STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075057	A. Building B. Wing	03/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyview Rehab and Nursing	35 Marc Drive Wallingford, CT 06492

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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. Based on facility documentation review, facility policy review, and interviews for 5 of 5 residents (Resident #17, #29, #40, #52, and #70) reviewed for grievances, the facility failed to ensure residents were provided information on how to file a grievance. The findings include: Review of the Resident Council Monthly Meeting Minutes dated 1/27/25 through 2/10/26 failed to reflect residents were educated or provided information on the grievance policy, the location of the grievance forms, how to file a grievance, or the resolution process. A Resident Council Meeting was held on 3/9/26 at 12:56 PM, and Residents #17, #29, #40, #52, and #77 indicated they were not aware of the grievance process, policy, or how to file a grievance. The residents further indicated they did not know who the Grievance official was or where the grievance forms were located. Interview with NA #7 on 3/16/26 at 10:07 AM identified that she does not know where the grievance forms are located. Interview with NA #6 on 3/16/26 at 10:08 AM identified that she does not know how grievances are handled or where the forms are located.Interview with Housekeeper #1 on 3/16/26 at 10:11 AM identified she has worked at the facility for 5 years and had never filled out a grievance form for a resident. Housekeeper #1 identified that if a resident asked her to fill out a grievance form, she did not know where they were located, so she would just Interview with RN #2 (day supervisor) on 3/16/26 at 10:15 AM, identified when a resident or resident's representative wishes to file a grievance, she writes it on a blank piece of paper because there are no grievance forms. RN #2 indicated she does not know who the Grievance Official is, but thinks it is the Director of Nurses (DNS). Observation on 3/16/26 at 10:18 AM identified an unlabeled smoke colored bin approximately 4 feet 3 inches off the floor/ground, not visible or reachable for a resident in a wheelchair. The 2 folders in the bin had a small label with grievance handwritten on them that is not visible from the wheelchair level. Interview with Social Worker (SW) SW #1 on 3/16/26 at 10:19 AM identified that she, the Administrator, and DNS are responsible for the grievance book. SW #1 indicated that if a resident has a grievance, the staff can give the completed grievance form to any of them. SW #1 indicated that if she receives the grievance form, she will read it, give it to the department that is involved, start the investigation, and include the DNS and Administrator. SW #1 indicated a grievance must be resolved in 5-7 days. SW #1 indicated that someone would inform the resident or resident representative of the outcome and then the grievance form is filed. SW #1 indicated that there is a folder outside of her office with the grievance forms. SW #1 identified grievance forms are not kept at the nurse's stations. SW #1 identified at the time of admission residents and resident representatives are educated on the grievance form and policy. SW #1 was unable to explain why information on how to file a grievance or complaint was not available to the residents. Interview with the Administrator on 3/16/26 at 9:45 AM identified grievance forms are outside of SW #1's office. The Administrator identified SW #1 was responsible for the grievance forms. Interview with RN #7 (charge nurse and fill in supervisor) on 3/16/26 at 10:28 AM identified if a resident or residents' representative had a complaint and wanted to file a grievance he would tell them to speak with SW #1 but if it was a weekend he would tell them to wait and talk to SW #1 on Monday. Review of facility Grievance policy identified the policy is designed to ensure that all residents residing at the facility, their families, and other interested (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	parties, are given a fair and proper procedure to voice complaints, grievances, or suggestions. The objective is to ensure that all residents receive the following: confidentiality, fair and equal treatment, and the ability to resolve problems without prejudice, threat of discharge or other reprisals. If the assistant director of nursing, the DNS, or the Director of social services cannot resolve the problem, they will refer the problem to the administrator. The administrator will make every effort to resolve the questions, problems, or grievances. The policy does not identify the timeframes for the resolution process. Review of the Resident Rights Policy identified that federal and state laws guarantee certain basic rights to residents in the facility which include the right to voice a grievance to the facility without discrimination or reprisal and without fear of discrimination or reprisal. The residents have the right to receive a response to his/her grievances from the facility.