STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075271	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mystic Healthcare & Rehabilitation Center, LLC	475 High St Mystic, CT 06355

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #3, Resident #11, and Resident #78) reviewed for nutrition, the facility failed to obtain admission weights, monthly weights and re-weights per the facility policy. The findings include: Resident #3's diagnoses included type 2 diabetes, malignant neoplasm of the lower stomach, and atrial fibrillation (irregular heart rhythm). The Minimum Data Set assessment (MDS) assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status of 8, indicating moderate cognitive impairment. The Resident Care Plan in effect from 7/13/25 through 1/14/26 identified dysphagia. Interventions included to maintain diet consistency per speech recommendation and/or physician order for LCS (low concentrated sweets) NAS (no added salt) regular texture and thin liquids and to check lung sounds every shift if indicated. The Resident Care Plan also indicated the resident had a cardiac diagnosis, with interventions that included staff to obtain vitals as ordered. A physician's order in effect for November 2025 directed to obtain the resident's weight monthly on the day shift starting on the first and ending on the first every month. Interview with Licensed Practical Nurse (LPN) #6 on 1/14/26 at 12:08 PM, identified she was unable to locate a weight for Resident #3 in the electronic medical records for November, and could not find a note indicating why the resident wasn't weighed. LPN #6 stated she had been the staff member who obtained the resident's weight in October and December of 2025 but could not remember why she had not obtained Resident 3's weight in November. She stated the Director of Nurses (DNS) sent out notices that reminded nursing staff to obtain the weights that had not been obtained during a month but was unable to recall if she had received a notice to obtain Resident #3's weight in November 2025. Interview with the DNS on 1/14/26 at 12:14 PM identified that per facility policy the residents should be weighed, at minimum, every month. The DNS stated that she did send out a monthly reminder to nursing staff indicating which residents still needed a monthly weight, that Resident #3 should have been weighed in November, and that the facility must have dropped the ball. Review of facility policy for Weight Assessment and Intervention indicated, in part, that the nursing staff will measure resident weights on admission, the next day, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter. 2. Resident #11's diagnoses included Sepsis, Dysphagia (difficulty swallowing) and Dementia. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the hospital Discharge summary dated [DATE] identified a weight on 12/19/25 at 5:00 AM of 68.9 Kilograms (151.90 pounds). A clinical Nursing admission assessment dated [DATE] at 9:58 PM failed to identify an admission weight was obtained (left blank). A physician's order dated 12/20/25 directed to obtain a weight on admission and then weekly every evening shift on Fridays for 4 consecutive weeks post admission then reassess. A review of the Nutrition assessment dated [DATE] identified an admission weight was pending and a documented hospital weight of 152 pounds was noted. The baseline Resident Care Plan dated 12/21/25 identified that a nutritional status/diet problem. Interventions included diet/fluids as ordered regular high moisture, mechanical soft, thin liquids, assist with feeding, determine likes/dislikes, and provide speech therapy as needed. The admission Minimum Data Set assessment dated [DATE] identified Resident #11 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6 and required total assistance with eating, dressing, transfers, bed mobility and a weight was coded as 152 pounds. The Resident Care Plan dated 12/31/25 identified dysphagia. Interventions included a speech consult as ordered, diet consistency per speech recommendation and physician's order, assist with feeding however may refuse assistance, check lungs sounds every shift if indicated, and crush all medications as indicated. A physician's order dated 12/31/25 directed to obtain and record current weight, provide an Ensure supplement 3 times a day, provide Promod Liquid protein once a day for hypoalbuminemia (low albumin) 30 milliliters every day. A review of the weights and vital sign summary report in the electronic medical record (EMR) failed to indicate that the facility had obtained an admission or subsequent weight. An interview and record review with Licensed Practical Nurse (LPN) #3, (the MDS Coordinator), on 1/12/26 at 9:29 AM indicated that weights were documented in the electronic medical record and that no weight had been documented in Resident 11's clinical record. She indicated that the admission nurse was responsible to obtain the weight on admission, and subsequent nursing staff were responsible to ensure the admission weight had been obtained. This was then reviewed in the morning clinical meeting and also reviewed during at risk meetings. The MDS Coordinator could not explain why the weight was not obtained or documented. An interview and record review with Registered Nurse (RN) #2 (Supervisor), on 1/12/26 at 10:24 AM indicated that in the admission MDS dated [DATE], a weight of 152 pounds was recorded. This information was identified in the Dietician note dated 12/21/25 that the weight was documented from the hospital Discharge Summary. The policy for obtaining weights was upon admission and then weekly for 4 weeks then monthly as documented in the physician's orders. RN #2 could not explain why the medical record failed to identify an admission weight. Subsequent to surveyor inquiry, Resident #11's weight was obtained on 1/12/26 at 10:56 AM via a mechanical lift scale and was noted as 133 pounds (a loss of 19 pounds). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with the Dietician on 1/12/26 at 11:54 AM indicated that the weights were only documented in the EMR. The policy for obtaining weights was upon admission and weekly for 4 weeks then monthly. The Dietician could not explain why the medical record failed to identify any weights for Resident #11. The Dietician indicated that she had entered the weight in the MDS assessment from the hospital weight because there was no admission weight obtained by the facility. Further, using a hospital weight was an acceptable facility practice, and a report and review of resident weights was discussed during the At-Risk meeting A review on 1/12/26 at 12:05 PM of the At-Risk meeting report dated 12/24/25 identified that Resident # 11 was a new admission on [DATE] and was missing his/her admission weight. An interview with the Director of Nursing (DNS) on 1/12/26 at 1:33 PM indicated the policy for obtaining admission weights was upon admission and then weekly times 4 weeks then monthly. The DNS further indicated there was no good reason Resident #11's wasn't obtained, the team met to discuss this, but it was her responsibility to ensure that this was completed. A physician's order dated 1/14/26 directed to weigh on admission and then continue to weigh for 4 consecutive weeks post admission then reassess: once a day every Tuesday for 4 weeks. A Dietician note dated 1/14/26 at 7:48 AM identified an admission weight of 133 pounds was obtained on 1/12/26 and orders were obtained to continue weekly weights for 4 weeks and follow up any progress or changes. An interview with the Dietician on 1/14/26 at 10:08 AM indicated that she did not know why it took so long to obtain an admission weight. She further indicated that she told the team at the At-Risk meeting that the admission weight was needed but was unable to explain why it was never obtained. The Dietician indicated that she would consider getting a reweight, but it took so long to get the first weight, it was not feasible. She indicated she was not concerned about the 12.5% weight change from the hospital to present because Resident #11 was receiving supplements, liquid protein, consuming 50-100% of meals and a pressure ulcer had resolved. An interview with the DNS and the Director of Clinical Services, Registered Nurse (RN) #5 on 1/14/26 at 10:20 AM identified that the weight of 133 pounds should have been accurate, but a reweight to confirm accuracy should be conducted per the policy, and the weight loss of 12.5 % was concerning. Additionally, laboratory work and notification of the physician or Advanced Practice Nurse Practitioner and family should be completed. A significant change MDS assessment would be considered if the weight change was confirmed, laboratory results were abnormal, or a change in the plan of care was needed. A review of the admission of a resident policy, dated revised May 2023 directed, in part, within 24 hours of admission, a height and weight would be obtained. A review of the weighing and measuring policy directed, in part, weight was usually measured upon admission and monthly during the resident's stay. Documentation of the weight and the signature of the person recording the data. Reporting significant weigh loss to the nurse supervisor. The threshold for significant unplanned and undesired weight loss will be based on the following criteria: percentage of body weight loss = usual weight minus actual weight divided by usual weight multiplied by 100. 1 month = 5% weight loss was significant, greater than 5% was severe. Report other information in accordance with facility policy and professional standards of practice. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.Resident #78's diagnoses included chronic combined systolic and diastolic heart failure, diabetes mellitus, and end stage renal disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #78 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, was independent for eating, dressing and transfers. Additionally, the MDS identified Resident #78 weighed 201 pounds. The Resident Care Plan dated 11/11/25 identified nutritional status was compromised secondary to end stage renal disease. Interventions included a daily fluid restriction, and weights per the physician's order. The discharge MDS assessment dated [DATE] identified Resident #78 had a discharge with an anticipated return from the hospital and weighed 208 pounds. Review of the hospital Discharge summary dated [DATE] at 10:50 AM identified Resident #78's weight at time of hospital discharge was 86.9 kilograms (191.6 pounds). A physician's order dated 1/6/26 directed to obtain Resident #78's weight on admission, then continue to weigh for 4 consecutive weeks on the day shift on Wednesdays. The clinical admission Nursing assessment dated [DATE] at 1:48 PM failed to identify a weight was obtained upon re-admission for Resident #78 (the weight section was blank). A review of the weight and vitals summary identified Resident #78 had a weight obtained on 12/7/25 of 208 pounds and a weight on 1/9/25 (3 days after readmission) of 192.9 pounds, a 15.1 pound (7.26 %) weight loss in 1 month (the resident was readmitted from the hospital on 1/6/25). Review of Resident #78's nurses notes dated 1/6/26 to 1/13/26 failed to identify a weight had been obtained upon readmission, or that there was documentation of a 15.1 pound (7.26 %) weight loss in 1 month. Interview and record review with the Dietician on 1/13/26 at 9:48 AM identified she performed nutritional assessments within 2 weeks of admission/readmission from the hospital and did not get notifications from the Nursing Department on weight loss but tracked the weight loss as needed after she reviewed weights in the electronic health record. Resident #78's record review with the Dietician identified that a readmission weight should have been obtained on 1/6/26, and that she had not seen Resident #78 yet (7 days post re-admission), but was planning to tomorrow, and planned on checking in with the hemolytic treatment center on the weight obtained on 1/9/26. Interview and record review with the Director Nurses (DNS) on 1/13/26 at 10:19 AM identified it was facility policy to obtain weights upon admission, then weekly for 4 weeks, then monthly with the responsibility being a team effort among nurse aids and unit nurses. Review of Resident #78's clinical record identified that there was no readmission weight obtained but there should have been. Additionally, the 1/9/26 weight was not obtained by the facility, but a hemolytic treatment center obtained weight was used as the facility readmission weight. The DNS identified that although there was a significant weight loss since discharge (15.1 pounds, 7.26% in one month), Resident #78 had not yet been seen by the Dietician who was due to be in tomorrow. The DNS added that nursing does not notify the Dietician of weight fluctuations, but weight loss tracking is the Dietician's responsibility, which she reviewed in the electronic health record. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Weighing and Measuring the Resident Policy directed in part that weight is obtained upon admission and monthly. Review of the Weight Assessment and Intervention Policy directed in part that nursing staff will obtain resident weights upon admission. Additionally, any weight change of 5% or more since the last weight will be retaken the next day for confirmation and if verified, nursing will contact the Dietician immediately.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and facility policy for 2 of 2 medication storage carts and 2 of 2 medication rooms reviewed for medication storage, the facility failed to label open medications appropriately. The findings include:Interview and observation with Licensed Practical Nurse (LPN) #4 on 1/13/26 at 9:35 AM of unit D-wing's medication cart identified the following:CoQ10 100 milligram (mg), 1 open bottle with no open dateDocusate Sodium 100 mg, 2 open bottles with no open dateBiotin 1000 micrograms (mcg), 1 open bottle with no open dateAcidophilus Probiotic, 1 open bottle with no open dateMelatonin 5 mg, 1 open bottle with no open dateMelatonin 3 mg, 1 open bottle with no open dateMelatonin 1 mg, 1 open bottle with no open dateGeri-Knot, 1 open bottle with no open dateBisacodyl 5 mg, 1 open bottle with no open dateProbiotic, 1 open bottle with no open dateNaproxen Sodium, 1 open bottle with no open date Fish Oil 1000 mg, 1 open bottle with no open date Calcium 600 mg,1 open bottle with no open date Eye Relief Ophthalmic Solution, 1 open bottle with no open date Latanoprost Ophthalmic Solution, 1 open bottle with no open date Albuterol Sulfate Inhalation Aerosol 90 mcg, 9 open with no open date Fluticasone Propionate Nasal Spray 50 mcg, 1 open with no open date Fluticasone Propionate HFA Inhalation 110 mg, 1 open with no open date Bevespi Aerosphere, 1 open with no open date.LPN #4 indicated that open medications should be labeled with open date per facility policy. LPN #4 identified that it is the responsibility of the nurse who opens the medication bottle to label it with the open and expiration date. LPN #3 indicated that the nurse assigned to the medication cart should check to ensure all medications are labeled appropriately when starting their shift. LPN #4 identified that he had not been labeling medications as he opened them due to time constraints and that he would label medications when he opens a new bottle in the future. Interview and observation with LPN #5 on 1/13/26 at 10:40 AM of unit C-wing medication cart identified the following:Melatonin 3 mg, 1 open bottle with no open dateMelatonin 1 mg, 1 open bottle with no open dateCalcium 500 mg,1 open bottle with no open dateGeri-Knot, 1 open bottle with no open dateDelsym, 1 open bottle with no open dateLPN #5 identified that open medications should be labeled with open date and expiration per policy and that it is the responsibility of the nurse who opens the medication to label with open date and expiration date. LPN #5 indicated that she did not check the cart like she normally did when starting her shift to ensure all open medications were labeled appropriately.Interview and observation with the Director of Nursing (DNS) on 1/14/26 at 10:40 AM of unit A/B and C/D medication rooms identified the following:Humalog 100ml vial, open with no open or expiration dateAcetylcysteine Solution 20%, open with no open or expiration dateTubersol (Mantoux), 2 vials open with no open or expiration dateAzelastine Hydrochloride ophthalmic solution 5 %, open with no open or expiration dateThe DNS identified that open medications should be labeled with open date and expiration in the medication rooms and medication carts per policy. The DNS indicated that it is the responsibility of the nurse who opens the medication to label with open date and expiration date. The DNS indicated that insulin and eye drops should have expiration dates of 28 days after the opening date. The DNS could not identify why the facility policy was not being followed. Additionally, the DNS indicated that all nursing staff would be re-educated on the proper labeling of opened medications.Review of the storage of medications policy, dated 10/1/15 directed in part that when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical records and policy, for the only sampled resident (Resident #2) reviewed for urinary catheters, the facility failed to provide a privacy covering for a urinary collection bag, and for 2 of 4 sampled residents (Resident #9 and Resident #73) reviewed for dignity, the facility failed to ensure dignified treatment was maintained. The findings include:1. Resident #2's diagnoses included flaccid neuropathic bladder, retention of urine, and hematuria (blood in urine).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had a Brief Interview of Mental Status (BIMS) score of 11 indicating moderate cognitive impairment, required set up for eating and was dependent on staff for toileting and transfers. The Resident Care Plan dated 11/21/25 identified Resident #2 had alteration in urinary elimination related to a urinary catheter (urine drainage tube). Interventions included assessing urine output, change the urinary catheter and bag per the physician's orders, and monitor for leakage.A physician's order dated 12/4/25 directed the insertion of a urinary catheter.Observations from the hallway on 1/7/26 at 10:16 AM and 1/8/26 at 9:30 AM identified Resident #2 in the bed by the door, with the urinary collection hanging at the foot of the bed. Yellow urine was noted in the bag which was without the benefit of a privacy cover.Interview and observation with Nurse Aid (NA) #1 on 1/8/26 at 11:48 AM identified Resident #2's urinary collection bag remained unchanged and in view from the hallway. Although NA #1 indicated the facility policy on urinary collection bags included hanging the bag on the bedside and emptying it during the shift, she did not indicate a privacy cover was needed or that the urinary collection bag should have been out of view.Interview and observation with Licensed Practical Nurse (LPN) #2 on 1/8/26 at 11:54 AM identified Resident #2's urinary collection bag remained unchanged