STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075294	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whispering Pines Rehabilitation and Nursing Center	38 Talmadge Avenue East Haven, CT 06512

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations, clinical record review, and review of facility policy for the only sampled resident reviewed for respiratory care (Resident #37), the facility failed to ensure a safe environment for a resident on continuous oxygen by allowing the resident (Resident #37) to self-administer a petroleum-based ointment into the nose without physician orders, proper assessment, or staff interventions. Staff failed to recognize and act on posted safety signage (Oxygen in use-no petroleum lotions), did not remove the flammable material from the room, and did not educate the resident on the danger of using petroleum products with oxygen therapy. These systemic failures exposed the resident to a significant fire risk and potential respiratory complications, resulting in Immediate Jeopardy. The findings include: Resident #37's diagnoses included chronic obstructive pulmonary disease (COPD), acute and chronic respiratory failure with hypercapnia (abnormally elevated level of carbon dioxide in the blood), and mild persistent asthma. Physician orders dated 2/2/26 and currently in effect directed Oxygen at 2 liters/minute via nasal cannula related to hypoxia for COPD and continuous every shift. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #37 had intact cognition and was dependent with toileting, transfers, and bed mobility. The MDS further indicated Resident #37 had a diagnosis of COPD and was on oxygen therapy. The Resident Care Plan (RCP) dated 2/8/26 identified Resident #37 had an altered respiratory status and difficulty breathing related to oxygen dependence and COPD. Interventions included to monitor Resident #37 for signs and symptoms of respiratory distress and providing oxygen as ordered. Observation during the initial tour on 2/25/26 at 11:16 AM identified Resident #37 was in bed and on continuous oxygen at 2 liters/minute via nasal cannula with 1 small (1.76 ounce) uncovered tub of VapoRub ointment (petroleum based chest rub) which was 1/2 empty and 1 large (3.53 ounce) uncovered tub of VapoRub ointment which was 1/2 empty on the overbed table (resting over the bed and in front of the resident). A second observation and an interview with Resident #37 on 2/25/26 at 1:45 PM identified his/her family member had brought in the 1 small (1.76 ounce) tub of VapoRub ointment and 1 large (3.53 ounce) tub of VapoRub ointment and the resident had been self-administering the ointment inside of his/her nose (with the oxygen running) several times a day for months. Resident #37 indicated he/she applied the ointment when his/her nose felt dry or congested. Resident #37 stated the nursing staff was aware he/she had the 1 small (1.76 ounce) uncovered tub of VapoRub ointment and 1 large (3.53 ounce) uncovered tub of VapoRub ointment on his/her overbed table and was self-administering the ointment inside of his/her nose while on continuous oxygen. Additionally, Resident #37 identified he/she had been on continuous oxygen for many years at home and also while at the facility. Resident #37 noted he/she was never told and was not aware he/she should not have been using a petroleum-based ointment while receiving oxygen. Observation, interview, and review of the clinical record with LPN #1 on 2/25/26 at 1:48 PM identified she was aware Resident #37 had 1 small (1.76 ounce) uncovered tub of VapoRub ointment and 1 large (3.53 ounce) uncovered tub of VapoRub ointment on the overbed table (which sat over the bed and in front of the resident). LPN #1 indicated she was aware that the resident was self-administering the (continued on next page)

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

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	petroleum-based ointment inside of his/her nose while on continuous oxygen. LPN #1 indicated although there was a sign attached to the doorway of the resident's room which indicated ?Oxygen in use, no petroleum lotions', she was not aware the resident should not have been using the VapoRub ointment and had never noticed the signage outside of the resident's room. Review of the clinical record with LPN #1 identified Resident #37 did not have a current order for the VapoRub and the resident had not had a self-administration of medication assessment completed. LPN #1 indicated she would need to remove the 2 tubs of VapoRub ointment from Resident #37's room. An observation of 2/26/26 at 11:25 AM identified, subsequent to surveyor inquiry, the 1 small (1.76 ounce) uncovered tub of VapoRub ointment and 1 large (3.53 ounce) uncovered tub of VapoRub ointment on Resident #37's overbed table had been removed. Interview and review of the clinical record with the DNS on 3/2/26 at 12:42 PM identified Resident #37 should not have had or been self-administering VapoRub ointment inside of his/her nose while on continuous oxygen. The DNS indicated the nursing staff should have ensured Resident #37 did not have VapoRub ointment in his/her room as indicated on the oxygen in use' sign attached to the resident's doorway, as it was a potentially flammable item. The DNS stated the nursing staff should have educated Resident #37 to not use the VapoRub ointment because it was unsafe, and the resident should not have been self-administering a medication without a physician's order or a completed self-administration of medication assessment. Additionally, the DNS identified although the nursing staff had been educated on oxygen administration, she would need to provide further education. Interview with the Branch Manager of the oxygen company on 3/11/26 at 12:34 PM identified VapoRub ointment was a petroleum-based material which, due to flammability, should not come into direct contact with the flow of oxygen. The Branch Manager indicated oxygen and VapoRub ointment were flammable materials and if Resident #37 was applying VapoRub ointment inside of his/her nose while receiving oxygen via nasal cannula there would be a risk for burns or potential fire. The Branch Manager identified use of petroleum-based products should not be used around oxygen and it would be unsafe to be in a resident's room while oxygen was running. Interview with NA #2 on 3/11/26 at 1:20 PM identified several weeks ago Resident #37 had 1 small (1.76 ounce) uncovered tub of VapoRub ointment and 1 large (3.53 ounce) uncovered tub of VapoRub ointment located on the overbed table. NA #2 indicated she was aware that the resident was self-administering the petroleum-based ointment inside of his/her nose while on continuous oxygen. NA #2 indicated although there was a sign attached to the doorway of the resident's room which indicated Oxygen in use, no petroleum lotions', she was not aware the resident should not have been using the VapoRub ointment and had never noticed the signage outside of the resident's room. Review of the VapoRub ointment ingredients and directions for use indicated it was a petroleum jelly-based ointment, and it should not be applied inside of the nostrils. Review of the VapoRub ointment Safety Data Sheet (SDS) identified it had a moderate flammability hazard rating. Review of the facility policy, Oxygen Therapy, undated, directed oxygen therapy shall be provided for residents in an emergency situation and for long term use oxygen may only be administered by licensed personnel.The above deficiency resulted in the finding of Immediate Jeopardy (IJ). After observations made on 2/25/26 and 2/26/26 (with additional information obtained on 3/11/26), the facility Administrator was provided with the IJ template on 3/11/26 at 2:37 PM and submitted a removal plan which was approved by the State Agency on 3/11/26.The Removal Plan noted in part, that the DNS immediately removed the VapoRub from Resident #37's room, provided education to all staff, resident families and a message was also sent to all staff via a messaging system ensuring that oil or petroleum-based products were not used with residents receiving oxygen therapy. Additionally, staff were educated to immediately remove and notify the resident and nursing supervisor of any petroleum-based products found in resident rooms for residents receiving oxygen therapy. Additionally, the removal plan identified a housewide audit was completed on 2/25/26 (after initial observations were made of VapoRub being used by Resident #37) ensuring that no resident on oxygen was utilizing any petroleum-based products. The facility will implement weekly audits on each unit to ensure no (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	petroleum-based products were in the room of residents receiving oxygen.Observations on 3/13/26 identified that the facility implemented the removal plan and the IJ was removed.