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #25) reviewed for personal property, the facility failed to ensure a resident had access to personal property timely. The findings include:Resident #25 had diagnoses that included congestive heart failure, Type 2 Diabetes, and major depression.The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 had a Brief Interview for Mental Status (BIMS) score of 11 indicative of moderately impaired cognition, did not experience delusions, was dependent with transfers, and required maximal assistance with bed mobility. The Resident Care Plan (RCP) dated 2/11/2026 identified Resident #25 was at risk of falling with interventions that directed to keep personal items within reach and anticipate the resident's needs.Interview with Resident #25 on 3/5/2026 at 11:43 AM identified he/she was missing multiple personal items including a phone. Resident #25 indicated he/she reported the missing items to several staff members, and the Administrator was aware of the missing items.Interview SW #1 on 3/10/2026 at 10:29 AM identified Resident #25 notified her on 3/9/2026 that he/she was missing multiple items, including a cell phone. SW #1 indicated the facility was still searching for the missing items.Interviews with NA #8 and NA #9 on 3/10/2026 at 1:53 PM identified Resident #25's phone was not in his/her room because the phone was sitting on the nurse's station counter for several days. NA #9 identified Resident #25's phone was moved from the nurse station into the supervisor's office because the phone was not holding a charge. Interview and observation with the Director of Nursing Services (DNS) on 3/10/2026 at 2:09 PM identified Resident #25's phone was not in the locked cabinet in the supervisor's office. The DNS identified she thought the phone was given back to Resident #25 a few days ago but was going to check with the nurse managers to inquire when the phone was returned to Resident #25.On 3/10/2026 at 2:22 PM, the DNS indicated she was informed by the supervisor Resident #25's phone had not been returned. Interview with the DNS on 3/11/2026 at 9:45 AM identified Resident #25's phone was located and given to SW #1.Interviews with Resident #25, the DNS, and SW #1 on 3/11/2026 at 1:32 PM identified Resident #25's phone had not been returned to him/her. SW #1 identified the phone was still in her office, and she had not returned it to Resident #25 because the phone needed to be charged.Interview with SW #1 on 3/16/2026 at 9:12 AM identified Resident #25's phone had not been returned to him/her. SW #1 indicated the reason the phone had not been returned to Resident #25 was because she didn't want the phone to be misplaced and the phone had not been charged.Subsequent to surveyor inquiry, on 3/16/2026 at 9:43 AM, Resident #25's phone was returned to him/her, and it was charging in his/her room.Review of the facility's Resident Rights policy identified, in part, that the residents have a right to self-determination, to have the facility respond to his or her grievances and shall retain and use personal possessions to the maximum extent that space and safety permit.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on facility documentation review, facility policy review, and interviews, the facility failed to address the Resident Council's repeated requests regarding the use of personal items for the Resident Council group reviewed. The findings include: Review of the Resident Council meeting minutes dated 12/10/25 identified residents inquired about having and using a hair dryer. Review of the Resident Council meeting minutes dated 1/13/26 identified residents again requested the use of a hair dryer. The meeting minutes identified staff informed the residents that blowˆdryers are not permitted due to fireˆhazard risk.A Resident Council Meeting was held on 3/9/26 at 12:56 PM with Residents #17, # 29, #40, #52, and #77. The residents identified hairˆdryer use was discussed in both December and February meetings, and they were told each time hair dryers were not permitted due to fireˆhazard concerns. The residents identified the Director of Maintenance had informed the Director of Recreation that residents still could not have hair dryers.Interview with the Assistant Maintenance Director on 3/16/26 at 12:07 PM identified he was instructed by the Director of Maintenance that residents were not allowed to have hair dryers because they are fire hazards. The Assistant Maintenance Director indicated a hair dryer could cause a fire if dropped in water, could short-out an electrical circuit, and it was against state regulations, though he was unable to identify the specific regulation. Interview with the Director of Recreation on 3/16/26 at 12:12 PM identified she records the Resident council meeting minutes. The Director of Recreation identified she recalled Resident #52, who is alert and oriented, requesting a hair dryer. The Director of Recreation indicated after speaking with the Director of Maintenance, she informed the residents that hair dryers were not allowed due to fireˆhazard concerns. The Director of Recreation identified when the issue was raised again in February 2026, she informed residents that the Director of Maintenance had already declined the request, so she did not consult him again. The Director of Recreation identified she did not report the issue to the Administrator.Interview with the Administrator on 3/16/26 at 12:20 PM indicated she became aware of Resident #52's hair dryer request only after reviewing the Resident Council minutes. The Administrator indicated staff had not asked her whether residents were permitted to have a hair dryer, and she believed the Resident Council went directly to Maintenance. The Administrator identified she did not know whether residents are permitted to have a hair dryer. and viewed the issue as a lifeˆsafety matter.Review of the Resident and Facility Handbook identified personal possessions that are electrical equipment brought into the facility must be inspected and tagged by the maintenance staff between 8:00 AM and 4:00 PM Monday through Friday prior to usage. (Please note: Fire and Safety Code prohibit the use of extension cords.)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 3 residents (Resident #4) reviewed for Advance Directives, the facility failed to implement Advance Directives according to the resident's expressed wishes. The findings include:Resident #4 had diagnoses that included cardiac arrythmia, end-stage renal disease, and type 2 diabetes.Review of the clinical record identified Resident #4 signed an Advance Directives form on 4/6/2025 indicating he/she wished to be a Full Code (all life-saving measures).A physician's order dated 2/21/2026 directed Do not resuscitate (DNR) and Do not Intubate (DNI).