and in view from the hallway. He identified the facility policy directed following the physician's orders for changing urinary collection bags and for flushing. LPN #2 identified that urinary collection bags are kept on the side of the bed, as observed, but he failed to indicate that that Resident #2's urinary collection bag should have been covered or out of view for privacy. Interview and observation with Registered Nurse (RN) # 4 on 1/8/26 at 11:56 AM identified Resident #2's urinary collection bag remained unchanged and in view. RN #4 failed to identify facility policy on urinary collection bags, stating she would have to check since she had only been working at the facility for 2 months.Interview with the Director of Nurses (DNS) on 1/8/26 12:06 PM identified the facility policy directed urinary drainage bags to hang to gravity, stay covered, and physician's orders were to be followed. Subsequent to surveyor inquiry, the DNS indicated that staff would be educated and a privacy cover would be applied to the collection bag.Interview with the Clinical Regional, Nurse, RN #3 on 1/8/26 at 1:53 PM identified that there were no privacy bags available in the facility but were ordered.Review of the Catheter Irrigation policy dated 10/16/25 directed in part that privacy bags will be available and catheter drainage bags will be covered at all times when in use.2. Resident #9's diagnoses included radiculopathy, asthma and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #9 had a Brief Interview of Mental Status (BIMS) score of 13 indicating intact cognition, and required set up help for eating, dressing, and transfers.The Resident Care Plan dated 12/1/25 identified Resident #9 needed social enrichment in the environment of choice. Interventions included assessing and discussing resident needs, interests, and ability to participate in activities of choice and 1:1 visit.Interview with Resident # 9 on 1/13/26 at 9:52 AM identified he/she was out of the room frequently and has heard staff on the 3:00 PM to 11:00 PM refer to residents as inmates as well as conversations between NA's complaining about having to provide care to residents and stating they were not babysitters. Additionally, Resident #9 identified she did not bring it up to anyone's attention because when he/she has brought up concerns in the past he/she was told by staff that she/he were overstepping.3. Resident #73's diagnoses included (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	suspected adult neglect (hospital diagnosis), anxiety, and neuropathy.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #73 had a Brief Interview of Mental Status (BIMS) score of 12 indicating moderate cognitive impairment, required set up for eating and substantial/maximal assistance for hygiene, dressing and transfers. The MDS did not identify any signs or symptoms of delirium or behaviors.The Resident Care Plan dated 1/4/26 identified Resident #73 had the potential for impaired psychosocial wellbeing related to long term care placement, diagnosis of alcohol dependence, and loss of independence and autonomy. Interventions included to involve Resident #73 in daily activities, encourage participation in activities, and encourage the resident to verbalize his/her feelings.Interview with Resident #73 on 1/7/26 at 1:46 PM identified that when he/she talked to the Nursing Aids (NAs) they turn away and ignore me or just walk away, they think I can't hear them, but I can hear them. On one occasion a couple months ago, I heard the nurse in the hallway telling someone that she just had to get the inmate his/her medication prior to coming into my room. Although Resident #73 could not identify the nurse, and stated he/she did not tell anyone, he/she teared up when recalling the incident.Interview with the Director Nurses (DNS) on 1/13/26 at 10:19 AM identified that although she was not aware of any resident referred to as an inmate it would be an undignified way to treat residents. Subsequent to surveyor inquiry, the DNS indicated that staff would be educated on dignity.Review of the Residents' [NAME] of Rights directed in part that residents have the right to be treated with consideration, respect, and full recognition of dignity and individuality.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 2 Residents (Resident #56) reviewed for falls, the facility failed to notify a representative/emergency contact following a fall. The findings include:Resident #56?s diagnoses included fracture of sacrum, difficulty in walking, and diastolic (congestive) heart failure. The Resident Care Plan dated in effect on 12/ 26/25 identified Resident #56 was a fall risk related to left hip pain. Interventions included ensuring appropriate footwear was worn, keeping the bed in the lowest position, and frequent rounding for safety and redirection.A Reportable Event form dated 12/26/25 identified Resident #56 had an unwitnessed fall at 6:45 PM but failed to indicate the resident's family was notified.A post fall evaluation dated 12/26/25 at 8:56 PM identified Resident #56 had an unwitnessed fall, but the responsible party had not been notified as no next of kin was listed due to Resident #56 being newly admitted .The admission Minimum Data Set assessment dated [DATE] identified Resident #56 was moderately cognitively impaired, required setup or clean-up assistance for eating, and partial/moderate assistance for transfers.An interview with Person #1 on 1/7/26 at 10:34 AM identified that he/she was the emergency contact for Resident #56. Person #1 indicated that he/she was not informed of Resident #56's fall on 12/26/25. Further Person #1 found out that Resident #56 had fallen only after requesting copies of his/her medical records and reading staff's documentation.A interview and medical record review with the Licensed Practical Nurse (LPN) #4 on 1/13/26 at 9:46 AM identified that the facility policy directed notification of a resident representative/emergency contact following a fall, and the unit nurse or supervisor was responsible to ensure notification. LPN #4 indicated that if the information for an emergency contact was not listed in the resident's electronic health record, he would look at other records to find the contact information. LPN #4 indicated that if he was unable to locate a contact, he would let the supervisor know. LPN #4 identified that he was working during the time of