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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 - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of the medical record, facility documentation, observations, and facility policy for 3 of 3 residents (Resident #7, Resident #14 and Resident #20) reviewed for urinary tract infections, the facility failed to ensure the Advanced Practice Registered Nurse (APRN) was notified when a medication was unavailable and therefore not administered. The findings include: 1.Resident #7 was admitted to the facility in October 2025 with diagnoses that included dementia, urinary retention with chronic foley use and urinary tract infections (UTI).The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 was severely cognitively impaired and required set up for meals, moderate assistance for activities of daily living (ADLs) and had a urinary foley catheter.Physician orders dated 2/3/26 directed to administer D-Mannose (supplement used for prevention of UTIs) 1 scoop of powder two times a day.The Resident Care Plan (RCP) dated 2/6/26 identified Resident #7 had Catheter-Associated UTIs related to indwelling urinary catheter use with interventions that included to change catheter tubing as indicated, monitor for evidence of catheter blockage or leakage and flush per physician's orders. Additional interventions included monitoring for signs and symptoms of UTI and perform careful peri-care. The Medication Administration Record (MAR) for February 2026 identified that D-Mannose was not administered on 2/13/26 at 8:30 AM (but at 4:30 PM and on 2/25/26 at 8:30 AM signed as administered despite being unavailable on previous and subsequent days/shifts), 2/25/26 at 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM and 2/27/26 at 8:30 AM (a total of 5 missed doses) as it was coded as being unavailable. Nursing notes from 2/3/26 through 2/26/26 lacked documentation that the APRN was notified that Resident #7 had 5 missed doses of the D-Mannose.A progress note dated 2/24/26 and written by Advanced Practice Registered Nurse (APRN) indicated that Resident #7 was at high risk for developing UTI due to a chronic urinary foley and poor fluid/ food intake. Additionally, the APRN progress note did not reflect that Resident #7 missed 5 dose(s) of the D-Mannose.Interview with APRN #1 on 3/3/26 at 9:00 AM identified that she was not made aware of the D-Mannose not being available or administered on 2/13/26 at 8:30 AM, 2/25/26 at 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM until 2/27/26 when she wrote alternative orders to give Cranberry 250 milligrams (mg) tablets if D-Mannose is unavailable. She indicated that the policy was that the practitioner was to be notified when medication was not given due unavailability and that she should have been notified that Resident #7 missed doses. She indicated that although she was trialing the medication on several residents, she would have written alternative orders for Cranberry tabletsSubsequent to surveyor inquiry, alternative orders were obtained from APRN #1 on 2/27/26 for Cranberry tabs 450 milligrams (mg) to be given if D-Mannose was unavailable for Resident #7.2. Resident #14's diagnoses included dementia, diabetes, benign prostatic hyperplasia (BPH) (enlarged prostate) and calculus of ureter (kidney stone).The Resident Care Plan (RCP) dated 12/11/25 identified Resident #14 was incontinent of bowel and bladder related to impaired mobility. Interventions included to offer the urinal every 2 hours and monitor for signs and symptoms of urinary tract infection (UTI): pain, burning, blood-tinged urine, no urinary output, elevated temperature, urinary frequency, foul smelling urine, altered mental status, and change in eating habits.The RCP further identified Resident #14 was at risk for urinary complications related to BPH. Interventions included administering medications as ordered, monitoring dysuria, hematuria, urgency, and frequency of urination, and report changes to the medical doctor.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact, had no behavior symptoms, had no rejections of care, had urinary incontinence, was not on a urinary toileting program, required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers.A physician order dated 2/3/26 directed to administer D-Mannose oral powder (supplement used for prevention of UTIs) 1 scoop by mouth, 2 times a day for UTI prevention.The Medication Administration (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record (MAR) for February 2026 identified D-Mannose was not administered 26 out of 51 opportunities (50.9%) as follows: on 2/8/26 at 4:30 PM, 2/9/26 at 8:30 AM, 2/10/26 at 8:30 AM, 2/11/26 at 8:30AM and 4:30 PM, 2/12/26 at 8:30 AM and 4:30 PM, 2/13/26 at 8:30 AM and 4:30 PM, 2/20/26 at 8:30 AM and 4:30 PM, 2/21/26 at 8:30 AM, 2/22/26 at 8:30 AM and 4:30 PM, 2/23/26 at 8:30 AM and 4:30 PM, 2/24/26 at 8:30 AM and 4:30 PM, 2/25/26 at 8:30 AM and 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM 2/27/26 at 8:30 AM and 4:30 PM, and 2/28/26 at 8:30 AM and 4:30 PM and was coded by the nurse in the electronic medical record as being unavailable.Review of the February 2026 MAR and nursing notes dated 2/1/26 through 2/26/26 identified out of the 22 times D-Mannose was coded in the electronic health record (EMR) as not given due to being unavailable, 19 nursing notes were written which indicated D-Mannose was unavailable and/or on order from the pharmacy but failed to identify the physician or Advanced Practice Registered Nurse (APRN) was notified that D-Mannose was unavailable and Resident #14 had missed 22 doses.An APRN progress written by APRN #1 on 2/20/26 at 2:35 PM indicated Resident #14 was seen for a rash on the face. The progress note identified Resident #14 had history of UTIs and had a stent placed in his/her ureter in August of 2023. The progress note failed to reflect that Resident #14 had missed doses of the D-Mannose.A physician progress note dated 2/23/26 at 8:15 AM identified Resident #14 was seen for a 30-day regulatory visit. The progress note identified Resident #14 had a diagnosis of BPH unspecified for whether urinary tract symptoms were present. The note failed to reflect Resident #14 had missed doses of the D-Mannose.An APRN progress written by APRN #1 on 2/25/26 at 3:32 PM indicated Resident #14 was seen for UTI symptoms and follow-up on facial rash. The progress note identified Resident #14 complained of dysuria (pain on urination) on exam, that he/she had a history of UTIs and stent placement, and that Resident #14 was supposed to have the ureteral stent replaced last year but refused the procedure. The progress note identified Resident #14 had suprapubic tenderness with palpation and the treatment plan was to send a urine test, obtain blood work, encourage fluids, monitor output, and monitor for signs and symptoms of UTI. The progress note failed to reflect that Resident #14 had missed doses of the D-Mannose which had been ordered for UTI prevention.Interview with Licensed Practical Nurse (LPN) #2 on 2/27/26 at 1:48 PM identified that D-Mannose was not available on the medication cart and that it had not been available since about 2/20/26. LPN #2 identified the ADNS orders the D-Mannose and when it's available she brings it to LPN #2 to place inside the medication cart. LPN #2 further identified she did not notify the APRN that the D-Mannose was unavailable but indicated she had notified the ADNS.Subsequent to surveyor inquiry, a nursing note dated 2/27/26 at 4:41 PM identified D-Mannose was unavailable, the APRN was notified, and a new order was received to administer Cranberry tablet 450 mg by mouth every 24 hours as needed if D-Mannose was unavailable.Subsequent to surveyor inquiry an APRN order dated 2/27/26 directed to administer D-Mannose oral powder 1 scoop by mouth 2 times a day for UTI prevention with the directive that if unavailable may use cranberry tablet.An APRN order dated 2/27/26 directed to administer Cranberry tablet 250 milligrams (mg) by mouth every 24 hours as needed (PRN) for UTI prophylaxis with the directive to use when D-Mannose was unavailable.Interview with APRN #1 on 3/3/26 at 10:25 AM identified the order for D-Mannose was put in place by herself as a trial to see if adding it into the resident's regimen would have beneficial results. She indicated that she was sure she had overheard the D-Mannose was unavailable, but that she had not felt that the missing doses would be harmful and so hadn't recommended anything further until she was notified by a nurse on 2/27/26 that the D-Mannose was unavailable.3.Resident #20 was admitted to the facility in August 2023 with diagnoses that included dementia with behaviors, sepsis, and type 2 diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #20 was severely cognitively impaired, required set up for meals and was dependent on staff for all other activities of daily living (ADLS). The Resident Care Plan (RCP) dated 1/26/26 identified Resident #20 had UTIs related to weakness and urosepsis (UTI that spreads to the blood stream) with interventions that included to monitor vitals signs, monitor for signs and symptoms of UTI and notify (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the practitioner, provide frequent incontinent care as needed, encourage fluids during the day to promote prompt voiding, incontinent care before lunch, and