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Interview for Mental Status (BIMS) score of 15, indicative of intact cognition.Interview and clinical record review with Licensed Practical Nurse (LPN) #4 on 3/11/2026 at 10:14 AM identified Resident #4's code status did not match the signed Advance Directives form dated 4/6/2025 indicating Full Code. LPN #4 indicated that in an emergency, she would first check the signed hard copy and then the electronic health record to verify the physician ordered code status. LPN #4 identified nurses are responsible for placing signed Advance Directives in the paper chart and entering the order into the electronic health record.Interview and clinical record review with Register Nurse (RN) #5 on 3/11/2026 at 10:25 AM identified supervisors are responsible for ensuring a resident's code status order matches their signed Advance Directives form. RN #5 identified Resident #4's signed Advance Directives form did not match the code status order placing Resident #4 at risk of not receiving cardiopulmonary resuscitation in an emergency. RN #5 further identified that this risk existed within the facility and at the dialysis center, which relies on the facility's electronic health record for Resident #4's code status.Interview with the Director of Nursing Services (DNS) on 3/11/2026 at 10:31 AM identified nurses are responsible for reviewing Advance Directives with upon admission, placing the signed Advance Directives form in the paper chart, and entering the order into the electronic health record. The DNS stated supervisors are responsible for ensuring the signed Advance Directive form matches the physician- ordered code status. The DNS identified, although, Resident #4 was recently re-admitted to the facility rather than newly admitted , the process to verify the correct Advance Directives is the same. The DNS identified Resident #4's code status did not match his/her signed Advance Directives form.Subsequent to surveyor inquiry, on 3/11/2026 at 10:57 AM RN #5 entered a physician's order dated 3/11/2026 into Resident #4's electronic health record that directed a Full Code. RN #5 also notified the dialysis center of Resident #4's correct code status.Review of the facility policy titled Advanced Directives undated identified in part that all residents will be asked upon admission if they have Advanced Directives and a copy of the Advanced Directives will be placed in the resident chart.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and staff interviews, for 1 sampled resident (Resident #8) reviewed for physical restraints, the facility failed to conduct elopement risk assessments for a resident with a Wander Guard alarm to indicate if continued use was appropriate. The findings include:Resident #8 had diagnoses that included depression, anxiety, and stroke. The physician's order dated 5/15/25 directed to place a Wander Guard (wearable bracelet alerts staff by setting off audible alarms) to the right ankle, check placement on every shift, and check function every day on the night shift.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #8 had intact cognition, had no behaviors, and required use of a wander/elopement alarm less than daily.The Resident Care Plan (RCP) dated 5/26/25 identified Resident #8 was at risk for elopement, due to a history of attempts to leave the facility unattended, impaired safety, and awareness. Interventions included a Wander Guard to the right ankle, check functioning every shift, and providing structured activities, including walking inside and outside the facility.The physician's order dated 5/15/26 directed to check Wander Guard placement every shift. The annual MDS assessment dated [DATE] identified Resident #8 had moderately impaired cognition, had no behaviors, and required use of a wander/elopement alarm daily. Observation and interview on 3/11/26 at 10:48 AM identified Resident #8 was ambulating independently throughout the facility with a Wander Guard bracelet in place on the right ankle. Resident #8 stated he/she attempted to leave the facility approximately one year ago and had not attempted to leave since that time. Resident #8 stated he/she could not recall how long the Wander Guard bracelet had been in place. Resident #8 stated he/she ambulated throughout the facility daily but avoided the front entrance doors to prevent activation of the alarm. Resident #8 stated he/she wanted the Wander Guard bracelet removed.Interview with RN #2 on 3/11/26 at 11:21 AM identified Resident #8 was identified at risk for elopement upon admission, and staff applied a Wander Guard bracelet at that time. RN #2 stated she had not observed any exit-seeking behaviors by Resident #8. RN #2 identified because Resident #8 ambulated independently throughout the facility, the Wander Guard was used for his/safety. Interview and clinical record review with the DNS on 3/11/26 at 12:36 PM identified Resident #8's last elopement assessment was completed on 2/26/25. The DNS identified elopement assessments were required to be completed at least quarterly to indicate if a resident required the use of a Wander Guard. The DNS was unable to explain why the quarterly elopement assessments were not conducted on Resident #8 to determine if he/she still required a Wander Guard. The DNS identified she had not observed any exit seeking behaviors from Resident #8. The DNS identified Resident #8's elopement assessment should had been done quarterly. Subsequent to surveyor inquiry on 3/11/26, the DNS conducted an Elopement Risk Scale assessment for Resident #8, and Resident #8's Wander Guard was discontinued by the physician. The Elopement Risk Scale assessment dated [DATE] at 1:13 PM completed by the DNS identified Resident #8 was not at risk for elopement. Review of the Elopement Prevention policy dated 6/23, identified the facility shall complete a wandering/elopement risk assessment on every resident. Assessments will be conducted upon admission, quarterly and after elopement incidents. It also identified the quarterly elopement assessments would be conducted at the same time that the quarterly Minimum Data Sets (MDS) were completed.