STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075296	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Road Branford, CT 06405

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 6 residents (Resident #57) reviewed for activities of daily living, the facility failed to ensure podiatry services were provided timely. The findings include: Resident #57 was admitted to the facility in January 2024 with diagnoses that included Alzheimer's disease, onychomycosis (fungal infection of the toenails), and left and right toe pain. A Physician Consult Form dated 1/30/24 and signed by Resident #57 identified he/she agreed for podiatry services contracted by the facility. A podiatry consult form dated 3/20/25 identified Resident #57 had moderately aching, painful toenails in shoes and with pressure and walking which was alleviated by cutting nails out. Treatment was rendered as appropriate with the aim of allowing the resident to ambulate and use shoes without pain. Follow-up was indicated to occur in 2-3 months. A physician's order dated 7/25/25 and currently in effect directed a podiatry consult would be obtained as needed for resident health and comfort. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #57 was severely cognitively impaired and was dependent with transfers and toileting and required substantial/maximal assistance with bed mobility. The Resident Care Plan dated 1/13/26 identified Resident #57 had a self-care deficit and needed staff assistance with activities of daily living (ADLS) related to weakness and dementia. Interventions included to set up and assist the resident as needed, nails to be cleaned and filed and obtain podiatry consult as needed for resident health and comfort. Observation on 1/28/26 at 12:04 PM noted Resident #57 seated barefoot in a chair in his/her room. His/her toenails on both feet were extremely lengthy and thick. bilaterally barefoot and seated in a chair with extremely lengthy and thick toenails on both feet. Interview and review of the clinical record with the DNS on 1/29/26 at 12:00 PM identified Resident #57 was last seen for a podiatry consult at the facility on 3/20/25. The DNS indicated Resident #57 was out of the facility for a hospitalization in July 2026 and she would need to put the resident on the list to be seen by podiatry. Interview and review of the clinical record with the Chief Executive Officer (CEO) of the podiatry consult company on 1/29/26 at 2:51 PM identified the podiatrist came to the facility weekly and would know a resident needed services when an enrollment form was received. Review of the clinical record with the CEO indicated an enrollment form for Resident #57 was on file from 2024 and the resident had been receiving services since then. The CEO further identified Resident #57 was last seen for podiatry services on 3/20/25 because the facility had informed them the resident was discharged . The CEO further stated she was just notified of Resident #57's return to the facility subsequent to surveyor inquiry with the facility. Interview and review of the clinical record with Director of Social Services (SW) #1 on 1/29/26 at 1:15 PM identified Resident #57 went out to the hospital on 7/7/25 and returned on 7/25/25. The resident also went to the emergency department overnight on 1/2/26 and returned on 1/3/26. SW #1 indicated Resident #57 had otherwise been in the facility and had no other transfers or discharges other than what she identified. Another interview, observation, and review of the clinical record with the DNS on 2/5/26 at 10:30 AM identified Resident #57 had not received podiatry services after his/her re-admission to the facility on 7/25/25 (despite the podiatrist being at the facility on a monthly basis). Observation of the resident's feet/toenails (continued on next page)

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

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the DNS indicated extremely lengthy and thickened toenails on both feet. The DNS stated she would have expected the nurse aide (NA) to have observed the condition of the resident's feet and notified the charge nurse or unit manager that the residents feet needed attention. The DNS indicated the nursing staff should have assessed the resident's feet and put Resident #57 on the podiatry list again. Additionally, the DNS identified the facility had failed to notify the consulting podiatrist company that the resident had returned to the facility on 7/25/25 which led to the delay in podiatry care for Resident #57. Review of the facility policy, Foot Care, undated, directed nursing personnel would provide routine foot care during AM care and report any signs of discoloration, lesions, or redness to the physician. Review of the facility policy, Consultations Policy, undated, directed residents of the facility will have consultation services provided and the facility will do all it can to arrange for in-house consults. Podiatry, Dental, Ophthalmology, and Audiology can be provided in house.