monitor and report to MD any possible medical causes of incontinence.APRN #1's progress note dated 2/3/26 identified Resident #20 was at high risk for UTIs due to dementia, incontinence, use of briefs and limited mobility. Resident #20 to start on D-Mannose for urinary tract health and UTI monitoring once a shift for retention, urgency, frequency, hematuria (blood in urine), dysuria (painful urination) and hesitation, encourage fluids, and follow up with urology as needed. Physician orders dated 2/3/26 directed to administer D-Mannose powder one scoop 2 times a day, urinary tract monitoring (UTI) every shift, document in nursing notes and Advanced Practice Registered Nurse (APRN) book of any signs and symptoms of UTI.The Medication Administration Record (MAR) for February 2026 identified D-Mannose was not administered on 2/8/26 at 4:30 PM, 2/9/26 at 8:30 AM and 4:30 PM, 2/11/26 at 8:30AM and 4:30 PM, 2/12/26 at 8:30 AM, 2/13/26 at 8:30 AM and 4:30 PM, 2/19/26 at 4:30 PM, 2/20/26 at 8:30 AM and 4:30 PM, 2/21/26 at 8:30 AM and 4:30 PM, 2/23/26 at 8:30 AM, 2/25/26 at 8:30 AM and 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM and 2/27/26 at 8:30 AM (a total of 19 missed doses) as it was coded as being unavailable.Nursing notes from 2/3/26 through 2/26/26 lacked documentation that the APRN was notified that Resident #20 had missed 19 doses of the D-Mannose.Interview, review of medical supplier packing slips (2/4/26 and 2/10/26) with the Central Supply Clerk and observation of over-the counter (OTC) supply closet on 2/2/7/26 at 11:20 AM identified that she was responsible for placing OTC order for the D-Mannose with the medical supply vendor. She indicated that she only places orders for OTC medications from the medical supply vendor and the nurses are responsible for ordering medications including OTCs if needed from the pharmacy. She indicated on 2/4/26 she did not place an order for the D-Mannose (even though physician's orders were initiated on 2/3/26). An order was placed for 1 case of the D-Mannose powder (12 bottles in a case) on 2/10/26 from the medical supply vendor. The order had not yet come in from the vendor as of 2/27/26. The packing slips identified that no order was placed on 2/4/26 and an order was placed on 2/10/26 for one case. She indicated that she had made the Assistant Director of Nursing (ADNS) aware that the medication was on back order. She could not recall the exact date but as soon as she was made aware, she notified the ADNS, which was at least a week or two ago. An inspection of the OTC cabinet identified there was D-Mannose available.An interview with LPN #2 on 2/27/26 at 12:00 PM identified that there was not any D-Mannose in any of the medication carts and she could not administer D-Mannose to any of her residents that were to receive the medication. She could not recall when it was last available, but she had made the ADNS and central supply aware when it was no longer available. Interview with Pharmacy Manager on 3/3/26 at 8:30 AM identified that the pharmacy does have D-Mannose available for order in capsule form but not powder. She indicated that an initial order was received on 2/3/26 for Resident #20 for the D-Mannose. However, when the pharmacy had called back (3 times) they were unable to get a response from the charge nurse or the nursing supervisor regarding sending the D-Mannose. She indicated that a pharmacy technician had spoken to a nurse on 2/3/26 at 12:35 PM but was not sure who it was but believed it was the ADNS and was told not to send D-Mannose as it was an OTC medication.Interview with APRN #1 on 3/3/26 at 9:00 AM identified that she was not made aware of the D-Mannose not being available until 2/27/26 when she wrote alternative orders Cranberry tablets 250 milligrams if D-Mannose unavailable. She indicated that the policy was that the practitioner was to be notified when medication was not given due unavailability and that she should have been notified that Resident #20 had missed several doses. She indicated that although she was trialing the medication on several residents, she would have written alternative orders for Cranberry tablets.Interview with the ADNS on 3/3/26 at 10:00 AM indicated that she was aware that D-Mannose was unavailable and the nurses and central supply had notified her sometime in February 2026, but she could not recall the date. She indicated that she did not contact the pharmacy to inquire if D-Mannose was available as they have a formulary the facility follows. The ADNS also did not recall speaking to someone from the pharmacy on 2/3/26. In addition, she indicated (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that she had not notified APRN #1 but thought she already knew that the D-Mannose was unavailable. The ADNS indicated that the policy was the practitioner was to be notified if medication was not given due to unavailability. She indicated that she should have contacted the pharmacy to inquire if D-Mannose was available for order. Furthermore, she indicated that the nurses should not have signed off medication as given if it was not available and could not explain why it was signed off on one shift as given and documented on the following shift as being unavailable.Subsequent to surveyor inquiry, alternative orders were obtained from APRN #1 on 2/27/26 for Cranberry tabs 450 milligrams (mg) to be given if D-Mannose was unavailable for Resident #20.Review of the Refill Orders policy (pharmacy policy) directed, in part, to anticipate refill needs and not to wait until a resident is completely out of a medication before reordering.Review of the Medication Administration-General Guidelines policy directed, in part, if a medication with an active order cannot be located within the medication cart, the medication room, and/or other units in the facility should be searched to locate the medication, The policy directed if the medication cannot be located to contact the pharmacy. The policy directed if a regularly scheduled medication is unavailable or refused it is documented within the EMR and an explanatory nursing note is written. The policy further directed if (xx consecutive doses-no number entered) of a vital medication are not administered the physician is notified and the nurse documents the notification and the response.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy, and interviews for 1 of 4 residents (Resident #3) reviewed for hospitalization, the facility failed to perform fingerstick glucose levels for a diabetic resident as indicated by the providers note and for 3 of 3 residents (Resident #7, Resident #14 and Resident #20) reviewed for urinary tract infections, the facility failed to ensure medications were administered per physician's orders. Additionally, for 1 of 3 residents (Resident #65) reviewed for non-pressure skin conditions, the facility failed to identify a change in wound status. The findings include: 1.Resident #3's diagnoses included Type 2 diabetes with diabetic neuropathy, history of sepsis related to urinary tract infections, chronic kidney disease, and morbid obesity. An annual Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #3 was cognitively intact and independent with wheelchair mobility; however, the resident required assistance for transfers into the wheelchair. Physician orders initially dated 11/3/23 and currently in effect directed Metformin twice daily as a hypoglycemic agent for diabetes management, as well as orders to administer Instaˆ Glucose gel if Resident #3's blood glucose level fell below 70 mg/dL with symptoms, or below 60 mg/dL regardless of symptoms, followed by a repeat glucose check in 15 minutes. The orders also directed the administration of intramuscular Glucagon if the resident was unable to swallow, with a subsequent repeat blood glucose check. The provider additionally ordered annual laboratory studies that included a glucose value however, the provider did not issue orders for routine fingerstick blood glucose monitoring. In the absence of such orders, nursing staff did not have the means to obtain timely, realˆ time glucose values necessary to identify and respond to hypoglycemia or hyperglycemia in accordance with the ordered treatment parameters. A progress note written by Advanced Practice Registered Nurse (APRN) #1 and dated 10/24/25 at 5:05 PM directed staff to monitor Resident #3's fingerˆ stick blood glucose levels, A1C, B12 levels, and weights in relation to the resident's diabetes diagnosis. Despite the APRN's directive for fingerˆ stick glucose monitoring, there were no corresponding physician orders put in place, and nursing staff did not complete routine fingerˆ stick blood glucose checks as indicated in the APRN's progress note. The Resident Care Plan (RCP) dated 12/1/25 identified Resident #3's diagnosis of diabetes, with interventions that included obtaining fasting serum blood glucose levels as ordered and monitoring for signs and symptoms of both hypoglycemia and hyperglycemia. On 12/18/25 at 12:07 PM, lab work consisting of a Basic Metabolic Panel (BMP) and a Complete Blood Count (CBC) were collected by a diagnostic laboratory and radiology service, which included a blood glucose level test. A nursing note dated 12/18/25 at 12:41 PM identified Resident #3 exhibited new symptoms, including lethargy, newˆ onset cough, and nausea. Resident #3 was tested for COVIDˆ 19 and the result was