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #7) reviewed for personal property, the facility failed to report an allegation of misappropriation of property to the State Agency within the required time frame. The findings include:Resident #7 had diagnoses that included Type 2 Diabetes, non-pressure chronic ulcers of the skin, and a history of malignant neoplasm of bladder.The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12 indicative of moderately impaired cognition.The Resident Care Plan (RCP) dated 2/11/2026 identified Resident #7 was at risk for falls with interventions that directed to anticipate the resident's needs and keep personal items within reach.Interview with Person #1 on 3/5/2026 at 10:23 AM, identified he/she notified the Administrator about Resident #7's missing electronic device/tablet approximately one month ago.A review of facility documentation from 1/1/2025 to 3/10/2026 identified no grievances filed regarding missing items or the missing electronic device/tablet, and no State Reportable event was completed for Resident #7's missing device. Interview with Social Worker #1 (SW) on 3/10/2026 at 10:02 AM identified Person #2 (Resident #7's conservator) informed her Resident #7's electronic device/tablet was missing when he/she returned from the hospital. SW #1 indicated she was never told the electronic device/tablet was stolen, only that a replacement was needed. SW #1 identified she did not document the communication with Person #2 in a social service progress note within Resident #7's medical record.Interview with Person #2 on 3/10/2026 at 2:31 PM identified Resident #7 was transferred to the hospital in November 2025, and his/her electronic device/tablet was stolen while he/she was in the hospital. Person #2 indicated he/she notified the Administrator that Resident #7's electronic device/tablet was stolen and was told by the Administrator the facility would investigate the missing device.Interviews with the Director of Nursing Services (DNS), the Administrator, and SW #1 on 3/11/2026 at 9:57 AM identified the facility did not file a State Reportable event for Resident #7's missing electronic device/tablet, and an investigation was not completed.Subsequent to surveyor inquiry, the facility reported an allegation of misappropriation of property to the State Agency on 3/11/2026 at 2:30 PM.Review of the facility Abuse policy identified, in part, that reporting of alleged violations are to be made to the Administrator with notification provided to the state agency, ombudsman, resident representative, law enforcement officials, and primary physician.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 2 residents (Resident #7) reviewed for personal property, the facility failed to conduct a complete and thorough investigation for an allegation of misappropriation of property. The findings include:Resident #7 had diagnoses that included Type 2 Diabetes, non-pressure chronic ulcers of the skin, and a history of malignant neoplasm of bladder.The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 had a Brief Interview for Mental Status (BIMS) score of 12 indicative of moderately impaired cognition.The Resident Care Plan (RCP) dated 2/11/2026 identified Resident #7 was at risk for falls with interventions that directed to anticipate the resident's needs and keep personal items within reach.Interview with Person #1 on 3/5/2026 at 10:23 AM, identified he/she notified the Administrator about Resident #7's missing electronic device/tablet approximately one month ago.Review of facility documentation, clinical record, and Social Service progress notes from 1/1/2026 through 3/10/2026 was unable to provide documentation to reflect an investigation was completed for Resident #7's alleged stolen electronic device/tablet.Interview with Social Worker #1 (SW) on 3/10/2026 at 10:02 AM identified Person #2 (Resident #7's conservator) informed her Resident #7's electronic device/tablet was missing when he/she returned from the hospital. SW #1 indicated she was never told the electronic device/tablet was stolen, only that a replacement was needed. SW #1 identified she did not document the communication with Person #2 in a social service progress note within Resident #7's medical record.Interview with Person #2 on 3/10/2026 at 2:31 PM identified Resident #7 was transferred to the hospital in November 2025, and his/her electronic device/tablet was stolen while he/she was in the hospital. Person #2 indicated he/she notified the Administrator that Resident #7's electronic device/tablet was stolen and was told by the Administrator the facility would investigate the missing device.Interviews with the Director of Nursing Services (DNS), the Administrator, and SW #1 on 3/11/2026 at 9:57 AM identified the facility did not complete an investigation regarding Resident #7's missing electronic device/tablet.Subsequent to surveyor inquiry, the facility initiated an investigation and reported an allegation of misappropriation of property to the State Agency on 3/11/2026 at 2:30 PM. Review of the facility Abuse policy identified in part, that reporting of alleged violations are to be made to the Administrator with notification provided to the state agency, ombudsman, resident representative, law enforcement officials, and primary physician. Unless otherwise requested by the resident, the social service representative will provide the administrator and the director of nursing services with a written report of his/her findings through social service progress notes in the medical record.