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on a tour of the Dietary Department, review of facility policy and staff interview, the facility failed to ensure stored food was dated when opened, expired food was discarded, and a cleaning chemical was not stored in a refrigerator designated for resident food. The findings included: A tour of the Dietary Department on 1/27/26 at 10:31 AM with the Food Service Director (FSD) identified:1. The walk-in freezer was observed to have the following items with open boxes that contained opened plastic bags within the boxes that were undated when they were opened:a. One opened plastic bag of riblets (1/4 full)b. One opened plastic bag of onion rings (1/2 full)c. One opened plastic bag of pork chops (1/2 full)d. One opened plastic bag of hamburger patties (3/4 full)e. One opened plastic bag of fish cakes (3/4 full)f. One opened plastic bag of meatballs (1/2 full)g. One opened plastic bag of stuffed shells (1/2 full)h. One opened plastic bag of French Toast sticks (3/4 full) 2. In Reach in Cooler #3, the following items were being stored in the refrigerator and were not dated when they were opened, were expired or did not contain an expiration date:a. One 96-ounce container of sour cream (1/4 full), expired on 12/22/25b. One 128-ounce container of Caesar Dressing (1/8 full), no expiration datec. One 128-ounce container of Italian Dressing (3/4 full), no expiration date 3. In Reach in Cooler #3, the following items were being stored in the refrigerator and were not dated when they were opened:a. One 96-ounce container of sour cream (1/2 full)b. One 96-ounce container of cottage cheese (1/2 full)c. Two 1-pound blocks of butter (1/2 blocks) wrapped in plastic wrap (out of original packaging)d. One 128-ounce container of mayonnaise (3/4 full)Additionally, one 32-ounce spray bottle of Clorox Clean-Up Cleaner with Bleach (3/4 full) was observed on the 2nd shelf 4. In Reach in Cooler #3, the following foods were being stored in the refrigerator:a. an unidentified portion of pink colored raw meat wrapped in aluminum foilb. 3/4 of one cut onion that was uncovered5. In the dry goods storage area, the FSD identified the following foods were not dated when opened with packages resealed:a. One 5-pound package of egg noodles (1/2 full)b. One 5-pound package of elbow pasta (1/2 full)c. One 5-pound package of spaghetti pasta (3/4 full) 6. In the kitchen food prep area, the FSD identified the following foods were not dated when opened, were expired, or did not identify an expiration date:a. One 24-ounce bottle of Lemon extract (1/4 full), opened and undated, expired 3/2/23b. One 12-ounce container of Cream of Tartar (1/4 full) with no open date, sticker indicated it was received in 2019 with no expiration date.c. One 5-ounce container of Dill weed (1/4 full) with no open date, expired 1/1/26d. One 12-ounce container of Poultry seasoning (1/2 full) with no open date and no expiration datee. One 5-ounce container of Bay leaves (1/4 full) with no open date and no expiration datef. One 12-ounce container Black pepper (1/2 full) with no open date and no expiration dateg. One 12-ounce bottle of Balsamic glaze (1/2 full) with no open date and no expiration date 7. In the kitchen food prep area, the FSD identified the following foods were not dated when opened:a. One 20-ounce container of Celery salt (1/4 full)b. One 22-ounce container of Ground cumin (1/2 full)c. One 22-ounce container Granulated garlic (3/4 full)d. One 96-ounce box of Mashed potatoes (1/2 full)e. One 12-ounce container of Whole celery seed (1/3 full)f. One 12-ounce bottle of Imitation vanilla (1/2 full)g. One 16-ounce package of Powdered sugar 1/2 fullh. One 6-ounce container of Old Bay seasoning 3/4 fullInterview with the FSD at that time identified that he had instructed dietary staff to date items when opened and he must have left the cleaning chemical inside Cooler #3. The FSD indicated that all dietary staff were responsible for dating items when the packaging was opened, it was facility policy to date every product when opened and to discard expired products. Facility