STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075228	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arden Care Center	850 MIX Ave Hamden, CT 06514

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 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 a review of clinical records, facility documentation, facility policies, and interviews for one of two residents (Resident #2) reviewed for wound care, the facility failed to ensure the APRN was notified timely of Resident #2's refusal of physician ordered daily wound dressings. The findings include: Resident #2 was admitted to the facility with diagnoses that included peripheral vascular disease (PVD), paraplegia (loss of voluntary movement and sensation to the lower half of the body) and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 (indicated he/she was alert and oriented) and was dependent for personal hygiene, moderate assist for bed mobility and transfers, and had one (1) venous or arterial ulcer. A resident care plan (RCP) dated 2/11/2026 identified Resident #2 was resistive to care, refused care (including wound care), and was at risk for skin breakdown related to PVD, paraplegia and weakness. Interventions directed to provide wound treatment as ordered, explain all care, including procedures (one step at a time), and the reason for performing the care before initiating and to provide with the opportunity for choice during care/activities to provide a sense of control. A physician order dated 3/14/2026 directed to cleanse a right shin wound with normal saline (NS), followed by calcium alginate (absorbent wound dressing that changes into a gel upon wound contact to promote healing) followed by a dry clean dressing every day shift. A facility reportable event (RE) dated 3/19/2026 at 1:00 PM identified during wound rounds it was noted that Resident #2's dressing was not changed for three (3) days by LPN #3. An investigation was initiated and the MD/APRN (provider) was notified. A facility RE summary dated 4/1/2026 identified on 3/19/2026 Resident #2's wound dressing was noted to be dated 3/15/2026. Resident #2 was self-responsible and had refused the right shin wound treatments, however the nurse failed to notify the physician/APRN. Interview and record review with APRN #2 on 4/14/2026 at 1:30 PM identified wound dressings are dated when changed to identify the date the treatment was provided. APRN #2 stated she was completing wound rounds with LPN #7 on 3/19/2026 when they noted that Resident #2's right lower extremity dressing was dated 3/15/2026 (indicating the treatment was not provided for 3 days). Resident #2 frequently refused wound treatments. APRN #2 stated staff were required to notify her or the medical APRN if a treatment was refused, but stated staff did not notify her of any refusals of 3/16, 3/17 and 3/18/2026, and she would want to have been notified. Interview and review of facility documents with the DON on 4/14/2026 at 10:15 AM identified upon interview with LPN #3 on 3/20/2026, LPN #3 reported Resident #2 had refused to have the dressing changed on 3/16, 3/17 and 3/18/2026. The DON stated she expected staff to notify the physician/APRN of any treatment refusals and LPN #3 had indicated she forgot to notify an APRN of the refusals. Attempts to contact LPN #3 were unsuccessful during survey. The facility Skin Integrity and Wound Management Policy dated 2/1/2023 directed in part, to collaborate with the provider to review conditions that may affect healing. The facility Treatment: Refusal Policy dated 3/1/2022 directed in part, if a patient refuses treatment to notify the physician of the refusal of treatment. The facility policy Change in Condition: Notification of dated 6/1/2021 directed in part, to notify the physician of a significant (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075228	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/15/2026
NAME OF PROVIDER OR SUPPLIER Arden Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 850 MIX Ave Hamden, CT 06514	

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	change in condition and a need to alter treatment. Further, the Policy directed to provide timely notification about changes relevant to the patient's condition.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for two of two sampled residents (Residents #11 & #12) who were reviewed for abuse, the facility failed to ensure Resident #11 was free from sexual abuse by Resident #12. The findings include:1.Resident #11's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic kidney disease stage, epilepsy, unspecified mood (affect) disorder and unspecified psychosis not due to a substance or known physiological condition. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #11 had moderately impaired cognition, was dependent on staff for all activities of daily living. The Resident Care Plan dated 12/12/25 identified Resident #11 had impaired and a decline in cognitive function or impaired thought processes related to a condition other than delirium; impaired decision making. Interventions directed to observe and evaluate types of changes in cognitive status, allow the resident to make daily decisions, use verbal cues, gestures and demonstration to assist in decision making, and provide consistent, trusted caregiver and structured daily routine. The nurse's note dated 2/25/26 at 10:14 PM identified the charge nurse reported an inappropriate verbal comment requesting for Resident #11 to touch Resident #11 to touch him/herself was made by Resident #11's roommate, Resident #12. The note further identified there was no physical contact observed, both residents were assessed and the privacy curtain was closed to promote privacy and maintain appropriate boundaries. The nurse's note dated 3/1/26 at 11:30 AM identified Resident #11 was moved to a different room to maintain safety, there was no specific documentation of an incident with the roommate after the 2/25/26 event. 2. Resident #12's diagnoses included dementia with agitation, adjustment disorder with anxiety and depression and mild neurocognitive disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #12 was cognitively intact, was independent with bed mobility and transfers. The Resident Care Plan dated 1/1/26 identified Resident #12 had impaired and a decline in cognitive function or impaired thought processes related to a condition other than delirium; short/long term memory loss and impaired decision making. Interventions directed to observe and evaluate types of changes in cognitive status, evaluate responses from Brief Interview for Mental Status (BIMS-a tool used to calculate cognitive status), evaluate behavioral symptoms for underlying causes, and evaluate need for psych/behavioral health consult as needed. The nurse's note dated 2/26/26 at 3:42 AM identified the charge nurse reported Resident #12 was making inappropriate comments to his/her roommate Resident #11. The note identified there was no physical contact between the residents. The note identified Resident #12 was provided with education regarding inappropriate behavior and maintaining boundaries and the privacy curtain was pulled between the two (2) residents. The note indicated Resident #12 became upset with the Nursing Supervisor shouted at the supervisor to leave the room, stating it was a private conversation between him/her and the roommate. The note indicated the situation would be closely monitored by nursing to ensure safety and appropriateness of behavior throughout the shift. A revision was made to the care plan on 2/26/26 to include Resident #12 exhibits or potential to demonstrate verbal behaviors related to sexually inappropriate language. Interventions directed to evaluate nature and circumstances of the behaviors with the resident, evaluate the need for psych/behavioral health consultation, and social service visits to provide support as needed. The practitioner's note dated 2/27/26 at 3:01 PM identified Resident #12 was evaluated for inappropriate verbal comments directed toward roommate, nursing documentation reflects Resident #12 asked his/her roommate to touch self and made sexually inappropriate statements. The note indicated Resident #12 was placed in the psych communication book and psychiatry was notified with evaluation pending. The practitioner's note dated 3/6/26 at 8:40 AM identified Resident #12 was seen following documented behavioral concerns within the facility. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note indicated episodes of unusual behavior towards the roommate, including sitting at the end of the roommate's bed and speaking to the roommate during the nighttime hours. Review of the Residents #11and Resident #12's clinical records failed to reflect documentation addressing an incident on 3/1/26 incident, only that Resident #11 was moved to another room for safety. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #4, on 4/14/26 at 1:56 PM identified on 3/1/26 upon arriving for her shift, she observed Resident #12 sitting at the end of Resident #11's bed and heard Resident #12 ask Resident #11 if he/she enjoyed last night. LPN #4 explained she observed Resident #11 with his/her brief down to the right side, which Resident #11 would not be able to do by him/herself. LPN #4 identified she did not observe any semen present on either resident. LPN #4 identified she immediately notified the supervisor and at that time Resident #11 was provided with a room change for safety. LPN #4 identified she created a nurse's note after the incident, but review of the clinical documentation of both Resident #11 and Resident #12 failed to identify a nurse's note was present in the clinical record. Interview with the 3-11PM nursing supervisor, Registered Nurse (RN) #6, on 4/14/26 at 2:31 PM identified on 3/1/26 it was reported to her that Resident #12 was observed fondling his/herself at the end of Resident #11's bed. RN #6 indicated she assessed both residents and provided Resident #11 with a room change for safety. Interview and clinical record review with the Social Worker (SW) #1, on 4/14/26 at 2:46 PM identified an incident was reported to her that on 3/1/26 Resident #12 had displayed some type of sexual behaviors. SW #1 indicated she was not made aware of the 2/25/26 incident until after the 3/1/26 incident. SW #1 identified she provided follow-up with Resident #12 who declined to discuss anything with her at that time and continued to refuse during attempts to reapproach Resident #12. SW #1 identified that making a sexual statement towards another resident would be considered abuse and it should be reported immediately. Interview with RN #1 on 4/15/26 at 8:46 AM identified on 2/25/26 the charge nurse reported to her Resident #12 asked Resident #11 to touch his/herself. RN #1 indicated she went to both residents to have a conversation with each of them. RN #1 explained although Resident #12 stated he/she was not aware of what she was talking about and Resident #11 reported he/she was not upset, she notified the Director of Nursing (DON). RN #1 identified both residents denied anything happened, the privacy curtain was pulled, and a room change was offered at that time to Resident #11 who declined. Interview and clinical record review with the DON on 4/15/26 at 11:51 AM identified it was reported to her that on 2/25/26 Resident #12 was overheard making sexual talk in front of Resident #11. The DON identified social services and psych services were provided to Resident #12 and Resident #11 was provided with psych services as well. The DON identified an investigation was not initiated on 2/25/26 as the incident was reported as an overheard comment. The DON explained the facility did not report the allegation to the state agency as she did not feel this was verbal or sexual abuse as it was just sexual talk and Resident #12 has the right to talk like this in his/her room. The DON identified on 3/1/26 she was notified Resident #12 was verbalizing something to the effect of I am playing with myself and do you want to see it towards Resident #11. The DON identified at the time of the 3/1/26 incident, Resident #11 was provided with a room change and Resident #12 was noted to be very hypersexual in what he/she says. The DON indicated the facility policy on abuse defines sexual abuse as non-consensual sex or contact with any resident, and she did not believe these incidents fit into that definition. Interview with the administrator on 4/15/26 at 2:35 PM identified on 2/25/26 an incident was discussed where Resident #12 was making sexual comments in the room shared with Resident #11. The administrator identified on 3/1/26 an incident was reported that Resident #12 was at the end of Resident #11's bed and touching him/herself, there was no touching of Resident #11, Resident #11 was provided with a room change, each resident was assessed, appropriate parties were notified and psych consults were requested. The administrator identified the facility policy on abuse stated (read off from actual policy) verbal abuse is any use of oral, written or gestured language that willfully includes disparaging and derogatory terms to patients or their families or within their hearing distance, regardless of their age, ability to comprehend or disability. The (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator identified sexual abuse is a non-consensual sexual contact of any type with a patient, it includes but is not limited to sexual harassment, sexual coercion, or sexual assault. Review of the facility policy title Abuse Prohibition, last revised 10/24/22, directed, in part, the center prohibits abuse, mistreatment, neglect, misappropriate of resident property and exploitation for all residents and this included, but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restrain not required to treat the residents medical symptoms. The policy further defines verbal abuse as any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents and their families or within their hearing distance regardless of their age, ability to comprehend, or disability. The policy further defined sexual abuse as any non-consensual sexual contact of any type with a resident and included, but was not limited to sexual harassment, sexual coercion, or sexual assault.

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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 clinical record reviews, reviews of facility documentation, facility policies, and interviews for five (5) of six (6) sampled residents (Residents #4, #5, #6, #7 and #8) reviewed for neglect, the facility failed to ensure staff reported an allegation of neglect and failed to ensure the State Agency was notified of the allegations of neglect and for two sampled residents (Residents #11 and #12) who were reviewed for reporting an allegation of abuse, the facility failed to ensure two (2) incidences where Resident #12 made inappropriate sexual comments to Resident #11 were reported to the state agency. The findings include: A. Resident #4 was admitted with diagnoses that included polyneuropathy (multiple nerve dysfunction that causes numbness, tingling and muscle weakness), traumatic brain injury and depression. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #4 was alert and oriented with a Brief Mental Interview for Mental Status (BIMS) of fifteen (15), and was dependent for toileting, was frequently incontinent of urine, always incontinent of bowel, and was at risk for pressure ulcers. The Resident Care Plan (RCP) dated 3/11/2026 identified Resident #4 a risk for skin breakdown due to immobility and incontinence. Interventions directed to turn and reposition every two (2) hours and observe skin for any signs of breakdown. Resident #5 was admitted with diagnoses that included dementia, diabetes mellitus and depression. A quarterly MDS dated [DATE] identified Resident #5 was alert and oriented (BIMS score 13), was dependent for toileting, was frequently incontinent of urine, and was at risk for pressure ulcers. The RCP dated 3/18/2026 identified Resident #5 a risk for skin breakdown due to limited mobility and cognitive loss. Interventions directed to turn and reposition every one (1) to two (2) hours while in bed and observe skin for any signs of breakdown. Resident #6 was admitted with diagnoses that included multiple sclerosis and peripheral vascular disease (PVD). The RCP dated 12/28/2025 identified Resident #6 at risk for skin breakdown due to limited mobility and incontinence. Interventions directed incontinent care and to observe skin for any changes. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #6 was alert and oriented, was occasionally incontinent of urine, and was at risk for pressure ulcers. Resident #7 was admitted with diagnoses that included multiple sclerosis, paraplegia. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #7 was alert and oriented and was incontinent of urine. The Resident Care Plan (RCP) dated 3/2/2026 identified Resident #7 wat risk for skin breakdown. Interventions directed incontinent care as indicated, observe skin for any changes, and turn and position four (4) times a shift. Resident #8 was admitted with diagnoses that included PVD and paraplegia. The Resident Care Plan (RCP) dated 1/2/2026 identified Resident #8 had altered mobility, compromised circulation and contractures. Interventions directed to reposition resident every two (2) hours and as needed resident allows. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #8 was alert and oriented, was occasionally incontinent of urine, was incontinent of bowel, and was at risk for (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pressure ulcers. A facility reportable event (RE) dated 3/27/2026, submitted to the State Agency at 4:30 PM for Resident #8 identified an allegation of neglect several residents didn't receive incontinent care on 11-7 3/26/26. The RE further identified a staff member reported that during rounds it was noted that several residents did not receive incontinent care timely. They were soaked and some also had feces on them. Additional review of the RE failed to identify the time the rounds were conducted that identified the lack of incontinent care, and failed to identify who the additional residents were. Review failed to identify why the additional residents were not identified in the report, and why the State Agency was not notified until 9 1/2 hours after the start of the day shift. Request by the State Agency to the facility on 3/31/2026 to identify the additional residents. A response was received on 4/1/2026 at 3 PM (5 days after the facility was aware of the allegation) that identified the affected residents were Residents #3, 4, 5, 6, 7 and 8. A RE summary dated 4/1/2026 identified on 3/27/2026 on morning rounds staff reported that several residents did not receive incontinent care timely. They were soaked and some had feces on them. An investigation was immediately initiated, and residents