positive. Additionally, the nursing note indicated the APRN was present in the facility and was made aware of Resident #3's new symptoms and positive diagnosis of COVID-19. The documentation did not indicate that a fingerstick blood glucose level was obtained at that time, although facility policy noted nursing staff were directed to obtain a fingerˆ stick blood glucose level on diabetic residents receiving (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin or oral hypoglycemic agents if the resident exhibited any signs or symptoms of hypoglycemia or hyperglycemia, including mental status changes, dizziness, headache, or lethargy (see facility policy below). A nursing note dated 12/18/25 at 3:31 PM identified that the laboratory notified the facility of a critically high blood glucose level of 709 milligrams/deciliter (mg/dL). The APRN was informed, and Resident #3 was subsequently sent to the emergency department for further evaluation. An APRN note dated 12/18/25 at 6:20 PM indicated that nursing staff reported a critically high glucose level of 709 mb/dL following bloodwork obtained in response to Resident #3's symptoms of lethargy, poor appetite, nasal congestion, cough, and a positive COVIDˆ19 diagnosis. The resident was subsequently transferred to the emergency department for a higher level of care due to the risk of hyperosmolar hyperglycemic state and the anticipated need for intravenous insulin, intravenous fluids, and continuous monitoring. Resident #3 returned to the facility from the acute care hospital with a diagnosis of hyperglycemia and having been administered intravenous insulin and fluids. Interview and clinical record review with APRN #1 on 3/2/26 at 10:20 AM noted that the clinical record failed to reflect that she had written orders to monitor Resident #3's fingerˆstick blood glucose levels as noted in her progress notes from 10/24/25. Additionally, APRN #1 identified although she recommended finger-stick blood glucose monitoring from her progress note, she could not identify how often to perform finger sticks. APRN #1 also stated that an order should have been written to obtain a fingerstick glucose and that obtaining orders was a shared responsibility between the providers and the nursing staff. APRN #1 further stated that she would ordinarily review laboratory results that she recommended as part of her assessment but was unsure why she did not identify that fingerstick glucose levels were not being obtained for Resident #3. An interview with the ADNS on 3/2/26 at 11:15 AM identified that nursing reviews new orders every 24 hours but does not currently have a process to identify recommendations from the provider progress notes. The ADNS further indicated that although nursing can help place new orders, they must then be signed by the provider. Review of the facility's undated policy titled, Hypoglycemia Management, indicated that nursing staff were directed to obtain a fingerˆstick blood glucose level on diabetic residents receiving insulin or oral hypoglycemic agents if the resident exhibited any signs or symptoms of hypoglycemia or hyperglycemia, including mental status changes, dizziness, headache, or lethargy. 2.Resident #7 was admitted to the facility in October 2025 with diagnoses that included dementia, urinary retention with chronic foley use and urinary tract infections (UTI). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 was severely cognitively impaired and required to be set up for meals, moderate assistance for activities of daily living (ADLs) and had a urinary foley catheter. Physician orders dated 2/3/26 directed to administer D-Mannose (supplement used for prevention of UTIs) 1 scoop of powder two times a day. The Resident Care Plan (RCP) dated 2/6/26 identified Catheter-Associated UTIs related to indwelling (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	urinary catheter use as a concern with interventions that included to change catheter tubing as indicated, monitor for evidence of catheter blockage or leakage, flush per physician's orders, monitor for signs and symptoms of UTI, and perform careful peri-care. The Medication Administration Record (MAR) for February 2026 identified that D-Mannose was not administered on 2/13/26 at 8:30 AM (but at 4:30 PM and on 2/25/26 at 8:30 AM signed as administered despite being unavailable on previous and subsequent days/shifts), 2/25/26 at 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM and 2/27/26 at 8:30 AM (a total of 5 missed doses) as it was coded as being unavailable. Nursing notes from 2/3/26 through 2/26/26 lacked documentation that the APRN was notified that Resident #7 had missed doses of the D-Mannose. An Advanced Practice Registered Nurse (APRN) #1 progress note dated 2/24/26 indicated that Resident #7 was at high risk for developing UTI due to chronic urinary foley and poor fluid/ food intake. Her progress note did not reflect that Resident #7 missed dose(s) of the D-Mannose. Subsequent to surveyor inquiry, alternative orders were obtained from APRN #1 on 2/27/26 for Cranberry tabs 450 milligrams (mg) to be given if D-Mannose was unavailable for Resident #7. 3. Resident #14's diagnoses included dementia, diabetes, benign prostatic hyperplasia (BPH) (enlarged prostate) and calculus of ureter (kidney stone). The Resident Care Plan (RCP) dated 12/11/25 identified Resident #14 was incontinent of bowel and bladder related to impaired mobility. Interventions included to offer the urinal every 2 hours, encourage fluids during the day to promote prompted voiding responses, monitor intake and output, and monitor for signs and symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, no urinary output, elevated temperature, urinary frequency, foul smelling urine, altered mental status, and change in eating habits. The RCP further identified Resident #14 was at risk for urinary complications related to BPH. Interventions included administering medications as ordered, monitoring for dysuria, hematuria, urgency, and frequency of urination, and report changes to the medical doctor. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact, had no behavior symptoms, had no rejections of care, had urinary incontinence, was not on a urinary toileting program, required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers. A physician order dated 2/3/26 directed to monitor every shift (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM) for signs and symptoms of UTI and document any signs or symptoms in a nursing note and Advanced Practice Registered Nurse (APRN) book. a. A physician order dated 2/3/26 directed to administer D-Mannose oral powder (supplement used for prevention of UTIs) 1 scoop by mouth 2 times a day for UTI prevention. The Medication Administration Record (MAR) for February 2026 identified D-Mannose was not administered 22 out of 51 opportunities (43.1%) as follows: on 2/8/26 at 4:30 PM, 2/9/26 at 8:30 AM, 2/10/26 at 8:30 AM, 2/11/26 at 8:30AM and 4:30 PM, 2/12/26 at 8:30 AM and 4:30 PM, 2/13/26 at 8:30 AM and 4:30 PM, 2/20/26 at 8:30 AM and 4:30 PM, 2/21/26 at 8:30 AM, 2/22/26 at 8:30 AM and 4:30 PM, 2/23/26 at 8:30 AM and 4:30 PM, 2/24/26 at 8:30 AM and 4:30 PM, 2/25/26 at 8:30 AM and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4:30 PM, and 2/26/26 at 8:30 AM and 4:30 PM and was coded in the electronic medical record as being unavailable. Nursing notes dated 2/1/26 through 2/26/26 identified 19 nursing notes which indicated D-Mannose was unavailable and/or on order. Interview, review of medical supplier packing slips (2/4/26 & 2/10/26) and observation of over-the counter (OTC) supply closet with the Central Supply Clerk on 2/27/26 at 11:20 AM identified that she was responsible for placing the over the counter (OTC) order for D-Mannose with the medical supply vendor. She indicated that she only placed orders for OTC medications from the medical supply vendor and the nurses were responsible for ordering medications including OTCs if needed from the pharmacy. She indicated on 2/4/26 she did not place an order for the D-Mannose (even though physician's orders were initiated on 2/3/26). An order was placed for 1 case of the D-Mannose powder (12 bottles in a case) on 2/10/26 from the medical supply vendor. The order had not yet come in from the vendor as of 2/27/26. The packing slips identified that no order was placed on 2/4/26 and an order was placed on 2/10/26 for one case. She indicated that she had made the Assistant Director of Nursing (ADNS) aware that the medication was on back order and not available. She could not recall the exact date but as soon as she was made aware, she notified the ADNS, which was at least a week or two ago. On 2/27/26 at 11:20 AM an inspection of the OTC cabinet identified that there currently was D-Mannose available. Interview with Licensed Practical Nurse (LPN) #2 on 2/27/26 at 1:48 PM identified that D-Mannose was not available on the medication cart and that it had not been available since about 2/20/26. LPN #2 identified the ADNS orders D-Mannose and when it's available, she brings it to LPN #2 to place in the medication cart Subsequent to surveyor inquiry, a nursing note dated 2/27/26 at 4:41 PM identified D-Mannose was unavailable, the APRN was notified, and a new order was received to administer Cranberry tablet 450 mg by mouth every 24 hours as needed if D-Mannose was unavailable. Subsequent to surveyor