policy regarding Storage of Frozen and Refrigerated Foods (undated) directed to properly re-seal packages of frozen foods that have been opened to prevent freezer burns and spoilage and label and date all leftovers and refrigerate immediately. Facility policy regarding Storage of Dry Food and Supplies, dated 7/20/15, directed to reseal open boxes effectively and bulk pasta is to be stored in properly labeled and sealed containers or tightly closed food grade plastic bags after being opened.Review of (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the safety data sheet (SDS) for Clorox Clean-Up Cleaner with Bleach directed advice on general occupational hygiene was to avoid contact with the eyes and prolonged skin contact and storage precautions were to store in a cool and well-ventilated space.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, review of the clinical record and facility policy for 1 of 5 residents (Resident #3) reviewed for transmission-based precautions, the facility failed notify the resident of the need and reason for isolation precautions and the facility failed to ensure isolation precautions were maintained for a resident with an undiagnosed respiratory illness. Additionally, for 1 of 3 residents (Resident #124) reviewed for Enhanced Barrier Precautions (EBP), the facility failed to donn (wear) the appropriate Personal Protective Equipment (PPE) during care of a gastrostomy tube, and for 1 of 3 residents (Resident #144) reviewed for pressure ulcers, the facility failed to ensure infection control standards of practice were followed during a dressing change. The findings include: 1.Resident #3's diagnoses included an autoimmune disease of the central nervous system, gastrostomy status, and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was cognitively intact and had upper and lower extremity impairments. The MDS indicated Resident #2 was dependent with bed mobility, toileting, and transfers. The Resident Care Plan dated 11/25/25 identified Resident #3 was on Enhanced Barrier Precautions and had a urostomy (urinary tube) and gastrostomy (feeding) tube. Interventions included staff must wear gloves, gown and a mask when performing device care or direct care of the resident. An Advanced Practice Registered Nurse (APRN) progress noted dated 1/22/26 at 3:39 PM identified Resident #3 was being seen for new onset cough and congestion and the resident was reporting fatigue and feeling generally unwell. The resident's assessment indicated nasal congestion with decreased breath sounds bilaterally and an upper respiratory infection with cough and congestion. A physician's order dated 1/24/26 directed infection precautions of droplet/contact every shift for suspected viral illness for 7 days. A nursing note dated 1/26/26 at 11:34 PM identified droplet precautions were maintained, the resident had no signs or symptoms of respiratory distress and had an occasional non-productive cough. Initial tour observation and interview on 1/27/26 at 12:15 PM identified Resident #3 was in a wheelchair sitting outside the doorway of his/her room with a visitor. Although a sign outside of the resident's room indicated Contact/Droplet Precautions and to wear a mask, the resident and visitor were without the benefit of wearing masks. Resident #3 indicated he/she was not aware he/she was on isolation precautions and he/she had not been directed by staff to wear a mask if outside of his/her room. Interview and review of the clinical record with LPN #2 on 1/27/26 at 12:18 PM identified Resident #3 was on Contact/Droplet precautions for symptoms of an undiagnosed viral respiratory illness and per the physician's order the resident was to be on precautions until 1/31/26. LPN #2 indicated Resident #2 had a cough and congestion and was put on precautions a few days ago. An observation on 1/27/26 at 1:30 PM noted Resident #3 and his/her visitor in the hallway, getting on the elevator to the ground floor without the benefit of wearing masks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation on 1/27/26 at 2:00 PM noted Resident #3 and his/her visitor in the resident lounge with the door closed without the benefit of wearing masks in the presence of 7 other unmasked residents. An observation on 1/27/26 at 3:00 PM noted Resident #3 seated in a wheelchair with his/her eyes closed in a recreation room on another unit of the facility without the benefit of masks. An interview and review of the clinical record with the Infection Preventionist (LPN #3) on 1/29/26 at 10:30 AM identified Resident #3 was placed on