STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065429	A. Building B. Wing	09/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Longmont Health and Rehab, LLC	1960 S Fordham St Longmont, CO 80503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide an effective pain management regimen in a manner consistent with professional standards of practice, resident-centered care plans, and resident preferences for two (#15 and #42) of seventeen residents out of 36 sample residents.Specifically, the facility failed to:-Ensure Resident #15 was administered pain medication as ordered;-Implement effective interventions to prevent Resident #15 from running out of her medication; and,-Offer and administer scheduled and as-needed medication for pain as ordered for Resident #42.RESIDENT #15Resident #15 was admitted to the facility on [DATE] with a diagnosis of acute and chronic respiratory failure, schizoaffective disorder (mental illness), bipolar disorder (mental illness), muscle weakness, frequent pain and limited range of motion. The facility failed to ensure Resident #15, with a diagnosis of chronic pain, was assessed for pain accurately and administered pain medications as ordered. The resident reported increased levels of pain.Resident #15's pain assessment documented the resident had pain, which affected her day-to-day activities. On 9/8/25, the resident reported she did not always get her pain medication as ordered on time. She said her pain affected her sleep and her ability to get around. The resident said she had not slept in two days.Due to the facility's failure to ensure Resident #15's pain medications were consistently administered as ordered and promptly, the resident sustained increased pain on 9/8/25 and was transported to the hospital via stretcher at approximately 4:00 p.m. for chronic pain.RESIDENT #42Resident #42 was admitted to the facility on [DATE] with diagnoses of quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder (a mental health condition in which people have an unreasonably high sense of their own importance). The resident had chronic pain related to quadriplegia, a left humerus fracture and decreased mobility.On 9/10/25 RN #2 documented Resident #42 did not receive a scheduled dose of gabapentin (nerve pain medication) because he was out of the facility. On the evening of 9/10/25, Resident #42 was yelling he was in pain and swearing at staff in the vicinity of RN #2. RN #2 informed the resident he could have a dose of Ibuprofen (pain medication), which the resident refused because he said it would not help. RN #2 failed to offer the resident his missed dose of gabapentin or an as needed dose of methocarbamol (a muscle relaxer medication) and Resident #42 continued to yell about his pain.On 9/11/25 at 8:23 a.m. Resident #42 rated his pain level at an 8 out of 10 requested a dose of PRN ibuprofen and a dose of PRN methocarbamol from licensed practical nurse (LPN) #2. When LPN #2 cautioned the resident about taking multiple pain medications close together, Resident #42 said he had taken them before and he was fine. LPN #2 said she would be back with his medication. Resident #42 could be heard moaning and calling out for help while he waited for his medication, however, no staff entered the resident's room. LPN #2 had not returned to the resident's room by the end of the continuous observation at 9:57 a.m., over an hour and a half after Resident #42 requested the as needed pain medications. At 8:23 a.m. Resident #42 pushed his call light. The call light was responded to by LPN #2 at 8:24 a.m. Resident #42 reported pain and requested PRN medication. LPN #2 completed a pain assessment using a 1 to 10 pain scale. Resident #42 rated his pain level at an 8 out of 10 during the conversation. LPN #1 offered Resident #42 his (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 0697 Level of Harm - Actual harm Residents Affected - Few	PRN Ibuprofen or PRN Methocarbamol (a muscle relaxer) and Resident #42 requested both medications. LPN #2 reminded Resident #42 he recently received his morning scheduled medications for pain and cautioned Resident #42 about taking multiple medications close together. Resident #42 said he had taken them before and he was fine. LPN #2 said she would be back with his medication.Due to the facility's failure to ensure Resident #42 received his PRN pain medications in a timely manner after the resident reported a pain level of 8 out of 10, the resident experienced unnecessary pain for an extended period of time.Findings include: I. Facility policy and procedure The Pain Management policy, revised 4/11/25, was provided by the regional vice president of operations. on 9/11/25 at 1:26 p.m. The policy read in pertinent part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. The facility will utilize a pain assessment tool, tailored to the resident's cognitive status, to assist staff in consistently evaluating a resident's pain. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Pharmacological interventions will follow a systematic approach for selecting medications and doses to treat pain. The interdisciplinary team is responsible for developing a pain management regimen that is specific to each resident who has pain or who has the potential for pain. The following are general principles the facility will utilize for prescribing analgesics: Evaluate the resident's medical condition, current medication regimen, cause and severity of the pain, and course of illness to determine the most appropriate analgesic therapy for pain. Consider evidence-based practice tools to assist in the assessment of the resident's pain. Consider administering medication around the clock instead of PRN (as needed) or combining longer-acting medications with PRN medications for breakthrough pain. II. Resident #15 A. Professional reference According to the manufacturer's instructions for Belbuca, 10/16/22, retrieved on 9/16/25 from https://medlineplus.gov/druginfo/meds/a616019.html, Belbuca is used to relieve severe and persistent pain in people who are expected to need an opioid and cannot be treated with other pain medications. Belbuca should not be used to treat mild or moderate pain, short-term pain, or pain that can be controlled with medication taken as needed. Buprenorphine (Belbuca) is a class of medications called opiate partial agonists. It works by changing the way the brain and nervous system respond to pain. B. Resident status Resident #15, age less than 65, was admitted on [DATE]. According to the September 2025 (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	computerized physician orders (CPO), diagnoses included acute and chronic respiratory failure, schizoaffective disorder, bipolar disorder, muscle weakness, frequent pain and limited range of motion. The 8/1/25 minimum data set (MDS) assessment revealed the resident had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. The resident did not exhibit any rejection of care behaviors and was dependent on staff for transfers, locomotion, dressing, toileting, and personal hygiene. The assessment indicated the resident was on a scheduled pain medication regimen and had experienced pain frequently. C. Resident interview Resident #15 was interviewed on 9/8/25 at approximately 9:23 a.m. The resident said she was in a lot of pain. She said she had a headache, back pain and both of her knees hurt. She said her pain medication was usually given to her late. The resident said she was scheduled to receive pain medication at 8:00 a.m., and it was not administered until 1:00 p.m. The resident said there were several occasions that she had to wait until late in the afternoon before she received her morning medication. Resident #15 said range of motion (ROM) exercises and massages had helped in the past to alleviate her leg pain. She said the staff did not offer her those interventions. D. Observation On 9/8/25 at approximately 4:25 p.m., Resident #15 was observed on a stretcher being transported by emergency medical services (EMS). EMS said the resident was being transported to the hospital for complaints of severe leg pain. E. Record review The pain management care plan, initiated on 7/26/25, revealed Resident #15 had actual pain related to decreased mobility, chronic respiratory failure, sleep apnea and schizophrenia. Interventions included identifying and recording previous pain history and management of the pain and its impact on the resident's function and anticipating the resident's need for pain medication. -Review of Resident #15's care plan did not reveal documentation regarding Resident #15's preferred non-pharmacological pain interventions of ROM exercises and massages (see interview above). Review of Resident #15's September 2025 CPO revealed the following physician's order: Belbuca buccal film 75 microgram (mcg), place and dissolve one film orally twice a day (at 9:00 a.m. and 6:00 p.m.) for chronic pain, ordered 9/2/25. The 9/8/25 hospital report revealed Resident #15 was admitted to the hospital with left leg pain and chest pain as well. On arrival, the resident appeared chronically ill. The note documented she had mild leg swelling on the left side. The swelling appeared chronic and was noted on the right side as well, but she had more pain in the left knee. Upon arrival, the resident's vital signs were reassuring. She (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	was ordered her previous oxycodone pain medication and a plan for an ultrasound to evaluate for deep vein thrombosis (DVT). The note documented there were no signs of trauma, and the resident had not had any falls or injury. Review of Resident #15's September 2025 (from 9/1/25 to 9/5/25) medication administration record (MAR) revealed the following: -On 9/2/25, the resident was administered her 6:00 p.m. dose of Belbuca at 9:39 p.m.; and, -On 9/5/25, the resident was administered her 6:00 p.m. dose of Belbuca at 9:16 p.m. Further review of Resident #15's September 2025 (from 9/6/25 to 9/11/25) MAR revealed the following: -On 9/9/25 the resident missed her morning dose of Belbuca; -On 9/9/25 the resident missed her morning and evening doses of Belbuca; and, -On 9/10/25 the resident missed her morning dose of Belbuca. Review of Resident #15's electronic medical record (EMR) revealed the following progress notes: The 9/9/25 nursing progress note, documented at 8:57 a.m., revealed Resident #15's Belbuca was out of stock. The 9/9/25 nursing progress note, documented at 10:56 p.m., revealed the resident's Belbuca was pending delivery from the pharmacy. The 9/10/25 nursing progress note, documented at 10:23 a.m., revealed the resident's Belbuca was out of stock. The progress note documented the resident's pain was 2 out of 10. The 9/10/25 nursing progress note, documented 6:08 p.m., revealed the medication was unavailable. The note documented the nurse spoke with the pharmacy and the medication would be delivered that evening. The 9/11/25 nursing progress note, documented at 9:00 a.m., revealed the morning dose of Belbuca was not given. The 9/11/25 nursing progress note, documented at 6:15 p.m., revealed Resident #15 stated her Belbuca was not effective and the resident requested new pain medication. The nurse notified the director of nursing (DON) and the physician. The note documented the physician did not recommend changing the resident's medication. F. Staff interviews Registered nurse (RN) #1 was interviewed on 9/10/25 at 10:47 a.m. RN #1 said when a medication was low on stock, she would reorder the medication through the pharmacy and notify the DON and the physician. She said she could utilize the emergency stock medication dispensing machine to obtain (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	medications if medications were out of stock by calling the pharmacy and obtaining the verification code to access the machine. She said a resident who did not receive their pain medications for a few days could potentially develop increased pain, anxiety and an increase in blood pressure, which could lead to hospitalization. Regional director of clinical services #1 was interviewed on 9/10/25 at 4:20 p.m. Regional director of clinical services #1 said Resident #15 had a physician's order for Belbuca 75 mcg, twice a day. She said the resident reported the medication was ineffective and the facility had notified the physician of the resident's concerns. She said the physician said that she would not change the order until she met with the resident to discuss her plan of care and completed a review of her pain regimen. Regional director of clinical services #1 said the medication should have been ordered by the nursing staff when it was out of stock. Regional director of clinical services #2 was interviewed on 9/11/25 at 11:27 a.m. Regional director of clinical services #2 said the Belbuca was out of stock and the resident missed her doses of the medication from 9/9/25 to 9/11/25. She said the side effects of stopping an opiate could lead someone to become uncomfortable, anxious, experience headaches and an increase in the resident's pain. Regional director of clinical services #2 said the nurses were responsible for ordering residents' medication before the medication ran out. Regional director of clinical services #2 said the facility had access to Belbuca in the emergency stock medication dispensing machine. She said the nurses should have ordered the medication before running out. She said missing scheduled pain medication and administering pain medication past their scheduled times could result in increased pain, agitation and increased behaviors. Regional director of clinical services #2 said she would ensure all nurses were trained on appropriate MAR documentation, the medication reordering process, the time frame for reordering medications and also receive training on ordering requests in order to ensure residents were not missing their ordered medications. Regional director of clinical services #2 said she would monitor to ensure residents were receiving their pain medications promptly. III. Resident #42 A. Resident status Resident #42, age less than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included quadriplegia, neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder. The 8/21/25 MDS assessment revealed Resident #42 was cognitively intact with a BIMS score of 15 out of 15. He required moderate assistance to roll side to side and required substantial assistance with eating, hygiene, bathing, toileting, and dressing. He was dependent on staff assistance for transfers and used a motorized wheelchair for mobility. B. Resident interview (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Resident #42 was interviewed on 9/9/25 at 9:29 a.m. Resident #42 said the physician at the facility was no longer willing to prescribe him opioid medication that he used to take at his previous facility. Resident #42 said he frequently spent hours with intense pain after requesting pain medication from staff with the current physician's orders. Resident #42 said sometimes he requested pain medication in the evening and did not receive any PRN medication until the next morning. Resident #42 said he frequently felt more anxious and irritable because he was in pain and it felt like nobody cared. Resident #42 said some days he did not get out of bed because he was in too much pain. C. Observations On 9/10/25 at 5:36 p.m. Resident #42 was in his motorized wheelchair in the common area next to the nurses' station. Resident #42 was calling out for help, yelling he was in pain and swearing at the staff in the nurses' station. RN #2 was standing at the medication cart approximately 15 feet away from Resident #42. The nursing home administrator (NHA) approached Resident #42 to ask what he could do to help. Resident #42 told the NHA he was in pain and the physicians in the facility would not do their job and treat his pain. The NHA offered to transport Resident #42 to the hospital due to his severe pain. Resident #42 said he was willing to go, but did not think it would help. The NHA talked to RN #2 about offering Resident #42 as needed (PRN) pain medication. RN #2 offered Resident #42 his PRN dose of ibuprofen. Resident #42 refused the dose, telling RN #2 it was not going to help. Resident #42 continued to yell and swear at staff and an unidentified resident commented on how upset Resident #42 appeared. -RN #2 did not provide Resident #42 with his missed dose of gabapentin or offer the resident a PRN dose of methocarbamol (see record review below). During a continuous observation on 9/11/25, beginning at 7:56 a.m. and ending at 9:57 a.m., the following was observed: At 8:23 a.m. Resident #42 pushed his call light. The call light was responded to by LPN #2 at 8:24 a.m. Resident #42 reported pain and requested PRN medication. LPN #2 completed a pain assessment using a 1 to 10 pain scale. Resident #42 rated his pain level at an 8 out of 10 during the conversation. LPN #2 offered Resident #42 his PRN ibuprofen or PRN methocarbamol and Resident #42 requested both medications. LPN #2 reminded Resident #42 he recently received his morning scheduled medications for pain and cautioned Resident #42 about taking multiple medications close together. Resident #42 replied he had taken them before and he was fine. LPN #2 replied that she would be back with his medication. At 8:36 a.m. Resident #42 was heard from the hallway moaning and calling out for help in his bed. No staff members responded to the resident's room. At 8:45 a.m. Resident #42 was heard again from the hallway calling out for help. Resident #42 was heard crying in his room. No staff members responded to the resident's room. At 9:57 a.m. LPN #2 had yet to return to Resident #42's room and no other interventions had been provided to Resident #42 for management of his pain. D. Record review Resident #42's pain care plan, initiated 7/22/25 and revised 9/8/25, revealed Resident #42 had (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	chronic pain related to quadriplegia, a left humerus fracture and decreased mobility. The goal for the care plan was for Resident #42 to not have an interruption to normal activities due to pain. Interventions included an implanted baclofen pump (pain pump), anticipating the need for pain relief and responding immediately to any complaint of pain, notifying the physician if interventions for pain were unsuccessful or if the current complaint was a significant change from the resident's past experience of pain, administering pain medication as ordered and utilizing nonpharmacological interventions of repositioning, deep breathing, diversional activities and offering snacks or fluids. Review of Resident #42's September 2025 CPO revealed the following physician's orders: Gabapentin 300 milligram (mg) capsule. Take one tablet by mouth three times a day for pain related to quadriplegia, ordered 9/5/25. Ibuprofen 600 mg tablet. Take one tablet by mouth every six hours as needed for pain, ordered 8/8/25. Methocarbamol 500 mg tablet. Take one tablet by mouth every six hours as needed for muscle spasms related to muscle weakness, ordered 9/5/25. Review of Resident #42's September 2025 MAR (from 9/1/25 to 9/10/25) revealed that on 9/10/25, RN #2 documented Resident #42's scheduled dose of gabapentin was not administered because the resident was out of the building at an appointment. -However RN #2 did not offer Resident #42 his missed dose of scheduled gabapentin despite the resident reporting pain (see observations above). Further review of Resident #42's September 2025 MAR (from 9/1/25 to 9/10/25) revealed that on 9/11/25, Resident #42 did not receive PRN medication for pain until 10:41 a.m., over two hours after he originally requested pain medication (see observations above). E. Staff Interviews LPN #2 was interviewed on 9/11/25 at 10:03 a.m. LPN #2 said she still planned to administer Resident #42 his pain medication, but she had not been able to return to his room yet because she was working with other residents. LPN #2 said she had not heard him calling out or she would have responded to him. Regional director of clinical services #2 was interviewed on 9/11/25 at 1:42 p.m. Regional director of clinical services #2 said she was made aware of Resident #42's behaviors in the common area during the late afternoon on 9/10/25. She said she was not aware Resident #42 did not receive his scheduled gabapentin earlier in the day or that he was not offered one of his PRN medications for pain during a pain crisis. She said she was not sure if the missed interventions would have managed his pain or reduced his behaviors. She said they had given these medications to the resident before and Resident #42 continued to request opioid medication and continued to yell or threaten others. Regional director of clinical services #2 said due to his psychiatric diagnosis of narcissistic personality disorder, Resident #42 made multiple threats to the in-house physicians when he was told they wanted to taper him off of his opioid pain medication. She said because Resident #42 continued to make threats after the physician attempted to explain his reasoning on multiple occasions, the (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	physician at the facility documented on 9/2/25 that he was signing off from managing any aspects of Resident #42's care or pain management. She said since then, the facility referred the resident to a pain management clinic.