inquiry an APRN order dated 2/27/26 directed to administer D-Mannose oral powder 1 scoop by mouth 2 times a day for UTI prevention with the directive that if unavailable may use cranberry tablet. b. An APRN order dated 2/27/26 directed to administer Cranberry tablet 250 milligrams (mg) by mouth (a discrepancy with the nursing note dated 2/27/26 that identified a new order for Cranberry tablet 450 mg) every 24 hours as needed (PRN) for UTI prophylaxis with the directive to use when D-Mannose was unavailable. Interview and clinical record review with LPN #2 on 3/2/26 at 12:45 PM identified D-Mannose was now available and on the medication cart, but it had not been available at 8:30 AM when she administered Resident #14's medications. LPN #2 identified she had administered a 450 mg cranberry tablet to Resident #14 in substitution for D-Mannose that was unavailable, but she had not signed it out in the electronic medical record (EMR). LPN #2 identified she hadn't realized there was an actual PRN order in place for the cranberry tablet and indicated she had administered the cranberry tablet based on the directions written within the D-Mannose order. Additionally, LPN #2 identified she did not know why the PRN order was for a 250 mg cranberry tablet because the facility did not have that (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dosage available which was the reason she had given a 450 mg cranberry tablet (despite the APRN order dated 2/27/26 to administer 250 mg cranberry tablet). Interview with the ADNS on 3/2/26 at 1:20 PM identified that the nurses should be signing off the PRN order for a cranberry tablet in the EMR when the D-Mannose was unavailable. She identified the nurses should know to look for a PRN order after reading the direction within the D-Mannose order instructing to give the cranberry tablet if the D-Mannose was unavailable. Additionally, she identified that no medication should be given without a physician order and/or without signing it out in the EMR. The ADNS further identified the order for cranberry tablet 250 mg must have been a data entry error because the facility only had cranberry 450 mg available. Subsequent to surveyor inquiry an APRN order dated 3/2/26 directed to discontinue the order for Cranberry tablet 250 mg every 24 hours PRN and directed to start the order to administer Cranberry tablet 450 mg by mouth every 24 hours PRN for UTI if D-Mannose was unavailable. Review of the MAR for March 2026 identified that D-Mannose was not administered 3 out of 4 opportunities (3/1/26 at 8:30 AM, 3/1/26 at 4:30 PM, and 3/2/26 at 8:30 AM) with 3/1/26 coded as Hold/see nurse note, and 3/1/26 at 4:30 PM and 3/2/26 at 8:30 AM both coded as Other/see nurse note. Additionally, the MAR failed to identify that either dosage of Cranberry tablet was signed out as administered due to D-Mannose being unavailable on 3/1/26 or 3/2/26. Interview with APRN #1 on 3/3/26 at 9:00 AM identified that she was not made aware of the D-Mannose not being available until the facility notified her on 2/27/26 when she wrote alternative orders directing Cranberry tabs 450 milligrams (mg) to be given if D-Mannose was unavailable. (Please refer to F 580). Interview with the ADNS on 3/3/26 at 10:00 AM indicated that she was aware that D-Mannose was unavailable and the nurses and central supply had notified her sometime in February 2026 but could not recall the date. She indicated that she did not contact the pharmacy to inquire if D-Mannose was available as they have a formulary the facility follows. The ADNS also did not recall speaking to someone from the pharmacy on 2/3/26. In addition, she indicated that she had not notified APRN #1 but thought APRN #1 already knew that the D-Mannose was unavailable. 4. Resident #20 was admitted to the facility in August 2023 with diagnoses that included dementia with behaviors, sepsis, and type 2 diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #20 was severely cognitively impaired, required to be set up for meals and was dependent on staff for all other activities of daily living (ADLS). The Resident Care Plan (RCP) dated 1/26/26 identified Resident #20 had UTIs related to weakness and urosepsis (UTI that spreads to blood stream) with interventions that included monitoring vital signs, monitoring for signs and symptoms of UTIs and notify practitioner, provide frequent incontinent care as needed, encourage fluids during the day to promote prompt voiding, incontinent care before lunch, and monitor and report to MD any possible medical causes of incontinence. A progress note written by APRN #1 and dated 2/3/26 identified Resident #20 was at high risk for UTIs due to dementia, incontinence, use of briefs and limited mobility. Resident #20 to start on D-Mannose for urinary tract health and UTI monitoring once a shift for retention, urgency, frequency, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hematuria (blood in urine), dysuria (painful urination) and hesitation, encourage fluids, and follow up with urology as needed. Physician orders dated 2/3/26 directed to administer D-Mannose powder one scoop 2 times a day and urinary tract monitoring (UTI) every shift document in nursing notes and Advanced Practice Registered Nurse (APRN) book of any signs and symptoms of UTI. The Medication Administration Record (MAR) for February 2026 identified D-Mannose was not administered on 2/8/26 at 4:30 PM, 2/9/26 at 8:30 AM and 4:30 PM, 2/11/26 at 8:30 AM and 4:30 PM, 2/12/26 at 8:30 AM, 2/13/26 at 8:30 AM and 4:30 PM, 2/19/26 at 4:30 PM, 2/20/26 at 8:30 AM and 4:30 PM, 2/21/26 at 8:30 AM and 4:30 PM, 2/23/26 at 8:30 AM, 2/25/26 at 8:30 AM and 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM and 2/27/26 at 8:30 AM (a total of 19 missed doses) as it was coded as being unavailable. Nursing notes from 2/3/26 through 2/26/26 lacked documentation that the APRN was notified that Resident #7 and Resident #20 had missed doses of the D-Mannose. Interview, review of medical supplier packing slips (2/4/26 & 2/10/26) and observation of over-the counter (OTC) supply closet with the Central Supply Clerk on 2/27/26 at 11:20 AM identified that she was responsible for placing the over the counter (OTC) order for D-Mannose with the medical supply vendor. She indicated that she only placed orders for OTC medications from the medical supply vendor and the nurses were responsible for ordering medications including OTCs if needed from the pharmacy. She indicated on 2/4/26 she did not place an order for the D-Mannose (even though physician's orders were initiated on 2/3/26). An order was placed for 1 case of the D-Mannose powder (12 bottles in a case) on 2/10/26 from the medical supply vendor. The order had not yet come in from the vendor as of 2/27/26. The packing slips identified that no order was placed on 2/4/26 and an order was placed on 2/10/26 for one case. She indicated that she had made the Assistant Director of Nursing (ADNS) aware that the medication was on back order. She could not recall the exact date but as soon as she was made aware, she notified the ADNS, which was at least a week or two ago. On 2/27/26 at 11:20 AM an inspection of the OTC cabinet identified there was D-Mannose available. An interview with LPN #2 on 2/27/26 at 12:00 PM identified that there was not any D-Mannose in the medication carts and she could not administer the D-Mannose to any of her residents that were to receive the medication. She could not recall when it was last available, but she had made the ADNS and central supply aware when it was no longer available. Subsequent to surveyor inquiry, alternative orders were obtained from APRN #1 on 2/27/26 for Cranberry tabs 450 milligrams (mg) to be given if D-Mannose was unavailable for Resident #20. Interview with Pharmacy Manager on 3/3/26 at 8:30 AM identified that the pharmacy does have D-Mannose available for order in capsule form but not powder. She indicated that an initial order was received on 2/3/26 for Resident #7 however, when the pharmacy had called back (3 times) they were unable to get a response from the charge nurse or the supervisor regarding sending the D-Mannose. She indicated that a pharmacy technician had spoken to a nurse on 2/3/26 at 12:35 PM but was not sure who it was and was told not to send D-Mannose as it was an OTC medication. Interview with APRN #1 on 3/3/26 at 9:00 AM identified that she was not made aware of the D-Mannose not being available until the facility notified her on 2/27/26 when she wrote alternative (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	orders directing Cranberry tabs 450 milligrams (mg) to be given if D-Mannose was unavailable. (Please refer to F 580). Interview with the ADNS on 3/3/26 at 10:00 AM indicated that she was aware that D-Mannose was unavailable and the nurses and central supply had notified her sometime in February 2026 but could not recall the date. She indicated that she did not contact the pharmacy to inquire if D-Mannose was available as they have a formulary the facility follows. The ADNS also did not recall speaking to someone from the pharmacy on 2/3/26. In addition, she indicated that she had not notified APRN #1 but thought APRN #1 already knew that the D-Mannose was unavailable. Furthermore, she indicated that the nurses should not have signed off medication as given if it was not available and could not explain why it was signed off on one shift as given and documented on the following shift as being unavailable. A review of Medication Administration Policy (undated) directed, in part, if a dose or regularly scheduled medication is withheld, refused, not available or given at a time other than scheduled time, the space provided on the front of the MAR for that dosage administered is initialed and circled. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedure for the use of eMAR system. An explanatory note is entered. If XX consecutive doses of vital medication are withheld, refused or not available the physician is notified. Nursing documents the notification and physician's response. 5. Resident #65 had diagnoses that included senile degeneration of the brain, anxiety, and hypertension. A significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #65 was significantly cognitively impaired, was at risk for developing pressure ulcers, had a pressure reducing device for the chair and bed, and had applications of medication/ointment other than to the feet. Additionally, Resident #65 used a wheelchair, required substantial/maximal assistance with eating, and was dependent for bed mobility and transfers. A physician order dated 2/2/26 directed to complete a weekly body audit every Sunday on the 7:00 AM to 3:00 PM shift. The Resident Care Plan (RCP) dated 2/8/26 identified Resident #65 had the potential for pressure injury/skin impairment related to incontinence and impaired mobility. Interventions included a low air loss mattress to the bed with settings according to weight, check mattress placement and settings every shift, perform a weekly skin assessment, and for daily treatment: assess, monitor, record the wound healing/progress and report improvements and decline to the medical doctor (MD)/wound nurse. A physician progress note written by the wound physician and dated 2/11/26 at 10:47 AM identified Resident #65 was seen as a consultation for evaluation of wound(s). The note identified Resident #65 had an area of moisture associated skin damage (MASD) to the bilateral buttocks first evaluated on 2/11/26 that had a cluster of open areas and measured 2.5 centimeters (cm) long by 3.0 cm wide by 0.1 cm deep. Additionally, the wound base was 75-99% granulation tissue (moist bumpy red or pink tissue that forms on the surface of healing wounds) with moist scar tissue (dense fibrous connective tissue that replaces healthy tissue following an injury) noted to the periwound, and a moderate amount of serosanguinous (SS) drainage (thin watery wound drainage that is pink or red in color). The (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	note further identified the treatment recommendation was twice a day cleansing of the wound and apply Calcium Alginate (highly absorbent topical wound dressing) to the base of the wound followed by secure with a dry clean dressing (DCD). A physician order dated 2/18/26 directed to cleanse the bilateral buttocks with Normal Saline, followed by pat dry, followed by application of Collagen (advanced topical wound dressing), followed by applying Hydrogel (cut to fit) (water or glycerin-based sheet that provides moisture to dry wounds), followed by applying a dry clean dressing. Additionally, the order directed for that dressing to be performed two times a day on the day shift (7:00 AM to 3:00 PM) and the evening shift (3:00 PM to 11:00 PM), and then as needed for dislodgement or saturation of the dressing. A physician progress note written by the wound physician and dated 2/25/26 at 8:33 PM identified Resident #65 had an area of MASD to the bilateral buttocks (first evaluated on 2/11/26) that now had 2 open areas that were improved with delayed wound closure and measured 0.5 cm by 0.5 cm by 0.1 cm. Additionally, the wound base was 25-49 % epithelial tissue (light pink regenerated tissue formed during healing), and 50-74% granulation tissue with scar tissue noted to the peri wound, and a small amount of SS drainage. The note further identified the treatment recommendation was twice a day cleansing of the wound and applying Collagen followed by a Hydrogel sheet to the base of the wound followed by securing with a dry clean dressing. A Weekly Non-Pressure Wound Tracking Form completed by the wound nurse (the Assistant Director of Nursing Services) on 2/25/26 at 2:40 PM identified Resident #65 had a partial thickness (superficial) facility acquired wound of MASD to the bilateral buttocks with date of origin 2/11/26 that measured 0.5 cm by 0.5 cm by 0.1 cm, consisted of 2 open areas with 50% granulation tissue and 50% epithelial tissue, a small amount of SS drainage, and scar tissue to the peri wound (skin immediately surrounding a wound). Observation of Resident #65's dressing change and interview with Licensed Practical Nurse (LPN) #2 on 3/3/26 at 11:05 AM identified LPN #2 removed the used dry, clean dressing (DCD) covering the wound and then removed the used Collagen/Hydrogel that was placed over the wound located on the coccyx. Once the dressing was removed a wound was observed to the coccyx that appeared larger in size than the measurements documented on 2/25/26. The wound bed was observed to have greater than 75% slough tissue with remaining granulation tissue less than 25%. The slough tissue was observed to be yellow with brown coloring to the slough located at the center of the wound bed. There was a large amount of scar tissue noted to the entire peri wound. LPN #2 cleansed the wound and prepared the Collagen and Hydrogel to place on the wound. As LPN #2 proceeded to pick up and place the new Collagen and Hydrogel onto the wound she was requested by the surveyor to measure the wound bed. LPN #2 obtained a measuring device for the wound and upon returning she identified the wound had previously been 2 smaller areas located 1 on each buttock but now those were larger and had come together over the coccyx. She identified the wound had looked like this the previous day (3/2/26), but she could not recall what the wound had looked like when she worked on 2/27/26. Additionally, she identified she had not reported to the ADNS (wound nurse) or MD/APRN on 3/2/26 that the wound appeared different and that the wounds had merged into one larger wound because they were going to perform wound rounds on 3/4/26 so they would evaluate the wound at that time. Observation of Resident #65's wound and interview with the wound nurse/ADNS on 3/3/26 at 11:20 AM identified she could not recall if the current presentation of the wound was how it had looked on 2/25/26 during wound rounds without reviewing the documentation from 2/25/26. The ADNS measured the wound and identified the wound measured 2.2 cm by 3.6 cm by 0.1 cm and that 2 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	separate wounds originally only on the buttocks had merged into one wound that extended from each buttock and merged over the coccyx. She identified she would notify the wound MD. Subsequent to surveyor inquiry a Weekly Non-Pressure Wound Tracking Form completed by wound nurse the ADNS on 3/3/26 at 11:46 AM identified Resident #65 had a full thickness (deeper) facility acquired wound to the bilateral buttocks and coccyx with date of origin 2/11/26 that had worsened and measured 2.2 cm by 3.6 cm by 0.1 cm with 25% granulation tissue and 75% slough tissue, a moderate amount of SS drainage, and maceration (moist wrinkled skin) to the top edge of the peri wound. A new physician order dated 3/3/26 directed to cleanse the bilateral buttocks with Normal Saline, followed by patting dry, followed by applying Alginate, followed by applying a dry clean dressing. Additionally, the order directed for the dressing to be performed two times a day on the day shift and evening shift, and then as needed for dislodgement or saturation of dressing. Interview with the wound nurse/ADNS on 3/3/26 at 12:05 PM identified she had notified the wound MD, and APRN of Resident #65's new wound appearance and a new treatment order had been implemented. The ADNS further identified the nurses should report to her and/or the nursing supervisor when there was a deteriorating change in a wound appearance, and that LPN #2 should have notified her yesterday that Resident #65's wound appearance had changed. The Documentation policy directed, in part, nursing documentation is related to addressing resident needs and problems. The policy directed for treatments a description of the area treated is recorded weekly and when indicated such as a change in appearance, and that significant changes are noted and the physician notified. The Pressure Ulcer Policy directed, in part, risk factors that impact the development of pressure ulcers includes pressure points, moisture exposure of the skin to urinary and fecal incontinence, and impaired mobility. The policy directed the facility should have a system in place that assures changes in skin condition are recognized and reported to the residents' physician and wound nurse. The policy directed the facility shall provide treatment and services to prevent pressure ulcer development, identify and evaluate risk factors and changes in the resident's condition, and monitor the effectiveness of interventions. The policy further directed staff shall remain alert to potential changes in the resident's skin condition and shall evaluate and document identified changes on a daily basis and reported to the physician when applicable.