contact/droplet precautions for an undiagnosed viral respiratory illness on 1/24/26. Review of the clinical record with LPN #3 failed to indicate documentation that the resident had been informed of the reason and need for contact/droplet precautions. LPN #3 identified the resident should have been made aware and should not have been out of his/her room without a mask on. LPN #3 indicated it would have been the responsibility of the nursing staff to ensure Resident #3 was not out of his/her room, off the floor or in common areas with other residents without a mask on. Another interview and review of the clinical record with LPN #2 on 1/29/26 at 12:52 PM identified LPN #3 put Resident #3 on contact/droplet precautions and should have notified and educated the resident about not leaving his/her room and visitors needed to wear a mask. Review of the clinical record with LPN #2 failed to indicate documentation that the resident had been informed of the reason and need for contact/droplet precautions. LPN #2 indicated she and the nursing staff on the unit should have made sure if the resident was leaving his/her room the resident should have worn a mask and anyone visiting should have worn a mask but failed to notice Resident #3 was out of his/her room on 1/27/26 without a mask. Another interview with the Infection Preventionist (LPN #3) on 1/30/26 at 11:30 AM identified she was being proactive when she put Resident #3 on droplet/contact precautions, and it was due to the resident having respiratory symptoms. LPN #3 indicated although other viral respiratory illnesses (Influenza and RSV) were present on Resident #2's unit, the resident was only tested for COVID. LPN #3 was unsure if Resident #3 was updated about being put on precautions and the charge nurse would have been responsible to inform and educate the resident when the resident was put on precautions. LPN #3 identified Resident #3 should have been encouraged to stay in his/her room or put on a mask if leaving the room and any visitors should have been informed to wear a mask. Interview with the DNS on 2/5/26 at 10:30 AM identified it would have been the responsibility of the charge nurse or unit manager to inform Resident #3 when and why he/she was being put on contact/droplet precautions. The DNS indicated it would have been the responsibility of the nursing staff ensure the resident was not outside of his/her room or on other units of the facility without the benefit of a mask and the nursing staff should have noticed and intervened when that was happening. Review of the facility policy, Transmission Based Precautions, undated, directed contact/droplet precautions would be initiated for an individual documented or suspected to be infected with microorganisms that can be transmitted by coughing, sneezing, or talking. While on contact/droplet precautions residents should be strongly encouraged to stay in the room and if unable a surgical mask should be encouraged. 2. Resident #124 had diagnoses that included diabetes, dementia, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #124 was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severely cognitively impaired, had a feeding tube and received 51% or more of his/her total calories through the feeding tube. The MDS assessment further identified Resident #124 used a wheelchair, and was dependent for eating, bed mobility, and chair/bed transfers. The Resident Care Plan (RCP) dated 12/15/25 identified Resident #124 required Enhanced Barrier Precautions (EBP) related to the presence of an indwelling medical device (feeding tube). Interventions included staff must wear gloves, gown and a mask when performing device care or use of a feeding tube (however the EBP policy identified only a gown and gloves was required). The RCP further identified Resident #124 had a feeding tube in place to assist with maintaining nutritional status due to inadequate oral intake. Interventions included check placement of tubing as ordered, ensure the head of the bed is elevated per physician order, and provide nutrition and flushes via the feeding tube per physician orders. A physician order dated 1/29/26 directed to utilize EBP related to Resident #124's gastronomy tube (g-tube) every shift (7:00 AM to 3:00 PM, 3:00 PM to 11:00 PM, and 11:00 PM to 7:00 AM). Observation of Registered Nurse (RN) #3 performing care of the g-tube on 1/30/26 at 12:15 PM identified RN #3 collected the supplies (tube feed bottle, tubing, piston syringe). RN #3 performed hand hygiene with an alcohol based hand rub (ABHR) then labeled and dated