 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated yesterday she went into Resident 12's room when he was complaining of shortness of breath and tried to control his breathing and anxiety. LVN 2 stated she has not seen Resident 12 have an episode like this before and is not aware of any triggers that he has. During an interview on 8/27/2025 at 4:14 p.m. with Registered Nurse (RN) 7, RN 7 stated she was there when Resident 12 arrived back from the hospital last night. RN 7 stated Resident 12 has episodes of anxiety where he starts yelling. RN 7 stated there does not seem to be reasons for the episodes and they seem random. During an interview on 8/28/2026 at 9:31 a.m. with the SCD, the SCD stated if a resident does not want to talk about their trauma or triggers when first assessed, another assessment should be attempted at a different time, or the questions could be asked in a different way. The SCD stated a resident might not want to share as much on admission. The SCD stated this would be documented in a progress note. The SCD stated there is no progress note she can find indicating there was another attempt to identify the resident's triggers at a different time or with a different approach. The SCD stated triggers should be assessed because they would not want to trigger an episode for Resident 12 and have him (Resident 12) become angry or be upset. During an interview on 8/28/2025 at 3:43 p.m. with the Director of Nursing (DON), the DON stated for a resident with PTSD both social services and nursing would assess the resident. The DON stated they should assess the causes of the trauma and what triggers the resident's PTSD if it is known. The DON stated if they do not know the resident's triggers or have interventions specific to him in the plan of care for PTSD, they cannot provide the needed care for the resident's PTSD. The DON stated if the resident is triggered, they could harm themselves, have anxiety, or not be able to control their emotions. During a review of the facility's policy and procedure (P&P) titled Behavioral Health Services, last reviewed 3/10/2025, the P&P indicated trauma survivors will receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. The P&P further indicated the Social Services designee will make every effort to identify the triggers. The P&P indicated residents with PTSD will have an individualized person-centered plan of care that addresses the needs of the resident.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess a resident for risk of entrapment (when a resident is trapped in the spaces in between or around the bed rails [adjustable metal or rigid plastic bars that attach to the bed that are available in a variety of types, shapes, and sizes], mattress, or bed frame), obtain an informed consent and a physician order for the use of bedside rails for one of two of residents (Resident 9). This deficient practice had the potential to place the resident at risk of accidents such as a body part being caught between the rails which could lead to injury. Cross reference with F689. Findings: During a review of Resident 9's admission Record, the admission Record indicated the facility originally admitted the resident on 5/09/2025 and readmitted on [DATE], with diagnoses including unspecified dementia (a condition where a person experiences cognitive [the mental processes involved in gaining knowledge and comprehension] decline that cannot be definitively diagnosed as a specific type of dementia) and gastroesophageal reflux disease (a condition in which stomach acid repeatedly flows back up into the tube connecting the mouth and stomach). During a review of Resident 9's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated 7/23/2025, the MDS indicated the resident's cognitive skills for daily living are severely impaired. The resident is totally dependent on staff for eating, oral hygiene, toileting hygiene, shower, upper body dressing, lower body dressing, putting on /taking off footwear and personal hygiene. During an observation on 8/26/2025 at 8:05 a.m., Resident 9 was observed in bed eating with quarter bedside rails up on both sides of the bed. The bedside rails have gaps between the bars. During an interview and record review on 08/27/2025 at 10:17 a.m., with the Director of Nursing (DON), the review indicated that there is no physician order and Bedside Rails assessment conducted for Resident 9. The DON stated that before bedside rails are installed, they will first obtain an order from the physician, obtain consent from the resident or responsible party and conduct a bedside rails risk of entrapment assessment. The bedside rails assessment includes assessment of the risks and benefits of the bedside rails and assess the resident's safety due to the possibility of entrapment which can lead to injury. During an interview on 8/27/2025 at 10:28 a.m., Certified Nurse Assistant 4 (CNA 4) stated that she is assigned to Resident 9, and she took her to the activity room. CNA 4 stated that after Resident 9 is done with the activity, she will bring her back to her bed and put the bedside rails up. During a review of the facility's policy and procedures titled