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F 0698 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents who required dialysis services received such services consistent with professional standards for two (#8 and #7) of two residents reviewed for dialysis out of 36 sample residents. Resident #8 was admitted on [DATE] for long-term care with diagnoses of end-stage renal disease, dependence on renal dialysis and type 2 diabetes mellitus.The 6/3/25 dialysis communication form (a form used for communication between the facility and the dialysis center) revealed the resident's central venous catheter (CVC) site (dialysis access site) was bloody and the resident pulled on the catheter line. The form documented that the dialysis center requested that the facility contact them. However, there was no documentation in Resident #8's electronic medical record (EMR) to indicate that the facility attempted to communicate with the dialysis center. Resident #8's weekly nursing skin assessment documentation did not identify the resident had skin impairments related to her CVC dialysis access site. The 6/3/25 weekly skin assessment failed to even identify that the resident had a CVC site in her chest.On 6/28/25, Resident #8 was sent to the hospital from the dialysis center due to blood all around the CVC site, there was swelling to the area and the resident complained of pain. The resident was hospitalized for five days for recurrent hemodialysis line infection, gram-positive cocci bacteremia (an infection in the bloodstream) and chest wall cellulitis (bacterial infection that affects the deeper layers of the skin). Furthermore, the facility failed to follow up in a timely manner related to the dialysis center's request (on 8/7/25) to schedule Resident #8 for the placement of an arteriovenous fistula (AVF - a surgical procedure that creates a connection between an artery and a vein to provide access for hemodialysis) due to the resident's recurrent CVC infections and start the resident on antibiotics in a timely manner, per the dialysis center's request on 9/9/25. Additionally, the dialysis communication forms for Resident #8 and Resident #7, who was also receiving hemodialysis treatment, were not completed consistently and thoroughly. Specifically, the facility failed to: -Consistently monitor and document the condition of Resident #8's dialysis access site in order to prevent an infection in her hemodialysis line, which resulted in a five day hospital stay for the resident;-Ensure recommendations and communication from the dialysis center were consistently addressed in a timely manner, specifically a recommendation for a fistula (a surgical connection between a vein and artery used for dialysis) placement and starting an antibiotic medication for Resident #8; -Consistently and thoroughly complete and maintain dialysis communication forms between the facility and the dialysis center for Resident #8 and Resident #7; and,-Ensure thorough documentation was completed consistently on Resident #8's medication administration records (MAR) for the resident's dialysis-related physician's orders.Findings include: I. Facility policy and procedure The Hemodialysis policy and procedure, revised 4/11/25, was provided by the regional vice president of operations on 9/8/25 at 4:34 p.m. It revealed in pertinent part, The facility will coordinate and collaborate with the dialysis facility to assure that there is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff. The nurse will monitor and document the status of the resident's access site(s) upon return from the dialysis treatment to observe for bleeding or other complications.The facility will ensure the physician's order for dialysis includes the type of access for dialysis, the dialysis schedule, the nephrologist, the dialysis facility name and phone number, transportation arrangements to and from the dialysis facility, any medication administration or withholding of specific medications prior to dialysis treatments, any fluid restriction if ordered by the physician.II. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included vascular dementia, end-stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus and cellulitis of the chest wall. The 7/13/25 minimum data set (MDS) assessment revealed that the resident was moderately cognitively impaired with a brief interview for mental (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	status (BIMS) score of 11 out of 15. She required a wheelchair. She required set up assistance with eating and oral hygiene. She required substantial assistance with toileting and showering. She required moderate assistance with personal hygiene. The assessment indicated the resident received dialysis while at the facility. The assessment did not indicate that the resident had any skin issues. B. Resident interview Resident #8 was interviewed on 9/8/25 at 10:30 a.m. Resident #8 said the facility did not have her ready for dialysis frequently. She said the facility did not tell her what time she needed to be ready. She said she was supposed to have a fistula placed but her dialysis site was infected about a month ago. She said she scratched herself all over her body, including around her dialysis access site because her skin itched. During the interview, a whiteboard was observed in Resident #8's room. The whiteboard indicated that the resident needed to be in a button-up shirt and ready by 10:30 a.m. on Tuesdays, Thursdays and Saturdays.C. Record review 1. Failed to consistently monitor and document the condition of Resident #8's dialysis access site in order to prevent an infection of her hemodialysis line, which resulted in a five day hospital stay for the residentReview of Resident #8's dialysis care plan, initiated 6/20/25 and revised 9/8/25 (during the survey), revealed the resident was dependent on dialysis related to end-stage renal failure via a dialysis port. Interventions included checking and changing the dressing daily at the access site, not drawing blood or taking a blood pressure in the arm with the graft, monitoring intake and output, monitoring, documenting and reporting as needed new or worsening peripheral edema. -However, the resident had a central venous catheter (CVC) on her chest, not a graft (access site) on her arm that would affect taking a blood pressure. Review of Resident #8's skin integrity care plan, initiated on 6/20/25 and revised 8/8/25, revealed the resident was at risk for impaired skin integrity related to chronic kidney disease, a decline in mobility and the need for assistance with transfers. She had old and new scratch marks and rashes all over her body related to dry skin. Interventions included consulting a dietitian, ensuring the resident's nails were clipped, evaluating for bowel incontinence, evaluating for edema, evaluating for urinary incontinence, evaluating the resident's skin for areas of blanching or redness, evaluating for redness or excoriation, moisturizing skin as needed and monitoring for signs and symptoms of infection. -However, the care plan did not include personalized interventions to prevent the resident from scratching the affected areas of her skin, including around the dialysis access site in her chest. A review of Resident #8's weekly skin assessments from 6/3/25 through 6/24/25 revealed the following: The 6/3/25 weekly skin assessment did not reveal there was a dialysis access site on the resident's chest or dry, patchy skin anywhere on the resident's skin. The 6/10/25 weekly skin assessment revealed there was a dialysis access site on the resident's chest and dry patchy skin on the upper arms, back, sides and legs. The assessment said there was treatment in place for the dry patchy skin. The 6/17/25 weekly skin assessment revealed the resident's skin was intact and there were no skin impairments observed. The skin assessment did not identify that the resident had a dialysis access site on her chest.The 6/24/25 weekly skin assessment revealed there were scattered linear scabs all over the resident's body and she had dry skin. The assessment said there was a treatment in place for the skin concerns. The skin assessment did not identify that the resident had a dialysis access site on her chest.-However, the 6/24/25 did not identify where on the resident's body the scabs were located. Resident #8's 6/3/25 dialysis communication form (a form used to communicate between the facility and the dialysis center) was reviewed. The dialysis center section (the section the dialysis center completed to communicate to the facility) documented the dialysis access site dressing was bloody and the central venous catheter (CVC) site had bloody trauma to it. The dialysis center documented that Resident #8 appeared to have pulled on the catheter line. The dialysis center requested for the facility to please contact the clinic and the clinic phone number was provided on the form. -However, there was no documentation in the resident's EMR to indicate the facility addressed the dialysis center's request to contact them.The 6/5/25 physician's note revealed Resident #8 had pruritus (an uncomfortable sensation that triggers the urge to scratch the affected areas). The note revealed the resident had widespread skin excoriation from scratching. (continued on next page)

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F 0698 Level of Harm - Actual harm Residents Affected - Few	areas. Leave open to air every shift and as needed. Report to the doctor if signs and symptoms of skin infection are noted. Every shift for dermatitis per wound care provider, ordered 8/25/25. Review of Resident #8's June 2025, July 2025, August 2025 and September 2025 MARs revealed the following: -There was no documentation to indicate dialysis treatment occurred on 7/1/25 through 9/10/25. -There was no documentation to indicate the Nepro supplement was administered on 6/29/25 through 9/10/25. -There was no documentation to indicate the amount consumed for the Nepro supplement on 6/2/25 through 6/10/25, 6/12/25 through 6/22/25, 6/24/25, 6/26/25, 6/28/25 and 6/29/25. -There was no documentation to indicate the hydrocortisone cream was administered on 8/4/25, 8/18/25, 8/29/25, 9/3/25 and 9/10/25. -There was no documentation to indicate monitoring of the resident's hemodialysis port site was observed on 8/1/25, 8/3/25, 8/4/25, 8/10/25, 8/14/25, 8/16/25, 8/18/25, 9/3/25, 9/5/25, 9/6/25 and 9/20/25. -There was no documentation to indicate wound care to the resident's left chest dermatitis was administered on 9/1/25, 9/3/25, 9/5/25, 9/6/25 and 9/10/25. III. Resident #7A. Resident status Resident #7, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included end-stage renal disease, diabetes mellitus with diabetic chronic kidney disease, schizotypal disorder and dementia in other diseases. According to the 9/12/25 MDS assessment, the resident was cognitively intact with a BIMS score of 13 out of 15. He used a wheelchair. He required set up assistance with eating and oral hygiene. He was dependent on staff assistance with toileting and required supervision with personal hygiene. He required maximal assistance with showering. The 9/12/25 assessment indicated the resident received dialysis. B. Resident interview Resident #7 was interviewed on 9/8/25 at 2:12 p.m. in his room. Resident #7 said he went to dialysis on Tuesdays, Thursdays and Saturdays. He said he had to tell the nursing staff when to have him ready for dialysis. He said if he did not tell them, he would not be ready in time to go to dialysis. He said the facility gave him a protein bar as a snack when he went to dialysis but he said he did not like the protein bars they gave him. He said the facility knew he did not like the protein bars but they did not do anything about it. He said sometimes the dialysis center refused to give him dialysis because his Hoyer lift sling was not placed in the right position by the facility staff. He said it had happened three times. He said he had to wait in the lobby until the facility returned to pick him up. He said it had taken the dialysis center a long time to get a hold of someone at the facility to pick him up. He said he cried because he felt like he was going to die. He said he was a diabetic and his blood sugar was low. He said he ended up being okay. During the interview, there was a bag of Nugo protein bars observed on the resident's dresser underneath the window and one protein bar on the bedside table next to the resident's bed. There were eleven protein bars with flavors of peanut butter, orange and banana. There was no whiteboard to indicate when the resident needed to be ready for dialysis. C. Record review The dialysis care plan, initiated 6/18/25 and revised 9/8/25 (during the survey) revealed the resident had dialysis related to end stage renal failure. The care plan revealed the name of the dialysis center, dialysis appointments on Tuesday, Thursday and Saturday at 12:45 p.m. and dialysis right chest port. Interventions included checking, changing and documenting dressing daily at the dialysis access site, not drawing blood or taking blood pressure in the arm with the graft, monitoring labs and reporting to the doctor as needed, monitoring, documenting and reporting as needed for signs and symptoms of bleeding, bacteremia and septic shock (a life threatening condition when the body's immune system overreacts to an infection), monitoring, documenting and reporting as needed for new and worsening peripheral edema. Review of Resident #7's September 2025 CPO revealed the following physician's order:Dialysis appointment: Tuesday, Thursday, Saturday. Appointment time: 12:45 p.m. Please have a packet ready with a face sheet and medication list, ordered 8/28/25. Review of Resident #7's dialysis communication forms, from 6/2/25 to 9/10/25, revealed the following: The 6/3/25 pre-dialysis section had no documentation for the dialysis time. The 6/5/25 pre-dialysis section had no documentation for the meal and snack and there was no nurse's signature.The 6/7/25 and 6/28/25 pre-dialysis section had no documentation for the meal and snack.The 6/10/25, 6/12/25, 6/21/25, 7/1/25 and 7/12/25 pre-dialysis sections had no (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure residents and their representatives had a right to participate in the development and implementation of their person-centered plan of care for three (#13, #18 and #46) of 17 residents out of 36 sample residents.Specifically, the facility failed to invite Resident #13, Resident #18 and Resident #46 and/or their representatives to participate in the initial care conferences to develop the resident's plan of care.Findings include: I. Facility policy and procedures The Care Planning-Resident Participation policy, implemented on [DATE], was provided by the chief nursing officer on [DATE] at 1:26 p.m. The policy revealed this facility supported the resident's right to be informed of, and participate in, his or her care planning and treatment (implementation of care). The facility would inform the resident, in a language he or she could understand, of his or her rights regarding planning and implementing care, including the right to be informed of his or her total health status. The physician, other practitioner, or professional would inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment, and treatment alternatives/options. The facility would notify the resident and/or resident representative, in advance, of the care to be furnished and the type of caregiver or professional that would furnish care, as well as changes to the plan of care. The facility would encourage and assist the resident and/or resident representative to participate in choosing care and treatment options including the initial decisions about treatment, decisions about changes and the right to refuse treatment. The care planning process would include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. The facility would honor the resident's choice in individuals to be included in the care planning process. The facility would honor requests for care plan meetings and acknowledge requests for revisions to the person-centered plan of care. The facility would honor the resident's right to participate in establishing the expected goals and outcome of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. The facility would discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes. The facility would make an effort to schedule the conference at the best time of the day for the resident/resident's representative. The facility would obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan. If the participation of the resident and/or resident representative was determined not practicable for the development of the resident's care plan, an explanation would be documented in the resident's medical record. II. Resident #13 A. Resident status Resident #13, age greater than 65, was admitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included chronic kidney disease stage IV, chronic pain syndrome, obesity, major depressive disorder and chronic diastolic (congestive) heart failure. The [DATE] minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status score (BIMS) of 15 out of 15. The resident required partial/moderate (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Longmont Health and Rehab, LLC	1960 S Fordham St Longmont, CO 80503

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff assistance (staff did less than half of the effort. Staff lifted, held, or supported the trunk or limbs, but provided less than half the effort) for lower body dressing, putting on/talking off footwear and personal hygiene. The assessment indicated the resident and family participated in this assessment and goal setting. B. Resident interview Resident #13 was interviewed on [DATE] at 9:58 a.m. Resident #13 said she had resided in the facility for three weeks and had not had an initial care conference. She said she would attend a care conference if invited. Resident #13 was interviewed again on [DATE] at 10:23 a.m. Resident #13 said she would have liked to have had a care conference within the first few days of residing in the facility, to know what care she would receive in the facility and her ability to get ancillary services for dental and hearing. C. Record review Review of Resident #13's care plan revealed the resident would have the opportunity to attend care conferences upon admission and at least quarterly to discuss plan of care, discharge plan/goals, and questions/concerns. -A review of Resident #13's electronic medical record (EMR) revealed there was no documentation that the resident was invited to a care conference since admitting to the facility. D. Staff interviews The social services director (SSD) was interviewed on [DATE] at 10:12 a.m. She said she had worked at the facility for about two weeks. She said Resident #13 had not received an initial care conference as of this date. She said the facility tried to complete an initial care conference within the first few days after admission III. Resident #18 A. Resident status Resident #18, age less than 65, was admitted on [DATE]. According to the [DATE] CPO, diagnoses included acute ischemic heart disease, sequelae of unspecified cerebrovascular disease, depression, anxiety and muscle weakness. The [DATE] MDS assessment revealed the resident was cognitively intact with a BIMS of 15 out of 15. The resident had impairment on one side of the upper and lower extremities in functional limitation of ranges of motion. The resident required partial/moderate assistance (staff died less than half of the effort. Staff lifted, held, or supported the resident's trunk or limbs, but provided less than half the effort) for upper and lower body dressing and putting on/off footwear. The assessment indicated the resident did participate in this assessment and in setting goals. B. Resident interview (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18 was interviewed on [DATE] at 9:58 a.m. Resident #18 said he had not had an initial care conference and had resided in the facility for three weeks. He said he would attend the care conference if he were invited. Resident #18 was interviewed again on [DATE] at 11:30 a.m. Resident #18 said as of this date ([DATE]) he had not had an initial care conference. He said he would attend to find out about the services provided by the facility C. Record review -A review of Resident #18's EMR revealed there was no documentation that the resident was invited to a care conference since admitting to the facility. D. Staff interviews The SSD was interviewed on [DATE] at 10:17 a.m. The SSD said she reviewed Resident #18's EMRand did not see that the resident had a care conference as of this date. She said she would like to have the initial care conference within the first 48 hours after admission to assess the needs of the resident. Regional director of clinical services #2 was interviewed on [DATE] at 10:25 a.m. Regional director of clinical services #2 said an initial care conference should be conducted within the first hours after admission to assess the needs and services that a resident required. IV. Resident #46 A. Resident status Resident #46, age [AGE], was admitted on [DATE]. According to the [DATE] CPO, diagnoses included Parkinson's disease without dyskinesia (involuntary movement of the body), dementia and depression. The [DATE] MDS assessment revealed Resident #46 had a mild cognitive impairment with a BIMS score of 12 out of 15. B. Resident #46's representatives interview Resident #46's representative was interviewed on [DATE] at 2:15 p.m. The representative said Resident #46 was admitted to the facility on [DATE] and had not had an initial care conference yet. C. Record review -Review of Resident #46's electronic medical record (EMR) revealed no documentation regarding an initial care conference. D. Staff interviews The SSD was interviewed on [DATE] at 10:59 a.m. The SSD said she was auditing all residents to see who needed a care conference so she could schedule it. She said Resident #46's care conference was scheduled for the week after the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to honor resident choices for five (#1, #25, #42, #17 and #38) of 17 residents out of 36 sample residents. Specifically, the facility failed to honor the preferred shower days and/or preferred number of showers per week for Resident #1, Resident #25, Resident #42, Resident #17 and Resident #38.Findings include: I. Facility policy and procedure The Promoting/Maintaining Resident Self-Determination policy, revised April 2025, was provided by the chief nursing officer on 9/11/25 at 1:26 p.m. It revealed in pertinent part, It is the practice of this facility to protect and promote resident rights by facilitating resident self-determination through support of resident choice. The facility will ensure that each resident has the opportunity to exercise his/her autonomy regarding those things that are important in his/her life such as interests and preferences. Each resident has the right to choose their schedules (including sleeping, eating, bathing and waking times), consistent with their interests, assessments, and plans of care. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included moderate vascular dementia with mood disturbance, heart disease, muscle wasting and atrophy and lack of coordination. The 6/12/25 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition and impaired memory. Resident #1 was dependent on staff assistance for dressing, hygiene, toileting, bathing, transfers and repositioning. Resident #1 used a wheelchair for mobility. B. Resident representative interview Resident #1's representative was interviewed on 9/8/25 at 2:18 p.m. The representative said she initially told the facility Resident #1's preferred shower days were Wednesday and Saturday evenings. The representative said Resident #1 preferred evening showers because he stayed up late. The representative said in August 2025, the facility hired additional certified nurse aides (CNA) to specifically provide baths to residents. The representative said she was told the bath aides were only available Monday through Friday and that baths over the weekend were no longer available. The representative said she was not sure if Resident #1 received showers on the weekend or if he received two showers a week in general. C. Record review Review of Resident #1's CNA task sheet for showers, from 8/11/25 to 9/10/25, revealed the resident's shower preference days were Wednesday and Sunday in the evening. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Documentation on Resident #1's CNA task sheet for showers revealed the resident received the following showers from 8/11/25 to 9/10/25: -8/24/25 at 12:05 a.m. (Sunday); -8/27/25 at 4:01 p.m. (Wednesday); -8/28/25 at 5:56 a.m. (Thursday); -9/3/25 at 8:40 a.m. (Wednesday); and, -9/10/25 at 10:00 a.m. (Wednesday). -The resident received showers on all but one of his preferred shower days, however, documentation revealed four out of the five showers documented were given in the daytime hours and not the evening hours, as was the resident's preference. -There was no documentation on the CNA task sheet for showers to indicate if the resident received showers between 8/11/25 and 8/24/25. III. Resident #25 A. Resident status Resident #25, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included type 2 diabetes, polyneuropathy (nerve pain), impaired mobility and contractures of the left and right hands. The 8/18/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. He required moderate assistance with dressing, personal hygiene and footwear. He required touching assistance with bathing, repositioning and transfers. He used a wheelchair for mobility. B. Resident interview Resident #25 was interviewed on 9/8/25 at 10:55 a.m. Resident #25 said he was told what days were his assigned shower days and he was able to choose the time of day, but not which days. Resident #25 said his preference was to shower at least twice a week. Resident #25 said recently he had only gotten one shower a week and this made him feel dirty and uncomfortable. C. Record review Review Resident #25's CNA task sheet for showers, from 8/11/25 to 9/10/25, revealed the resident's scheduled shower days were Tuesday and Saturday during the day. Documentation on Resident #25's CNA task sheet for showers revealed the resident received the following showers from 8/11/25 to 9/10/25: -8/15/25 at 2:26 a.m. (Friday); (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/18/25 at 11:12 p.m. (Monday); -8/22/25 at 4:55 a.m. (Friday); -8/27/25 at 1:35 a.m. (Wednesday); -8/28/25 at 9:52 a.m. (Thursday); -9/2/25 at 5:59 p.m. (Tuesday); and, -9/9/25 at 11:11 a.m. (Tuesday). -Out of six showers documented, Resident #25 received a shower on two of his scheduled shower days and two of the documented showers were in the evening, not during the day as was documented for his shower schedule. -There was no documentation on the CNA task sheet for showers to indicate if the resident received showers between 8/11/25 and 8/15/25. IV. Resident #42 A. Resident status Resident #42, age less than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder. The 8/21/25 MDS assessment revealed Resident #42 was cognitively intact with a BIMS score of 15 out of 15. He required moderate assistance to roll side to side, and required substantial assistance with eating, hygiene, bathing, toileting and dressing. He was dependent on staff assistance for transfers and used a motorized wheelchair for mobility. B. Resident interview Resident #42 was interviewed on 9/9/25 at 9:29 a.m. Resident #42 said the facility did not bathe him according to his preferred shower days or shower frequency. Resident #42 said he preferred to bathe on Monday, Wednesday and Friday, but he often only received one or two showers per week. Resident #42 said he felt dirty and oily because he did not shower enough. C. Record review Review Resident #42's CNA task sheet for showers, from 8/11/25 to 9/10/25, revealed the resident's preferred shower days were Monday, Wednesday and Friday with no preferred time. Documentation on Resident #42's CNA task sheet for showers revealed the resident received the following showers from 8/11/25 to 9/10/25: -8/19/25 at 11:57 a.m. (Tuesday); (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-8/25/25 at 5:59 p.m. (Monday); -8/27/25 at 5:38 p.m. (Wednesday); -8/29/25 at 6:29 a.m. (Monday); -9/1/25 at 11:51 a.m. 9/3/25 at 9:45 a.m. (Wednesday); and, -9/8/25 at 12:32 p.m. (Monday). -The CNA task sheet for showers documented Resident #42 was not available to shower on his preferred day on 9/5/25, however, there was no documentation to indicate if the resident was offered a shower on a different date. -Out of six showers documented, Resident #42 received a shower on all but one of his preferred shower days, however, the resident only received his preferred number of showers per week (three) during one week in the reviewed time period. -There was no documentation on the CNA task sheet for showers to indicate if the resident received showers between 8/11/25 and 8/19/25. V. Resident #17 A. Resident status Resident #17, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included hemiplegia and hemiparesis (neurological conditions that cause weakness or paralysis on one side of the body), chronic atrial fibrillation, muscle weakness, anxiety disorder, and bradycardia (a condition characterized by a slow heart rate). The 8/4/25 MDS assessment revealed the resident was unable to complete the BIMS assessment. The staff assessment for mental status revealed the resident required maximum assistance with personal hygiene, toileting, and showers, and set-up assistance with eating. The resident had a short-term memory problem, but was able to recognize staff names and faces. B. Resident interview Resident #17 was interviewed via a language interpreter line on 9/9/25 at 8:19 a.m. Resident #17 said she had not received a shower in a while. She said the staff never came to offer her a shower. She said she preferred to take a shower twice a week. C. Record review The 7/24/25 admission assessment screener documented that Resident #17 required total assistance with showers. The care plan task history documented on 8/23/25 that Resident #17 preferred a shower two times a week and was scheduled for Wednesday and Sunday night shifts. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-However, the resident's shower preference sheet was updated on 9/9/25 (during the survey) to one shower per week. Resident #17's shower documentation, from 7/24/25 to 9/9/25, was provided by the regional vice president of operations on 9/10/25 at 5:15 p.m. -The shower documentation revealed Resident #17 received one shower on 9/4/25 at 3:20 a.m., which was one shower provided out of 11 opportunities for a shower. -The shower documentation revealed Resident #17 refused showers on 7/24/25, 7/27/25, 8/20/25, 8/23/25 and 8/27/25 however, there was no documentation to indicate the facility followed up with the resident to offer another shower on the days she refused or that they attempted to determine why she was refusing the showers. VI. Resident #38 A. Resident status Resident #38, age less than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included Parkinson's disease without dyskinesia (a neurological condition characterized by involuntary, repetitive, and often abnormal movements), schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder). anxiety disorder, muscle weakness, and pain in the right hip. The 7/11/25 quarterly MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She required maximal assistance with showers, moderate assistance with toileting and personal hygiene and set-up assistance with eating. B. Resident interview Resident #38 was interviewed on 9/9/25 at 11:15 a.m. Resident #38 said she had not received a shower in over a week. Resident #38 said she was supposed to have a shower over the weekend but was told there were no shower aides. The resident's hair was tied up in a ponytail and was greasy in appearance. Resident #38 was interviewed again on 9/10/25 at 3:10 p.m. Resident #38 said she did not receive her scheduled showers as she preferred because there were no shower aides available and the CNAs were too busy to provide showers. The resident's hair was still tied up in a ponytail and was greasy in appearance. C. Record review The ADL care plan, revised 7/10/25, revealed Resident #38 had an increased risk for decline related to the disease process of Parkinson's disease. Interventions included providing substantial assistance to maximum assistance from staff for showers. -Review of the comprehensive care plan did not reveal documentation that indicated the resident's shower preferences. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review Resident #38's CNA task sheet for showers, from for 8/1/25 to 9/9/25, revealed the following: The August 2025 (8/1/25 to 8/31/25) CNA task sheet for showers documentation revealed Resident #38 was provided bathing on four out of eight bathing opportunities. -There was no documentation to indicate why the resident did not receive her other showers during the month. The September 2025 (9/1/25 to 9/9/25) CNA task sheet for showers documentation revealed Resident #38 was provided bathing on one out of two bathing opportunities. -There was no documentation to indicate why the resident did not receive her other shower. VII. Staff Interviews Registered nurse (RN) #1 was interviewed on 9/10/25 at 3:53 p.m. RN #1 said the shower aide was responsible for completing the resident's showers. She said all showers should be documented in the resident's medical record, and documentation should indicate if the shower was completed or the resident refused. She said the shower aides would notify the nurse when a resident refused to shower. She said she would attempt to encourage the resident to shower and offer a bed bath if every alternative attempt to provide a shower to the resident failed. CNA #3 was interviewed on 9/10/25 at 5:27 p.m. CNA #3 said she was hired as a CNA specifically to provide baths to residents, but also helped on the floor when needed. CNA #3 said while she and CNA #1, who was also hired to provide baths, typically worked Monday through Friday, she said residents should be able to get a bath or a shower on any day they chose. CNA #3 said she was not sure if residents were or were not receiving baths on their preferred days during the weekend, but she said she offered bathing assistance to as many residents as she could in order to try to ensure residents were not going too long without bathing. Regional director of clinical services #2 was interviewed on 9/11/25 at 1:42 p.m. Regional director of clinical services #2 said the facility recently received complaints about residents not getting timely showers or showers on their preferred day, so the facility hired two CNAs dedicated to bathing residents. She said residents at the facility could choose either the day or the time of day they could shower. She said she was not aware residents were told they could not have baths on weekends. She said some of the times documented may not be accurate since the CNAs might forget to back-time the documentation to the time the shower occurred. She said the time in the CNA task documentation might have been when the CNA was able to document the shower was completed for the shift. Regional director of clinical services #2 said she planned to educate staff that the addition of dedicated bath aides on weekends did not mean that they did not have to provide baths to residents whose preferred showers days were on the weekend. CNA #1 was interviewed on 9/11/25 at 3:56 p.m. CNA #1 said she was hired along with one another CNA (CNA #3) to provide baths to residents. CNA #1 said she and CNA #3 typically worked Monday through Friday. CNA #1 said they had a sheet that documented each resident's preferred bath days, but they also offered as many baths as they could to all residents each day, in case someone refused a bath on their preferred day, or a resident wanted an additional shower. CNA #1 said she was not sure if CNAs working the weekends were offering baths to residents. CNA #1 said she was not aware if residents were told they could not have baths on the weekend.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed failed to ensure meaningful activities designed to support residents physical, mental and psychosocial well-being were provided for six (#1, #32, #42, #29, #38 and #18) of 17 residents reviewed for activities out of 36 sample residents.Specifically, the facility failed to:-Provide a meaningful activity program for Residents #1, #32, #42, #29, #38 and #18; and,-Ensure an initial activity assessment was completed for Resident #18.Findings include: I. Facility policy and procedure The Activities policy, revised April 2025, was provided by the chief nursing officer on 9/11/25 at 1:26 p.m. It revealed in pertinent part, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction within the community. All staff will assist residents to and from activities when necessary. The facility will consider accommodations in schedules, supplies and timing in order to optimize a resident's ability to participate in an activity of choice. II. Resident #1 A. Resident status Resident #1, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included moderate vascular dementia with mood disturbance, heart disease, muscle wasting and atrophy and lack of coordination. The 6/12/25 minimum data set (MDS) assessment revealed the resident had moderately impaired cognition and impaired memory, per the staff assessment for mental status. Resident #1 was dependent on staff assistance for dressing, hygiene, toileting, bathing, transfers and repositioning. Resident #1 used a wheelchair for mobility. The MDS assessment indicated Resident #1 had preferred activities of keeping up with the news, reading and group activities. B. Resident representative interview Resident #1's representative was interviewed on 9/8/25 at 2:18 p.m. The representative said the facility had not had an activities director (AD) for approximately six months. She said when the previous AD left the facility, a certified nurse aide (CNA) was planning the activities for the residents. The representative said the CNA did not have any training to provide activities for residents and also ended up leaving the facility. The representative said since those two staff members had left, the facility would occasionally have bingo, but otherwise did not provide activities to the residents. She (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said Resident #1 was unable to participate in bingo due to his cognitive impairment and the facility did not provide any activities that were appropriate for Resident #1. The representative said the facility used to provide a calendar with activities, but she had not received one for September 2025. Cross reference F680 for failure to ensure the activities program was directed by a qualified professional. C. Record review Resident #1's care plan, initiated 6/25/25 and revised 6/25/25, revealed Resident #1 preferred activities were to watch sports, television (TV), visit with family, birdwatching and sitting outside when weather permitted. Resident #1's favorite activity documented was to tinker with tools and fasteners. Interventions included giving reminders to Resident #1 when his favorite sports were on TV, providing a monthly program calendar and providing space for birdwatching. III. Resident #32 A. Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominent side (a stroke affecting the left side of the body) depression and narcolepsy. The 8/1/25 MDS assessment revealed Resident #32 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident had impaired functional range of motion of the upper and lower extremities on the left side. She required substantial assistance with hygiene, toileting, bathing and transfers. She required supervision and cues to eat. She required moderate assistance with the use of a wheelchair for mobility. The MDS assessment indicated Resident #32 had preferred activities of listening to music, reading, keeping up with the news and attending religious services B. Resident representative interview Resident #32's representative was interviewed on 9/9/25 at 11:06 a.m. The representative said Resident #32 tended to isolate herself and did not know activities were available unless someone cued her or provided reminders about activities. The representative said she asked the staff specifically to assist Resident #32 to a church service activity the facility had when Resident #32 first arrived at the facility. The representative said Resident #32 had never attended any activities in the facility to her knowledge She said whenever she came to visit, Resident #32 was always sitting alone in her room. C. Record review Resident #32's care plan, initiated 8/22/25, revealed Resident #32 had none to little activity involvement due to physical limitation. Interventions included establishing Resident #32's prior level of activity and interests, making a daily schedule to accommodate activity participation as requested and monitoring for the impact of medical problems on the resident's activity level. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #32's September CPO revealed the following physician's order: Please ask the CNA to assist the resident with getting ready for church service the night before on every Saturday evening, ordered 8/7/25. -Review of Resident #32's August 2025 treatment administration record (TAR) (8/1/25 to 8/31/25) revealed missing documentation of the above CNA task being completed on 8/16/25. -Review of Resident #32's September 2025 (9/1/25 to 9/10/25) MAR revealed missing documentation of the above CNA task being completed on 9/6/25. IV. Resident #42 A. Resident status Resident #42, age less than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder. The 8/21/25 MDS assessment revealed Resident #42 was cognitively intact with a BIMS score of 15 out of 15. He required moderate assistance to roll side to side, and required substantial assistance with eating, hygiene, bathing, toileting, and dressing. He was dependent on staff assistance for transfers and used a motorized wheelchair for mobility. The MDS assessment indicated Resident #42's preferred activities included listening to music, visiting with animals, going outside and attending religious services. B. Resident interview Resident #42 was interviewed on 9/9/25 at 9:29 a.m. Resident #42 said he had not attended any activities at the facility since his admission (on 7/20/25). He said when he first admitted to the facility, a CNA was leading activities with residents. Resident #42 said he was not able to attend the activities because by the time multiple staff were available to use the hoyer lift to transfer him to his wheelchair, the activity was usually over. Resident #42 said recently, the only activity available was bingo and he said he felt bingo was not an engaging activity for most residents his age. He said no staff members in the facility provided him with individual activities in his room as an alternative to group activities. C. Record review -Residents #42's care plan, initiated 7/22/25 and revised 9/8/25, revealed Resident #42 did not have a care plan focus for activities. Resident #42's trauma informed care plan documented to provide Resident #42 with meaningful activities, but did not specify what activities to provide for Resident #42. V. Staff interviews The temporary activities director (AD) was interviewed on 9/10/25 at 2:36 p.m. The temporary AD said she did not normally work at the facility, but worked full-time as the AD at a sister facility. The (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temporary AD said she was asked to come to the facility to provide activities this week (during the survey). The temporary AD said she did not plan to provide activities to residents at the facility on a full-time basis and she was meeting the residents for the first time on the day of the interview. The temporary AD said to her knowledge, the facility did not have anyone previously hired as the AD. The temporary AD said she heard someone was offered the position and she was told by the nursing home administrator (NHA) that the plan was for her to train the new AD for the facility whenever the new AD started. The chief nursing officer was interviewed on 9/11/25 at 1:42 p.m. The chief nursing officer said the facility had been trying to hire an AD since the previous AD left. The chief nursing officer said they had made an offer to one person who declined the offer on the last day the offer was available, so they had to start over looking for an AD. The chief nursing officer said they had another potential candidate for the AD position and they planned to start training that person as soon as possible. VI. Resident #29 A. Resident status Resident #29, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included chronic obstructive pulmonary disease (lung disease), dementia and acute and chronic respiratory failure with hypoxia (not enough blood in the organs). The 8/7/25 MDS assessment revealed Resident #29 had a moderate cognitive impairment with a BIMS score 11 out of 15. Resident #29 required partial or moderate assistance for toileting, showering, getting dressed and personal hygiene. The MDS assessment indicated having items to read, listening to music, being around animals, keeping up with the news, being in a group of people and completing favorite activities were documented as being somewhat important to Resident #29. B. Observations During a continuous observations on 9/10/25, beginning at 8:00 a.m. and ending at 10:30 a.m., the following was observed: At 8:00 a.m. Resident #29 was sitting in her recliner. -There was no music or television turned on in the room, and the resident did not have any meaningful activities to do. At 8:28 a.m. Resident #29 received her breakfast tray. At 9:29 a.m. CNA #1 picked up Resident #29's breakfast tray. At 9:35 a.m. Resident #29 asked for more coffee. At 10:09 a.m. two CNAs were standing outside Resident #29's room, said hello to the resident and went into a different resident's room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-The CNAs did not offer to provide any meaningful activities for the resident. At 10:30 a.m. Resident #29 was still sitting in her recliner. -There was no music or television turned on in the room, and the resident did not have any meaningful activities to do. C. Representative interview Resident #29's representative was interviewed on 9/8/25 at 10:47 a.m. The representative said she routinely found Resident #29 sitting in her recliner. She said the resident did not have activities to do unless the representative was there to help provide activities. D. Record review Resident #29's activity care plan, initiated 8/22/25, documented the resident had little or no activity involvement due to poor adjustment to the facility and the resident wished to not participate. -However, the care plan failed to indicate what activities were provided to the resident as an alternative to group activities. E. Staff interviews The staffing coordinator was interviewed on 9/11/25 at 8:55 a.m. The staffing coordinator said the CNAs and nurses were not involved in providing activities. CNA #1 was interviewed on 9/11/25 at 9:13 a.m. CNA #1 said activities had not been provided to the residents for over a month because there was not an activity director or activity staff in the facility. The temporary AD was interviewed on 9/11/25 at 11:05 a.m. The temporary AD said she was from a sister facility and it was her second day providing activities. She said activities were very important and they gave residents a more meaningful life and helped with anxiety and depression. VII. Resident #38 A. Resident status Resident #38, age less than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnosis included Parkinson's disease without dyskinesia (a neurological condition characterized by involuntary, repetitive, and often abnormal movements), schizoaffective disorder (a mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder). anxiety disorder, muscle weakness, and pain in the right hip. The 7/11/25 quarterly MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. She required maximal assistance with showers, moderate assistance with toileting and personal hygiene, and set-up assistance with eating. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The assessment documented that it was very important for the resident to complete her favorite activities. B. Resident interview Resident #38 was interviewed on 9/9/25 at 8:39 a.m. Resident #38 said the activity department had been nonexistent for quite some time, ever since the activity staff quit working at the facility. The resident said there had been no activities in the facility since the AD quit. Resident #38 said the facility used to have a lot of activities during the day and on the weekends, but now there were none. She said it got really boring when all residents could do was go to the dining room to eat. She said her roommate did not speak English, and therefore she could not engage in conversation with her. C. Record review -Review of Resident #38's comprehensive care plan, revised 7/10/25, revealed there was not an activity care plan focus or interventions for the resident's activity preferences. -Review of Resident #38's electronic medical record (EMR) did not reveal evidence of an activity log participation for the resident. D. Staff interviews CNA #4 was interviewed on 9/11/25 at 1:10 p.m. CNA #4 said the residents engaged in their own individual activities. She said she had not seen any group activities being offered outside of the residents being seated together in the common area to watch television. CNA #4 said she had not seen an activity staff member in the facility for quite a while. She said the facility used to have bingo sessions as an activity. VIII. Resident #18 A. Resident status Resident #18, age less than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included acute ischemic heart disease, sequelae of unspecified cerebrovascular disease, depression, anxiety and muscle weakness. The 8/12/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident had impairment on one side of the upper and lower extremities and functional limitation in ranges of motion. The resident required partial/moderate assistance for upper and lower body dressing and putting on/off footwear. The MDS assessment indicated it was somewhat important for the resident to have books, newspapers and magazines to read, listen to music he liked, be around animals such as pets, keep up with the news, do things with groups of people and participate in his favorite activities. B. Resident interview Resident #18 was interviewed on 9/8/25 at 10:55 a.m. Resident #18 said he had not been invited to activities since his admission (on 8/3/25) and he would attend if invited. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #18 was interviewed a second time on 9/11/25 at 11:30 a.m. Resident #18 said he still had not had an activity assessment by staff, had not been invited to any activities and reiterated that he would attend activities if he was invited. C. Record review A care plan for being independent/dependent on staff for meeting the resident's emotional, intellectual, physical, and social needs related to cognitive deficits was revised on 8/26/25. Interventions included conversing with the resident while providing care, assisting the resident with arranging community activities, establishing and recording the resident's prior level of activity involvement/interests by talking with the resident, caregivers, and family on admission and as necessary, introducing the resident to other residents with similar backgrounds and interests and encouraging/facilitating interaction and inviting the resident to scheduled activities. -The resident did not have an activity care plan that was specific to the resident's individual interests and preferences. -Review of Resident #18's EMR failed to reveal documentation of an initial activity assessment. D. Staff interviews The temporary AD was interviewed on 9/8/25 at 2:45 p.m. The temporary AD said she was the AD at another facility and this was her first day in the facility. She said an initial activity assessment should be done within the first 48-hours after a resident's admission and should be documented in the resident's medical record. She said the facility utilized multiple recreation assessments (the story of me, recreation therapy data collection, recreation therapy assessment and activity choices) for each resident. The AD said she did not see any of these documents in Resident #18's medical record. She said a resident should be invited to all the activities in the facility. She said attendance should be taken at each activity to facilitate accurate documentation in the resident's medical record. Regional director of clinical services #2 was interviewed on 9/11/25 at 10:25 a.m. Regional director of clinical services #2 said an initial activity assessment should be conducted within the first 48-hours after admission to assess the resident's activities needs, likes and dislikes. She said each resident should be invited to activities and staff should document attendance to activities.