the bottle of tube feed (Jevity 1.5) and brought the bottle of tube feed and additional supplies into Resident #124's room. RN #3 opened the tubing package, spiked the bottle of tube feed with the end of the tubing and hung the bottle on the pole above the tube feeding pump. RN #3 then applied a pair of gloves to his hands, loaded the tubing into the pump, programmed the pump settings to 67 milliliters (ml) per hour with a goal of 1206 mls. RN #3 then spoke to Resident #124 and explained that he would be hooking up the tubing to his/her g-tube so that he could administer the tube feeding. RN #3 then attached the end of a 30-ml syringe to Resident #124's g-tube stopcock and pulled back on the syringe to aspirate the residual stomach contents. RN #3 indicated there were 10 mls of residual tube feed in the syringe, and then he pushed on the syringe plunger to return the 10 mls of residual. RN #3 then disconnected the syringe, pulled the plunger out of the syringe and replaced the syringe without the plunger back onto the g-tube stopcock and proceeded to administer a 150 ml water flush by filling the syringe with 30 ml of water at a time and allowing it to enter the g-tube via gravity. Once the 150 ml of water was administered, RN #3 removed the syringe, he hooked the end of the tube feed tubing onto the g-tube stopcock and pressed the start button to initiate the tube feed. RN #3 told Resident #124 that everything was all set and the tube feeding was in progress. RN #3 picked up all trash and discarded it, removed his gloves, and performed hand hygiene. Interview and observation of the EBP signage posted outside Resident #124's room with RN #3 on 1/30/26 at 12:25 PM identified the signage posted on the wall outside Resident #124's room was there to identify Resident #124 was on EBP. RN #3 identified the EBP sign indicated that PPE consisting of a gown and gloves were supposed to be worn by staff when performing direct care for Resident #124. RN #3 identified flushing, checking residual, and administration of the tube feed were direct care activities for which PPE was to be worn. RN #3 identified he should have been wearing a gown in addition to his gloves when he performed care of Resident #124's g-tube. RN #3 identified he had not worn a gown because he had forgotten to put the gown on before entering the room Interview with the DNS on 2/5/26 at 3:15 PM identified RN #3 should have followed EBP directions and worn all necessary PPE (gown and gloves) while checking the residual and managing the tube feeding for Resident #124. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Enhanced Barrier Policy directed, in part, EBP were an infection control intervention intended to reduce transmission of multidrug-resistant organisms during high contact resident care activities. The policy directed EBP included the putting on of gown and gloves during high contact resident care activities. The policy directed EBP was indicated for residents with an indwelling medical device which included feeding tubes. The policy indicated that when EBP was indicated for a resident it was to be utilized when performing high contact resident care activities which included the care or use of a feeding tube. 3. Resident #144 was admitted in November 2025 with diagnoses that included elevated white blood cells, malignant neoplasm of the colon and depression. A 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #141 was unable to complete A Brief Interview for Mental Status due to cognitive impairment and required moderate assistance of 1 staff member for activities of daily living including bed mobility. The MDS further identified that Resident #141 was at risk for pressure ulcers and had a (1) Stage 3 pressure ulcer (loss of the top 2 layers of skin and fatty tissue). The Resident Care Plan (RCP) dated 1/13/26 identified Stage 3 pressure ulcers to the coccyx and right buttock. Interventions included treatments per physician orders, low air loss mattress, Braden Scale per policy, skin check weekly, monitor effectiveness of treatment, incontinent care as needed, provide good nutrition and hydration including supplements as ordered, wound consultant as needed and turn and position per standards of care/policy, and pressure reducing cushion to wheelchair A Wound Assessment Report completed by the Wound Physician (MD #1) on 1/19/26 identified that Resident #141 had a Stage 3 pressure ulcer to the coccyx and a Stage 3 pressure ulcer to the right buttock. The coccyx wound measurements were 2.0 centimeters (cm) length by 1.50 cm width by 