Bed Rails, last reviewed on 3/10/2025, the facility indicated that it is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail. After the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the resident's assessed needs. The facility interdisciplinary team (IDT) will assess the resident for risks of entrapment. The risks and benefits regarding the use of bed rails will be considered for each resident. If the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one (1) of two sampled residents (Resident 52) observed received their medication on time when Resident 52 received Zenpep (a prescription medication used to treat exocrine [releasing substances through a duct to the outside of the body or into an organ] pancreatic insufficiency (EPI), a condition in which the pancreas does not produce enough enzymes to properly digest food. When taken with a meal or snack, it helps break down food and helps the body to properly absorb nutrients from food, which can relieve symptoms such as fatty stools, gas, and bloating) more than 2 hours after the scheduled time as prescribed to be taken with meals. This failure had the potential to worsen resident's health condition. Findings: During a review of Resident 52's admission Record, the record indicated Resident 52 was re-admitted on [DATE] with diagnoses including but not limited to: adrenocortical insufficiency (a condition where the adrenal glands do not produce enough of the hormones cortisol [a hormone that helps the body respond to stress, control blood sugar, reduce inflammation, and regulate energy] and aldosterone [a hormone that helps control blood pressure])) and liver cirrhosis (a chronic liver disease leading to impaired liver function).During a review of Resident 52's physician's order (dated 10/25/2023 at 5:27 PM), the order indicated to give 2 capsules of Zenpep with meals for liver cirrhosis/pancreatic insufficiency (when the pancreas [organ in the belly that helps digest food and controls blood sugar] do not make enough enzymes [special proteins in the body] to properly digest food so the body can use the nutrients)). The scheduling details of this order indicated to administer at 7:30 AM, 12 noon, and 5 PM. During an interview on 8/26/2025 at 12:04 PM, with LVN 1, LVN 1 stated Resident 52 had breakfast at around 7:30 AM. LVN 1 confirmed she administered Zenpep capsules to Resident 52 at around 9:50 AM and stated the medication administration happened more than 2 hours after the scheduled time at 7:30 AM. During an interview on 8/26/2025 at 12:24 PM, with the Director of Nursing (DON), the DON stated breakfasts are served between 7:30 AM - 8 AM. The DON reviewed Resident 52's Zenpep order and stated the order was to be given with meals, during breakfast (serves at 7:30 AM), lunch (serves at 12 noon), and dinner (serves at 5 PM). The DON stated giving Zenzep to Resident 52 at around 9:50 AM was late and not with meals. During a review of the facility policy and procedures, Medication Administration - General Guidelines (not dated), the policy indicated Medications are administered as prescribed. Medications are administered within 60 minutes of scheduled time .		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately document in the medical record for one of 28 sampled resident (Resident 69) for the provision for Restorative Nursing Aide ([RNA]) nursing aide program that helps residents to maintain their function and joint mobility) services on 8/26/2025. This failure resulted in inaccurate medical records for the provision of Resident 69's RNA services for sit-to-stand transfers. Findings: During a review of Resident 69's admission Record, the admission Record indicated the facility admitted Resident 69 on 6/26/2025 with diagnoses including Type 2 diabetes mellitus ([DM]) disorder characterized by difficulty in blood sugar control and poor wound healing), unspecified fall, abnormalities of gait (manner of walking) and mobility, and hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side. During a review of Resident 69 Physical Therapy ([PT]) profession aimed in restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment, dated 6/27/2025, the PT Evaluation indicated Resident 69's range of motion ([ROM]) full movement potential of a joint) in both legs were within functional limits ([WFL]) sufficient joint movement without significant limitation). The PT Evaluation indicated Resident 69 required substantial/maximal assistance (helper does more than half the effort) for rolling, transferring from lying to sitting on the side of the bed, chair/bed-to-chair transfers, and sit-to-stand transfers. During a review of Resident 69's Minimum Data Set ([MDS]) a federally mandated resident assessment tool), dated 6/30/2025, the MDS indicated Resident 69 had clear speech, had difficulty expressing ideas and wants, understood verbal content, and had severely impaired cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 69 did not have any functional limitations in ROM (limited ability to move a joint that interferes with daily functioning or places the resident at risk of injury) on both arms and legs. The MDS also indicated Resident 69 required