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure the activities program was directed by a qualified professional. Specifically, the facility failed to employ a qualified activities director in order to provide a program of activities for residents requiring activity and recreational support.Findings include: I. Professional referenceAccording to the National Certification Council of Activity Professionals (NCCAP) (2023), retrieved on 9/15/25 from www.nccap.org, An activity director must meet specific qualifications in education, certification and/or experience.The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist; or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body; or has two years of experience in a social or recreational program within the last five years, one of which was full-time in a therapeutic activities program; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.An activity director is responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program. This includes completion of the activities component of the comprehensive assessment; contribution to the comprehensive care plan goals and approaches that are individualized to match the skills, abilities, and interests/preferences of each resident.II. Facility policy and procedure The Activities Director Qualifications policy and procedure, revised 4/11/25, was provided by the chief nursing officer on 9/11/25 at 4:56 p.m. It read in pertinent part, The activities director, at minimum, shall meet the following qualifications: an activity professional certified by the National Certification Council for Activity Professionals as an Activity Director Certified (ADC) or Activity Consultant Certified (ACC); an occupational therapist or occupational therapy assistant meeting the requirements for certification by the American Occupational Therapy Association and having at least one year of experience in providing activity programming in a nursing care facility; a therapeutic recreation specialist, registered by the National Council for Therapeutic Recreation Certification, having at least one year of experience in providing activity programming in a nursing care facility; a person with a Master's or Bachelor's degree in the social or behavioral sciences who has at least one year of experience in providing activity programming in a nursing care facility; a person who has completed, within a year of employment, a training course for activity professionals in an accredited state facility and who has at least two years' experience in social or recreational program work, at least one year of which was full-time in an activities program in a health care setting, or a person who has monthly consultation with a person meeting the qualifications set forth in subsections The consultation shall be sufficient in amount to assist the activity staff members in meeting resident needs.III. Resident representative interviewResident #8's representative was interviewed on 9/9/25 at 11:38 a.m. The representative said she visited Resident #8 almost every day. She said the last time she saw the activities director was approximately 8/15/25. IV. Observations On 9/8/25 at 7:00 a.m., during the initial facility walkthrough, there were no calendars in the hallways, in the main living area, or in the dining area describing the activities for the day, for the week, or for the month of September 2025. On 9/8/25 at 10:30 a.m., resident room [ROOM NUMBER] was observed. There were no activities calendars for the day, for the week or for the month of September 2025 visible in the room. There was an activities calendar for the month of August 2025 observed hanging below the whiteboard on the wall next to the resident's bathroom. On 9/8/25 at 2:57 p.m., room [ROOM NUMBER] was observed. There were no activities calendars for the day, for the week or for the month of September 2025 visible in the room. There was an activities calendar for the month of August 2025 observed hanging below the resident's whiteboard next to the closet. On 9/9/25 at 12:20 p.m. room [ROOM NUMBER] was observed. There were no activities calendars for the day, for the week or for the month of September 2025 or August (continued on next page)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2025 visible in the room. Cross-reference F679 for failure to provide activities that meet the interests/needs of each resident.V. Record reviewThe key personnel contact list was provided by the regional vice president of operations on 9/8/25 at 9:29 a.m. The contact list revealed there was no activities director identified on the list. The staff list with titles was provided by the regional vice president of operations on 9/9/25 at 8:00 a.m. The staff list revealed there was no activities director identified on the list. VI. Staff interviewsCertified nurse aide (CNA) #6 was interviewed on 9/11/25 at 1:35 p.m. CNA #6 said there used to be one activity person for the facility. She said the last time she saw the activities person was about a month ago (August 2025). She said she had not seen any activities being conducted in the facility since the last time she had seen the activities person, until 9/10/25. She said activities were important for residents because activities enriched the residents' lives. She said activities gave the residents something to do other than staring at the wall and it helped prevent the residents from getting caught up in their thoughts. Registered nurse (RN) #1 was interviewed on 9/11/25 at 2:26 p.m. RN #1 said she did not know the exact date she last saw someone from the activities department in the facility, but she said it was at least the last week of August 2025. She said activities were important for residents because activities helped the residents' mental states. She said depending on the activity, the activity helped mobilize residents' hands and feet. She said activities prevented residents from boredom. The chief nursing officer was interviewed on 9/11/25 at 11:43 a.m. The chief nursing officer said there was currently no activities director for the facility. She said the facility had a qualified activities director (AD) but the AD had resigned. The chief nursing officer did not know the resignation date but she said it was sometime in August 2025. She said the facility had found someone to replace the AD so there would not be a gap in activities coverage for the residents, but the person they offered the position to had decided to accept another job offer elsewhere. The chief nursing officer said there was an AD from another facility working in the facility on 9/10/25 and 9/11/25 (during the survey) to help provide activities for the residents.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observations, record review and interviews, the facility failed to consistently serve food that was palatable and attractive at the appropriate temperatures.Specifically, the facility failed to ensure food was palatable and served at the appropriate temperature.Findings include:I. Facility policy and procedureThe Food Preparation Guidelines policy, implemented 4/11/25, was provided by the regional vice president of operations on 9/11/25 at 1:26 p.m. It read in pertinent part, It is the policy of this facility to prepare foods in a manner to preserve and enhance a resident's nutrition and hydration status. Food and drinks shall be palatable, attractive, and at a safe and appetizing temperature. Strategies to ensure resident satisfaction include providing meals that are varied in color and texture, using spices or herbs to season food in accordance with recipes, serving hot foods/drinks hot and cold foods/drinks cold, addressing resident complaints about foods/drinks, and honoring resident preferences, as possible, regarding foods and drinks, food shall be provided in a form (regular, cut, chopped, ground, pureed) that meets each resident's individual needs in accordance with his or her assessment and care plan.II. Resident group interviewA group interview, consisting of four residents (#38, #43, #46 and #55) who were assessed by the facility to be interviewable, was conducted on 9/10/25 at 2:00 p.m. The residents said meals were served cold and it did not matter if the residents ate in their rooms or the dining room.Resident #38 said the food was bland, and most of the time it was inedible because the food was usually cold. She said it was mostly okay in the dining room, but if staff had to bring a food tray to her room, then it would be delivered cold.Resident # 43 said he usually ate meals in his room. He said warm foods were delivered cold and cold foods were usually warm.III. Additional resident interviewsResident #38 was interviewed on 9/8/25 at 2:59 p.m. Resident #38 said the food was always served cold unless you went to the dining room early when the kitchen opened. Resident #38 said the food was bland and did not taste good.Resident #15 was interviewed on 9/9/25 at 9:02 a.m. Resident #15 said the food was served cold, and it tasted horrible.Resident #37 was interviewed on 9/10/25 at 4:51 p.m. Resident #37 said the food was served cold and late all the time. She said they would not even serve coffee until meal times.IV. ObservationsA test tray for a regular diet was evaluated by four surveyors immediately after the last resident had been served their room tray for lunch on 9/10/25 at 12:20 p.m. The room trays did not have hot plates to keep the food warm The test tray consisted of noodles, ham, tossed salad, tomato soup, pudding, and ranch dressing. The following was observed: -The temperature for the noodles was 112 degrees fahrenheit (F), was cool to the palate and tasted bland with no butter flavoring;-The temperature of the ham was 114 degrees F, and it was cool to the palate and tasted salty.-The temperature of the ranch dressing was 55 degrees F, and it was warm to the palate.-The temperature of the pudding was 72 degrees F and it was warm to the palate.-The temperature of the salad was 66.4, and it was warm to the palate.V. Staff interviewsCertified nurse aide (CNA) #4 was interviewed on 9/10/25 at 1:46 p.m. CNA #4 said there was usually only one CNA passing room trays for each hall, and that could be a factor in the residents' food being delivered cold. She said residents complained of cold food most of the time. She said she would offer to reheat the food for the residents when they complained of the food being cold. The nutrition services manager was interviewed on 9/10/25 at 1:55 p.m. The nutrition services manager said the facility did not have equipment to keep cold food items on the tray line cold. She said she was running behind and did not have enough time to prepare the cold food ahead of time to keep it in the main refrigerator to maintain the proper temperature. She said she would immediately obtain a storage container to keep cold food in, together with ice around it to keep it cold.The nutrition services manager said she would talk with the nursing home administrator (NHA) regarding obtaining an insulated food cart to help keep the food warm.The NHA was interviewed on 9/10/25 at 2:30 p.m. The NHA said the facility was aware of the residents' complaints about the food's palatability regarding temperatures. He said the facility had obtained an insulated food cart (during the survey), which would be delivered in a few days. He said (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	he believed that when the insulated carts arrived, the issue of cold food would be resolved. He said he would ensure the dietary staff were educated immediately on food substitutions, temperatures and following the recipe to obtain the right taste and texture of all food items.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents received food prepared in a form designed to meet their needs per physician orders for one (#29) of one resident reviewed for a mechanically altered diet texture out of 36 sample residents.Specifically, the facility failed to serve Resident #29 with food that was altered to the correct texture.Findings include:I. Professional referenceCambridge University Hospital (2023) Minced and Moist Food IDDSI Level 5, retrieved from https://www.cuh.nhs.uk/patient-information/minced-moist-food-iddsi-level-5/ No regular bread due to high choking risk.II. Facility policy and procedureThe Food Preparation Guidelines policy, implemented 4/11/25, was provided by the chief nursing officer (CNO) on 9/11/25 at 1:27 p.m. It read in pertinent part: Food shall be provided in a form (regular, cut, chopped, ground, pureed) that meets each resident's individual needs in accordance with his or her assessment and care plan.III. Resident #29A. Resident statusResident #29, age less than 6590, was admitted on [DATE]. According to the September computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia (not enough oxygen in the body), and dementia.The 8/7/25 minimum data set (MDS) revealed Resident #29 had a moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. Resident #29 required setup or clean-up assistance for eating.B. Observations During a continuous observation on 9/9/25, beginning at 11:45 a.m. and ending at 12:43 p.m., the following was observed:At 12:38 p.m. Resident #29 received a peanut butter and jelly sandwich with the crust cut off and the sandwich was cut in half diagonally across.At 12:39 p.m. Resident #29 ate the peanut butter and jelly sandwich.-The resident's representative was not present while the resident was consuming the meal (see interviews below).B. Resident #29's representative interviewResident #29's representative was interviewed on 9/8/25 at 10:47 a.m. The representative said Resident #29 was at risk of choking.C. Record reviewThe September 2025 CPO revealed a physician's order for a minced and moist texture diet with thin liquids, ordered on 8/9/25. Resident #29's dental care plan, revised 8/6/25, revealed the resident had dentures. Interventions included serving the residents diet as ordered and consulting with the dietitian if chewing/swallowing problems were identified. Review of Resident #29's electronic medical record (EMR) did not reveal documentation indicating the resident was able to consume sandwiches (see interviews below).IV. Staff interviewsCertified nurse aide (CNA) #2 was interviewed on 9/9/25 at 12:40 p.m. CNA #2 said when Resident #29 did not like her meal, she offered her a sandwich because the resident liked sandwiches. She said the resident was able to eat the sandwich if her representative was present.-However, review of the resident's EMR did not reveal documentation regarding the resident consuming sandwiches when the representative was present.The social service director (SSD) was interviewed on 9/10/25 at 11:52 a.m. The SSD said Resident #29 was unable to have bread because she was on an altered diet. The SSD said Resident #29 was yelling for toast all morning so she sent a message to the speech therapist to evaluate the resident and see if she could eat bread safely.The staffing coordinator was interviewed on 9/11/25 at 8:55 a.m. He said a minced and moist diet meant food was chopped into tiny pieces and moistened with a sauce. The staffing coordinator said residents who were prescribed a minced and moist diet could not have bread.CNA #1 was interviewed on 9/11/25 at 9:13 a.m. CNA #1 said a diet order described what the resident could eat, including allergies and if the resident was a choking hazard. She said a minced and moist diet meant the food was chopped up into tiny pieces and it was wet. She said Resident #29 was prescribed a minced and moist diet and was unable to have bread. She said Resident #29 should not have received a sandwich from staff. She said sometimes Resident #29 received a whole piece of cake if her representative was present because the representative said it was okay for the resident to eat.Regional director of clinical services #2 was interviewed on 9/11/25 (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 11:18 a.m. She said a diet order described the diet type a resident was on. She said a minced and moist diet meant the food was cut into tiny pieces and moistened with a sauce. She said residents prescribed a minced and moist diet were not able to have bread. She said Resident #29 should not have received a sandwich from the staff.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure consent was obtained for the use of psychotropic medications for two (#47 and #3) of five residents reviewed for unnecessary medications out of 36 sample residents.Specifically, the facility failed to ensure informed consent, which included the reason for medication use, risks and benefits associated with the medication use and any black box warning (a safety warning, highlighting a drug's potential to cause serious, life-threatening adverse reactions, or to cause harm that could be prevented by specific prescribing practices) was obtained from the resident or the resident's representative prior to the resident's use of a psychotropic medication for Resident #47 and Resident #3.Findings include: I. Facility policy and procedureThe Use of Psychotropic Medication policy and procedure, revised 4/28/25, was provided by the regional vice president of operations on 9/8/25 at 4:34 p.m. It read in pertinent part, Prior to initiating or increasing a psychotropic medication, the resident, family, and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warnings for antipsychotic medications, in advance of such initiation or increase. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of the proposed care, the treatment alternatives or other options.II. Resident #47A. Resident status Resident #47, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, vascular dementia, anxiety disorder and depression. The 8/15/25 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. She used a wheelchair. She required set up assistance from staff with eating. She was dependent on staff assistance for oral hygiene, toileting, showering and personal hygiene. The assessment revealed the resident received an antipsychotic medication and an antidepressant medication. The assessment revealed the resident felt down, depressed or hopeless on two to six days (or several days) during the assessment look-back review period. The assessment revealed the resident did not exhibit any behaviors and did not reject care. B. Record review Resident #47's psychotropic medication care plan, initiated and revised 8/8/25, revealed the resident used psychotropic medications related to dementia with behaviors. Interventions included discussing with the physician and the resident's family regarding the ongoing need for the use of the medications. Review of Resident #47's September 2025 CPO revealed the following physician's orders: Risperdal (antipsychotic medication) 2 milligram (mg) tablet. Take one tablet by mouth one time a day for dementia with behaviors, ordered 8/7/25. Zoloft (antidepressant medication) 100 mg tablet. Take two tablets by mouth one time a day for anxiety, ordered 8/7/25. Lorazepam (antianxiety medication) 0.5 mg tablet. Take 0.75 mg by mouth two times a day for anxiety. Administer 30 to 45 minutes before insulin administration, ordered 8/7/25. A request for the consent forms for Risperdal, Zoloft and lorazepam was made to the regional vice president on 9/9/25 at 1:47 p.m. A review of the consent forms for Risperdal, Zoloft and lorazepam revealed Resident #47 provided verbal consent for the three medications on 9/10/25 (during the survey). A review of Resident #47's August 2025 and September 2025 medication administration records (MAR) revealed Risperdal, Zoloft and lorazepam were administered to the resident prior to the resident providing verbal consent for the medications on 9/10/25. III. Resident #3A. Resident status Resident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 CPO, diagnoses included schizoaffective disorder (a mental health condition characterized by a combination of symptoms of schizophrenia - a disconnection from reality and a mood disorder like depression or mania), atherosclerotic heart disease (buildup of fats and cholesterol in and on the walls of the heart arteries), hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, major depressive disorder (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and anxiety disorder. The 9/8/25 MDS assessment revealed the resident was severely cognitively impaired with a BIMS score of four out of 15. She required moderate assistance from staff with eating. She was dependent on staff assistance with oral hygiene, toileting and showering. The assessment revealed Resident #3 received an antianxiety medication and an antidepressant medication. The assessment revealed Resident #3 had little interest or pleasure in doing things and felt down, depressed or hopeless two to six days (or several days) in the assessment's look-back period. The assessment revealed Resident #3 exhibited verbal behavioral symptoms directed towards others on one to three days during the assessment look-back review period. The assessment revealed Resident #3 did not reject care. B. Record review Resident #3's antidepressant care plan, initiated and revised 8/4/25, revealed the resident used an antidepressant medication. Interventions included administering antidepressant medications as ordered by the physician. Resident #3's antianxiety care plan, initiated and revised 8/22/25, revealed the resident used antianxiety medications related to anxiety. Interventions included administering antianxiety medications as ordered by the physician. Review of Resident #3's September 2025 CPO revealed the following physician's orders: Sertraline (antidepressant medication) 50 mg. Take one tablet by mouth in the morning for major depressive disorder, ordered 7/8/25. -The diagnosis for the sertraline medication was changed on 8/22/25 from major depressive disorder to schizoaffective disorder. Trazodone (antidepressant medication) 50 mg. Take one tablet by mouth at bedtime for insomnia, ordered 7/8/25. -The diagnosis for the trazodone medication was changed on 8/2/25 from insomnia to major depressive disorder. -The diagnosis for the trazodone medication was changed again on 8/22/25 from major depressive disorder to schizoaffective disorder. Buspirone (medication used to treat anxiety) 15 mg. Take one tablet by mouth three times a day for anxiety, ordered 7/8/25. A review of the consent forms for sertraline, trazodone and buspirone revealed Resident #3 provided verbal consent for the medications on 8/26/25. A review of Resident #3's July 2025, August 2025 and September 2025 MARs revealed sertraline, trazodone and buspirone were administered to the resident prior to the resident providing verbal consent for the medications on 8/26/25.IV. Staff interviews Registered nurse (RN) #1 was interviewed on 9/11/25 at 2:26 p.m. RN #1 said consent was required for psychotropic medications. She said social services or the nurse was responsible for obtaining consent from the resident or the resident's representative. She said consent was required before the facility administered a psychotropic medication to a resident. Regional director of clinical services #2 was interviewed on 9/11/25 at 3:22 p.m. Regional director of clinical services #2 said consent was required for psychotropic medications. She said the nurse was responsible for obtaining consent from the resident or the resident's representative. She said consent was required before the facility administered a psychotropic medication to a resident. The chief nursing officer was interviewed on 9/10/25 at 6:30 p.m. The chief nursing officer said consent was required for psychotropic medications. She said the nurse was responsible for obtaining consent from the resident or the resident's representative. She said consent was required prior to administering a psychotropic medication to a resident. The chief nursing officer said Resident #47 and Resident #3 did not provide consent to receive psychotropic medications prior to the facility administering psychotropic medications to the residents.