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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 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, review of the clinical record, and facility policy for the only resident reviewed for nutrition (Resident #62), the facility failed to provide adaptive equipment per the physician's order for a resident with dysphagia. The findings include: Resident #62's diagnosis included Type 2 diabetes mellitus, dysphagia (difficulty swallowing), and gastro-esophageal reflux disease.An Occupational Therapy (OT) requisition form for adaptive equipment dated 11/11/25 directed Resident #62 was to have a sippy cup, foam built-up utensils and the beverage cart list (which identified residents' need for adaptive equipment) had been updated. A physician's order dated 2/2/26 directed to provide a sippy cup and foam handle built up utensils for all meals. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #62 was moderately cognitively impaired, dependent with transfers, toileting, and bed mobility. The MDS indicated Resident #62 required setup or clean up assistance when eating and was on a mechanically altered and therapeutic diet. The Resident Care Plan (RCP) dated 2/17/26 identified Resident #62 required assistance with eating, had poor nutritional intake and a potential for a nutritional deficit. Interventions included to assist the resident with meals, to set-up at mealtime as needed and to consult with the dietician for nutritional concerns. Review of the Nurse Aide (NA) care card directed the use of a sippy cup and adaptive equipment with all meals.Observations on 2/25/26 at 12:30 PM and 2/26/26 at 12:42 PM noted Resident #62 in bed eating pasta and mashed potatoes and drinking water and juice without the benefit of foam handle built up utensils and a sippy cup. Resident #62 was observed with a regular utensil/spoon and a large clear cup without a handle for both meals.Review of the unit's beverage cart list (attached to the beverage cart and identified the residents' diets and adaptive equipment orders) dated 2/26/26 indicated Resident #62 required a sippy cup and foam handle utensils for breakfast, lunch, and dinner.Observation and interview with Licensed Practical Nurse (LPN) #1 on 2/27/26 at 12:42 PM identified Resident #62 was dining in his/her room and was in bed feeding him/herself mashed potatoes with regular utensils without the benefit of foam handle built up utensils and a sippy cup for his/her beverage. LPN #1 indicated it would have been the responsibility of the kitchen to send the adaptive equipment up to the unit, the Nurse Aide (NA) should have reviewed the beverage cart list and NA care card and ensured the resident was provided the foam handle built up utensils and sippy cup with his/her lunch. Observation, interview, and review of facility documents with the Director of Dietary on 2/27/26 at 12:46 PM identified Resident #62 was drinking from a Kennedy cup (a tall, lidded cup with a straw) and should have had a sippy cup (a short double handled cup with a sippy lid). The Director of Dietary further indicated Resident #62 should have been eating with foam built up utensils (which were sent from the kitchen and kept on the beverage cart) but the resident was eating with a regular spoon. The Director of Dietary proceeded to point out a clear bin on the beverage cart which contained the foam built up utensils and a sippy cup on top of the beverage cart and instructed NA #2 to provide them to the resident. The Director of Dietary stated it was the responsibility of the NA to provide adaptive equipment for Resident #62 and reviewed the beverage cart list with NA #2 and provided further education.Observation, interview, and review of facility documents with NA #2 on 2/27/26 at 12:48 PM identified she served and set up Resident #62 for lunch without the benefit of foam built up utensils and a sippy cup. NA #2 indicated she was not aware Resident #62 needed the foam built up utensils and sippy cup because she had failed to review the beverage cart list and NA care card prior to serving the residents meal. Review of the beverage cart list with the Director of Dietary and NA #2 indicated Resident #62 was to have a sippy cup and foam handle utensils for breakfast, lunch, and dinner. NA #2 proceeded to locate a sippy cup (on top of the beverage cart) and foam built up utensils (in a clear bin on the beverage cart that had a printed list on the lid which indicated the resident's room number and initials and ?red foam (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	handle utensils') and provided them to Resident #62. Resident #62 began eating chocolate ice cream with the red foam built up utensil/spoon. Review of the residents NA care card with NA #2 directed that Resident #62 was to have a sippy cup and adaptive equipment with all meals. Interview with Occupational Therapist (OT) #1 on 3/2/26 at 12:25 PM identified Resident #62 had difficulty while eating due to bilateral weak hand grip strength and required a sippy cup and foam handle built up utensils for all meals. OT #1 indicated the adaptive equipment was to promote independence for the resident and would ensure Resident #62 had increased meal intake. OT #1 identified it was the responsibility of the NA to ensure the resident was provided the adaptive equipment with each meal. OT #1 also noted if Resident #62 was not provided the foam handle built up utensils that could cause the resident to be unable to feed him/herself and decrease the resident's nutritional intake.Interview with the DNS on 3/2/26 at 12:39 PM identified the NA should have referred to the care card or the list on the beverage cart and provided the adaptive equipment to Resident #62 at mealtime. Additionally, the DNS identified she would need to conduct additional education with the NA's regarding adaptive equipment.Review of the facility policy, Nutrition Supervision of Resident, undated, directed residents were served diets as prescribed and to promote optimal health status. Adaptive, self-help devices are provided to contribute to the resident's independence in eating and the resident's diet card should be checked prior to serving the meal.

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, interview, and facility policy for 2 of 5 residents (Resident #31 and Resident #32) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure that a redetermination was submitted to the appropriate state agency when a short-term approval expired. The findings include: 1.Resident #31 was admitted to the facility in [DATE] with diagnoses that included schizophrenia, major depression, and moderate intellectual disabilities. A Level of Care Screening Assessment (determines what type of healthcare facility a person needs) was completed on [DATE] at the hospital prior to admission to the long term care facility with an approval for short-term 60 days (expired in [DATE]). A 5 day admission Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #31 did not have a serious mental illness that required a level 2 Preadmission Screening and Resident Review (PASRR) (ensures residents with certain conditions are appropriate placed and receive the services needed), was cognitively intact, required supervision and/or moderate assistance with activities of daily living (ADLS) and coded diagnoses of schizophrenia and depression. The Resident Care Plan (RCP) dated [DATE] identified Resident #31 was taking psychotropic drugs secondary to schizophrenia and depression. Interventions included administering medications per orders, monitor for side effects and dose reduction as indicated. In addition, the RCP identified that Resident #31 had been placed for long term care with interventions that included will receive daily opportunities for social contact, encourage to participate in conversations with other residents and provide situations as much as possible for the resident to control environment. Interview with Social Worker (SW) #1 on [DATE] at 11:45 AM identified that she had not submitted a redetermination when the 60-day approval had expired in [DATE]. SW #1 indicated that she was responsible for submitting the redetermination and it was an oversight that it was not completed. Subsequent to surveyor inquiry, SW #1 submitted to the contracted state agency for a new Level of Care Screening on [DATE] at 2:22PM (151 days after the 60-expiration date from the [DATE] submission). 2.Resident #32 was admitted to the facility on [DATE] with diagnoses that included catatonic schizophrenia, major depressive disorder with recurrent severe psychotic symptoms, and obsessive-compulsive disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #32 had severe cognitive impairment, was dependent for transfers, and was receiving antianxiety, antidepressant, and anticonvulsant medications. A Notice of PASSR Level I Screen Outcome dated [DATE], issued by the state contracted agency noted Resident #32 had a PASSAR condition and was approved to remain in the facility for up to 30 days from the date of admission without requiring a PASRR Level II screen. The notice also indicated that if Resident #32 required a stay beyond the 30ˆday period, a nursing facility representative must update the state contracted agency to submit an updated screen along with a completed Level of Care form on or before the 30th day of admission so that a PASRR Level II screen could be completed. (continued on next page)