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, observations, and interviews for 1 of 3 sampled residents (Resident #70) reviewed for medication administration, the facility failed to ensure parameters were followed prior to administering a blood pressure medication. The findings include:Resident #70's diagnoses included congestive heart failure, coronary artery disease, and hypertension.The physician's order dated 9/16/25 directed to administer Amlodipine besylate (medication used to treat high blood pressure) oral tablet 2.5 milligrams, give 1 tablet by mouth one time a day for hypertension, hold for systolic blood pressure less than 110 or heart rate less than 50 beats per minute.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #70 was moderately cognitively impaired. The Resident Care Plan dated 2/18/26 identified Resident #70 had an altered cardiovascular status. Interventions included monitoring vital signs, notifying the physician of any significant abnormalities, report changes in lung sounds on auscultation, edema, and changes in weight.Observation and interview on 3/5/26 at 9:55 AM with Licensed Practical Nurse (LPN) #2 identified she administered Amlodipine Besylate 2.5 mg (one tablet by mouth) to Resident #70 without first obtaining a blood pressure or pulse, as directed on the medication label and per the physician's orders. LPN #2 stated Resident #70 did not have any specific parameters required prior to medication administration. Subsequent to surveyor inquiry, LPN #2 stated she reread the label on Resident #70's Amlodipine Besylate label after administration and identified instructions to hold the medication for a systolic blood pressure less than 110 or a heart rate less than 50 beats per minute. LPN #2 returned to Resident #70's room, obtained his/her blood pressure and pulse and recorded the blood pressure as 128/63 and a pulse of 66 beats per minute. Interview on 3/5/26 at 1:28 PM with the Director of Nursing Services (DNS) identified LPN #2 should have checked Resident #70's blood pressure and pulse before she administered Amlodipine Besylate oral tablet 2.5 milligrams. The DNS stated LPN #2 should have followed the physician orders.Review of the facility Physician Order policy dated 7/2023 directed to provide residents with prompt accurate treatment and orders must be documented in the resident's legal electronic medical record.Although requested, a facility policy for medication administration with perimeters was not provided.

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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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #22) reviewed for Activities of Daily Living, the facility failed to ensure showers were provided. The findings include:Resident #22 was admitted to the facility in July 2025 with diagnoses that included diabetes and heart disease.The Resident Care Plan dated 10/15/25 identified that Resident #22 was at risk for falling with interventions that directed to keep personal items and the call light within reach.The quarterly MDS dated [DATE] identified Resident #22 had moderately impaired cognition, and required supervision or touching assistance for showers, transfers, bathing, and dressing the lower body.The physician's orders dated 1/1/26 directed weekly showers with the assistance of 1 staff member, every Wednesday on the 3:00 PM - 11:00 PM shift.Review of Resident #22's nurse aide flow sheets dated 1/14/26, 1/21/26, 1/28/26, and 2/25/26 identified NA #4 documented N/A for showers, indicating showers were not applicable.Review of Resident #22's nurse aide flow sheet dated 2/25/26 identified NA #7 documented N/A for shower, indicating shower was not applicable.Interview with Resident #22 on 3/5/26 at 11:00 AM identified that he/she had not received a weekly shower for at least the last 3 weeks. Resident #22 further indicated he/she had only received maybe 2 showers in the last few months. Resident #22 identified for several months that he/she has been requesting additional showers for several months from the nurse aides and nurses, as he/she prefers to shower daily. Resident #22 indicated his/her requests were ignored. Resident #22 indicated he/she would like to receive two showers at least twice per week.Interview with NA #3 for Resident #22 on 3/10/26 at 9:31 AM identified that she works full-time and is assigned to care for Resident #22. NA #3 identified Resident #22 required maximum assistance with showers and could not be left alone. NA #3 identified that she provided Resident #22 with only one shower on 2/4/26.Interview with LPN #3 on 3/10/26 at 11:30 AM identified she works full-time on the 3:00 PM to 11:00 PM shift and is assigned to care for Resident #22. LPN #3 indicated the nurse aides have not reported any refusals of showers by Resident #22 within the past few months. LPN #3 identified that although she had not seen Resident #22 being brought into the shower room, there was no reason why Resident #22 should not have been given his/her weekly shower.Interview and clinical record review with NA #4 on 3/10/26 at 1:53 PM identified that she did not give Resident #22 any showers despite documenting that showers were given. NA #4 indicated that although she was assigned to provide showers to Resident #22, she did not do so because she is pregnant and found it physically difficult. NA #4 identified had not seen Resident #22 being brought into the shower room.Interview with NA #5 on 3/10/26 at 2:11 PM identified that showers are provided to Resident #22 upon request. NA #5 indicated Resident #22 was independent with showering. NA #5 identified that she could not recall whether Resident #22 received showers in February 2026.Interview and clinical record review with the DNS on 3/10/26 at 2:20 PM identified that shower assignments are based on room number, and Resident #22 is scheduled for showers on Wednesday evenings during the 3:00 PM to 11:00 PM shift. The DNS identified there was no documentation indicating that Resident #22 had refused showers. The DNS indicated that if a resident refuses a scheduled shower, the nurse aide is expected to re-approach the resident two to three times during the shift, and if the resident continues to refuse, the nurse aide is to notify the nurse, who will re-approach the resident and document the refusal in a progress note. The DNS indicated she was not aware that Resident #22 was not provided with his/her weekly showers or that Resident #22 requested showers more frequently. The DNS identified that her expectation is the charge nurse ensures nurse aides complete resident showers according to the established schedule. The DNS further identified that if a resident asks for a shower, it should be done, and if a resident wants a shower twice a week, it should be scheduled.Review of the Activities of Daily Living Policy identified residents will be provided with care, treatment and services as (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriate to maintain or improve as able, their ability to carry out activities of daily living (ADL's). Residents who are unable to carry out activities of daily living independently will receive the services necessary for activities of daily living.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy, and interviews for 1 of 3 residents (Resident #43) reviewed for nutrition, the facility failed to provide a resident with a physician-ordered assistive device for eating. The findings include:Resident # 43 had diagnoses that included Parkinson's Disease, dementia, and bilateral nuclear cataracts.A physician's order dated 12/13/2024 directed adaptive equipment consisting of a divided plate for all meals.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 had a Brief Interview for Mental Status (BIMS) score of 12, indicative of moderately impaired cognition and required set-up assistance for eating.The Resident Care Plan (RCP) dated 2/18/2026 identified Resident #43 was at risk for nutrition problems related to Parkinson's, dementia, impaired mental health, and a significant weight change. Interventions included monitoring/recording/reporting to the Medical Doctor signs and symptoms of malnutrition and providing and serving the diet as ordered.An observation and interview on 3/5/2026 at 12:20 PM identified Resident #19 seated in the dining room with his/her lunch without the benefit of a divided plate, although the meal ticket directed adaptive equipment consisting of a divided plate. SLP #1 identified Resident #43 required the adaptive equipment listed, but the divided plate had not been provided. SLP #1 identified the kitchen was responsible for providing the divided plate.Interview on 3/5/2026 at 12:25 PM with the Director of Dietary identified Resident #43 required adaptive equipment, but the divided plate had not been provided. The Director of Dietary identified that the Cooks are responsible for providing adaptive equipment. The Director of Dietary identified that the divided plate should have been provided to Resident #43 with his/her lunch meal. The Director of Dietary indicated it was an error.Interview on 3/13/2026 at 12:06 PM with [NAME] #1 identified she is responsible for placing food on a divided plate for residents with an order for a divided plate. [NAME] #1 indicated that during tray line, she was made aware that a divided plate was needed for certain residents as the kitchen staff would call the order out to her when reading the ticket. [NAME] #1 identified Resident #43's lunch meal should have been served on a divided plate.Review of the facility's Resident Adaptive Feeding Equipment Changes Policy identified that orders for feeding adaptive equipment should be included on pre-printed dietary tray tickets and staff should check for tray accuracy prior to trays going to the units.

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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 review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #22) reviewed for activities of daily living, the facility failed to ensure the clinic record was complete and accurate to include personal care. The findings include:a.Resident #22 was admitted to the facility in July 2025 with diagnoses that included diabetes and heart disease.The Resident Care Plan dated 10/15/25 identified that Resident #22 was at risk for falling with interventions that directed to keep personal items and the call light within reach.The quarterly MDS dated [DATE] identified Resident #22 had moderately impaired cognition, and required supervision or touching assistance for showers, transfers, bathing, and dressing the lower body.The physician's orders dated 1/1/26 directed weekly showers with the assistance of 1 staff member, every Wednesday on the 3:00 PM - 11:00 PM shift.Review of the Treatment Administration Records (TAR) identified on 1/7/26, 1/14/26, 1/21/26, and 1/28/26 during the 3:00 PM to 11:00 PM shifts, LPN #3 signed off Resident #22 received his/her weekly shower. Review of the TARs identified on 2/4/26, 2/11/26, 2/18/26, and 2/25/26 during the 3:00 PM to 11:00 PM shifts, LPN #3 signed off Resident #22 received his/her weekly shower. Review of the TAR dated 3/4/26 identified on the 3:00 PM to 11:00 PM shift, LPN #3 signed off Resident #22 received his/her weekly shower.Interview with Resident #22 on 3/5/26 at 11:00 AM identified he/she had not received a weekly shower for at least the last 3 weeks. Resident #22 further indicated he/she had only received maybe 2 showers in the last few months.Interview