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interviews, the facility failed to make immediate notification to the resident representative when the resident had a significant change in condition requiring a need to alter treatment, initiate a resident's transfer or discharge from the facility or when the resident was involved in an accident with an injury for one (#16) of 17 residents out of 36 sample residents.Specifically, the facility failed to ensure Resident #16's representative was notified when the resident experienced a choking episode that required the Heimlich maneuver (a first aid method used for choking) by staff.Findings include:I. Facility policy and procedureThe Notification of Changes policy, implemented on [DATE], was provided by the chief nursing officer on [DATE] at 12:14 p.m. The policy was to ensure the facility promptly informed the resident, consulted the resident's physician; and notified, consistent with his or her authority, the resident's representative when there was a change requiring notification.The facility must inform the resident, consult with the resident's physician and /or notify the resident's family member or legal representative when there was a change requiring such notification.Circumstances requiring notification included a significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This might include life-threatening conditions and/or clinical complications.For competent residents, the facility must still contact the resident's physician and notify the resident's representative, if known. The facility must contact a family that wished to be informed would designate a member to receive calls. When a resident was mentally competent, such a designated family member should be notified of significant changes in the resident's health status because the resident might not be able to notify them personally, especially in the case of sudden illness or accident.II. Resident #16A. Resident statusResident #16, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the [DATE] computerized physician orders (CPO), diagnoses included acute on chronic diastolic (congestive) heart failure, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease, paroxysmal atrial fibrillation and morbid obesity.The [DATE] minimum data set (MDS) assessment revealed the resident had intact cognition with a brief interview for mental status (BIMS) score of 14 out of 15. The resident did not have any swallowing disorders.B. Resident representative interviewResident #16's representative was interviewed on [DATE] at 12:16 p.m. The representative said she was the resident's primary decision maker. She said she was not notified that Resident #16 had choked or that the facility had performed the Heimlich maneuver when she was choking. She said she was told of the event by the resident the next day. She said none of her family members were contacted either. She said she should have been notified of the event. She said she wanted to be notified any time, day or night, of any changes in Resident #16's condition. She said she wanted to be notified so that she could make the best decisions for the resident.C. Record reviewResident #16's care plan for code status, initiated [DATE], revealed the resident was full code (the resident wished to receive all possible life-saving measures) and indicated staff were to initiate cardiopulmonary recitation (CPR). The intervention was for staff to attempt resuscitation of the resident.A physician's order, dated [DATE] at 1:48 p.m., revealed the resident's advanced directive was a full code status.A nurse note, dated [DATE] at 9:00 p.m. and written by a registered nurse (RN), revealed Resident #16 was swallowing her medications when she choked on some mucus. The resident started to cough and wheeze. The resident was in respiratory distress and was quickly cyanotic (blue). The nurse turned the resident's oxygen liter flow to five liters of oxygen per minute and quickly attempted to reposition the resident to maximize her oxygen intake. The nurse then delivered multiple back blows in an attempt to dislodge any medication/mucus that was present. The interventions seemed to have little effect. The nurse shouted for help while continuing to position the resident. A certified nurse aide (CNA) arrived at the resident's room and began delivering back (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blows and repositioning Resident #16 while the nurse ran to grab the as needed albuterol vial (an inhaled medication used to help relax muscles around airways to make breathing easier). The CNA also began abdominal thrusts. The resident was still wheezing heavily with an oxygen saturation level (level of oxygen in the blood) of 89% (percent). The nurse quickly administered an albuterol nebulizer (small machine that turns liquid medicine into a mist that can be easily inhaled) treatment by way of a mask while coaching the resident to take deep breaths. Resident #16 soon regained normal skin color and her oxygen saturation level increased to 96%, which was the resident's baseline. The resident said she felt much better. The resident said her pain level was 3 out of 10 in her stomach area from the Heimlich maneuver. The resident's stomach area had blanchable redness. The resident denied any extra interventions for this issue. The resident also denied any additional pain or discomfort at this time. The nurse remained in the room with the resident for 15-minutes to ensure her breathing was back to baseline. The resident continued to deny any pain or discomfort over the time period and eventually asked to be put into bed soon. Vital signs were taken and the resident's breathing was even and unlabored. The resident was left in her room with a pulse oximeter (electronic device that measures the oxygen level in the blood) after the resident demonstrated that she knew how to use it. The resident's call light was in reach and the nurse reported the event to the resident's physician. The nurse attempted to call the resident's representative at 5:00 a.m. and 5:15 a.m., however neither of the calls were answered. The choking event was discussed with the oncoming nurse, who was to inform the resident's representative.-There was no documentation in Resident #16's electronic medical record (EMR) to indicate the oncoming nurse notified the resident's representative regarding the resident's choking episode.III. Staff interviewsThe nursing home administrator (NHA) and regional director of clinical services #2 were interviewed together on [DATE] at 1:08 p.m. The NHA and regional nurse consultant #2 agreed that Resident #16's representative should have been notified of the resident's change of condition (choking episode) on [DATE] at 9:00 p.m. Regional director of clinical services #2 reviewed Resident #16's EMR and was unable to find any documentation that the resident's representative was notified of the choking incident. Regional nurse consultant #2 said choking was considered a change of condition and the resident's representative should have been notified.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to maintain a system of documenting grievances and demonstrating prompt actions for one (#37) of two residents reviewed for grievances out of 36 sample residents.Specifically, the facility failed to effectively address, resolve and demonstrate a timely response to Resident #37's grievances.Findings include:I. Facility policy and procedureThe Grievance policy and procedure, implemented 4/11/25, was provided by the regional vice president of operations on 9/11/25 at 1:26 p.m. It read in pertinent part, It is the policy of this facility to support each resident's and family member's right to voice grievanceswithout discrimination, reprisal, or fear of discrimination or reprisal.The Grievance Officer is responsible for overseeing the grievance process; receiving and tracking grievances through to their conclusion, leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances; issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary.II. Resident #37A. Resident statusResident #37, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician order (CPO), diagnoses included [NAME]-Danlos syndrome (are a group of inherited disorders that affect connective tissues, primarily the skin, joints, and blood vessels), acute respiratory failure with hypoxia (an absence of enough oxygen in the tissues to sustain bodily function), encephalopathy, acute kidney failure, muscle weakness and depression.The 6/27/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. She was dependent on staff and required substantial/maximal assistance with toileting, showers and personal hygiene.B. Resident interviewResident #37 was interviewed on 9/10/25 at 11:16 a.m. Resident #37 said she had filed several grievances since she was admitted to the facility on [DATE]. She said the facility had not resolved most of the grievances that she had reported. She said she was not notified of the resolution to a particular grievance she reported about a staff member's (certified nurse aide (CNA) #5) comment during her care. She said she felt uncomfortable with a staff member and requested that they were not assigned to take care of her anymore. The resident said she believed her concerns were not investigated. She said the director of nursing (DON) and the social services director (SSD) talked to her once about the issue in her room and had not heard anything since. The resident said she informed several facility staff about her concern and how it made her feel, but believed nothing was done about it. C. Record reviewThe facility was unable to provide documentation to indicate a grievance form was completed regarding Resident #37's concern of a staff member making an inappropriate comment or that the resident's concern was followed up on.The 8/25/25 grievance form filed by Resident #37 documented that she was not receiving her as-needed medication promptly from licensed practical nurse (LPN) #3. The grievance form revealed the nurse would not leave the keys to the medication cart with another nurse when leaving for his break. The follow-up section of the form documented that the facility followed up with LPN #3 and the medication keys were now being left with another nurse during his break. The portion of the grievance form that reveals whether the resident was satisfied with the resolution of the grievance was not completed.A cold, inedible food grievance was reported on 9/7/25 and was marked as resolved on 9/8/25. The NHA purchased food through delivery for the resident. -However, the portion of the grievance form that revealed whether the resident was satisfied with the resolution of the grievance was not completed.The facility failed to complete a grievance form, investigate, and resolve the resident's concern about CNA #5's comments while providing care to the resident (see resident interview above and staff interviews below).D. Staff interviewsLicensed practical nurse (LPN) #1 was interviewed on 9/11/25 at 10:55 a.m. LPN #1 said she was informed by the DON about the incident of an inappropriate comment made by CNA #5 to Resident #37 and she was asked to follow (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up with CNA #5. LPN #1 said she spoke about the incident with CNA #5 and asked that CNA #5 not be assigned to work with the resident. LPN #1 said she believed it was a misunderstanding between the resident and CNA #5. She said she thought the DON had reached a resolution and followed up with Resident #37. The SSD was interviewed on 9/11/25 at 11:10 a.m. The SSD said grievance forms were kept at the front of the building. The SSD said the forms could be filled out by residents, staff members, or submitted anonymously. The SSD said the social services department was an integral part of the grievance process. She said the NHA was the grievance official for the facility. She said grievances were discussed in the morning meetings and forwarded to the appropriate department for follow-up. The SSD said a resolution to a grievance should be reached with the resident or the resident's representative within 72 hours of the date the grievance was filed. The SSD said she was informed by the DON about Resident #37's concern of a staff member making an inappropriate comment to her during care and the SSD believed the DON documented the incident in question. She said the DON informed her about the incident and they both had a discussion with the resident about it. The SSD said she did not complete any documentation on the issue in her social services notes. The nursing home administrator (NHA) was interviewed on 9/11/25 at 11:35 a.m. The NHA said he remembered hearing about Resident #37's concern regarding CNA #5 making an inappropriate comment during her care, but he said he could not confirm whether a grievance form was completed for the resident's concern. He said the resident used unconventional means to report incidents, and that could sometimes be overlooked. He said he could not find any grievance information regarding CNA #5's inappropriate comment towards Resident #37 during her care.The NHA said the facility had informed Resident #37 to utilize and follow the approved grievance process for completing the forms instead of sending text messages, which could get lost. The NHA said he would review the facility's grievance procedure and offer education to all staff to ensure the grievance process was followed and functional.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to incorporate the recommendations from the preadmission screening and resident review (PASRR) level II determination and evaluation report into the assessment, care planning, and transition of care for one (#3) of four residents reviewed for PASRR out of 36 sample residents. Specifically, the facility failed to take steps to ensure services were provided as recommended in Resident #3's PASRR level II report.Findings include: I. Resident #3A. Resident status Resident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included schizoaffective disorder (a mental health condition characterized by a combination of symptoms of schizophrenia - a disconnection from reality and a mood disorder like depression or mania), cerebral infarction (stroke) affecting the right dominant side, chronic kidney disease, major depressive disorder, and anxiety disorder. The 9/8/25 minimum data set (MDS) assessment revealed the resident was cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She required partial assistance with eating. She was dependent on staff assistance with oral hygiene, toileting, and showering. The assessment revealed she had verbal behavior symptoms directed towards others on one to three days in the assessment look-back review period. The assessment revealed she did not refuse care and she did not have a PASRR-related diagnosis. B. Record reviewResident #3's PASRR level II, dated 2/17/25, revealed the resident had a PASRR condition and required specialized services. The specialized services required were case management, psychiatric case consultation, neurocognitive evaluation and individual therapy. -A review of Resident #3's electronic medical record (EMR), from 7/8/25 to 9/11/25, did not reveal documentation that indicated the resident was receiving case management, neurocognitive evaluation, psychiatric case consultation or individual therapy as recommended on the 2/17/25 PASRR level II determination. II. Staff interviewsThe social services director (SSD) was interviewed on 9/11/25 at 12:45 p.m. The SSD said she had started working at the facility at the end of August 2025 and worked closely with the nursing home administrator (NHA), the director of nursing (DON) and regional director of clinical services #2 as she learned the residents and the facility processes. She said she would check with the NHA, the DON or the regional director of clinical services #2 regarding when to determine whether or not a PASRR level II was needed. She said a level I PASRR should be completed prior to the resident being admitted to the facility. She said based on the PASRR level II recommendations, she was responsible for carrying out the recommendations and ensuring the services were provided for the resident. She said she would check with management, but she thought the PASRR level II recommendations were documented on the residents' care plans. She said depending on the PASRR level II recommendations, the interdisciplinary team (IDT) divided and conquered the recommendations to ensure the resident received the services recommended on the PASRR level II. The SSD said she was familiar with Resident #3. She said she did not know if the resident had any PASRR level II recommendations. The chief nursing officer was interviewed on 9/11/25 at 1:58 p.m. She said a PASRR level II determination was identified at admission. The chief nursing officer said based on the PASRR level II recommendations, the facility care planned and implemented the recommendations. She said the SSD was typically responsible for updating the care plan with the recommendations and then the SSD relayed the resident's needs to other IDT members. The chief nursing officer said she was familiar with Resident #3. She said she could not find documentation that indicated the facility had implemented the PASRR level II specialized services recommendations for Resident #3.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents who were unable to carry out activities of daily living (ADL) received the necessary services and assistance for bathing for two (#29 and #33) of 17 residents reviewed for ADLs out of 36 sample residents.Specifically, the facility failed to provide Resident #29 and Resident #33, who were dependent upon staff assistance for ADLs, with timely incontinence care.Findings includeI. Facility policy and procedureThe Activities of Daily Living (ADLs) policy, implemented 4/11/25, was provided by the chief nursing officer on 9/11/25 at 1:27 p.m. It read in pertinent part, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services will be provided for the following activities of daily living: bathing, dressing, grooming and oral care; transfer and ambulation; and toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming and personal and oral hygiene.II. Resident #29A. Resident statusResident #29, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included chronic obstructive pulmonary disease (lung disease), dementia and acute and chronic respiratory failure with hypoxia (not enough blood in the organs).The 8/7/25 minimum data set (MDS) assessment revealed Resident #29 had a moderate cognitive impairment with a brief interview for mental status (BIMS) score 11 out of 15. Resident #29 required partial or moderate assistance for toileting, showering, getting dressed and personal hygiene.B. ObservationsDuring a continuous observation on 9/10/25, beginning at 8:00 and ending at 10:30 a.m., the following was observed:At 8:00 a.m. Resident #29 was observed sitting in her recliner in her room.At 8:28 a.m. an unidentified certified nurse aide (CNA) brought Resident #29 her breakfast tray. -The unidentified CNA did not offer to toilet the resident.At 9:29 a.m. CNA #1 picked up Resident #29's breakfast tray.-CNA #1 did not offer to toilet the resident.At 9:35 a.m. Resident #29 turned on her call light.At 9:36 a.m. the social services director (SSD) answered Resident #29's call light and Resident #29 asked for more coffee. At 9:38 a.m. the SSD brought the resident a cup of coffee. At 10:09 a.m. two CNAs were standing outside Resident #29's room. The CNAs said hello to the resident and went into a different resident's room.-The two CNAs did not offer to toilet Resident #29.At 10:30 a.m. Resident #29 was still sitting in her recliner and the front of her pants was observed to be wet with urine. -Resident #29 was not offered toileting or incontinence care assistance for two and a half hours.C. Resident representative interviewResident #29's representative was interviewed on 9/8/25 at 10:47 a.m. The representative said she routinely found Resident #29 sitting in her recliner wet with urine. She said staff were not toileting the resident in a timely manner.D. Record reviewResident #29's ADL care plan, revised 8/6/25, revealed the resident was at risk for a decline in ADL function related to decreased mobility and impaired cognition. Interventions included staff providing assistance with toileting and transferring and toileting the resident every two hours.III. Resident #33A. Resident statusResident #33, age less than 65, was readmitted to the facility on [DATE]. According to the September 2025 CPO, diagnoses included bipolar disorder (mental health disorder), blindness in the right eye, blindness in the left eye and anxiety. The 9/10/25 MDS assessment revealed Resident #33 had a mild cognitive impairment with a BIMS score of 12 out of 15. Resident #33 required substantial or maximal assistance for toileting.B. ObservationsDuring a continuous observation on 9/10/25, beginning at 8:00 and ending at 10:30 a.m., the following was observed:At 8:00 a.m. Resident #33 was lying in bed with the television on At 8:43 a.m. CNA #1 delivered Resident #33's breakfast tray.-CNA #1 did not offer toileting assistance or incontinence care to the resident. At 10:30 a.m. Resident #33 was still in bed with her breakfast tray in front of her and the television on. No staff members had entered the resident's room to offer incontinence care or toileting assistance since CNA #1 delivered the resident's breakfast tray.-Resident #33 was not offered toileting or incontinence care assistance (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for two and a half hours.C. Resident interviewResident #33 was interviewed on 9/10/25 at 10:33 a.m. Resident #33 said staff often took a long time to come and change her. She said the longest she had waited for assistance was two and a half hours. During the interview, Resident #33 said she was wet and said it made her feel like a loser because she was not important enough for the staff to come check on her and change her. She said she was blind in both eyes and required a lot of help from the staff when it came to toileting. D. Record reviewResident #33's ADL care plan, revised 7/25/25, revealed the resident was at risk for decline in ADL function related to weakness, obesity and decline in mobility. Interventions included the resident was totally dependent upon staff assistance for personal hygiene and required help from two staff members for transferring.IV. Staff interviewsThe staffing coordinator was interviewed on 9/11/25 at 8:55 a.m. The staffing coordinator said residents needed to be toileted every two hours.CNA #1 was interviewed on 9/11/25 at 9:13 a.m. CNA #1 said residents were toileted every two to four hours. Regional director of clinical services #2 was interviewed on 9/11/25 at 11:18 a.m. Regional director of clinical services #2 said residents needed to be toileted every three hours or more often, depending on what their care plans documented was needed for the resident.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, record review and interviews, the facility failed to ensure received treatment and care in accordance with professional standards of practice for two (#33 and #32) of four residents out of 36 sample residents. Specifically, the facility failed to:-Ensure staff followed physician's orders for Resident #32's toe wound dressing; and, -Ensure medications were not documented as being administered prior to the medications being administered to Resident #33.Findings include: I. Failed to ensure staff followed physician's orders for Resident #32's toe wound dressing A. Resident status Resident #32, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician's orders (CPO), diagnoses included hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side (a stroke affecting the left side of the body), depression and narcolepsy. The 8/1/25 minimum data set (MDS) assessment revealed Resident #32 had moderate cognitive impairment with a brief interview for mental status (BIMS) score of 11 out of 15. The resident had impaired functional range of motion of the upper and lower extremities on the left side. She required substantial assistance with hygiene, toileting, bathing and transfers. She required supervision and cues to eat. She required moderate assistance with the use of a wheelchair for mobility. B. Resident representative interview Resident #32's representative was interviewed on 9/9/25 at 10:34 a.m. The representative said when Resident #32 was admitted to the facility, she had a wound to her left great toe. The representative said the orders from the previous physician were to clean and change the dressing daily. The representative said she came to visit the resident on 7/29/25, three days after the resident's admission to the facility and noticed the same bandage with the same date (7/26/25) was on Resident #32's left great toe. The representative said when she asked the night nurse to clean and change the dressing, the night nurse told her that the physician's orders were for the dressing to be changed daily in the morning. The representative said she returned to visit Resident #32 the next day (7/30/25) and the dressing still had not been changed. The representative said by this point, the dressing appeared visibly soiled and had an odor. C. Observations On 9/9/25 at 10:34 a.m., Resident #32 was sitting in her recliner in her room. Resident #32 had a dressing over her left great toe. The dressing appeared clean and intact, but there was no date or initials on the dressing to indicate when the dressing was last changed. On 9/11/25 at 9:46 a.m. Resident #32 was lying in bed being provided with incontinence care. The same type of dressing as 9/9/25 (see above) was on the resident's left great toe. The dressing did not have a date or initials to indicate when the dressing was last changed. D. Record review (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #32's electronic medical record (EMR) revealed the following physician's orders and wound treatment documentation for August 2025 and September 2025: Wound care to all left toes. Cleanse all lower left extremity toes with wound cleanser or normal saline, pat dry, apply Aquacel AG (wound treatment) to the left great toe and secure with tape or bandaid. To the left second through fifth toes, apply Hydrofera blue (wound treatment) and secure with tape or a bandaid, change at bedtime every Monday, Wednesday, Friday, ordered 7/31/25. -Review of Resident #32's August 2025 treatment administration record (TAR) revealed no documentation to indicate the resident's wound care was completed on 8/6/25. Wound care to the left great toe abrasion. Cleanse with wound cleanser or normal saline, pat dry with clean gauze, apply Medihoney gel (wound treatment) to the affected area, cover with dressing daily and as needed, ordered 8/14/25. -Review of Resident #32's August 2025 TAR revealed no documentation to indicate the resident's wound care was completed on 8/16/25. Wound care to left great toe abrasion. Cleanse with wound cleanser or normal saline, pat dry with clean gauze. Apply Medihoney gel to the affected area, cover with a clean dressing, change daily and as needed, ordered 8/19/25. -Review of Resident #32's August 2025 TAR revealed no documentation to indicate the resident's wound care was completed on 8/19/25. Wound care to left great toe abrasion. Cleanse with wound cleanser or normal saline, apply betadine to the site and leave open to air every day, ordered 9/2/25. -Review of Resident #32's September 2025 TAR revealed no documentation to indicate the resident's wound care was completed on 9/3/25, 9/9/25 and 9/10/25. E. Staff interviews Licensed practical nurse (LPN) #2 was interviewed on 9/11/25 at 10:03 a.m. LPN #2 said she placed a dressing on Resident #32's left great toe on 9/8/25. LPN #1 said she forgot to write the date on the dressing when providing the resident's wound care. She said without dating the dressing, the only way she could verify the dressing change was completed was by her signature in the TAR. She said she was aware the physician's order said to leave the dressing open to air, but she said Resident #32's representative was upset when she visited earlier and Resident #32 had no dressing over her left great toe. LPN #2 said she planned to ask the wound care physician to look at the physician's order to see if it could be changed to add a dressing as needed for the resident's comfort. II. Failed to ensure medications were not documented as being administered prior to the medications being administered to Resident #33 A. Professional reference WisTechOpen (2023) 15.2 Basic Concepts of Administering Medications retrieved from https://wtcs.pressbooks.pub/nursingskills/chapter/15-2-basic-concepts-of-administering-medications/#:~:text=A (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	After administering medication, it is important to immediately document the administration. B. Facility policy and procedure The Medication Administration policy and procedure, revised 8/6/25, was provided by the chief nursing officer on 9/10/25 at 11:30 a.m. It read in pertinent part: Remove medication from source, taking care not to touch medication with bare hand. Administer medication as ordered in accordance with manufacturer specifications. Observe resident consumption of medication. Sign the medication administration record (MAR) after administered. C. Resident #33 1. Resident status Resident #33, age less than 65, was re-admitted to the facility on [DATE]. According to the September 2025 computerized physician order (CPO) diagnoses included bipolar disorder (mental health disorder), blindness in the right eye, blindness in the left eye and anxiety. The 9/10/25 minimum data set (MDS) assessment revealed Resident #33 had a mild cognitive impairment with a brief interview for mental status (BIMS) score of 12 out of 15. Resident #33 required substantial or maximal assistance for toileting. 