Resident #56's fall and did not know why the family had not been contacted.A interview and medical record review with the Director of Nursing (DNS) on 1/13/26 at 1:00 PM identified that it was the facility policy to notify a resident's family member of a fall, even if the resident was competent, and that it was the responsibility of the nursing supervisor to ensure notification had been completed and documented. Review of the hospital demographics form dated 12/23/25 identified contact information for Resident #56's emergency contact and that the date listed next to the form in the electronic health record, 12/23/25, was the date that the form was scanned into Resident #56's clinical record. The DNS indicated Resident #56's representative/emergency contact information at the time of the fall was in the clinical record and could not identify why the family member was never notified.A review of the facilities Fall Prevention program policy dated 10/16/25 directed in part that when any resident experiences a fall, the family will be notified.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility policy for 1 of 3 sampled residents (Resident #3) reviewed for discharge, the facility failed to revise the Resident Care Plan (RCP) to include interventions for triggers related to a diagnosis of Post Traumatic Stress Disorder (PTSD). The findings include:Resident #3's diagnosis included diabetes, anxiety, and PTSD.The Minimum Data Set assessment dated [DATE] identified Resident #3 had a Brief Interview of Mental Status score of 10 indicating moderate cognitive impairment and required assistance with bathing and transfers.Review of Resident #3's Resident Care Plan dated 7/3/25 through 1/14/26 failed to identify a diagnosis of PTSD with interventions that included the triggers related to PTSD or how to assist the resident when expressions or indications of distress that the resident has experienced due to PTSD trauma.Review of psychiatric provider notes from 7/8/25 through 1/7/26 identified a diagnosis of PTSD.Interview with Registered Nurse (RN) #3 on 1/13/26 at 1:45 PM identified that social services should have been responsible to ensure the RCP for PTSD was included in the clinical record, but that responsibility for RCP was building specific. RN #3 indicated that the facility did not currently have a policy related to PTSD but was working to create one, and that a PTSD RCP should have been implemented. Interview with Licensed Practical Nurse (LPN) #3, the Minimum Data Set Coordinator, on 1/14/26 at 10:45 AM identified that she was responsible for updating the RCP. LPN #3 was unsure of the policy but would be reviewing, and she must have overlooked implementing a RCP for PTSD for Resident #3. In the past the social worker had not been a part of the behavioral care planning, but going forward the facility planned on utilizing social services to implement behavioral RCP's such as PTSD.Interview with the Administrator on 1/14/26 at 2:45 PM identified that the facility process was to print out the PASRR level II, upload the document into the clinical record, and create a RCP for PTSD. The Administrator indicated that in the event of a PTSD episode the facility would have reached out to a provider as needed.

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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 observation, review of the clinical record, facility policy and interviews for 1 of 7 sampled residents (Resident #41) reviewed for medication administration, the facility failed to ensure a physician order for a subcutaneous injection was administered properly. The findings include: Resident #41?s diagnoses included gastroenteritis (stomach/intestinal inflammation) and colitis (inflammation of the colon). The admission Minimum Data Set assessment dated [DATE] identified Resident #41 had a Brief Interview of Mental Status score of 15 indicating Resident #41 was cognitively intact and required maximal assistance with eating, bathing, and personal hygiene. The Resident Care Plan dated 12/17/25 identified that due to the gastrointestinal inflammation Resident #41 was on a tube feed 14 hours per day and received medication through a Gastrostomy Tube (tube that goes directly into the stomach). Physician orders in effect 12/17/25 to 1/13/26 directed to administer Octreotide Acetate Injection Solution 100 micrograms per milliliter (mcg/ml) subcutaneously (into the fatty layer of the skin) 2 times a day for diarrhea. Observation and interview on 1/13/26 at 7:50 AM identified LPN #6 drawing up an Octreotide Acetate injection for Resident #41 using an intramuscular syringe with a 1-inch, large bore (diameter) needle. As LPN #6 crossed the door threshold prior to reaching Resident #41, the surveyor intervened and asked to speak with LPN #6 outside of Resident #41's room. LPN #6 reviewed the physician's order and noted that she had drawn up the medication using the incorrect type of needle. LPN #6 discarded the previous syringe and drew up the Octreotide Acetate 100 mcg using the correct 1 milliliter syringe with a 5/8 of an inch smaller bore needle for a subcutaneous injection. Interview with DNS on 1/14/26 at 9:50 AM stated that per facility policy a subcutaneous injection should not be given with an intramuscular size needle. Facility policy stated specific instructions based on the type of injection ordered for drawing up medications with dosage, syringe type, appropriate needle size, infection control, and injection site selection and care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and policy for the only sampled resident (Resident #73) reviewed for activities, the facility failed to ensure activities were offered to a dependent resident. The findings include:Resident #73 diagnoses included suspected adult neglect (from the hospital), anxiety, and neuropathy (nerve pain).The Resident Preferences Evaluation (completed upon admission) dated 1/29/25 identified Resident #73 found it very important to have books, newspapers and magazines to read, keep up with the news, and do his/her favorite activities (favorite activities were not specified).The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #73 had a Brief Interview of Mental Status (BIMS) score of 13 indicating no cognitive impairment, required set-up assistance for eating and partial/moderate assistance for dressing and transfers. Additionally, the