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	The Resident Care Plan (RCP) dated [DATE] identified Resident #32 as having a PASRR positive status related to mental illness, specifically schizophrenia/schizoaffective disorder and major depressive disorder, requiring specialized services including physical therapy, occupational therapy, and psychiatric services. The RCP further indicated Resident #32 may require assistance with reasoning, learning, problemˆsolving, activities of daily living (ADLs), and behavior management. Identified interventions included supportive counseling provided by social services staff, family therapy, and ADL (activities of daily living) training as needed. Interview with Social Worker (SW) #1 on [DATE] at 11:30 AM identified Resident #32 was approved for a 30ˆday stay in the facility beginning on the date of admission ([DATE]). SW #1 stated that she was responsible for updating PASRR screens as required and acknowledged that Resident #32 should have an updated PASSAR Level I Screen and a Level of Care form submitted on or before [DATE], since the resident remained in the facility beyond the initial 30ˆday period. Social Worker #1 also indicated that an updated PASSAR Level I and/or Level of Care Screen was not completed by the contracted state agency. Subsequent to surveyor inquiry SW #1 submitted a PASSAR Level I and a Level of Care Screening request to the contracted state agency on [DATE]. A review of the Pre-admission Screening and Resident Review (PASRR) policy (undated) directed, in part, it is the policy of the facility to assure all residents admitted to the facility receive a PASARR in accordance with state and federal regulations. The facility will coordinate assessments with the PASRR program under Medicaid in subpart C to this part to maximum extent practicable to avoid duplicative testing and effort. Coordination includes incorporating the recommendations for the PASRR level 2 determination and the PASRR evaluation report into a resident' assessment, care planning and transitions of care. Referring to all level 2 residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level 2 resident review upon a significant change in resident status assessment.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	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 interviews, review of the medical record, facility documentation, observations, and facility policy for 3 of 3 residents (Resident #7, Resident #14 and Resident #20) reviewed for urinary tract infections, the facility failed to ensure the Medication Administration Record (MAR) related to medication administration contained accurate documentation. The findings include: 1.Resident #7 was admitted to the facility in October 2025 with diagnoses that included dementia, urinary retention with chronic foley use and urinary tract infections (UTI). The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #7 was severely cognitively impaired and required set up for meals, moderate assistance for activities of daily living (ADLs) and had a urinary foley catheter. Physician orders dated 2/3/26 directed to administer D-Mannose (supplement used for prevention of UTIs) 1 scoop of powder two times a day. The Resident Care Plan (RCP) dated 2/6/26 identified Resident #7 had Catheter-Associated UTIs related to indwelling urinary catheter use with interventions that included to change catheter tubing as indicated, monitor for evidence of catheter blockage or leakage, flush per physician's orders, monitor for signs and symptoms of UTI, and perform careful peri-care. The Medication Administration Record (MAR) for February 2026 identified that D-Mannose was not administered on 2/13/26 at 8:30 AM (but at 4:30 PM and on 2/25/26 at 8:30 AM signed as administered despite being unavailable on previous and subsequent days/shifts), 2/25/26 at 4:30 PM, 2/26/26 at 8:30 AM and 4:30 PM and 2/27/26 at 8:30 AM (a total of 5 missed doses) as it was coded as being unavailable. An Advanced Practice Registered Nurse (APRN) #1 progress note dated 2/24/26 indicated that Resident #7 was at high risk for developing UTIs due to having a chronic urinary foley and poor fluid/ food intake. 2.Resident #14 had diagnoses that included dementia, diabetes, benign prostatic hyperplasia (BPH) (enlarged prostate) and calculus of ureter (kidney stone). The Resident Care Plan (RCP) dated 12/11/25 identified Resident #14 was incontinent of bowel and bladder related to impaired mobility. Interventions included to offer the urinal every 2 hours and monitor for signs and symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, no urinary output, elevated temperature, urinary frequency, foul smelling urine, altered mental status, and change in eating habits. The RCP further identified Resident #14 was at risk for urinary complications related to BPH. Interventions included administering medications as ordered, monitoring for dysuria, hematuria, urgency, and frequency of urination, and report changes to the medical doctor. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was cognitively intact, had no behavior symptoms, had no rejections of care, had urinary incontinence, (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	was not on a urinary toileting program, required setup or clean-up assistance with eating, and was dependent for bed mobility and transfers. A physician order dated 2/3/26 directed to administer D-Mannose oral powder (a supplement used for prevention of UTIs) 1 scoop by mouth 2 times a day for UTI prevention. The Medication Administration Record (MAR) for February 2026 identified D-Mannose was not administered 22 out of 51 opportunities (43.1%) and was coded in the electronic medical record as being unavailable. The MAR further identified that during the timespan when the D-Mannose was unavailable, there were 3 administration times when D-Mannose was documented as given (when it was unavailable prior to and after documentation D-Mannose administered) when it was coded as unavailable at the administration time on the same day and/or the previous day: on 2/9/26 at 4:30 PM (it was coded unavailable for 2 administration times prior on 2/8/26 at 4:30 PM and 2/9/26 at 8:30 PM and the next administration time after on 2/10/26 at 8:30 AM); on 2/10/26 at 4:30 PM (it was coded unavailable for the administration time prior on 2/10/26 at 8:30 AM and the next administration time after on 2/11/26 at 8:30 AM); and on 2/21/26 at 4:30 PM (it was coded unavailable for the administration time prior on 2/21/26 at 8:30 AM and the next administration time after on 2/22/26 at 8:30 AM). Interview with Licensed Practical Nurse (LPN) #2 on 2/27/26 at 1:48 PM identified D-Mannose was not available on the medication cart and that it had been unavailable since about 2/20/26. 3.Resident #20 was admitted to the facility in August 2023 with diagnoses that included dementia with behaviors, sepsis, and Type 2 diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #20 was severely cognitively impaired, required set up for meals and was dependent on staff for all other activities of daily living (ADLS). The Resident Care Plan (RCP) dated 1/26/26 identified Resident #20 had UTIs related to weakness and urosepsis (UTI that spreads to blood stream) with interventions that included monitoring vitals, monitoring for signs and symptoms of UTIs and notify practitioner, provide frequent incontinent care as needed, encourage fluids during the day to promote prompt voiding, incontinent care before lunch, and monitor and report to MD any possible medical causes of incontinence. A progress note written by APRN #1's and dated 2/3/26 identified Resident #20 was at high risk for UTIs due to dementia, incontinence, use of briefs and limited mobility. Resident #20 to start on D-Mannose for urinary tract health and UTI monitoring once a shift for retention, urgency, frequency, hematuria (blood in urine), dysuria (painful urination) and hesitation, encourage fluids, and follow up with urology as needed. Physician orders dated 2/3/26 directed to administer D-Mannose powder one scoop 2 times a day and urinary tract monitoring (UTI) every shift document in nursing notes and Advanced Practice Registered Nurse (APRN) book of any signs and symptoms of UTI. The Medication Administration Record (MAR) for February 2026 identified that D-Mannose was not administered on the following days in February as it was unavailable but documented as given on another shift on the same day. The MAR was signed as given at 8:30AM unavailable on 2/8/26 at 4:30PM, 2/12/26 at 8:30AM as unavailable at 8:30AM but given at 4:30PM, 2/19/26 given at 8:30AM (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	available at 4:30PM, 2/23/26 unavailable at 8:30AM given at 4:30PM (4 shifts with conflicting documentation of availability of medication for administration). Interview, review of medical supplier packing slips (2/4/26 & 2/10/26) and observation of over-the counter (OTC) supply closet on 2/2/7/26 at 11:20 AM with the Central Supply Clerk identified that she was responsible for placing OTC orders for D-Mannose with the medical supply vendor. She indicated that she only placed orders for OTC medications from the medical supply vendor and the nurses were responsible for ordering medications including OTCs if needed from the pharmacy. She indicated on 2/4/26 she did not place an order for D-Mannose (even though physician's orders were initiated on 2/3/26). An order was placed for 1 case of the D-Mannose powder (12 bottles in a case) on 2/10/26 from the medical supply vendor. The order had not yet come in from the vendor as of 2/27/26 (despite nursing signing off on the MAR as administering D-Mannose powder when it was not in the building). The packing slips identified that no order was placed on 2/4/26 and an order was placed on 2/10/26 for one case. An interview with LPN #2 on 2/27/26 at 12:00 PM identified that there was no D-Mannose in any of the medication carts and she could not administer the D-Mannose to any of her residents that were to receive the medication. She could not recall when it was last available, but she had made the ADNS and central supply aware when it was no longer available. LPN #2 stated that she unsure how nurses were signing off that the medication was given after she had signed that the medication was unavailable as she was certain that the medication was not available in the facility. Interview with the ADNS on 3/3/26 at 10:00 AM indicated that she was aware that D-Mannose was unavailable and the nurses and central supply had notified her sometime in February, but she could not recall the date. Furthermore, she indicated that the nurses should not have signed off medication as given if it was not available and could not explain why it was signed off on one shift as given and documented on the following shift as being unavailable. A review of Medication Administration Policy (undated) directed, in part, If a dose or regularly scheduled medication is withheld, refused, not available or given at a time other than scheduled time, the space provided on the front of the MAR for that dosage administered is initialed and circled. If electronic MAR is used, documentation of the unadministered dose is done as instructed by the procedure for the use of eMAR system. An explanatory note is entered. If XX consecutive doses of vital medication are withheld, refused or not available the physician is notified. Nursing documents the notification and physician's response.