2. Resident interview Resident #33 was interviewed on 9/10/25 at 10:33 a.m. Resident #33 said the nurses often took a long time to administer her medications to her. She said she had not yet received her morning medications for 9/10/25 and she was feeling anxious without her anxiety medications. 3. Record review On 9/10/25 at 10:35 a.m. a review of Resident #33's September 2025 MAR revealed Resident #33's 9/10/25 morning medications were documented as being administered successfully to the resident. D. Staff interviews Registered nurse (RN) #2 was interviewed on 9/10/25 at 10:42 a.m. RN #2 said she documented that Resident #33's medications had been administered, but she had not administered the medications yet. She said she was running behind and her medication pass was behind schedule. She said she marked the resident's 9/10/25 morning medications as administered because she usually worked the night shift and that was what she usually did on the night shift. Regional director of clinical services #2 was interviewed on 9/11/25 at 11:18 a.m. Regional director of clinical services #2 said medications should not be marked off as administered until after the medications were successfully administered to the resident. She said the nurses should not be (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	marking the medications as administered before the medications were given because it was false documentation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for 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 observations, record review and interviews, the facility failed to ensure residents received care consistent with professional standards of practice to prevent the occurrence or recurrence of pressure injuries for one (#25) of three residents reviewed out of 36 sample residents.Specifically, the facility failed to ensure appropriate interventions were in place to prevent Resident #25 from developing a non-blanchable (skin that does not turn white when pressure is applied to the area) wound to his left outer ankle.Findings include:I. Professional referenceAccording to the National Pressure Injury Advisory Panel, European Pressure Injury Advisory Panel and Pan Pacific Pressure Injury Alliance Prevention and Treatment of Pressure Injuries: Clinical Practice Guideline, third edition, [NAME] Haesler (Ed.), EPUAP/NPIAP/PPPIA (2019), retrieved on 9/19/25 from https://www.internationalguideline.com/guideline, Pressure ulcer classification is as follows:Category/Stage 1: Nonblanchable Erythema (discoloration of the skin that does not turn white when pressed, early sign of tissue damage)Intact skin with nonblanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have visible blanching; its color may differ from the surrounding area. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Category/Stage 1 may be difficult to detect in individuals with dark skin tones. May indicate at risk individuals (a heralding sign of risk).Category/Stage 2: Partial Thickness Skin LossPartial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister. Presents as a shiny or dry shallow ulcer without slough or bruising. This Category/Stage should not be used to describe skin tears, tape burns, perineal dermatitis, maceration or excoriation.Category/Stage 3: Full Thickness Skin LossFull thickness tissue loss. Subcutaneous fat may be visible, but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. The depth of a Category/ Stage 3 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and Category/ Stage 3 ulcers can be shallow. In contrast, areas of significant adiposity can develop extremely deep Category/Stage 3 pressure ulcers. Bone/tendon is not visible or directly palpable.Category/Stage 4: Full Thickness Tissue LossFull thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often include undermining and tunneling. The depth of a Category/Stage 4 pressure ulcer varies by anatomical location. The bridge of the nose, ear, occiput and malleolus do not have subcutaneous tissue and these ulcers can be shallow. Category/ Stage 4 ulcers can extend into muscle and/ or supporting structures (fascia, tendon or joint capsule) making osteomyelitis possible. Exposed bone/tendon is visible or directly palpable.Unstageable: Depth UnknownFull thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green or brown) and/or eschar (tan, brown or black) in the wound bed. Until enough slough and/or eschar is removed to expose the base of the wound, the true depth, and therefore Category/ Stage, cannot be determined. Stable (dry, adherent, intact without erythema or fluctuance) eschar on the heels serves as the body's natural (biological) cover and should not be removed.Suspected Deep Tissue Injury: Depth UnknownPurple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. Deep tissue injury may be difficult to detect in individuals with dark skin tones. Evolution may include a thin blister over a dark wound bed. The wound may further evolve and become covered by thin eschar. Evolution may be rapid, exposing additional layers of tissue even with optimal treatment.According to [NAME], P.A. and [NAME], A.G. et.al., (2021), Fundamentals of Nursing, 10 edition, pp 1255-1256, Repositioning (turning) patients is a consistent element of evidence-based pressure injury prevention. The two-fold aim of repositioning (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should be to reduce or relieve pressure at the interface between bony prominence and support surface (bed or chair) and to limit the amount of time the tissue is exposed to pressure. Support surfaces are specialized devices for pressure redistribution designed for management of tissue loads, microclimate, and/or other therapeutic functions (any mattress, integrated bed system, mattress replacement, overlay, seat cushion, or seat cushion overlay). Support surfaces redistribute tissue loads by immersion (depth of penetration or sinking into the support surface by the patient's body) and envelopment (deformation around the body), thus evenly distributing pressure across the entire body surface. Support surfaces reduce the hazards of immobility to the skin and musculoskeletal system. However, none eliminates the need for meticulous skin assessment and skin care. No single device completely eliminates the effects of pressure on the skin.II. Facility policy and procedureThe Pressure Injury Prevention and Management policy, revised April 2025, was provided by the chief nursing officer on 9/11/25 at 1:26 p.m. It revealed in pertinent part, The facility shall establish and utilize a systematic approach for pressure injury prevention and management, including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors; monitoring the impact of the interventions; and modifying the interventions as appropriate. Evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to: redistribute pressure (such as repositioning, protecting and/or offloading heels); minimize exposure to moisture and keep skin clean, especially of fecal contamination; provide appropriate, pressure-redistributing, support surfaces; provide non-irritating surfaces; and maintain or improve nutrition and hydration status, where feasible. The RN (registered nurse) unit manager, or designee, will review all relevant documentation regarding skin assessments, pressure injury risks, progression towards healing, and compliance at least weekly, and document a summary of findings in the medical record.III. Resident #25A. Resident statusResident #25, age greater than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included type 2 diabetes, polyneuropathy (nerve pain), impaired mobility and contractures of the left and right hands. The 8/18/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 14 out of 15. He required moderate assistance with dressing, personal hygiene and footwear. He required touching assistance with bathing, repositioning and transfers. He used a wheelchair for mobility.B. Resident interviewResident #25 was interviewed on 9/8/25 at 11:04 a.m. Resident #25 said he had a sore spot on his left ankle bone. He said he acquired a wound on his left ankle from lying on his side too long. He said a staff member told him they were going to find a boot to reduce pressure to his ankle but he had never received one. C. ObservationsOn 9/8/25 at 11:04 a.m. Resident #25 was lying in a regular bed without a pressure reducing mattress. Resident #25's left ankle was resting on the bed without pillows or a pressure reducing boot to offload the ankle. Resident #25 had an oval-shaped deep purple discoloration observed to the bony prominence (a part of the body where a bone is close to the skin's surface, lacking cushioning tissue) of his left outer ankle.During a continuous observation on 9/10/25, beginning at 1:58 p.m. and ending at 4:08 p.m., the following was observed:At 1:58 p.m. Resident #25 was resting in a regular bed without an air mattress. Resident #25 was clothed without blankets over him. Resident #25's left ankle was lying on the bed with the bony prominence lying directly on the mattress. From 1:58 p.m. until 3:59 p.m., no staff members entered the resident's room to provide care for him.At 3:59 p.m. Resident #25 pressed his call light. The call light was answered by licensed practical nurse (LPN) #1 and Resident #25 asked LPN #1 for a drink. Upon prompting, LPN#1 observed Resident #25's left ankle. LPN #1 said that the dark purple area on Resident #25's left ankle was intact but non-blanchable. Resident #25 denied pain to the area. At 4:08 p.m. LPN #1 provided Resident #25 with a pressure reducing ankle boot after observing his left ankle. D. Record reviewA weekly wound observation assessment, dated 7/18/25, documented Resident #25 admitted to the facility with a suspected deep tissue injury to his left outer ankle on 5/12/25. The assessment (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented the visible tissue at the time of the assessment was pink with epithelial tissue (the outer layer of tissue) present and the wound status was documented as healed. Interventions documented in the assessment included a pressure reducing mattress and a cushion on the resident's wheelchair. Resident #25's skin care plan, initiated 6/20/25 and revised 7/17/25, documented Resident #25 had a pressure ulcer to the left outer ankle. Interventions included an air mattress, monitoring of the resident's nutritional status and weekly treatment documentation to include measurements of each area of skin breakdown's width, length, depth, type of tissue and exudate (drainage) amount.-However, observations revealed Resident #25 did not have an air mattress on his bed (see observations above).The weekly skin assessment, dated 9/5/25, documented Resident #25 had discoloration to the left outer ankle.A progress note, dated 9/6/25, documented Resident #25 was put on alert charting for a new skin alteration to the left lateral ankle. The progress note documented the skin was intact and discolored but blanchable (skin that becomes lighter when pressure is applied to the area but returns to its original color when pressure is removed, indicating blood flow returning to the area)-However, review of Resident #25's care plan (see above) did not reveal documentation to indicate that a pressure relieving device, such as protective boots, were added as an intervention to prevent the pressure wound from potentially worsening.IV. Staff interviewsLPN #1 was interviewed on 9/10/25 at 4:06 p.m., during the observation of the resident's left ankle. LPN #1 said the skin to Resident #25's left ankle appeared discolored and nonblanchable. LPN #1 said she noted that Resident #25's ankle tended to lay with the bony prominence of the ankle resting against the mattress. LPN #1 said it was possible Resident #25 had another deep tissue injury forming on his ankle, but it was outside of her scope of practice to make that assessment. LPN #1 said she planned to provide Resident #25 with an ankle boot to reduce pressure immediately and she planned to inform the wound care physicians who completed skin rounds on residents every week. Regional director of clinical services #2 was interviewed on 9/11/25 at 1:42 p.m. Regional director of clinical services #2 said she was alerted regarding the discoloration to Resident #25's left outer ankle skin earlier that morning (9/11/25). Regional director of clinical services #2 said she was not sure why the resident was not currently on an air mattress, despite the intervention of an air mattress being documented in his care plan. Regional director of clinical services #2 said after she was informed of the resident's skin discoloration, she spoke with the maintenance department and she planned to have an air mattress installed on his bed later today (9/11/25).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure residents were free from accidents or hazards for two (#11 and #42) of four residents reviewed out of 36 sample residents. Specifically, the facility failed to ensure resident safety when using a Hoyer lift (mechanical lift) to complete transfers for Resident #11 and Resident #42.Findings include:I. Professional reference According to the Food and Drug Administration's (FDA) Safety Guide For Patient Lifts pp. 6, retrieved on 9/17/25 from https://www.fda.gov/files/medical%20devices/published/Patient-Lifts-Safety-Guide.pdf, Move lift base legs near or around the patient's device. Base legs are usually more stable in full open position. Ensure there is space for lift to pivot and move freely to the receiving area. Ensure lift is able to fit under or around the receiving surface and through doorways.II. Facility policy and procedureThe Safe Resident Handling/Transfers policy, revised April 2025, was provided by the chief nursing officer on 9/11/25 at 1:26 p.m. It revealed in pertinent part, All residents require safe handling when transferred to prevent or minimize the risk for injury to themselves and the employees that assist them. While manual lifting techniques may be utilized dependent upon the resident's condition and mobility, the use of mechanical lifts are a safer alternative and should be used. Staff will perform mechanical lifts/transfers according to the manufacturer's instructions for use of the device.III. Manufacturer's instructionsAccording to the Joerns Healthcare, (2020), User Instruction Manual: Hoyer Universal Sling pp. 10, 13, retrieved on 9/17/25 fromhttps://www.joerns.com/wp-content/uploads/2023/12/Hoyer_Advance_User_Manual.pdf, Do not lift a patient with the caster brakes on. Always let the lift find the correct center of gravity. Do not attempt to maneuver the lift by pushing on the mast, boom or patient. The lift has two braked casters, which can be applied for parking. When lifting, the casters should be left free and un-braked, so that the lift will then be able to move to the center of gravity of the lift. Do not apply the brakes. If the brakes are applied, the patient may swing to the center of gravity and this may prove distressing and uncomfortable.IV. Resident #42A. Resident statusResident #42, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder. The 8/21/25 minimum data set (MDS) assessment revealed Resident #42 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #42 required moderate assistance to roll side to side, and required substantial assistance with eating, hygiene, bathing, toileting and dressing. Resident #42 was dependent on staff assistance for transfers with a mechanical and used a motorized wheelchair for mobility. B. Resident interviewResident #42 was interviewed on 9/9/25 at 8:10 a.m. Resident #42 said he sustained multiple abrasions and a bruise to his left buttock during transfers when staff used the Hoyer lift. Resident #42 said yesterday (9/8/25) his leg was scratched when staff were transferring him prior to a doctor's appointment. Resident #42 said he also sustained a bruise to his left buttock when he was being transferred to the shower chair some time the week prior. Resident #42 said the Hoyer lift began to tip while over the shower chair and he landed roughly on the shower chair. Resident #42 said he thought certified nurse aide (CNA) #1 notified the nurse of the bruise when she found it, but he was not sure which nurse CNA #1 spoke to. C. Record reviewReview of Resident #42's September 2025 treatment administration record (TAR) revealed the following physician's orders:Wound care to the left lower leg: cleanse the wound with wound cleanser, apply betadine and leave open to air, ordered 9/8/25 at 6:18 p.m.Monitor new skin alteration: superficial scratch to left lower leg - monitor for signs and symptoms of decline/infection, ordered 9/8/25 at 6:15 p.m.A progress note, dated 9/9/25 at 4:55 p.m. documented no infection was noted to the superficial (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	scratch to Resident #42's left leg. The note did not identify how the resident obtained the scratch.A progress note, dated 9/11/25 at 4:55 p.m. documented no signs or symptoms of infection to the superficial scratch on Resident #42's left leg.Review of Resident #42's electronic medical record (EMR) did not reveal no documentation related to the bruise Resident #42 said he had on his left buttock.V. Resident #11A. Resident statusResident #11, age greater than 65, was admitted on [DATE]. According to the September 2025 CPO, diagnoses included aphasia (impaired speech) after a cerebral infarction, arthrogryposis multiplex congenita (a congenital condition causing joint stiffness and contractures), altered mental status and muscle weakness. The 6/9/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. Resident #11 had impaired speech and was only sometimes able to understand others or make herself understood. Resident #11 had limited range of motion to both lower extremities. Resident #11 was dependent on staff assistance for toileting, bathing, lower body dressing, footwear, repositioning and transfers. Resident #11 required assistance to use a wheelchair for mobility.B. ObservationsOn 9/10/25 at 5:42 p.m. a Hoyer lift transfer, completed by CNA #3 and CNA #4 was observed for Resident #11. CNA #3 operated the Hoyer lift while CNA #4 assisted the resident. The brakes of the Hoyer lift were applied prior to lifting the resident into the air with the sling attached to the Hoyer lift. While Resident #11 was in the sling, hanging in the air, the legs of the Hoyer lift became caught on a cable underneath the resident's bed while CNA #4 was turning the resident in the sling and maneuvering the resident over the bed. CNA #3 backed the Hoyer lift away from the bed so CNA #4 could clear the cable underneath the bed out of the way. CNA #3 commented that the legs of the Hoyer lift did not appear to fit under the bed. CNA #3 then closed the legs of the Hoyer lift to the closed (making the base of the lift more narrow) position and maneuvered the Hoyer lift with Resident #11 over the bed. CNA #4 kept her hands on Resident #11 to prevent the sling holding the resident from swaying in the air while moving. CNA #3 used the Hoyer lift's electronic controller to lower Resident #11 to the bed so incontinence care of the resident could be completed.After incontinence care was completed, CNA #3 brought the Hoyer lift back over to the resident in bed and locked the wheels of the lift. CNA #3 and CNA #4 then attached the straps of the sling that was positioned under the resident to the Hoyer lift. CNA #3 used the controller to lift Resident #11 into the air while the wheels of the Hoyer lift were locked and in the closed position. -However, according to the Hoyer lift manufacturer's instructions, the lift brakes should not be locked when lifting a resident (see manufacturer's instructions above).CNA #3 unlocked the wheels of the Hoyer lift and maneuvered Resident #11 back toward her wheelchair with the legs of the lift in the closed position. CNA #4 kept her hands on Resident #11's sling to prevent the sling from swinging and to guide the resident back into her wheelchair. VI. Staff interviewsCNA #3 was interviewed on 9/10/25 at 5:59 p.m. CNA #3 said she typically worked as the bath aide, but took over the floor duties for the hall on the afternoon of 9/10/25 because the other CNA needed to leave. CNA #3 said she closed the legs of the Hoyer lift to the closed position during the transfer because the legs of the Hoyer lift did not fit well under the beds. Licensed practical nurse (LPN) #2 was interviewed on 9/11/25 at 11:59 a.m. LPN #2 said she was aware of the bruise to Resident #42's left buttock. She said she was informed of it by a CNA the week prior. LPN #1 said she thought the bruise occurred during transfer of the resident with the Hoyer lift to the shower chair. LPN #1 said she was aware of the scratch to Resident #42's left leg. LPN #1 said she was working the day the scratch occurred but did not witness the scratch occur. Regional director of clinical services #2 was interviewed on 9/11/25 at 1:42 p.m. Regional director of clinical services #2 said CNA #3 likely had to close the legs of the Hoyer lift during the transfer of Resident #11 in order to fit the lift under the bed. Regional director of clinical services #2 said the Hoyer lift did not fit under certain beds, and it would be necessary to have the legs of the lift closed when raising and lowering a resident in the sling in order to position the bar the sling attached to on the mechanical lift in the proper place. Regional director of clinical services #2 said it depended on the size of the resident, but the legs of the Hoyer lift being in the closed position while in motion could increase the risk of the lift tipping for certain (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents. Regional director of clinical services #2 said she was not aware of an inappropriate transfer that occurred for Resident #42 or that he sustained a bruise to his left buttock because she had not been working in the facility on a daily basis at the time the resident said it occurred. Regional director of clinical services #2 said she planned to provide additional in-service education to the staff regarding ways to ensure the stability of the Hoyer lift during resident transfers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to provide respiratory services for one (#42) of two residents reviewed out of 36 sample residents. Specifically, the facility failed to:-Ensure Resident #42's bilevel positive airway pressure (BiPAP) machine was set up in order for the resident to utilize it at night; and,-Ensure the resident's care plan included the use of a BiPAP machine.Findings include:I. Resident #42A. Resident statusResident #42, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder. The 8/21/25 minimum data set (MDS) assessment revealed Resident #42 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. He required moderate assistance to roll side to side, and required substantial assistance with eating, hygiene, bathing, toileting, and dressing. He was dependent on staff assistance for transfers and used a motorized wheelchair for mobility. B. Resident interviewResident #42 was interviewed on 9/9/25 at 9:29 a.m. Resident #42 said he was admitted to the facility with his BiPAP machine, but he had not used it since admission on [DATE]. He said he had not used it because he had not seen a respiratory therapist at the facility or had anyone's assistance to set up the machine. He said he slept poorly most nights and was tired throughout the day because he did not have his BiPAP machine. C. Record reviewThe physician's note, dated 8/11/25 at 9:04 a.m., revealed that Resident #42 requested set up for his continuous positive air pressure (CPAP) machine. The note documented Resident #42 had a history of obstructive sleep apnea that was reported as stable. The note documented Resident #42 had not had his CPAP device set up and had not gone to a sleep clinic since his arrival to the state. The note documented the resident's CPAP was initially set up for him in another state.-The physician's note documented the resident needed help setting up his CPAP machine, however, Resident #42 had a BiPAP machine.Review of Resident #42's August 2025 CPO revealed the following physician's orders: Respiratory therapist for BiPAP settings; call (name of sleep clinic) one time only for BIPAP settings, ordered 8/4/25.-However, review of Resident #42's electronic medical record (EMR) revealed no documentation to indicate the facility had called the sleep clinic to have the resident's BiPAP set up. -Review of Resident #42's comprehensive care plan, initiated 7/22/25 and revised 9/5/25, revealed no specific care plan focus for Resident #42's BiPAP.II. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 9/11/25 at 9:57 a.m. CNA #5 said she had seen that Resident #42 had a device in his room, but she was not sure if it was a CPAP or a BiPAP device. CNA #5 said she had not seen him wear it, but she said if he wore it before bed, the night shift staff would be the one to put it on him. Licensed practical nurse (LPN) #2 was interviewed on 9/11/25 at 10:03 a.m. LPN #2 said she had not seen Resident #42 wear a BiPAP or CPAP device before. LPN #2 said she did not know why Resident #42 did not have physician's orders for a CPAP or BiPAP machine. She said he was frequently agitated and often refused interventions staff offered to him, so maybe he refused to wear it with the night shift staff.Regional director of clinical services #2 was interviewed on 9/11/25 at 2:58 p.m. Regional director of clinical services #2 said she was not aware that Resident #42 had a BiPAP machine in his room. She said she had not worked in the facility daily until recently and she did not know why he did not have physician's orders or a care plan for his BiPAP machine. Regional director of clinical services #2 said she planned to speak with Resident #42 immediately and if Resident #42 wanted to wear his BiPAP device, she would obtain physician's orders for it.