were interviewed by the social worker and DON. The summary indicated Resident #8 reported he/she had no care issues and care was provided timely. Other residents also interviewed and had no issues. Video surveillance reviewed and Aide in questions did provide care and last rounds was also done timely. The facility was unable to substantiate neglect. Interview with NA #2 on 4/15/2026 at 11:30 AM identified on 3/27/2026 she completed her initial rounds at the start of the 7 AM to 3 PM shift, and identified Residents #3, 4, 5, 6, 7 and 8 had saturated pads (wet with urine), and the briefs, night clothes and top sheets were wet. NA #2 stated she thought the night NA had not provided care on the last rounds prior to their shift ending at 7 AM as she started her rounds of her assigned residents at 7:00 AM. NA #2 stated she then provided breakfast for residents and completed AM care for all her assigned residents. NA #2 further stated she was uncomfortable reporting the allegation to the DON, and she when she went on break from the unit about 9:30 AM, she spoke with another staff member about her concerns. The other staff member then transcribed the concerns and assister her to report them to the DON on 3/27/2026. Further, NA #2 indicated although she included Resident #3 in her initial report, she stated Resident #3 was not found wet on the morning of 3/27/2026. Interview, record review and facility documentation review with the DON on 4/15/2026 at 2:17 PM identified the initial allegation of neglect involved Residents #3, 4, 5, 6, 7, and 8. The DON further stated she was notified of the allegation on 3/27/2026 at approximately 9:15 AM (7 hours and 15 minutes prior to notifying the State Agency). After assessing the six (6) residents involved, and interviewing all the residents, the facility identified there was no neglect and the DON stated she chose to only report the allegation for Resident #8 and not to include any information about Residents #3, 4, 5, 6 and 7. The DON stated she believed there was no harm in not notifying the State Agency of the allegations for Residents #3, 4, 5, 6 and 7. Interview further identified NA #2 should have reported the allegation before providing residents with breakfast and morning care. The facility policy Abuse Prohibition dated 10/24/2022 directed in part, neglect was defined as the failure to provide care and services to a patient that are necessary. The Policy further directed (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anyone who witnesses an incident of suspected abuse or neglect is to report the incident to his/her supervisor immediately, regardless of the shift. The notified supervisor will report the suspected abuse immediately to the Administrator or designee and other officials in accordance with state law. The Policy directed immediately upon receiving information concerning a report of suspected or alleged abuse, mistreatment or neglect, the Administrator or designee will to report allegations involving abuse not later than 2 hours after the allegation is made. 1.Resident #11's diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic kidney disease stage, epilepsy, unspecified mood (affect) disorder and unspecified psychosis not due to a substance or known physiological condition. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #11 had moderately impaired cognition, was dependent on staff for all activities of daily living. The Resident Care Plan dated 12/12/25 identified Resident #11 had impaired and a decline in cognitive function or impaired thought processes related to a condition other than delirium; impaired decision making. Interventions directed to observe and evaluate types of changes in cognitive status, allow the resident to make daily decisions, use verbal cues, gestures and demonstration to assist in decision making, and provide consistent, trusted caregiver and structured daily routine. The nurse's note dated 2/25/26 at 10:14 PM identified the charge nurse reported an inappropriate verbal comment requesting for Resident #11 to touch Resident #11 to touch him/herself was made by Resident #11's roommate, Resident #12. The note further identified there was no physical contact observed, both residents were assessed and the privacy curtain was closed to promote privacy and maintain appropriate boundaries. The nurse's note dated 3/1/26 at 11:30 AM identified Resident #11 was moved to a different room to maintain safety, there was no specific documentation of an incident with the roommate after the 2/25/26 event. 2. Resident #12's diagnoses included dementia with agitation, adjustment disorder with anxiety and depression and mild neurocognitive disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #12 was cognitively intact, was independent with bed mobility and transfers. The Resident Care Plan dated 1/1/26 identified Resident #12 had impaired and a decline in cognitive function or impaired thought processes related to a condition other than delirium; short/long term memory loss and impaired decision making. Interventions directed to observe and evaluate types of changes in cognitive status, evaluate responses from Brief Interview for Mental Status (BIMS-a tool used to calculate cognitive status), evaluate behavioral symptoms for underlying causes, and evaluate need for psych/behavioral health consult as needed. The nurse's note dated 2/26/26 at 3:42 AM identified the charge nurse reported Resident #12 was making inappropriate comments to his/her roommate Resident #11. The note identified there was no (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	physical contact between the residents. The note identified Resident #12 was provided with education regarding inappropriate behavior and maintaining boundaries and the privacy curtain was pulled between the two (2) residents. The note indicated Resident #12 became upset with the Nursing Supervisor shouted at the supervisor to leave the room, stating it was a private conversation between him/her and the roommate. The note indicated the situation would be closely monitored by nursing to ensure safety and appropriateness of behavior throughout the shift. A revision was made to the care plan on 2/26/26 to include Resident #12 exhibits or potential to demonstrate verbal behaviors related to sexually inappropriate language. Interventions directed to evaluate nature and circumstances of the behaviors with the resident, evaluate the need for psych/behavioral health consultation, and social service visits to provide support as needed. The practitioner's note dated 2/27/26 at 3:01 PM identified Resident #12 was evaluated for inappropriate verbal comments directed toward roommate, nursing documentation reflects Resident #12 asked his/her roommate to touch self and made sexually inappropriate statements. The note indicated Resident #12 was placed in the psych communication book and psychiatry was notified with evaluation pending. The practitioner's note dated 3/6/26 at 8:40 AM identified Resident #12 was seen following documented behavioral concerns within the facility. The note indicated episodes of unusual behavior towards the roommate, including sitting at the end of the roommate's bed and speaking to the roommate during the nighttime hours. Review of the Residents #11and Resident #12's clinical records failed to reflect documentation addressing an incident on 3/1/26 incident, only that Resident #11 was moved to another room for safety. Interview with the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #4, on 4/14/26 at 1:56 PM identified on 3/1/26 upon arriving for her shift, she observed Resident #12 sitting at the end of Resident #11's bed and heard Resident #12 ask Resident #11 if he/she enjoyed last night. LPN #4 explained she observed Resident #11 with his/her brief down to the right side, which Resident #11 would not be able to do by him/herself. LPN #4 identified she did not observe any semen present on either resident. LPN #4 identified she immediately notified the supervisor and at that time Resident #11 was provided with a room change for safety. Interview with the 3-11PM nursing supervisor, Registered Nurse (RN) #6, on 4/14/26 at 2:31 PM identified on 3/1/26 it was reported to her that Resident #12 was observed fondling his/herself at the end of Resident #11's bed. RN #6 indicated she assessed both residents and provided Resident #11 with a room change for safety. Interview and clinical record review with the DON on 4/15/26 at 11:51 AM identified it was reported to her that on 2/25/26 Resident #12 was overheard making sexual talk in front of Resident #11. The DON identified social services and psych services were provided to Resident #12 and Resident #11 was provided with psych services as well. The DON identified the incident was not reported to the state agency nor an investigation was not initiated on 2/25/26 as the incident was reported as an overheard comment. The DON explained the facility did not report the allegation to the state agency as she did not feel this was verbal or sexual abuse as it was just sexual talk and Resident #12 has (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the right to talk like this in his/her room. The DON identified she was not made aware Resident #11 had his/her brief down at any time. The DON identified on 3/1/26 she was notified Resident #12 was verbalizing something to the effect of I am playing with myself and do you want to see it towards Resident #11. The DON indicated the