partial/moderate assistance (helper does less than half the effort) for hygiene and substantial/maximal assistance for transferring from lying to sitting on the bed, chair/bed-to-chair transfers, and sit-to-stand transfers. During a review of Resident 69's PT Discharge summary, dated [DATE], the PT Discharge Summary indicated Resident 69 required substantial/maximal assistance for sit-to-stand transfers and chair/bed-to-chair transfers. The PT Discharge Summary indicated recommendations for the RNA program for passive range of motion ([PROM]) movement of a joint through the range of motion with no effort from person) to both legs and sit-to-stand mobility using side rails, five times per week as tolerated. During a review of Resident 69's physician's orders, dated 8/22/2025, the physician's orders indicated for the RNA program to provide sit-to-stand mobility using side rails, five times per week as tolerated. During a review of Resident 69's Documentation Survey Report (record of nursing assistant tasks) for 8/2025, the Documentation Survey Report indicated Resident 69 received RNA for sit-to-stand transfers on 8/25/2025 and 8/26/2025. During an observation on 8/26/2025 at 1:14 p.m. in the bedroom, Resident 69 was fully dressed and sleeping while sitting up in a wheelchair next to the bed. During an observation on 8/27/2025 at 9:11 a.m. in the bedroom, Resident 69 was fully dressed and sleeping while sitting up in a wheelchair next to the bed. Resident 69 was observed wearing socks without any grip on the sole. During an observation on 8/27/2025 at 10:40 a.m. in the bedroom with RNA 1, RNA 1 removed Resident 69's socks and replaced them with non-skid socks. Resident 69's left heel was observed wrapped in dressing. During a concurrent observation and interview on 8/27/2025 at 10:54 a.m., RNA 1 and Restorative Nursing Assistant 2 (RNA 2) wheeled Resident 69 into the hallway and positioned the wheelchair facing the hallway's handrail. RNA 1 stood on Resident 69's right side while RNA 2 stood on the left side. Resident 69 reached both arms forward and held onto the hallway handrail as RNA 1 and RNA 2 (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physically assisted Resident 69 to stand. Resident 69's hips were approximately six inches above the wheelchair seat and unable to stand fully with RNA 1 and RNA 2's physical assistance. RNA 1 stated Resident 69 required the assistance of two-persons for sit-to-stand transfers and could not remember the last time Resident 69 received RNA for sit-to-stand transfers. RNA 1 stated Resident 69 did not receive RNA for sit-to-stand transfers yesterday (8/26/2025) and assisted Certified Nursing Assistant 5 (CNA 5) with transferring Resident 69 from the wheelchair to the bed. During an interview on 8/28/2025 at 11:09 a.m. with RNA 1, RNA 1 stated RNA 1 forgot to provide Resident 69 with the RNA program for sit-to-stand transfers on 8/26/2025. During a concurrent interview and record review on 8/28/2025 at 11:09 a.m. with the Director of Nursing (DON), Resident 69's Documentation Survey Report for 8/2025 was reviewed. The DON stated the medical record (in general) documented the provision of services and should be accurate. The DON was informed that RNA 1 did not provide Resident 69's RNA program for sit-to-stand transfers on 8/26/2025. The DON reviewed Resident 69's Documentation Survey Report and stated it was not accurate for 8/26/2025. The DON stated RNA 1 documented providing Resident 69 with RNA for sit-to-stand transfers in medical record which was not actually provided. During a review of the facility's policy and procedure (P&P) titled, Reviewing Active Clinical Record for Deficiencies, dated 8/2016 and reviewed on 3/2025, the P&P indicated the facility ensured the resident's clinical record was accurate, complete, dated, and signed by the appropriate individuals.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review, the facility failed to ensure that three out of 35 resident rooms with three beds met the square footage requirement of 80 square feet (sq ft- unit of measure) per resident. This deficient practice had the potential to result in inadequate space to provide safe nursing care and privacy for the residents. Findings: During an observation and interview on 8/28/2025 at 5:30 p.m., with the Administrator (Admin.) and Maintenance Resource (MR), the MR measured three of the rooms, all with three bed capacity. The measurements were as follows: Room Number: Number of Beds: Sq. Ft: Sq. Ft per Resident: 10 3 237.89 79.3 12 3 234.08 78.0 24 3 236.00 78.66 The Admin. stated that she is aware of the regulation that multiple resident bedrooms must provide at least 80 square feet per resident in multiple resident bedrooms, but the three resident rooms (rooms 10, 12 and 24) did not meet the requirement. During a review of the facility's policy titled Physical Environment, last reviewed on 3/10/2025, the policy indicated that a resident room must: 1. Be designed and equipped for adequate nursing care, comfort, and privacy of residents 2. Accommodate no more than four residents 3. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in a single resident room.		