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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 record review and interviews, the facility failed to ensure that residents who were trauma survivors received 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 of the resident for one (#7) of two residents out of 36 sample residents. Specifically, the facility failed to: -Ensure an assessment was completed to identify potential trauma behaviors for Resident #7, who had a diagnosis of post-traumatic stress disorder (PTSD); -Identify triggers for Resident #7's trauma behaviors related to past childhood trauma; -Identify and document resident-specific care approaches that addressed Resident #7's past history of trauma and triggers, which may cause re-traumatization, and train staff on the resident's trauma and triggers; and, -Ensure Resident #7's trauma care plan included resident-specific interventions for the resident.Findings include: I. Facility policy and procedure The Trauma Informed Care policy and procedure, revised 4/11/25, was provided by the chief nursing officer on 9/11/25 at 4:56 p.m. It read in pertinent part, The facility will ask the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools such as the Resident Assessment Instrument (RAI), admission Assessment, the history and physical, the social history/assessment, and others. The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. The facility will identify triggers that may re-traumatize residents with a history of trauma. Trigger-specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident, and will be added to the resident's care plan. Trauma-specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma, such as substance abuse, eating disorders, depression, and anxiety. These interventions will also recognize the survivor's need to be respected, informed, connected, and hopeful regarding their own recovery.II. Resident #7A. Resident status Resident #7, age [AGE], was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included end-stage renal disease, diabetes mellitus with diabetic chronic kidney disease, schizotypal disorder and dementia in other diseases. The 9/12/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 13 out of 15. He used a wheelchair. He required set up assistance with eating and oral hygiene. He was dependent on staff assistance for toileting and required supervision with personal hygiene. He required maximal assistance with showering. The assessment indicated the resident did not have behaviors. The assessment indicated the resident did not have a diagnosis of PTSD. B. Resident interview Resident #7 was interviewed on 9/8/25 at 1:58 p.m. Resident #7 said the food was horrible because the facility staff said they had to make the food institutionalized. He said institutionalization meant the food was low quality and not appetizing. He said he wished he could have a cheeseburger or a salad whenever he wanted but the facility did not have that food readily available. He said he asked if he could have food in his room and he was told no, other than condiments, snacks and drinks. He said he wished he was able to make food in his room. He said the food at the facility either had too much salt or was tasteless. He said when the facility served turkey, the turkey was tasteless. He said the chili was horrible. He said even a cheap can of chili from the discount store tasted better than the chili the facility served. Resident #7 was interviewed a second time on 9/9/25 at 10:21 a.m. Resident #7 said he was abused by his mother and father as a child. He said his mother used food as a weapon. He said when he was a child, he lived in the basement and his mother was always in the kitchen. He said when he was a child, his mother made him food and then (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	put coffee grounds on top of the food and put the food in the trash. He said his father smashed the food with his foot so the resident could not eat the food. He said food was very important to him. He said living in the facility reminded him of his childhood home. He said his room reminded him of living in the basement and the facility's dining area reminded him of his childhood kitchen. He said the facility should know about his childhood trauma. C. Record reviewThe 8/11/25 behavioral health services note revealed Resident #7 reported childhood abuse. The note revealed the resident had a diagnosis of PTSD. The resident reported a traumatic childhood, starting at age [AGE], when his mother became abusive, both emotionally and physically. He reported his mother did not allow him to eat at the table with the family and would intentionally place food in the trash to prevent him from eating. He reported his mother physically abused him, including kicking him in the head with high heels. He said he was not allowed to communicate with his siblings, which caused him significant distress. He recalled crying behind a dresser in the corner due to this isolation. Resident #7's trauma care plan, initiated 8/14/25 and revised 9/10/25 (during the survey), revealed the resident had actual potential for mood problems related to significant trauma in the past. Interventions included administering medications as ordered, consulting with behavioral health as needed, educating the resident regarding the expectations of treatment, concerns with side effects and potential adverse effects, monitoring, documenting and reporting as needed any risk for harm to self, monitoring and recording the resident's mood to determine if problems seemed to be related to external causes, monitoring, recording and reporting to the physician as needed for acute episode feelings of sadness, monitoring, recording and reporting to the physician as needed mood patterns for signs and symptoms of depression, monitoring, recording and reporting to the physician as needed risk for harming others and observing for signs and symptoms of mania (severe and debilitating symptoms of bipolar disorder) or hypomania (mild and less disruptive symptoms of bipolar disorder compared to mania)-The care plan did not identify Resident #7's specific trauma behaviors related to his childhood physical and emotional abuse. The care plan did not identify what triggered the resident's behaviors and what resident-specific interventions helped decrease the trauma-related behaviors for Resident #7. -The care plan failed to identify the resident had a diagnosis of PTSD.-Review of Resident #7's electronic medical record (EMR) failed to reveal an assessment for trauma behaviors. III. Staff interviews Certified nurse aide (CNA) #6 was interviewed on 9/11/25 at 1:35 p.m. CNA #6 said she knew a resident had trauma because the resident told her. She said there was no documentation to find out if a resident had trauma and what triggered their trauma. She said she was familiar with Resident #7. She said he did not have trauma.Registered nurse (RN) #1 was interviewed on 9/11/25 at 2:26 p.m. RN #1 said she knew a resident had trauma by asking the resident at admission and the resident also shared their trauma when she built a relationship with the resident. She said trauma concerns were documented as a progress note. She said she did not know where a resident's triggers related to trauma were documented. She said if she found out a resident had trauma, she would document the trauma as a progress note, tell the social services director (SSD), and the director of nursing (DON). She said she was familiar with Resident #7. She said she did not know he had trauma, she did not know what triggered his trauma or what approaches helped him. The SSD was interviewed on 9/11/25 at 12:45 p.m. The SSD said she began working at the facility at the end of August 2025 and she worked closely with the nursing home administrator (NHA), the DON and regional director of clinical services #2 as she learned the residents and the facility's processes. She said she knew a resident had a history of trauma at the time of admission. She said an assessment for trauma was completed within 48 to 72 hours of admission. She said there was a specific resident trauma interview assessment that provided her with a picture of the resident's trauma, what they experienced, what triggered the resident and what helped the resident. She said she did not know how a resident's trauma was communicated to nursing staff. She said there was a morning meeting with the DON where trauma was discussed, if needed. She said if a resident had trauma, it was documented in the resident's care plan. The SSD said she was familiar with Resident #7, but she was (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unsure if he had any trauma related concerns. She said she would check with the NHA. She said if she had worked at the facility when Resident #7 saw behavioral health services on 8/11/25, she would have reviewed the behavioral health progress notes so she could coordinate with the rest of the team to provide the appropriate care services for the resident. Regional director of clinical services #2 was interviewed on 9/11/25 at 3:22 p.m. Regional director of clinical services #2 said nursing staff knew a resident had a history of trauma based on the resident's care plan. She said the SSD was responsible for reviewing the paperwork from the resident's admission referral and then interviewing the resident, and their family if possible. She said resident trauma was reviewed at the first care conference. She said triggers for trauma were identified based on the interviews and were documented in the social services assessment. Regional director of clinical services #2 said she was familiar with Resident #7, but she did not know if he had a history of trauma. She said that based on the 8/11/25 behavioral health note documented in the resident's EMR, the resident's care plan should have been specific to the resident's trauma regarding his childhood emotional and physical abuse surrounding food. She said Resident #7's care plan should have included any triggers related to his past trauma.

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure two (#47 and #3) of five residents diagnosed with a mental disorder or psychosocial adjustment difficulty received appropriate treatment and services to attain the highest practicable mental and psychosocial wellbeing out of 36 sample residents. Specifically, the facility failed to:-Ensure a complete, thorough and timely assessment, including non-pharmacological interventions and a documented rationale for prescribing antipsychotic and antidepressant medications was completed for Resident #47 and Resident #3; -Ensure hours of sleep were monitored for Resident #47 and Resident #3 while they were on antidepressant medications, known to cause drowsiness and; -Identify and implement effective interventions when Resident #47 and Resident #3 refused psychotropic medications.Findings include: I. Facility policy and procedure The Use of Psychotropic Medication policy and procedure, revised 4/28/25, was provided by the regional vice president of operations on 9/8/25 at 4:34 p.m. It read in pertinent part, The indications for initiating, maintaining, or discontinuing medications(s), as well as the use of non-pharmacological approaches, will be determined by evaluating the resident's physical, behavioral, mental, and psychosocial signs and symptoms in order to identify and rule out any underlying medical conditions, including the assessment of relative benefits and risks, and the preferences and goals for treatment. Non-pharmacological approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications.II. Resident #47A. Resident status Resident #47, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included hemiplegia and hemiparesis (paralysis and weakness on one side of the body) following a cerebral infarction (stroke) affecting the left non-dominant side, vascular dementia, anxiety disorder and depression. The 8/15/25 minimum data set (MDS) assessment revealed the resident was moderately cognitively impaired with a brief interview for mental status (BIMS) score of eight out of 15. She used a wheelchair. She required set up assistance from staff with eating. She was dependent on staff assistance for oral hygiene, toileting, showering and personal hygiene. The assessment revealed the resident received an antipsychotic medication and an antidepressant medication. The assessment revealed the resident felt down, depressed or hopeless on two to six days (or several days) during the assessment look-back review period. The assessment revealed the resident did not exhibit any behaviors and did not reject care. B. Record review Resident #47's psychotropic medication care plan, initiated and revised 8/8/25, revealed the resident used psychotropic medications related to dementia with behaviors. Interventions included administering psychotropic medications as ordered by the physician, including monitoring for side effects and effectiveness every shift, documenting behavior, side effects and non-pharmacological interventions per the medication administration record/treatment administration record (MAR/TAR), monitoring, documenting and reporting adverse reactions and monitoring and recording the occurrence of target behavior symptoms, including hallucinations, delusions and verbal and physical aggressions towards staff. Resident #47's antidepressant medication care plan, initiated and revised 8/8/25, revealed the resident used antidepressant medication. Interventions included administering antidepressant medications as ordered by the physician, including monitoring for side effects and effectiveness every shift, monitoring, documenting and reporting adverse reactions and monitoring and recording the occurrence of target behavior symptoms including self-isolation, restlessness and yelling. Resident #47's antianxiety care plan, initiated and revised 8/8/25, revealed the resident used anti-anxiety medications related to anxiety. Interventions included administering antidepressant medications as ordered by the physician, including monitoring for side effects and effectiveness every shift, (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitoring, documenting and reporting adverse reactions and monitoring and recording the occurrence of target behavior symptoms, including agitation and irritability. Review of Resident #47's September 2025 CPO revealed the following physician's orders:Risperdal (antipsychotic medication) 2 milligram (mg) tablet. Take one tablet by mouth one time a day for dementia with behaviors, ordered 8/7/25. Zoloft (antidepressant medication) 100 mg tablet. Take two tablets by mouth one time a day for anxiety, ordered 8/7/25. Lorazepam (antianxiety medication) 0.5 mg tablet. Take 0.75 mg by mouth two times a day for anxiety. Administer 30 to 45 minutes before insulin administration, ordered 8/7/25. A review of Resident #47's August 2025 and September 2025 MARs revealed the following:-The resident refused Risperdal on 8/8/25, 8/9/25, 8/12/25, 8/14/25 and 9/5/25; -The resident refused Zoloft on 8/14/25, 8/22/25, 9/1/25, 9/7/25 and 9/8/25; and, -The resident refused Lorazepam on 8/13/25, 8/14/25, 8/15/25, 8/16/25, 8/22/25, 8/31/25, 9/1/25, 9/2/25, 9/5/25, 9/7/25, 9/8/25 and 9/9/25.-There was no documentation in Resident #47's electronic medical record (EMR) to indicate the physician was notified of the resident's refusal of the Risperdal, Zoloft and lorazepam medications.-There was no documentation in Resident #47's EMR regarding what interventions were attempted when the resident refused the Risperdal, Zoloft and lorazepam medications. -A review of Resident #47's EMR failed to reveal the resident's hours of sleep were monitored. The 8/18/25 psychotropic meeting review form revealed Resident #47 took lorazepam for anxiety, Risperdal for dementia with behaviors and Zoloft for anxiety. -The meeting form failed to identify what target behaviors the resident had exhibited since admission, what non-pharmacological interventions were used to help manage the resident's psychiatric behavior symptoms and the resident's response to the interventions attempted. III. Resident #3A. Resident status Resident #3, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 CPO, diagnoses included schizoaffective disorder (a mental health condition characterized by a combination of symptoms of schizophrenia - a disconnection from reality and a mood disorder like depression or mania), cerebral infarction (stroke) affecting the right dominant side, chronic kidney disease, major depressive disorder and anxiety disorder. The 9/8/25 MDS assessment revealed the resident was severely cognitively impaired with a brief interview for mental status (BIMS) score of four out of 15. She required partial assistance with eating. She was dependent on staff assistance with oral hygiene, toileting and showering. The assessment revealed the resident had verbal behavior symptoms directed towards others on one to three days in the assessment look-back review period. The assessment revealed the resident did not refuse careThe assessment revealed Resident #3 took an antianxiety medication and an antidepressant medication. The assessment revealed Resident #3 had little interest or pleasure in doing things and felt down, depressed or hopeless on two to six days (or several days) in the assessment's look-back period. B. Record review Resident #3's antidepressant care plan, initiated and revised 8/4/25, revealed the resident used an antidepressant medication. Interventions included administering antidepressant medications as ordered by the physician. Resident #3's antianxiety care plan, initiated and revised 8/22/25, revealed the resident used antianxiety medications related to anxiety. Interventions included administering antianxiety medications as ordered by the physician. Review of Resident #3's September 2025 CPO revealed the following physician's orders: Sertraline (antidepressant medication) 50 mg. Take one tablet by mouth in the morning for major depressive disorder, ordered 7/8/25. -The diagnosis for the sertraline medication was changed on 8/22/25 from major depressive disorder to schizoaffective disorder. Trazodone (antianxiety medication) 50 mg. Take one tablet by mouth at bedtime for insomnia, ordered 7/8/25. -The diagnosis for the trazodone medication was changed on 8/2/25 from insomnia to major depressive disorder. -The diagnosis for the trazodone medication was changed a second time on 8/22/25 from major depressive disorder to schizoaffective disorder. Buspirone (medication used to treat anxiety) 15 mg. Take one tablet by mouth three times a day for anxiety, ordered 7/8/25. A review of Resident #3's July 2025, August 2025 and September 2025 MARs revealed the following:-The resident refused sertraline on 8/2/25 and 8/22/25; and, -The resident refused (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	buspirone on 8/2/25 and 8/22/25. -There was no documentation in Resident #3's EMR to indicate the physician was notified of the resident's refusal of the sertraline and buspirone medications.-There was no documentation in Resident #3's EMR regarding what interventions were attempted when the resident refused the sertraline and buspirone medications. The 7/9/25 psychotropic meeting review form revealed the resident took buspirone for anxiety and sertraline for major depressive disorder. The committee recommendations included a referral to behavioral health services. -The meeting form failed to identify what non-pharmacological interventions were used to help manage the resident's psychiatric behavior symptoms and the resident's response to the interventions attempted. -A review of the resident's EMR revealed no documentation to indicate Resident #3 had been seen by behavioral health services. Cross-reference F644 for failure to take steps to ensure services were provided as recommended in Resident #3's PASRR level II report. IV. Staff interviewsThe social services director (SSD) was interviewed on 9/11/25 at 12:45 p.m. The SSD said she had started working at the facility at the end of August 2025 and was working closely with the nursing home administrator (NHA), the director of nursing (DON) and regional director of clinical services #2 as she learned the residents and the facility processes. She said she collaborated with the interdisciplinary team (IDT) regarding what resident behaviors needed to be monitored. She said the behaviors she determined needed to be discussed with the IDT meeting were based on the risk level of the behavior and if the behavior affected the resident or other resident's safety. The SSD said the IDT meetings included collaborating with the physician. She said the IDT reviewed residents who were on psychotropic medication during the psychotropic pharmacy meeting. The SSD said she did not know how often the residents were reviewed by the IDT. She said she was not completely sure on everything that was covered in the meeting, but she said the meeting covered what medications the resident took, what behaviors the resident exhibited, if there were any behavioral changes and if there were any positive or negative side effects on the resident's sleeping or eating patterns. The SSD said she did not know how the nursing staff knew if a resident had a behavior, how the nursing staff monitored the resident's behaviors or where the nursing staff documented the resident's behaviors. She said non-pharmacological interventions should be offered continuously. She said typical behavior interventions should be person-centered. The SSD said she was familiar with Resident #47 and Resident #3. She said she did not know what behaviors were being monitored for the residents. Certified nurse aide (CNA) #6 was interviewed on 9/11/25 at 1:35 p.m. CNA #6 said she knew a resident had behaviors because the nurse told her verbally. She said typical interventions for behaviors were offering residents drinks and snacks. CNA #6 said a resident usually had a behavior because the resident needed something but the resident did not know the word for it or how to ask for it in general. CNA #6 said behavior interventions were not documented. She said interventions were based on trial and error. She said she documented it when she saw the behavior. She said she did not document what intervention was used for a specific behavior or if the intervention was effective in decreasing the behavior. CNA #6 said she was familiar with Resident #47. She said Resident #47 yelled when she wanted something. CNA #6 said Resident #47 yelled at her roommate. She said interventions that de-escalate Resident #47's behaviors included offering her the use of her iPad, offering juice and calming her roommate. CNA #6 said Resident #47 refused to get out of bed sometimes and take showers. CNA #6 said she was able to get Resident #47 out of bed by reminding her of the breakfast meal time. CNA #6 said she was familiar with Resident #3. She said Resident #3 had behaviors. CNA #6 said Resident #3 yelled, cried and refused care. She said new staff and being too quick when providing care escalated Resident #3's behaviors. CNA #6 said stepping back and asking Resident #3 what she needed helped de-escalate Resident #3's behaviors.Registered nurse (RN) #1 was interviewed on 9/11/25 at 2:26 p.m. RN #1 said she knew a resident had a behavior because the staff monitored all new residents for behaviors for the first 48 to 72 hours after admission to the facility in order to get to know the resident. She said she documented the behaviors as a progress note or as an evaluation. She said she offered non-pharmacological interventions if the (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was yelling or screaming. She said she de-escalated the resident by talking calmly, redirecting and offering food. She said she documented the interventions used and if the interventions were effective in the resident's TAR. She said if a resident refused medication, she would reattempt to administer the medication multiple times. She said if the resident still refused the medication, she told the DON, the physician, and the resident's representative. RN #1 said she was familiar with Resident #47. RN #1 said Resident #47 screamed when she needed assistance to go to bed. RN #1 said besides screaming to go to bed, the resident did not have any other behaviors. She said