facility policy on abuse directed to report abuse immediately and initiate an investigation immediately when there is an allegation. The DON identified she did not report the 3/1/26 incident to the state agency as they did not feel this was abuse. The DON identified it is the responsibility of the DON and/or the administrator to report allegations of abuse to the state agency. Interview with the administrator on 4/15/26 at 2:35 PM identified on 2/25/26 an incident was discussed where Resident #12 was making sexual comments in the room shared with Resident #11. The administrator identified on 3/1/26 an incident was reported that Resident #12 was at the end of Resident #11's bed and touching him/herself, there was no touching of Resident #11. The administrator identified on 3/1/26 it was reported that Resident #12 was at the end of Resident #11's bed and touching him/herself, but there was no touching of Resident #11. The administrator indicated the facility did not initiate an investigation or report the alleged incidences to the state agency because they did not feel these incidences met the definition of abuse, either verbal or sexual. Review of the facility policy title Abuse Prohibition, last revised 10/24/22, directed, in part, the center prohibits abuse, mistreatment, neglect, misappropriate of resident property and exploitation for all residents and this included, but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restrain not required to treat the residents medical symptoms. The policy further directed, in part, the administrator, or designee, is responsible for operationalizing policies and procedures that prohibit abuse, and the facility must ensure that all staff are aware of reporting requirements and must support an environment in which covered individuals report a reasonable suspicion of a crime. Additionally, the policy directed, in part, staff will identify events and trends that may constitute abuse and determine the direction of the investigation, this also includes resident to resident abuse. The policy further directed, in part, anyone who witnesses an incident of suspected abuse must report the incident to his/her supervisor immediately, regardless of shift worked, and the notified supervisor will report the suspected abuse immediately to the administrator or designee and other officials in accordance with state law. .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for three of six residents (Residents #4, #5 and #8) reviewed for neglect, the facility failed to ensure staff repositioned residents timely, in accordance with the plan of care. The findings include: Based on review of the clinical record, facility documentation, facility policy and interviews for three of six residents (Residents #4, #5 and #8) reviewed for neglect, the facility failed to ensure staff repositioned residents in accordance with the plan of care. The findings include: Resident #4 was admitted with diagnoses that included polyneuropathy (multiple nerve dysfunction that causes numbness, tingling and muscle weakness), traumatic brain injury and depression. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #4 was alert and oriented with a Brief Mental Interview for Mental Status (BIMS) of fifteen (15), and was dependent for toileting and bed mobility, was frequently incontinent of urine, always incontinent of bowel, and was at risk for pressure ulcers. The Resident Care Plan (RCP) dated 3/11/2026 identified Resident #4 a risk for skin breakdown due to immobility and incontinence. Interventions directed to turn and reposition every two (2) hours and observe skin for any signs of breakdown. The NA care card identified Resident #4 required assistance to turn and reposition every two (2) hours, as resident allowed. Resident #5 was admitted with diagnoses that included dementia, diabetes mellitus and depression. A quarterly MDS dated [DATE] identified Resident #5 was alert and oriented (BIMS score 13), was dependent for toileting and bed mobility, was frequently incontinent of urine, and was at risk for pressure ulcers. The RCP dated 3/18/2026 identified Resident #5 a risk for skin breakdown due to limited mobility and cognitive loss. Interventions directed to turn and reposition every one (1) to two (2) hours while in bed and observe skin for any signs of breakdown. The NA care card identified Resident #4 required assistance to turn and reposition every two (2) hours, as resident allowed. Resident #8 was admitted with diagnoses that included PVD and paraplegia. The Resident Care Plan (RCP) dated 1/2/2026 identified Resident #8 had altered mobility, compromised circulation and contractures. Interventions directed to reposition resident every two (2) hours and as needed resident allows. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #8 was alert and oriented, was dependent for bed mobility, was occasionally incontinent of urine, was incontinent of bowel, and was at risk for pressure ulcers. The NA care card identified Resident #8 required assistance to turn and reposition every 2 hours as resident allowed. ` A facility reportable event (RE) dated 3/27/2026, submitted to the State Agency at 4:30 PM for Resident #8 identified an allegation of neglect several residents didn't receive incontinent care on 11-7 3/26/26. The RE further identified a staff member reported that during rounds it was noted that several residents did not receive incontinent care timely. They were soaked and some also had feces on them. Additional review of the RE failed to identify the time the rounds were conducted that identified the lack of incontinent care and failed to identify who the additional residents were. A RE summary dated 4/1/2026 identified on 3/27/2026 on morning rounds staff reported that several residents did not receive incontinent care timely. They were soaked and some had feces on them. An investigation was immediately initiated, and residents were interviewed by the social worker and DON. The summary indicated Resident #8 reported he/she had no care issues and care was provided timely. Other residents also interviewed and had no issues. Video surveillance reviewed and Aide in questions did provide care and last rounds was also done timely. The facility was unable to substantiate neglect. Interview with NA #2 on 4/15/2026 at 11:30 AM identified on 3/27/2026 she completed her initial rounds at the start of the 7 AM to 3 PM shift, and identified Residents #3, 4, 5, 6, 7 and 8 had saturated pads (wet with urine), and the briefs, night clothes and top sheets were wet. NA #2 stated she thought the night NA had not provided care on the last rounds prior to their shift ending at 7 AM as she started her rounds of her assigned residents at 7:00 AM. Interview (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and review of facility documents with the DON on 4/15/2026 at 2:17 PM identified NA #1 reported that she had completed first rounds at around 1:15 AM and second rounds by 5:15 AM, and did not report completing any other rounds. The DON was aware a few of the residents identified by NA #2 (Residents #4, #5 and #8), had interventions to be repositioned at every one (1) to two (2) hours and stated she expected staff to check on residents in accordance with the care plan. The DON stated review of facility video monitoring during the 11 PM to 7 AM shift ending on 3/27/2026 identified NA #1 was observed to be sleeping on the shift, and record review identified NA #1 failed to document care provided to the residents. Interview with RN #11 identified she was the charge nurse on 3/26/2026 (shift ending at 7 AM on 3/27/2026) and saw that NA #1 had fallen asleep in the hallway after the first rounds was completed at around 1:30 AM. RN #11 stated she woke NA #1 up multiple times during the shift, but only observed NA #1 get up to complete second rounds at around 5:15 AM. RN #11 stated she did not recall if call lights were activated on any of NA #1's assigned residents but identified that the other staff assisted to answer call lights. RN #11 stated that NA #1 had told her she had another job where she had just finished a double shift, and RN #11 did not notify the supervisor that NA #1 was sleeping during the shift. Multiple attempts to contact NA #1 during the survey were unsuccessful. The facility policy Person Centered Care plan dated 10/24/2022 directed in part that the care plan is customized and includes instructions needed to provide effective and person-centered care.