MDS identified Resident #73 found it important to have books, newspapers and magazines to read, keep up with the news and do his/her favorite activities.The Resident Care Plan dated 1/4/26 identified Resident #73's quality of life should be maintained or improved by providing activities of interest. Interventions included 1:1 visits, assess and discuss resident needs, interest and ability to participate in activities of choice, and staff encouragement to participate in activities of choice by reminding the resident of activity time and location, assisting with care to be ready for the activity, provide transportation to the activity, and provide materials needed for individual bedside activities as needed.Observation and interview on 1/7/26 at 1:46 PM with Resident #73 identified him/her in bed watching television. The resident did not have access to reading materials in the room and an activity calendar was posted on the wall. Resident #73 identified that he/she had been in bed all day and staff never offered to have him/her attend activities. Additionally, Resident #73 identified he/she would have liked to attend activities, however, was unable to get there on his/her own due to the inability to self-propel the wheelchair. Resident #73 indicated that he/she was unaware staff would have assisted in bringing him/her to the activity programs as he/she was never offered to attend.Observations on 1/12/26 at 9:46 AM and 1/13/26 at 10:16 AM identified Resident #73 alone, awake, in bed, the television was turned off and there were no reading materials in the room.Interview and review of participation records with the Therapeutic Recreation Director (TRD) 1/12/26 at 12:42 PM identified that activities offered/attended were tracked on a participation calendar for each resident. A review of the January 2026 participation calendar identified Resident #73 had a 1:1 visit on 1/1/26 and was not offered any other activities during the month. Review of participation calendars for previous months identified an average of 3 to 4 activities daily as follows: In October 2025 Resident #73 was active/observed in an activity 8 times, had 1:1 visits 11 times with the therapeutic recreation staff and refused 5 activities. In November 2025 Resident #73 was active/observed in 2 activities, had 1:1 visits 4 with therapeutic recreation staff and refused 7 activities. In December 2025 Resident #73 was active/observed in 3 activities, had 1:1 visits 7 times with therapeutic recreation staff and refused 1 activity. The TRD identified that the Recreation Department was responsible for inviting residents to activities and that Resident #73 was not offered activities on a daily basis. Additionally, the TRD identified that Resident #73 was not offered more activities because, unfortunately, this happened when residents had refusals, they just trail off (referring to the decline in activities offered and attended by Resident #73). The TRD also identified that she was not aware Resident #73 expressed interest in attending more activities, was under the impression that he/she would have to self-transport him/herself, or that he/she was unable to self-transport. The TRD stated the Recreation Department would have to do better, and now that they were aware, they would work with the Nursing Department to get Resident #73 to offer more activities.Review of the Activities policy dated October 2025 directed, in part, to provide ongoing programs to support residents in their choice of activities to support physical, mental and psychosocial well-being. Additionally, residents are encouraged, not mandated to attend, and all staff will assist residents to and from activities when necessary.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, observation and interviews for 1 of 3 sampled residents (Resident #98) reviewed for pressure ulcers, the facility failed to follow physician orders to offload the resident's heels and failed to follow physician orders for the appropriate treatment of a wound. The findings include: Resident #98's diagnoses included severe protein-calorie malnutrition, dementia and pressure ulcer to their left ischium. The Nursing admission assessment dated [DATE] identified Resident #98 was alert and oriented to person and presented as chronically disoriented and confused. The Resident Care Plan identified Resident #98 was at risk for alteration in skin integrity. Interventions included using pressure redistribution devices as ordered, and perform treatments as ordered.A. A physician's order dated 1/5/26 directed to elevate bilateral heels off the bed with pillows or use foam boots to prevent heel ulcers. Observation on 1/7/26 at 1:45 PM, and on 1/8/26 at 11:31 AM identified that Resident #98 was lying in bed without the benefit of his/her heels being offloaded. Resident #98's Resident Care Plan was revised on 1/9/26 to include an increased risk for alteration in skin integrity. Observation on 1/12/26 identified that Resident #98's heels had been offloaded. Review of facility policy for Prevention of Pressure Ulcers/Injuries indicated, in part, to select appropriate support surfaces based on the resident's mobility, continence, skin moisture and perfusion, body size, weight and overall risk factors, and reposition the resident more frequently as needed, based on the condition of the skin and the resident's comfort. B. A physician's order dated 1/9/26 directed to cleanse the left ischium wound (backside section of the hip bone) with wound cleanser, apply Triad to the peri-wound, apply Santyl to the base of the wound, secure with a dry clean dressing, change daily and PRN (as needed) if soiled or dislodged every evening shift for pressure ulcer of left buttock. A physician's order dated 1/9/26 directed the nursing staff to cleanse the wound to the left lower leg with wound cleanser, apply silver hydrogel to the base of the wound, secure with dry clean dressing, change every other day and PRN if soiled and dislodged every evening shift for a skin tear to the right hand and left lower leg.Observation and interview with Licensed Practical Nurse (LPN) #1 on 1/12/26 at 1:34 PM identified that she applied the silver hydrogel (for the leg) and not Santyl as directed to the resident's left ischium bed, followed by a dry clean dressing. LPN #1 indicated that she thought the ischium area was the resident's hip which had previously healed. LPN #1 