with LPN #3 on 3/10/26 at 12:21 PM identified she was the charge nurse for Resident #22 on 1 /7/26, 1/14/26, 1/21/26, 1/28/26, 2/4/26, 2/11/26, 2/18/26, 2/25/26, and 3/4/26 from 3:00 PM to 11:00 PM. LPN #3 identified although she never witnessed Resident #22 receiving a shower nor did she confirm with the nurse aides that a shower was provided, she signed off on Resident #22's TARs. b. Review of Resident #22's nurse aide flowsheet dated 1/7/26, identified NA #4 signed off Resident #22 was independent with showers.Review of Resident #22's nurse aide flowsheets dated 1/4/26, 1/21/26, and 1/28/26 identified showers were documented as N/A (the key code indicated NA was not applicable).Review of Resident #22's nurse aide flowsheet dated 2/11/26, identified NA #5 signed off Resident #22 was independent with showers.Review of Resident #22's nurse aide flowsheets dated 2/18/26 and 2/25/26, identified showers were documented as N/A (the key code indicated NA was not applicable).Review of Resident #22's nurse aide flowsheets dated 2/1/26 through 2/28/26 identified activities of daily was not documented on 14 shifts over 28 days. Review of Resident #22's nurse aide flowsheets dated 3/1/26 through 3/9/26 identified activities of daily was not documented on 4 shifts over 9 days. Interview with NA #3 for Resident #22 on 3/10/26 at 9:31 AM identified that she works full-time and is assigned to care for Resident #22. NA #3 identified she was trained on how to document on the nurse aide flowsheet. NA #3 identified Resident #22 required maximum assistance with showers and could not be left alone. NA #3 identified she provided Resident #22 with only one shower on 2/4/26. Interview and clinical record review with NA #4 on 3/10/26 at 1:53 PM identified that she did not give Resident #22 any showers despite documenting that showers were given.Interview with NA #5 on 3/10/26 at 2:11 PM identified when she documents on flowsheets a 6 means independent for showers, and NA means no shower was given that day. NA #5 indicated Resident #22 was independent with showering. NA #5 identified that she could not recall whether Resident #22 received showers in February 2026.Interview and clinical record review with the DNS on 3/10/26 at 2:30 PM identified documentation must be complete and accurate to reflect care provided. The DNS identified LPN #3's signature on Resident #22's TARs indicated Resident #22 received his/her weekly shower. The DNS identified the documentation was inaccurate because LPN #3 only conducted the skin evaluation and did not ensure Resident #22's shower was provided.Interview with Administrator on 3/10/26 at 3:00 PM identified her expectation is for nurses and nurse aides to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document in the electronic medical record the complete and accurate information every day.Interview with the DNS on 3/11/26 at 9:20 AM identified nurse aides are expected to document in the medical record throughout the day and ensure it is completed by the end of their shift. The DNS identified that the documentation must be both complete and accurate and staff should only document what they did for the residents. The DNS stated she is responsible for ensuring the nurse aides complete their documentation by shift end.Review of facility Charting and Documentation Policy identified services provided to the residents, progress towards the care plan goals, or any changes in the residents' medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record as indicated. Documentation in the medical record will be objective, complete, and accurate. Entries may only be recorded in the resident's clinical record by licensed personnel in accordance with state law facility policy. Certified nursing assistants may only make entries in the residents' medical chart as permitted by the facility policy.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, observations, and interviews for 1 of 3 residents (Resident #2) reviewed for pressure ulcers, the facility failed to ensure staff wore appropriate Personal Protective Equipment (PPE) while providing care for a resident on precautions. The findings include: Resident #2 had diagnoses that included quadriplegia, Stage 4 pressure ulcer of the left and right buttock, Stage 4 pressure ulcer of sacral region, flaccid neuropathic bladder, and carrier or suspected carrier of methicillin resistant staphylococcus aureus (MRSA) (a type of bacteria that causes skin infections and is resistant to many antibiotics, making it harder to treat).The annual MDS assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicative of intact cognition, and dependent with bed mobility and transfers. The MDS further identified Resident #2 had three (3) stage 4 pressure ulcers.The physician's order dated 3/2/2026 directed Enhanced Barrier Precautions (EBP) related to chronic wounds, a suprapubic catheter, colostomy, history Extended-spectrum beta-lactamases (ESBL) (an enzyme with resistance to some antibiotics) and MRSA, and use of PPE per instruction on signage on every shift.The Resident Care Plan (RCP) dated 3/3/2026 identified Resident #2 was on EBP related to chronic wounds, a suprapubic catheter, colostomy, history of ESBL and MRSA with interventions that directed to maintain EBP per facility policy.Observation on 3/9/2026 at 1:03 PM noted Resident #2 had signage outside of his/her room regarding the need for EBP and directed during high contact activities a gown and gloves must be worn.Observation and interviews with NA #1 and NA #2 on 3/9/2026 at 1:04 PM identified Nurse Aide (NA) #1 and NA #2 were providing personal care to Resident #2 and were not wearing the appropriate PPE (no isolation gowns). NA #1 and NA #2 identified they had provided a bed bath to Resident #2 without the benefit of isolation gowns. NA #1 and NA #2 identified they were aware