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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 a review of clinical records, facility documentation, facility policies, and interviews for one of four residents (Resident #1) reviewed for medication errors, the facility failed to ensure previous orders were discontinued and new orders written for a resident readmitted to the facility, and failed to ensure the double check system verified physician orders accurately resulting in a medication error. The findings include: Resident #1 was admitted to the facility with diagnoses that included status post kidney transplant. A resident care plan (RCP) dated 3/22/2026 identified Resident #1 was at risk for impaired kidney function and complications related to kidney transplant. Interventions directed to administer medications as ordered and monitor for side effects. A quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) 3/24/3036 identified Resident # 1 had a Brief Interview for Mental Status (BIMS) score of 15 (was alert and oriented). Physician order dated 3/4/2026 directed to administer Envarsus XR (Tacrolimus; immunosuppressant used to prevent organ rejection) 4 milligrams, one tablet daily. Record review identified Resident #1 was transferred to the hospital on 3/24/2026 for evaluation related to abnormal lab values. Additional review identified Resident #1 was readmitted to the facility on [DATE] (six days later). A hospital interagency referral report (W-10) medication order dated 3/30/2026 at 3:40 PM directed Tacrolimus XR 24-hour tablet (Envarsus XR), take six (6) tablets for 6 mg total daily (six 1 mg tablets). An APRN note dated 3/30/2026 at 10:17 PM identified Resident #1was newly admitted (re-admitted) to the facility. admission orders and hospital discharge summary were reviewed with nursing supervisor and medication reconciliation was initiated. Medications reviewed included Tacrolimus XR (Envarsus XR) 6 mg by mouth daily. Record review identified the physician order dated 3/30/2026 directed to administer Envarsus XR oral tablet 4 mg (Tacrolimus), give 6 tablets by mouth one time a day to prevent rejection. Record review identified the physician order entered on 3/30/2026 conflicted with the Tacrolimus six tablets of one (1) mg for a daily total of 6 mg; instead, the order directed to administer six (6) tablets of 4 mg for a total dose of 24 mg (instead of 6 mg). A facility reportable event (RE) dated 3/31/2026 at 2:30 PM identified Resident #1's medication was transcribed incorrectly, and subsequently a wrong dose was administered to Resident #1. APRN assessment was completed with new orders for laboratory tests, monitor vital signs and mental status and to hold medication until laboratory results were obtained. No overt sign of injury was noted. A facility RE summary dated 4/2/2026 identified Resident #1 was given the incorrect dose of Tacrolimus on 3/31/2026; instead of administering the ordered 6 mg, Resident #1 received a total of 24 mg. The summary indicated the cause of the error was a transcription error. After the medication error, Resident #1 had no mental or medical changes and remained stable. Interview and record review with RN #1 on 4/13/2026 at 11:00 AM identified she was one (1) of two (2) evening supervisors on 3/30/2026. RN #1 stated Resident #1 was readmitted to the facility on [DATE] during her shift and RN #2 (the other supervisor) verified the new orders with the APRN. RN #1 entered Resident #1's medication orders into Resident #1 Electronic Medical Record (EMR). RN #1 stated since Resident #1 was a readmission, she was able to pull up the last medication orders in the EMR to update and she used those to reconcile to the hospital W-10. RN #1 indicated she did not realize she had entered the Tacrolimus dose incorrectly. The previous order was for one (1) tablet of 4 mg and she changed the one (1) tablet to match the new order of six (6) tablets; she did not change the tablet dosage because she did not see they were for different mgs - she only changed the number of tablets to administer. After she entered the orders, RN #2 was expected to verify the entered orders for accuracy, and the Tacrolimus 4 mg was available on the unit to administer to Resident #1 from his/her prior admission. RN #1 stated she must have misread the tablet strength on the hospital W-10 when she transcribed the orders. Interview and record review with LPN #1 on 4/13/2026 at 11:31 PM identified she administered the Tacrolimus dose as it was entered into the EMR on 3/31/2026, Tacrolimus Envarsus (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	XR oral tablet 4 mg (Tacrolimus), give six (6) tablets by mouth one time a day. LPN #1 stated two (2) supervisors had reconciled the medication orders for accuracy, and if the medication was available in the medication cart drawer, then she would not question the dose. Although attempted, an interview with RN #2 was not obtained during the survey. Interview and record review with the DON on 4/13/2026 at 11:00 AM identified the facility process was for a supervisor to review the W-10 with the APRN/MD and enters the orders into the EMR for any new admission or re-admission. Then a second supervisor does a second reconciliation to ensure the orders were entered correctly. The DON stated that when Resident #1's medication error occurred, the facility process was for the shift supervisor to reconcile and enter the orders in the EMR and the next shift supervisor to do a second reconciliation. The DON stated that a review of the record identified RN #2 did not complete the second reconciliation of the medication orders. The error was not identified until the afternoon of 3/31/2026 when the pharmacy completed their medication review, and they notified the facility of the transcription error. Since Resident #1 was a readmission, the Tacrolimus four (4) mg tablets were available in the medication cart for dose due at 6 AM on 3/31/2026 and Resident #1 received a total dose of 24 mgs instead of 6 mgs. The DON stated RN #2 did not complete the second reconciliation because she was busy with other incidents during the shift. the DON stated if a resident was discharged from the facility for five (5) or more days, upon readmission the prior orders should be discontinued and new orders should be entered (Resident #1 was discharged for six days). The facility policy Medication Reconciliation dated 9/1/2022 directed in part, that a resident's medication orders will be reconciled when admitted or readmitted from the hospital. Medication reconciliation was the process of comparing a resident's existing medications and involved obtaining and maintaining a complete and accurate list of current medications. Once reconciliation was completed, medication orders were obtained from the physician or APRN and entered into the EMR. A repeat reconciliation was performed to compare hospital medication listing to current facility medication listing to the medication administration record to ensure accuracy.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policies, and interviews for twenty (20) of twenty-six (26) residents who resided on the 3CD unit (Residents #4, #7, #8, #13, #14, #15, #16, #17, #20, #21, #23, #24, #26, #27, #28, #29, #31, #32, #33, #35, and #36), the facility failed to ensure the residents received their scheduled medications during the evening, 3-11PM, shift. The findings include:1.Resident #4's diagnoses included unspecified mood (affect) disorder, depression, seizures, insomnia, rheumatoid arthritis, spinal stenosis and personal history of traumatic brain injury. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #4 had no memory recall deficits. The physician's order dated 3/20/26 directed to administer Levetiracetam (a medication to treat seizures) 1000 milligrams (mg) give one tablet by mouth two times a day; Glycolax powder (a medication to treat constipation) 17 grams by mouth twice a day; Voltaren gel (a medication to treat pain) 1% apply to bilateral knees topically two times a day; Trazodone (a medication to treat insomnia) 50 mg by mouth at bedtime; Gabapentin (a medication to treat seizures) 300 mg twice a day; Melatonin (a medication to treat insomnia) 3 mg at bedtime and Risperidone (an antipsychotic medication) 1 mg give one and a half tablets once a day at bedtime. Review of the March 2026 Medication Administration Record identified Resident #4 did not receive the medications scheduled during the evening shift on 3/22/26. 2. Resident #7's diagnoses included multiple sclerosis, mild neurocognitive disorder, major depressive disorder, paraplegia, hypertension and diabetes. The annual MDS dated [DATE] identified Resident #7 had no memory recall deficits. The physician's order dated 3/1/26 directed to administer Atenolol (a medication to treat hypertension) 50 mg at bedtime; Ferrous Sulfate (iron supplement to treat anemia) 325 mg twice a day; Latanoprost Ophthalmic Solution (an eye drop to treat glaucoma) instill one drop in both eyes at bedtime, Melatonin 3 mg give 2 tablets at bedtime, Metformin (a medication to treat diabetes) 1000 mg twice a day; Sennosides-Docusate Sodium (a medication to treat constipation) 8.6-50 mg give 2 tablets at bedtime; Simvastatin (a medication to treat high cholesterol) 40 mg at bedtime; and Vitamin C (supplement) 500 mg twice a day. Review of the March 2026 MAR identified Resident #7 did not receive the medications scheduled during the evening shift on 3/22/26. 3. Resident #8's diagnoses included acute embolism and thrombosis (blood clot), atrial fibrillation, paraplegia, peripheral vascular disease and adjustment disorder. The quarterly MDS dated [DATE] identified Resident #8 had no memory recall deficits. The physician's order dated 3/17/26 directed to administer Ascorbic Acid (Vitamin C) 500 mg twice a day; Eliquis (a medication to prevent blood clots) 5 mg twice a day; Senna (a medication to prevent constipation) 8.6 mg give 2 tablets once a day at 9:00 PM; Gabapentin (used to treat neuropathic pain) 300 mg every 8 hours; Baclofen (a muscle relaxant) 10 mg every 8 hours; and Lipitor (a medication to treat high cholesterol) 40 mg once a day at 7:00 PM. Review of the March 2026 MAR identified Resident #8 did not receive the medications scheduled during the evening shift on 3/22/26. 