then applied silver hydrogel to Resident #98's left lower leg as ordered. Subsequent to surveyor inquiry, LPN #1 indicated that she had not followed the physician's order for Santyl to the ischium as directed and removed the resident's previously applied left ischium wound dressing. LPN #1 then performed wound care using the correct medication, Santyl, as directed. LPN #1 failed to apply Triad paste, as ordered, to the resident's peri-wound area during either of the ischium wound care treatment observations. LPN #1 indicated that she followed the wrong treatment orders for Resident #98 because she believed the ischium was Resident #98's hip and not the area she was treating. Interview with the facility wound nurse Registered Nurse (RN) #1 at 2:09 PM identified the left ischium was located on the resident's left lower buttock and was where Resident #98's wound was located. RN #1 stated she spoke with LPN #1 prior to her demonstrating wound care for Resident #98 and went over the wound care treatment procedure. RN #1 also stated that she instructed LPN #1 that if she was unsure of anything pertaining to the resident's orders, to find a supervisor for clarification prior to proceeding with care and that LPN #1 would be re-educated following the incorrect provision of wound care. Review of facility policy for Wound Care indicated, in part, to verify that there is a physician's order for this procedure, and apply treatments as indicated.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interview, and review of facility policy, for 1 of 5 sampled residents (Resident #74) reviewed for unnecessary medications, the facility failed to ensure that behavior monitoring was being performed with antipsychotic medication administration. The findings includeResident #74's diagnosis included dementia with behavioral disturbance, substance abuse, and diabetes.The Minimum Data Set assessment dated [DATE] identified a Brief Interview for Mental Status score of 12 indicating moderate cognitive impairment and required assistance with bed mobility and transfers. Further review of the MDS failed to identify a psychiatric diagnosis for the use of an antipsychotic medication.Review of the Resident Care Plan in effect from January 2025, through January 14, 2026, identified a behavioral disturbance. Interventions directed to conduct behavioral monitoring.A physician order dated 1/18/25 directed to administer Seroquel (an antipsychotic) 50 milligrams at bedtime for schizophrenia. The order was discontinued on 2/26/25. The antipsychotic medication order was subsequently re-written to be administered for a diagnosis of dementia with behavioral disturbance.Review of the clinical record from January 2025 through January 14, 2026, failed to indicate behavioral monitoring had been routinely conducted.Interview with Corporate Nurse, Registered Nurse (RN) #3 on 1/13/26 at 2:20 PM identified that the previous Director of Nursing (DNS) had mistakenly added a diagnosis of schizophrenia and discontinued behavioral monitoring in January 2025. When the mistaken diagnosis was corrected, the DNS failed to reimplement behavioral monitoring for Resident #74. RN #3 indicated that she had conducted a clinical record and Medication Administration Record review from January 2025 through January 2026 and was unable to find that Resident #74 had routine behavioral monitoring with the use of Seroquel for a diagnosis of dementia with behavioral disturbance. RN #3 indicated that the facility policy indicated that behavioral monitoring was required with the use of Seroquel for dementia. Review of the antipsychotic medication use policy identified that antipsychotic medications prescribed for behavioral symptoms would include documentation for target behaviors and expected outcomes.

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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, observations, interviews and facility policy for 2 of 3 sampled residents (Resident #11 and Resident #98) reviewed for Resident #11 reviewed for infection prevention practices, the facility failed to wear appropriate Personal Protective Equipment (PPE) for a resident on Enhanced Barrier Precautions (EBP), and for Resident #98 reviewed for pressure ulcers, the facility failed to follow appropriate hand hygiene practices. The findings include: 1.Resident #11 's diagnoses included Sepsis, Dysphagia (difficulty swallowing) and Dementia. A physician's order dated 12/20/25 directed to administer Ertapenem sodium injection solution reconstituted 1 gram intravenously once a day for Sepsis until 1/16/26 at 100 milliliters/hour over 30 minutes via a Peripherally Inserted Central Catheter. (PICC) The baseline Resident Care Plan dated 12/20/25 identified enhanced barrier precautions related to current antibiotic (intravenous) therapies. Interventions included handwashing between residents and as needed during care of this resident, staff to utilize gloves, facemask, when anticipated contact with body substances other PPE to be worn as necessary, medications as ordered. A physician's order dated 12/22/25 directed EBP related to a Peripherally Inserted Central Catheter (PICC) line and IV antibiotics The admission Minimum Data Set assessment dated [DATE] identified Resident #11 was severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 6 and required total assistance with eating, bathing, dressing, toileting, transfer, and bed mobility. Observation and interview with LPN #1 on 1/7/26 at 11:34 AM, identified LPN #1 in Resident #11's room which was marked with Enhanced Barrier Precautions (EBP) sign visible outside the door directing when performing high contact resident care activities which include device care: central lines, PICC lines, midline catheters, gowns and gloves were to be worn, and face masks may be needed when performing activities with risk of splashing or spraying. A supply cart was available and noted outside the entry containing PPE. LPN #1 was observed flushing and accessing Resident #11's PICC line with gloves, but without the benefit of wearing a gown. LPN #1 identified that she was flushing and disconnecting the antibiotic that ran via the PICC line because it had finished. Review of the EBP sign at the doorway identified that a gown and gloves were required when performing high contact care activities. LPN #1 stated oh I have to wear a gown. I just had gloves, then