Resident #2 was on EBP. NA #1 and NA #2 indicated they forgot to put on gowns, which they should have worn.Interview with the DNS on 3/9/2026 at 1:30 PM identified for residents on EBP, nursing staff should don an isolation gown and gloves when providing personal care or with high contact activity. The DNS indicated all staff had been educated on EBP. The DNS identified NA #1 and NA #2 should have known what PPE was required and should have donned an isolation gown when providing care to Resident #2. The DNS identified that she was unsure why NA #1 and NA #2 did not wear appropriate PPE when providing personal care to Resident #2.Review of the facility Enhanced Barrier Precautions policy identified in part that enhanced barrier precautions will be used for residents with infection or colonization of a Multidrug Resistant Organism, or with wounds or indwelling medical devices, regardless of Multi Drug Resistant Organism colonization status. EBP employs gown and glove use during high contact resident care activities.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on review of facility documentation, facility policy, and interviews, the facility failed to ensure staff were provided education on the benefits and risk associated with COVID-19 vaccination and failed to ensure staff were offered the COVID-19 vaccine or information on obtaining it. The findings include:Interview with LPN #1 (Infection Preventionist) on 3/10/26 at 8:12 AM identified the facility no longer offered COVID-19 vaccines to staff at the facility. LPN #1 identified the previously completed staff consent forms were shredded. LPN #1 identified staff were not offered COVID-19 vaccines or provided with education on the benefits and risks associated with COVID-19 vaccine. On 3/10/2026 at 8:26 AM, a request was made to the Administrator, Director of Nursing (DNS), and Infection Preventionist (IP) for COVID-19 staff education documentation. The facility did not provide documentation showing staff education on COVID-19 vaccination, including information on vaccine availability or where staff could receive the vaccine.Interview the Physical Therapist #1 (Director of Rehabilitation) on 3/10/26 at 10:22 AM identified during the facility's influenza clinic in October 2025, staff were informed that the facility would no longer provide the COVID-19 vaccine. Review of the facility Nursing and Infection Prevention Policy identified annual reviews were completed on 12/6/2024 and 12/2/2025. Review of facility Staff Vaccines: Influenza, Pneumococcal. and COVID-19 immunizations policy dated 8/23, identified all facility staff are to be fully vaccinated against COVID-19 with any of the approved vaccines unless there is a documented medical or religious exemption on file.

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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, interviews, and review of facility policy, the facility failed to post notice of the availability of the survey results in areas of the facility readily accessible to residents, family members, and legal representatives of residents. The findings include: Observations on 3/5/26 at various times identified the survey team could not locate any notices about the availability of the facility's survey results.Interviews with Resident Council members (Residents #17, #29, #40, #52, and #77) on 3/9/26 at 12:56 PM identified they did not know what the state survey results were or where they were located. The residents indicated staff had never reviewed this information with them individually or during Resident Council meetings.Observations on 3/10/26, 3/11/26, and 3/16/26 at various times identified the survey team could not locate any notices regarding the availability of the survey results.Interview with NA #6 on 3/16/26 at 9:22 AM revealed she did not know where the state survey results were located.Interview with NA #7 on 3/16/26 at 9:24 AM identified she believed state survey results should not be left out for residents or visitors. NA #7 indicated she would direct anyone requesting the results to ask the Director of Nurses (DNS).Interview with LPN #3 on 3/16/26 at 9:27 AM identified she believed the state survey results were kept in a binder at the desk but must be requested.Interview with LPN #4 on 3/16/26 at 9:30 AM identified she did not know where the state survey results were located.Interview with RN #2 (day shift supervisor), on 3/16/26 at 9:32 AM identified she did not know where the state survey results were located.Interview and observation with the DNS on 3/16/26 at 9:33 AM, the DNS indicated the survey results were kept in the front lobby. The DNS searched the reception and lobby areas but was unable to locate the results.Interview with Receptionist #1, with the DNS present, on 3/16/26 at 9:35 AM identified the results were not kept at the reception desk, and she did not know their location.Interview and observation with the Administrator, with the DNS present, on 3/16/26 at 9:36 AM identified the state inspection reports for the last three years were kept behind the reception desk. The Administrator pointed to a sign posted on the side wall above the front desk indicating a most recent copy of our state results can be found at the reception desk. The Administrator retrieved a binder labeled state survey binder, which contained complaint reports dated 10/24/23, 2/22/24, 12/16/24, and 3/5/25. The DNS stated she had not noticed the sign until the Administrator pointed it out. The sign was posted on a side wall behind the reception area, approximately 5 feet 4 inches from the floor, and not at wheelchair eye level.Review of the facility Resident Rights policy identified the guidelines are to follow the federal and state laws that guarantee certain basic rights to all residents at the facility and these include the right to examine the survey results.