4. Resident #13's diagnoses included chronic obstructive pulmonary disease (COPD), venous insufficiency, congestive heart failure (CHF) chronic pain, neuromuscular dysfunction of bladder, anemia, diabetes mellitus (DM) and acquired absence of other specified parts of the digestive tract. The annual MDS dated [DATE] identified Resident #13 had no memory recall deficits. The physician's order dated 3/1/26 directed to administer Apixaban (a medication to prevent blood clots) 5 mg every 12 hours; Atorvastatin (a medication to treat high cholesterol) 40 mg once a day; Calcium Carbonate (supplement) 500 mg every 8 hours; (Vitamin B-12) 1000 mcg once a day; Gabapentin 600 mg once a day; Lantus Solostar (an insulin used to treat DM) 50 units subcutaneously at bedtime; Ciprofloxacin (an antibiotic used to treat infection) 500 mg every 12 hours; Oxybutrin (a medication used to treat muscle spasms) 5 mg twice a day; Protonix (a medication used to treat esophageal reflux) 40 mg twice a day; and Oxycodone (a narcotic medication to treat pain) 5 mg three times a day. Review of the March 2026 MAR identified Resident #13 did not receive the medications scheduled during the (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	evening shift on 3/22/26. 5. Resident #15's diagnoses included liver disease, alcohol cirrhosis of the liver with ascites (swelling of the abdomen) hepatic encephalopathy, unspecified mood (affect) disorder, and gastroesophageal reflux disease (GERD). The significant change in status MDS dated [DATE] identified Resident #15 had some memory recall deficits. The physician's order dated 3/1/26 directed to administer Baclofen 10 mg tablet give 5 mg (1/2 tablet) at bedtime; Protonix 40 mg twice a day; Quetiapine Fumarate (a medication used to treat delusional disorder) 50 mg tablet give 2 tablets (100 mg) at bedtime; Senna 8.6 mg tablet give 2 tablets twice a day; and Sertraline (a medication used to treat depression) 50 mg tablet once a day at 9:00 PM. Review of the March 2026 MAR identified Resident #15 did not receive the medications scheduled during the evening shift on 3/22/26. 6. Resident #16 had diagnoses that included cardiomyopathy (disease of the heart muscle) dementia, malnutrition, obstructive and reflux uropathy, osteoarthritis, paranoid schizophrenia, depression, anxiety and mild cognitive impairment of unknown etiology. The annual MDS dated [DATE] identified Resident #16 had no memory recall deficits. The physician's order dated 3/1/26 directed to administer Jevity (an artificial nutrition supplement given via a gastric tube (g-tube)) 1.5 give a 420 cubic centimeters (cc) bolus four times a day; Ascorbic Acid 500 mg tablet twice a day, Benztropine Mesylate tablet (a medication used to treat tremors and stiffness of the muscles); Miralax oral packet (a medication used to prevent constipation) 17 grams (gm) one packet via g-tube twice a day; Olanzapine (a medication used to treat bipolar disorder) 20 mg tablet via g-tube at bedtime; Risperidone (a medication used to treat paranoid schizophrenia) 1 mg tablet via g-tube once a day in the evening; Trazodone 100 mg give 150 mg (one and a half tablets) via g-tube at bedtime; Clonazepam (a medication used to treat anxiety) give one tablet twice a day; Famotidine (a medication to treat GERD) 20 mg tablet via g-tube twice a day; Ferrous Sulfate 7.5 milliliters (ml) twice a day; and Methenamine Hippurate (a medication used to prevent urinary tract infection) 1 gram (gm) via g-tube twice a day. Review of the March 2026 MAR identified Resident #16 did not receive the medications scheduled during the evening shift on 3/22/26. 7. Resident #17 had diagnoses that included anoxic brain damage, adjustment disorder with anxiety, epilepsy, anemia, unspecified convulsions, and acute embolism and thrombosis of right iliac vein. The quarterly MDS dated [DATE] identified Resident #17 had severely impaired cognition. The physician's order dated 3/1/26 directed to administer Jevity 1.5 give 100 ml per hour (ml/hr) for 8 hours (10:00 PM to 6:00 AM via g-tube; Amlodipine Besylate(a medication used to treat high blood pressure) 10 mg via g-tube once a day; Apixaban 2.5 mg via g-tube twice a day; Baclofen 5 mg via g-tube three times a day; Clonidine (a medication used to treat high blood pressure) 0.3 mg via g-tube every 8 hours; Gabapentin 300 mg via g-tube every 8 hours; Propranolol (a medication used to treat high blood pressure) 20 mg via g-tube twice a day; Scopolamine Transdermal Patch 1 mg/3 days apply transdermal (on top of the skin) every 72 hours; Senna 8.6 mg 2 tablets via g-tube twice a day; and Zyrtec Allergy (a medication used to treat allergies) via g-tube once a day. Review of the March 2026 MAR identified Resident #17 did not receive the medications scheduled during the evening shift on 3/22/26. 8. Resident #20 had diagnoses that included DM, major depressive disorder, peripheral vascular disease (PVD), chronic pain, cerebrovascular disease and lymphedema. The quarterly MDS dated [DATE] identified Resident #20 had no memory recall deficits. The physician's order dated 3/1/26 directed to administer Carboxymethylcellulose Sod PF Ophthalmic Solution (a medication used to treat dry eyes) 0.5% instill 1 drop into both eyes twice a day and Famotidine (a medication used to treat GERD) 20 mg twice a day. Review of the March 2026 MAR identified Resident #20 did not receive the medications scheduled during the evening shift on 3/22/26. 9. Resident #21 had diagnoses that included atrial fibrillation (an irregular heartbeat), COPD, vascular dementia, hypertension, hyperlipidemia (high cholesterol), anxiety and adjustment disorder with disturbance of conduct. The quarterly MDS dated [DATE] identified Resident #21 had moderately impaired cognition. The physician's order dated 3/1/26 directed to administer Atorvastatin 40 mg tablet at bedtime; Metoprolol Tartrate (a medication used to treat high blood pressure) 25 mg tablet give a half a tablet (12.5 mg) twice a day, Senna 8.6 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg tablet give 2 tablets at bedtime; and Seroquel (a medication used to treat vascular dementia) 100 mg tablet one time a day in the evening. Review of the March 2026 MAR identified Resident #21 did not receive the medications scheduled during the evening shift on 3/22/26. 10. Resident #23 had diagnoses that included major depressive disorder, insomnia, chronic pain syndrome, mild neurocognitive disorder, anxiety, and GERD. The annual MDS dated [DATE] identified Resident #23 had moderately impaired cognition. The physician order dated 3/8/26 directed to administer Melatonin 5 mg tablet at bedtime; Lyrica (a medication used to treat nerve pain) 50 mg tablet three times a day; Trazodone 100 mg tablet at bedtime; Senna Plus 8.6-50 mg give 2 tablets twice a day; Quetiapine Fumarate 25 mg tablet (a medication used to treat anxiety/delusional disorder) three times a day; Omeprazole (a medication used to treat GERD) 20 mg tablet twice a day; and Eliquis 2.5 mg tablet twice a day. Review of the March 2026 MAR identified Resident #23 did not receive the medications scheduled during the evening shift on 3/22/26. 11. Resident #24 had diagnoses that included immunodeficiency, hyperlipidemia, insomnia, and hypertensive heart disease with heart failure. The quarterly MDS dated [DATE] identified Resident #24 had no memory recall deficits. The physician's order dated 3/20/26 directed to administer Tizanidine HCL (a muscle relaxant) 2 mg tablet three times a day; Trazodone 25 mg tablet at bedtime; Melatonin 5 mg tablet at bedtime; and Rosuvastatin Calcium (a medication for high cholesterol) 20 mg tablet at bedtime. Review of the March 2026 MAR identified Resident #24 did not receive the medications scheduled during the evening shift on 3/22/26. 12. Resident #26 had diagnoses that included epilepsy, insomnia, blindness and depression. The quarterly MDS dated [DATE] identified Resident #26 had no memory recall deficits. The physician's order dated 3/8/26 directed to administer Trazodone HCL 50 mg tablet at bedtime; Melatonin 3 mg tablet at bedtime; Depakote (a medication to treat seizures) Delayed Release 250 mg tablet give 4 tablets (1000 mg) twice a day; Lacosamide (a medication used to treat seizures) 150 mg tablet twice a day; and Atorvastatin Calcium 20 mg tablet once a day. Review of the March 2026 MAR identified Resident #26 did not receive the medications scheduled during the evening shift on 3/22/26. 13. Resident #27 had diagnoses that included spinal stenosis, osteoarthritis, insomnia, DM and major depressive disorder. The annual MDS dated [DATE] identified Resident #27 had no memory recall deficits. The physician's orders dated 3/17/26 directed to administer Trazodone 100 mg tablet at bedtime; Carboxymethylcellulose Sodium Ophthalmic Solution 0.5% instill 1 drop into both eyes four times a day; Atorvastatin 10 mg tablet at bedtime; Melatonin 3 mg tablet at bedtime, Lyrica 200 mg capsule three times a day; and Tramadol 50 mg tablet three times a day. Review of the March 2026 MAR identified Resident #27 did not receive the medications scheduled during the evening shift on 3/22/26. 14. Resident #28 had diagnoses that included paranoid schizophrenia, hyperlipidemia, heart failure, anxiety, moderate protein-calorie malnutrition, and hypertension. The quarterly MDS dated [DATE] identified Resident #28 had no memory recall deficits. The physician's order dated 3/8/26 directed to administer Depakote Sprinkles Delayed Release 125 mg capsule give 250 mg (2 capsules) twice a day (used to treat paranoid schizophrenia); Senna Plus 8.6-50 mg tablet at bedtime; Buspirone HCL (a medication to treat anxiety) 10 mg tablet twice a day; Hydralazine HCL (a medication to treat high blood pressure) 25 mg tablet give 75 mg (3 tablets) three times a day; Trazodone HCL 50 mg tablet twice a day, Ziprasidone HCL Capsule (a medication for paranoid schizophrenia) 50 mg capsule twice a day; and Lipitor 10 mg tablet at bedtime. Review of the March 2026 MAR identified Resident #28 did not receive the medications scheduled during the evening shift on 3/22/26. 