returned to Resident #11's room without applying a gown and finished flushing and disconnecting the tubing from the PICC line. Interview with Registered Nurse (RN) #3 and the Director of Nursing (DNS) on 1/7/26 at 12:30 PM identified that a gown and gloves should have been worn when disconnecting and flushing a PICC line. The DNS indicated that she would be educating LPN #1as well as educating all nursing staff immediately related to EBP and high contact activities. Review of the Enhanced Barrier Precautions policy directed, in part, enhanced barrier precautions require the use of gown and gloves for certain residents during specific high contact resident care activities in which there is an increased risk for transmission of multidrug resistant organisms. High contact resident care activities include device care and wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #98's diagnoses included severe protein-calorie malnutrition, dementia and pressure ulcer to the left ischium. The facility's Nursing admission assessment dated [DATE] identified that Resident #98 was alert and oriented to person and presented as chronically disoriented and confused. The Resident Care Plan identified a pressure ulcer to his/her bottom. Interventions included applying a pressure redistribution device as ordered, perform treatments as ordered, and perform frequent repositioning every shift to prevent skin breakdown A physician's order dated 1/9/26 directed to cleanse wound to left ischium with wound cleanser, apply Triad to peri-wound, Santyl to base of the wound, secure with a dry clean dressing, change daily and PRN (as needed) if soiled or dislodged every evening shift for pressure ulcer of left buttock, unstageable. Observation on 1/12/26 at 1:34 PM of Licensed Practical Nurse (LPN) #1 performing Resident #98's wound care identified that during the initial treatment to the left ischium, she had applied the incorrect medication to the wound. Following a treatment to the left lower extremity and prior to re-treatment of the left ischium using the correct medication, LPN #1 removed her gloves and placed on a new pair of gloves without the benefit of cleansing her hands. Interview with the facility wound nurse Registered Nurse (RN) #1 on 1/12/26 at 2:09 PM identified LPN #1 should have cleansed her hands prior to placing a new pair of clean gloves during Resident #98's wound care procedure. RN #1 stated that is unacceptable and that LPN #1 would be re-educated. Review of facility policy for Wound Care indicated, in part, to wash and dry your hands thoroughly (prior to wound care), then put on gloves.

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F 0865 Level of Harm - Potential for minimal harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on clinical record reviews, interviews and facility policy during a review of the Facility Quality Assurance Performance Improvement Plan (QAPI), the facility failed to initiate a QAPI subsequent to identifying that staff had not been following physician orders or their policy for obtaining resident weights. The findings include:Please also reference F692An interview with the Director of Nursing (DNS) on 1/12/26 at 1:33 PM indicated the policy for obtaining admission weights directed upon admission, then weekly times 4 weeks then monthly. The DNS further indicated there was no good reason for failing to follow the facility policy or physician orders, the team met to discuss weights, but it was her responsibility to ensure compliance.An interview with the DNS and the Director of Clinical Services (RN # 5) on 1/14/26 at 12:15 PM identified that the Quality Measures for weights had not been triggered. Additionally, the DNS indicated that the facility had not identified the problem with obtaining accurate weights prior to the survey team identifying the problem. The Director of Clinical Services indicated that the facility does run core reports and sends the reports to the regional staff for review, however the QAPI for this issue had not been started but will be started immediately.Interview and review of the QAPI/QAA program with the Administrator on 1/14/2026 at 11:52 AM identified that the facility is moving towards the Point Click Care (PCC) Electronic Health Record (EHR) event monitoring module. Currently the QAPI program utilizes different sources of information with a focus on root cause analysis to meet quality measurement goals. This is the method that the QAPI team utilized to decide what Performance Improvement Plans to work on.Review of the QAPI policy directed, in part, we monitor existing QI/QM results, internal monitors for falls, medication errors, pressure ulcers, incident reports, and infection reports. The Quality-of-Care Team meets monthly with the Medical Director and others to address care concerns. Our QAPI plan includes policies and procedures used to identify and monitor our performance, establish goals and thresholds for our performance measurement, resident, staff and family input. Additionally, identifying and prioritizing problems and opportunities for improvement, systematically analyzing underlying causes of systemic problems, adverse events and developing corrective action or performance improvement activities. The administrator has responsibility and is accountable to the Governing Board and our corporation for ensuring that QAPI is implemented throughout our organization. All department managers, the administrator, the director of nursing, infection control and prevention officer, medical director, consulting pharmacist, resident and or family representative if appropriate and 3 additional staff will provide QAPI leadership by being on the Quality Assessment and Assurance committee. The QAA committee will meet monthly. Our center will conduct Performance Improvement Projects that are designed to take a systematic approach to revise and improve care or services in areas that we identify as needing attention. Identifying potential topics for PIPS will be considered are high risk, high volume, or problem prone areas that affect health outcomes, quality of care and services and areas that affect staff. The QAA committee will prioritize topics for PIPs based on current needs of the residents and center. Root cause analysis is a structured facilitated team process to identify root causes of an event that resulted in an undesired outcome and develop corrective