Resident #47 did not refuse medications but she had a certain way of accepting medications. She said Resident #47 liked medications if the medication was mixed with applesauce or Med Pass (a nutritional supplement). RN #1 said she was familiar with Resident #3. RN #1 said Resident #3 said mommy mommy frequently. RN #1 said she used to think the resident said mommy mommy because it was an indication of the resident's pain, but when she did a pain assessment, the resident denied pain. She said when Resident #3's roommate was in the room, Resident #3 did not like her roommate being in the room and sometimes used profanity. She said cranberry juice helped de-escalate Resident #3' behavior. Regional director of clinical services #2 was interviewed on 9/11/25 at 3:22 p.m. Regional director of clinical services #2 said nursing staff and social services documented observations of the resident's behaviors and the IDT determined what behaviors needed to be monitored. She said if a behavior had a negative impact on a resident's quality of life, the behavior should be monitored. She said the IDT determined what behaviors to monitor because everyone on the team had their own observations of the resident, including what interventions worked or did not work for the resident's behaviors. She said non-pharmacological interventions should be offered when the resident started to have the behavior. Regional director of clinical services #2 said the IDT reviewed residents who were on psychotropic medications at a monthly meeting. She said the meeting reviewed the behaviors, what needed to be changed, the medications the resident was on and if a gradual dose reduction (GDR) of the medications was necessary. She said typical behavior interventions were redirection to an activity, snack, drink, music or talking. She said the behavior and the interventions were documented on the resident's treatment administration record (TAR). She said the IDT knew what interventions worked for the resident by asking the family, the resident and what activities the resident liked. Regional director of clinical services #2 said if a resident refused medication, the nurse should reapproach the resident to see if they were ready for the medication at a later time. She said if the resident still refused the medication, the nurse should let the physician know of the refusal. Regional director of clinical services #2 said she was familiar with Resident #47. She said the resident yelled obscenities. She said she was not sure what escalated Resident #47's behavior. She said talking to Resident #47 and offering juice and coffee de-escalated Resident #47's behaviors. Regional director of clinical services #2 said she did not know the resident refused her medications, other than her insulin. She said she did not know Resident #47's psychotropic meeting form did not include documentation for the non-pharmacological interventions that were used to help manage the resident's psychiatric behavior symptoms and the resident's response to the interventions attempted. Regional director of clinical services #2 said she was familiar with Resident #3. She said the resident had hallucinations and delusions. She said she yelled when staff did not explain care prior to providing the care. She said changing the resident's brief without explaining escalated the resident's behavior. She said stopping care and allowing the resident to catch her breath allowed the resident to de-escalate her behavior, as well as the staff explaining what care they tried to provide helped de-escalate the resident. Regional director of clinical services #2 said she did not know the resident refused her medications. She said Resident #3 might be refusing medications because the nurse did not explain what the medication was for or from some trauma she had in her past. She said she did not know Resident #3's psychotropic meeting form did not include documentation for the non-pharmacological interventions that were used to help manage the resident's psychiatric behavior symptoms and the resident's response to the interventions attempted The chief nursing officer was (continued on next page)

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F 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviewed on 9/10/25 at 6:30 p.m. The chief nursing officer said nursing staff and social services knew a resident had a behavior when the resident was admitted to the facility by looking at the admission referral paperwork and by the admission nursing report. She said nursing staff knew if they needed to monitor a resident's behavior by using their nursing judgment and based on the behavior monitoring implemented. She said non-pharmacological interventions should be offered for behaviors every day. She said typical behavior interventions were walks, diversional activities, activities specific to the resident, food, fluids and toileting. She said interventions should be documented as behavior monitoring or progress notes in the resident's EMR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure all drugs and biologicals were properly stored, secured and labeled in accordance with accepted professional standards. Specifically, the facility failed to: -Ensure topical medications were not left on Resident #8's bathroom counter; and,-Ensure medicated wound treatment supplies were not stored in an unlocked drawer in Resident #7's bedside table.Findings include: I. Resident #8A. Resident status Resident #8, age [AGE], was admitted on [DATE] and readmitted on [DATE]. According to the September 2025 computerized physician orders (CPO), diagnoses included vascular dementia, end-stage renal disease, dependence on renal dialysis, type 2 diabetes mellitus and cellulitis of the chest wall. The 7/13/25 minimum data set (MDS) assessment revealed that the resident was cognitively impaired with a brief interview for mental status (BIMS) score of 11 out of 15. She required a wheelchair. She required set up assistance with eating and oral hygiene. She required substantial assistance with toileting and showering. She required moderate assistance with personal hygiene. The assessment did not indicate that the resident had any skin issues problems. B. Resident interview and observation Resident #8 was interviewed on 9/8/25 at 10:30 a.m. Resident #8 said she scratched herself all over her body because her skin itched. She said nursing staff used cream on her for the itching. During the interview, the following items were observed on the resident's bathroom counter:There was a jar of triamcinolone acetonide 0.1% (percent) cream on the counter. The prescription label on the side of the jar had a different resident's name labeled on it. In a blue basket on the counter there were two tubes of zinc oxide ointment and one tube of hydrocortisone acetate 1% cream. All three tubes appeared to have less than half of the ointment or cream left in them. Resident #8 said the nursing staff used the creams and ointments in the bathroom on her skin. She said she did not know why the triamcinolone acetonide 0.1% cream was labeled with a different resident's name.C. Record review Review of Resident #8's electronic medical record (EMR) did not reveal documentation to indicate that the resident was able to self-administer her own medications and treatments. Review of Resident #8's EMR revealed the resident did not have a physician's order for the hydrocortisone acetate 1% cream. -However, the resident did have a physician's order for hydrocortisone acetate 2.5% cream. II. Resident #7A. Resident statusResident #7, age [AGE], was admitted on [DATE]. According to the September 2025 CPO, diagnoses included end-stage renal disease, diabetes mellitus with diabetic chronic kidney disease, schizotypal disorder (a mental health condition characterized by eccentric behaviors, odd thoughts and social difficulties) and dementia in other diseases. The 9/12/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 13 out of 15. He used a wheelchair. He required set up assistance with eating and oral hygiene. He was dependent on staff assistance for toileting and required supervision with personal hygiene. He required maximal assistance with showering. B. Resident interview and observationResident #7 was interviewed on 9/8/25 at 1:58 p.m. Resident #7 said he did not have any pressure ulcers. During the interview, a drawer on Resident #7's bedside table was noted to be labeled as wound supplies. The resident said he did not know what the supplies in the drawer were used for and gave permission to open the drawer. Upon inspection of the contents of the drawer, the following items were found:There was an eight ounce (oz) spray bottle labeled skin integrity wound cleanser, a 100 milliliter (ml) bottle of 0.9% sodium chloride irrigation, a four oz bottle of skin prep protective barrier spray, a six oz tube of triad hydrophilic wound dressing paste (medicated wound treatment) and a 1.5 fluid oz tube of medihoney gel (medicated wound treatment). Resident #7 said he did not know what the cleansers, sprays and tubes were used for. C. Record review Review of Resident #7's EMR did not reveal documentation to indicate that the resident was able to self-administer his own medications and treatments. III. Staff (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accel at Longmont Health and Rehab, LLC	1960 S Fordham St Longmont, CO 80503

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interviews Certified nurse aide (CNA) #2 was interviewed on 9/9/25 at 2:47 p.m. CNA #2 was familiar with Resident #8. She said she did not know why there were creams and ointments in Resident #8's bathroom. During the interview, Resident #8's bathroom was observed with CNA #2. The same medications observed on 9/8/25 were observed again in the same location (see 9/8/25 observation above). Registered nurse (RN) #2 was interviewed on 9/9/25 at 3:03 p.m. RN #2 said medications should never be left at a resident's bedside. RN #2 said the only time a medication could be left with a resident was if the resident had an assessment indicating the resident was able to self-administer medication. RN #2 said she worked both medication carts in the facility and there were no residents who had an assessment for self-administration of medications. She said there were residents who brought in over-the-counter medications when they were first admitted to the facility and she educated the residents that they were unable to keep the medications at the bedside. RN #2 said if the resident wanted their over-the-counter medication, they could ask the nurse and the nurse would check to see if there was a physician's order for the requested medication. RN #2 said she was familiar with Resident #8 and Resident #7. She said neither of the residents could self-administer their medications and treatments. During the interview, Resident #8's bathroom was observed with RN #2. RN #2 said the ointments and creams on the resident's bathroom counter should not be left in the resident's room. RN #2 said when Resident #8 returned to the facility, she would ask if other nursing staff used the creams and ointments on the resident.Resident #7's room was also observed during the interview with RN #2. RN #2 said she did not know why the wound treatment supplies were left in the resident's room. -However, RN #2 did not remove the treatment supplies from the resident's room during the observation and interview.The director of nursing (DON) was interviewed on 9/9/25 at 3:41 p.m. The DON said medications should never be left at a resident's bedside. The DON said the only time a medication could be left with a resident was if the resident had an assessment indicating the resident was able to self-administer medications. The DON said there were no residents in the facility who had an assessment that allowed them to self-administer medications. The DON said there were families who brought in medications and the nursing staff tried to educate the family and the resident that they were unable to keep the medication at their bedside. The DON said she was familiar with Resident #8 and Resident #7. She said RN #2 brought the triamcinolone cream found in Resident #8's room to her. The DON held up the same jar of triamcinolone cream that was observed in Resident #8's room. The DON said she did not know how the jar of cream ended up in the resident's room. The DON said Resident #7 should not have wound treatment supplies left in his room. The DON said Resident #8 and Resident #7 did not have an assessment completed that indicated they could self-administer their medications.

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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 observations, record review and interviews the facility failed to ensure accurate medical records were kept for one (#42) of two residents out of 36 sample residents reviewed. Specifically, the facility failed to maintain accurate records for Resident #42 of urine output and suprapubic catheter care in the electronic medical record (EMR).Findings include:I. Professional referenceAccording to [NAME], P.A. and [NAME], A.G. et.al., (2021), Fundamentals of Nursing, 10 edition, pp 366 Documentation is an important professional responsibility. To limit liability, your documentation needs to follow organizational standards, which include a clear description of individualized and goal-directed nursing care you provide based on your nursing assessment. Always document patient care in a timely manner following agency standards. Documenting all aspects of the nursing process is a critical nursing responsibility that limits nursing liability by providing evidence that you maintained or exceeded practice standards while taking care of patients. Mistakes in documentation that can result in malpractice include the following examples: failing to record pertinent health or drug information, failing to record nursing actions, failing to record medication administration, failing to record drug reactions or changes in patients' conditions, incomplete or illegible records, and failing to document discontinued medications.II. Resident #42A. Resident statusResident #42, age less than 65, was admitted on [DATE]. According to the September 2025 computerized physician's orders (CPO), diagnoses included quadriplegia (loss of motor function from the neck down), neurogenic bowel, neuromuscular dysfunction of the bladder and narcissistic personality disorder. The 8/21/25 minimum data set (MDS) assessment revealed Resident #42 was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. Resident #42 required moderate assistance to roll side to side, and required substantial assistance with eating, hygiene, bathing, toileting, and dressing. Resident #42 was dependent on staff for transfers and used a motorized wheelchair for mobility. The MDS assessment indicated the resident had an indwelling catheter.B. Resident interviewResident #42 was interviewed on 9/9/25 at 9:29 a.m. Resident #42 said the nursing staff did not empty his suprapubic catheter at a consistent time in the day. Resident #42 said most of the time it was only emptied when a staff member noticed the bag was almost full. Resident #42 said sometimes the catheter drainage bag became so full the urine would back up into the tubing causing discomfort. C. Record reviewReview of the August 2025 treatment administration record (TAR) revealed missing documentation on Resident #42's catheter care. Documentation was missing for the following dates: 8/3/25, 8/7/25, 8/13/25, 8/15/25, 8/16/25, 8/18/25, 8/22/25 and 8/28/25.Review of the August 2025 TAR revealed missing documentation on Resident #42's catheter output for the following dates: 8/3/25, 8/7/25 day shift and night shift, 8/8/25, 8/9/25, 8/13/25, 8/15/25, 8/16/25, 8/18/25, 8/23/25, 8/27/25, 8/30/25 and 8/31/25.Review of the September 2025 (9/1/25 to 9/11/25) TAR revealed missing documentation on Resident #42's catheter care. Documentation was missing for the following dates: 9/1/25, 9/3/25, 9/5/25 day shift and night shift, 9/6/25 and 9/10/25.Review of the September 2025 (9/1/25 to 9/11/25) TAR revealed missing documentation on Resident #42's catheter output. Documentation was missing for the following dates: 9/3/25 day shift and night shift, 9/5/25 day shift and night shift, 9/6/25 and 9/10/25.D. Staff interviewsCertified nurse aide (CNA) #5 was interviewed on 9/11/25 at 9:57 a.m. CNA #5 said the floor nurse was responsible for cleaning the catheter and the CNA assigned to the hall was responsible for emptying the catheters and recording the output. CNA #5 said the catheter did not need to be emptied at a certain time, but rather the task needed to be completed by the end of the shift. CNA #5 said usually catheter output was typically not reported in hand off order to ensure the catheter was emptied because they had so many residents requiring other information to be reported to the oncoming CNA. Licensed practical nurse (LPN) #2 was interviewed on 9/11/25 at 10:03 a.m. LPN #2 said the floor nurse was responsible for providing (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	catheter care and the assigned CNA was responsible for emptying the catheter and recording the output. LPN #2 said she did not think there was a specific time the catheter needed to be emptied, but most staff expected the catheters were emptied toward the end of the shift in order to estimate the output for their shift and inspect the bag and tubing to ensure it was secured and not pulling on a resident.Regional director of clinical services #2 was interviewed on 9/11/25 at 1:42 p.m. Regional director of clinical services #2 said staff were expected to empty the catheter and document the output every shift. Regional director of clinical services #2 said either a nurse or a CNA could empty the catheter and report the output and they were expected to if they observed that the catheter bag was full. Regional director of clinical services #2 said the tasks were also assigned in the CNA tasks and the TAR to ensure that each task was completed at minimum once per shift. Regional director of clinical services #2 said the missing documentation of catheter care and catheter output for Resident #42 was more likely an issue with recording and documenting care accurately and not that the care was not provided. Regional director of clinical services #2 said Resident #42 was able to make his needs known and would tell staff if he was experiencing discomfort or needed his catheter bag emptied. Regional director of clinical services #2 said catheter output was typically recorded toward the end of the shift. Regional director of clinical services said accurate recording of catheter care and catheter output help inform staff of changes and ensure adequate catheter care was completed to prevent complications with an indwelling catheter.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record review, and interviews, the facility failed to maintain an effective infection prevention and control program to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease.Specifically, the facility failed to ensure staff performed appropriate hand hygiene when assisting residents in the dining room.Findings includeI. Professional referenceAccording to The Centers for Disease Control and Prevention's (CDC). Clean Hands: About Handwashing 2/16/24), retrieved on 9/18/25 from https://www.cdc.gov/clean-hands/about/index.html, Many diseases and conditions are spread by not washing hands with soap and clean, running water. If soap and water are not readily available, use a hand sanitizer with at least 60% alcohol to clean your hands. Key times to wash hands: before, during, and after preparing food, and before and after eating food. Washing hands can keep you healthy and prevent the spread of respiratory and diarrheal infections. Germs can spread from person to person or from surfaces to people when you touch your eyes, nose, and mouth with unwashed hands, prepare or eat food and drinks with unwashed hands, touch surfaces or objects that have germs on them, blow your nose, cough, or sneeze into your hands, and then touch other people's hands or common objects.II. ObservationsOn 9/9/25, during a continuous observation of the lunch meal in the dining room, beginning at 11:40 a.m. and ending at 1:00 p.m., the following was observed:Ambulatory and wheelchair-bound residents were observed seated in the dining room, waiting for their meals.Hand sanitizing dispensers were observed on the wall next to the food-service window counter, towards the entrance of the dining room. There was one certified nurse aide (CNA) #4 who was attending to the residents seated in the dining area.CNA #4 started serving lunch to the residents who were seated in the dining room.CNA #4 was observed bringing lunch plates on trays from the kitchen to the residents and then returning to the window counter for another lunch plate. -CNA #4 did not sanitize her hands after serving each tray.At 12:00 p.m., CNA #4 was observed touching her hair and running her fingers through her hair on several occasions. -CNA #4 ran her fingers through her hair multiple times and continued to serve all the residents in the dining room without performing hand hygiene.III. Staff interviewsCNA #4 was interviewed on 9/11/25 at 10:15 a.m. CNA #4 said she touched her hair frequently when she became nervous. She said that by not performing hand hygiene, she could contaminate residents' food with her hair.CNA #4 said hand hygiene could keep you healthy and prevent the spread of infections. She said germs could spread from person to person or from surfaces to people when you touched your eyes, nose, and mouth with unwashed hands.Regional director of clinical service #2 was interviewed on 9/11/25 at 1:30 p.m. Regional director of clinical service #2 said staff should be performing hand hygiene when serving food to residents in the dining area. She said poor hand hygiene could lead to the spread of germs and foodborne illnesses.Regional director of clinical services #2 said CNA #4 should have washed her hands after touching her hair before touching residents' meals. She said staff education on hand hygiene would be completed immediately and as necessary.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, record review and interviews, the facility failed to ensure residents, family members and legal representatives had full access to review the results of the facility's most recent survey findings, including the survey results, certifications, complaint investigations and plans of correction in effect for the preceding three years. Specifically, the facility failed to:-Ensure the residents knew where the survey results binder was located; and,-Ensure the survey results binder was accessible for review by residents and visitors.Findings include:I. Facility policy and procedureThe Availability of Survey Results policy, dated 4/11/25, was provided by the chief nursing officer on 9/11/25 at 1:27 p.m. It read in pertinent part: A readable copy of our facility's most recent federal and/or state survey report and plan of correction for any identified deficiencies is maintained in a 3-ring loose-leaf binder titled Results of Most Recent Survey. The survey binder is located in the main lobby and is available for review by interested persons who wish to review information relative to our facility's compliance with federal and state rules, regulations, and guidelines governing our facility's operation.II. ObservationsOn 9/10/25 at 3:10 p.m. the survey results binder was unable to be located in the main lobby.On 9/10/25 at 5:00 p.m. the survey results binder was printed out and placed in the main lobby on a desk.III. Resident group interviewThe resident group interview was conducted on 9/10/25 at 2:00 p.m. with four residents (#55, #38, #43 and #46) who were identified by assessment and the facility as interviewable. The residents said they did not know what the survey binder was or where it was located.IV. Staff interviewsThe regional vice president of operations and the nursing home administrator (NHA) were interviewed together on 9/11/25 at 1:57 p.m. The regional vice president of operations said the survey binder should have been available during the survey, but it had not been printed. He said it had been printed out and placed in the facility's lobby area on 9/10/25.