15. Resident #29 had diagnoses that included schizoaffective disorder, bipolar type, pure hyperglyceridemia, chronic kidney disease, depression, DM, hyperlipidemia, benign prostatic hyperplasia (BPH), constipation and hypertension. The quarterly MDS dated [DATE] identified Resident #29 had no memory recall deficits. The physician's order dated 3/17/26 directed to administer Melatonin 3 mg tablet at bedtime; Clozapine (a medication used to treat schizophrenia) 100 mg tablet give 3 tablets (300 mg) once a day; Sennosides-Docusate Sodium 8.6-50 mg tablet give 3 tablets at bedtime; Atorvastatin Calcium 20 mg tablet once a day; Fenofibrate (a medication used to treat high triglycerides) 145 mg tablet at (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bedtime; Tamsulosin HCL capsule (a medication to treat BPH) 0.4 mg capsule once a day; and Lantus 100 unit/ml inject 30 units subcutaneously at bedtime. Review of the March 2026 MAR identified Resident #29 did not receive the medications scheduled during the evening shift on 3/22/26. 16. Resident #31 had diagnoses that included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, insomnia, anemia, chronic kidney disease, depression, and DM. The quarterly MDS dated [DATE] identified Resident #31 had no memory recall deficits. The physician's order dated 3/8/26 directed to administer Carvedilol (a medication used to treat high blood pressure) 12.5 mg tablet twice a day and Mirtazapine (a medication used as an appetite stimulant) 7.5 mg tablet at bedtime. Review of the March 2026 MAR identified Resident #31 did not receive the medications scheduled during the evening shift on 3/22/26. 17. Resident #32 had diagnoses that included atherosclerotic heart disease (narrowing of the artery), CHF, vascular dementia, hyperlipidemia, COPD, insomnia and depression. The annual MDS dated [DATE] identified Resident #32 had no memory recall deficits. The physician's orders dated 3/20/26 directed to administer Atorvastatin 40 mg tablet in the evening; Melatonin 3 mg tablet at bedtime; Entresto (a medication used to treat heart failure) 24-26 mg tablet twice a day, Eliquis 5 mg tablet twice a day; and Ranolazine Extended Relief (a medication used to treat chest pain) 500 mg tablet twice a day. Review of the March 2026 MAR identified Resident #32 did not receive the medications scheduled during the evening shift on 3/22/26. 18. Resident #33 had diagnoses that included multiple sclerosis, DM, paraplegia, and depression. The quarterly MDS dated [DATE] identified Resident #33 had no memory recall deficits. The physician's order dated 3/1/26 directed to administer Rosuvastatin Calcium 10 mg tablet at bedtime and Sennosides-Docusate Sodium 8.6-50 mg tablet at bedtime. Review of the March 2026 MAR identified Resident #33 did not receive the medications scheduled during the evening shift on 3/22/26. 19. Resident #35 had diagnoses that included hypertension, chronic kidney disease, protein-calorie malnutrition, hyperlipidemia, dementia, depression, insomnia, atrial fibrillation, constipation, COPD and chronic embolism and thrombosis of inferior vena cava. The MDS dated [DATE] identified Resident #35 has severely impaired cognition. The physician's orders dated 3/1/26 directed to administer Apixaban 2.5 mg tablet twice a day; Calcium Citrate-Vitamin D (supplement) 315-5 mg-microgram (mcg) tablet give 2 tablets twice a day; Melatonin 3 mg tablet at bedtime; Mirtazapine 15 mg tablet at bedtime; Pravastatin Sodium 20 mg tablet once a day; Sennosides 8.6 mg tablet give 2 tablets twice a day; and Tamsulosin HCl 0.4 mg capsule once a day. Review of the March 2026 MAR identified Resident #35 did not receive the medications scheduled during the evening shift on 3/22/26. 20. Resident #36 had diagnoses that included depression, iron deficiency anemia, constipation, paraplegia, chronic pain, muscle spasm and neuromuscular dysfunction of bladder. The quarterly MDS dated [DATE] identified Resident #36 had no memory recall deficits. The physician's order dated 3/1/26 directed to administer Acetaminophen (Tylenol) 1000 mg every 8 hours; Eliquis 5 mg tablet every 12 hours; Gabapentin 300 mg tablet every 8 hours; Gabapentin 600 mg tablet every 8 hours; Gabapentin 600 mg tablet three times a day; Lactase Enzyme 3000 unit tablet (a medication used to treat stomach upset) three times a day; Lactulose oral Solution 20 gm/30 ml give 30 ml twice a day; Lexapro (a medication used to treat depression) 20 mg tablet once a day; Lipitor 40 mg tablet at bedtime; Olopatadine HCL Ophthalmic Solution 0.1% (used for eye health) instill 1 drop into both eyes twice a day; and Remeron (a medication used to treat depression) 15 mg tablet at bedtime. Review of the March 2026 MAR identified Resident #36 did not receive the medications scheduled during the evening shift on 3/22/26. Review of the facility Medication error report dated 3/22/26 identified Resident #13 reported he/she had not received their scheduled medications during the evening shift on 3/22/26 andthrough the investigation, the facility found there were potentially twenty-six (26) residents who did not receive their medications during the evening shift on 3/22/26. Interview with the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #8, on 4/15/26 at 10:53 AM identified on 3/22/26 she was scheduled to go over to the 3CD unit after finishing her 3-11PM shift on another unit. LPN #8 indicated when she arrived on the unit an 11PM-7AM nurse aide (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	informed her that five (5) residents had reported they did not get their evening medications. LPN #8 identified she went to find the previous evening nurse, LPN #6, and found LPN #6 had left early, and no one came to cover the unit after LPN #6 left. LPN #8 indicated once she was made aware, she went to speak with the residents who had reported they did not receive their medications and she called the supervisor. LPN #8 identified the nursing supervisor, RN #7, attempted to brush the report off stating maybe they were just not signed off. Interview and clinical record review with the Director of Nursing (DON) on 3/15/26 at 12:04 PM identified it was reported to her on 3/23/26 that residents on the 3CD unit had not received their evening medications on 3/22/26. The DON indicated she initiated an investigation and spoke with RN #7 who could not remember if LPN #6 had reported to her that LPN #6 did not give the medications. The DON identified her conversation with LPN #6 identified LPN #6 reported she had given some medications, but not all and she reported this to the supervisor. The DON identified on 3/22/26 LPN #6 was scheduled to work 3-7PM and then allegedly told the supervisor, RN #7, that she would stay for the entire shift, until 11:00 PM. The DON indicated that when a staff nurse was working only a partial shift, there should be another nurse to take over that unit until the end of the shift and if no nurse was available, the supervisor would cover the unit, and she would expect that nurse would finish the medication pass. The DON identified there was no written policy on medication administration, but the expectation was that medications were given as ordered during the shift and it was the responsibility of the supervisors for ensuring the medication passes are completed prior to the licensed staff member ending their shift. The DON indicated she received conflicting reports on whether LPN #6 reported to RN #7 prior to leaving the facility that she had not completed the medication pass and the medication pass should have been completed on 3/22/26 on the 3CD unit in its entirety for the evening shift. Interview with the LPN #6 on 4/15/26 at 12:58 PM identified on 3/22/26 she was scheduled to end her shift at 7:00 PM. LPN #6 identified RN #7 asked her if she could stay the entire shift and she told RN #7 that she could not stay the entire shift but could stay a little longer. LPN #6 indicated at the time of her departure, she reported to RN #7 that she had not finished her medication pass and asked RN #7 if she wanted her to stay until the oncoming nurse arrived, but RN #7 declined and instructed her to punch out. LPN #6 identified she again informed RN #7 that the medication pass had not been completed, and RN #7 told her it's ok, the oncoming nurse will complete it. LPN #6 identified she left the facility at approximately 8:30-9:00 PM. LPN #6 did indicate it was her understanding that another nurse was scheduled to take over the unit once she left. Although attempted, an interview with RN #7 was unsuccessful. Review of the facility policy titled Medication Administration, last revised 5/1/24, directed, in part, the staff will follow written instructions provided by the MD/Advanced Practice Registered Nurse (APRN), which can include a prescription label or the prescriber's written or electronically recorded order for the prescription and will follow the 5 rights for medication administration (right resident, right medication, right dose, right time and right route).

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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 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 one of four residents reviewed for wound care (Resident #2) the facility failed to ensure the record was complete and accurate to include refusals of wound care, and for five of six residents (Residents #4, #5, #6, #7 and #8) reviewed for neglect, the facility failed to ensure the record was complete and accurate to include care provided during shift rounds. The findings include: Resident #2 was admitted to the facility with diagnoses that included peripheral vascular disease (PVD), paraplegia (loss of voluntary movement and sensation to the lower half of the body) and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 (indicated he/she was alert and oriented) and was dependent for personal hygiene, moderate assist for bed mobility and transfers, and had one (1) venous or arterial ulcer. A resident care plan (RCP) dated 2/11/2026 identified Resident #2 was resistive to care, refused care (including wound care), and was at risk for skin breakdown related to PVD, paraplegia and weakness. Interventions directed to provide wound treatment as ordered, explain all care, including procedures (one step at a time), and the reason for performing the care before initiating and to provide with the opportunity for choice during care/activities to provide a sense of control. A physician order dated 3/14/2026 directed to cleanse a right shin wound with normal saline (NS), followed by calcium alginate (absorbent wound dressing that changes into a gel upon wound contact to promote healing) followed by a dry clean dressing every day shift. A facility reportable event (RE) dated 3/19/2026 at 1:00 PM identified during wound rounds it was noted that Resident #2's dressing was not changed for three (3) days by LPN #3. An investigation was initiated and the MD/APRN (provider) was notified. A facility RE summary dated 4/1/2026 identified on 3/19/2026 Resident #2's wound dressing was noted to be dated 3/15/2026. Resident #2 was self-responsible and had refused the right shin wound treatments, however the nurse failed to notify the physician/APRN. Record review identified wound care was documented on the Treatment Administration Record (TAR) as refusded on 3/16/2026 and documented as completed on 3/17, and 3/18/2026. Additional review failed to identify the refusals of wound care on 3/16, 3/17, and 3/18/2026 was documented in the medical record. Interview and review of facility documents with the DON on 4/14/2026 at 10:15 AM identified upon interview with LPN #3 on 3/20/2026, LPN #3 reported Resident #2 had refused to have the dressing changed on 3/16, 3/17 and 3/18/2026. The DON stated LPN #3 documented the refusal on 3/16/2026, but did not document the refusals on 3/17 and 3/18/2026. The DON stated she expected staff to document any refusals. Although multiple attempts were made to contact LPN #3, an interview was not obtained during survey. 2. Resident #4 was admitted with diagnoses that included polyneuropathy (multiple nerve dysfunction that causes numbness, tingling and muscle weakness), traumatic brain injury and depression. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #4 was alert and oriented with a Brief Mental Interview for Mental Status (BIMS) of fifteen (15), and was dependent for toileting, was frequently incontinent of urine, always incontinent of bowel, and was at risk for pressure ulcers. The Resident Care Plan (RCP) dated 3/11/2026 identified Resident #4 a risk for skin breakdown due to immobility and incontinence. Interventions directed to turn and reposition every two (2) hours and observe skin for any signs of breakdown. Resident #5 was admitted with diagnoses that included dementia, diabetes mellitus and depression. A quarterly MDS dated [DATE] identified Resident #5 was alert and oriented (BIMS score 13), was dependent for toileting, was frequently incontinent of urine, and was at risk for pressure ulcers. The RCP dated 3/18/2026 identified Resident #5 a risk for skin breakdown due to limited mobility and cognitive loss. Interventions directed to turn and reposition every one (1) to two (2) hours while in bed and observe skin for any signs of breakdown. Resident #6 was admitted with diagnoses that included multiple sclerosis and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peripheral vascular disease (PVD). The RCP dated 12/28/2025 identified Resident #6 at risk for skin breakdown due to limited mobility and incontinence. Interventions directed incontinent care and to observe skin for any changes. A quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #6 was alert and oriented. was occasionally incontinent of urine, and was at risk for pressure ulcers. Resident #7 was admitted with diagnoses that included multiple sclerosis, paraplegia. An annual Minimum Data Set (MDS) dated [DATE] identified Resident #7 was alert and oriented and was incontinent of urine. The Resident Care Plan (RCP) dated 3/2/2026 identified Resident #7 wat risk for skin breakdown. Interventions directed incontinent care as indicated, observe skin for any changes, and turn and position four (4) times a shift. Resident #8 was admitted with diagnoses that included PVD and paraplegia. The Resident Care Plan (RCP) dated 1/2/2026 identified Resident #8 had altered mobility, compromised circulation and contractures. Interventions directed to reposition resident every two (2) hours and as needed resident allows. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #8 was alert and oriented, was occasionally incontinent of urine, was incontinent of bowel, and was at risk for pressure ulcers. A facility reportable event (RE) dated 3/27/2026, submitted to the State Agency at 4:30 PM for Resident #8 identified an allegation of neglect several residents didn't receive incontinent care during the 11 PM to 7 AM shift on 3/26/26. The RE further identified a staff member reported that during rounds it was noted that several residents did not receive incontinent care timely. They were soaked and some also had feces on them. Additional review of the RE failed to identify who the additional residents were. Request by the State Agency to the facility on 3/31/2026, with a response received on 4/1/2026 at 3 PM (5 days after the facility was aware of the allegation) identified the affected residents were Residents #4, 5, 6, 7 and 8. A RE summary dated 4/1/2026 identified on 3/27/2026 on morning rounds staff reported that several residents did not receive incontinent care timely. They were soaked and some had feces on them. An investigation was immediately initiated, and residents were interviewed by the social worker and DON. The summary indicated Residents #4, 5, 6, 7 and 8 all reported they had no care issues and care was provided timely. Video surveillance reviewed and Aide in questions did provide care and last rounds was also done timely. Record review for Residents #4, #5, #6, #7 and #8 failed to identify documentation of the first and second rounds care provided for the listed residents. Interview and record review with the DON on 4/15/2026 at 2:17 PM identified NA #1 reported that she had completed first rounds at around 1:15 AM and second rounds by 5:15 AM and did not report any other rounds. The DON stated she expected the staff to document the care they provided in the medical record, and NA #1 did not document the care that she provided. The DON stated video monitoring of the 11:00 PM to 7:00 AM shift on 3/26/2026 into 3/27/2026 had indicated that NA #1 performed the rounds as described and failed to document care provided to the residents. Although multiple attempts were made to contact NA #1 during the survey, an interview was not obtained during the survey. The facility policy Nursing Documentation dated 5/1/2023 directed in part that nursing documentation should accurately reflect the resident's condition and care provided by nursing staff.