0.1 cm depth that was worsening with 75-99% slough (dead tissue). The wound had moderate amount of serous drainage (clear/yellow fluid) with no order. The coccyx wound was in-house acquired on 11/25/25 (discrepancy regarding onsite date). The right buttock had a Stage 3 wound with measurement 1.0 cm length by 1.0 cm width by 0.1 cm depth. The wound contained 75-100% granulation tissue (new connective tissue) with a moderate amount of serous drainage with no odor. The right buttock wound was in-house acquired on 1/13/26. Physician orders dated 1/19/26 directed to cleanse the coccyx area, apply Metronidazole gel 0.7% (antibiotic gel) with Santyl Ointment (removes dead tissue) and Calcium Alginate (highly absorbent dressing) and apply a dry, clean dressing. Coccyx dressing to be changed twice a day and as needed. Additionally, physician orders directed to cleanse the right buttock and apply Santyl Ointment and Calcium Alginate and apply a dry, clean dressing. Right buttock dressing to be changed twice a day and as needed. Observation of the dressing change on 1/29/26 at 10:45 AM with Registered Nurse (RN) #5 identified that RN #5 attempted to apply the adherent secondary cover dressing over the Calcium Alginate to Resident #141's coccyx but the dressing size was too large. RN #5 removed the secondary cover dressing that was too large and proceeded to obtain a smaller adherent secondary cover dressing and apply it to Resident #141's coccyx. RN #5 then proceeded to apply Calcium Alginate and an adherent secondary cover dressing to Resident #141's right buttock without the benefit of performing hand hygiene or changing gloves after the treatment to Resident #141's coccyx. Interview with RN #5 (with the ADNS present) on 1/29/26 at 11:30 AM identified that RN #5 should (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have performed hand hygiene and changed gloves before applying the treatment from the coccyx to Resident #141's right buttock. RN #5 indicated that she should have treated the wound separately and performed hand hygiene and changed gloves before initiating the treatment to Resident #141's right buttock. RN #5 indicated that if a resident has 2 wounds even in the same area, the wounds were to be to be treated individually when performing a dressing change. RN #5 indicated that she was aware that she made an error when performing the dressing change, was nervous and forgot to perform hand hygiene and change gloves. Interview with the Wound MD (MD#1) on 1/30/26 at 2:15 PM identified that RN #5 should have performed hand hygiene and changed gloves after the treatment to Resident #141's coccyx before proceeding to the right buttock wound treatment. MD #1 indicated that each wound needed to be treated individually to prevent any contamination to wounds. The Skin Assessment and Pressure Ulcer Prevention Policy dated 1/2025 directed, in part, it is the policy of the facility that a resident who is admitted without a pressure ulcer does not develop a pressure ulcer unless clinically unavoidable. Any resident who has a pressure ulcer will receive care and services to promote healing and prevent additional ulcers. The CDC Infection Control practical applications in wound care dated 4/12/24 directed that change gloves between treating one wound and another on the same patient when there is a risk of transferring organisms from one wound site to another. Clean and dress one wound completely before moving to the next, with hand hygiene and fresh PPE between steps.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of clinical record, interviews and facility policy for 2 of 6 (Resident #41 and Resident #58) residents reviewed for activities of daily living (ADLs), the facility failed to ensure the care plan was comprehensive to include refusals for shaving for Resident #41 and trimming of fingernails for Resident #58. The findings include: 1.Resident #41 was admitted to the facility in October 2025 with diagnoses that included Parkinson's disease, dementia, and anxiety. Physician orders dated 10/14/25 directed assistance of 1 with ADLsThe admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 was severely cognitively impaired and required moderate assistance of 1 staff member for personal hygiene. The Resident Care Plan (RCP) dated 10/20/25 identified Resident #41 required assistance with activities of daily living related to recent hospitalization. Interventions included to assist as needed with toileting needs, assist of 1 for bed mobility, transfer and ambulation with assist of 1, deliver meal and assist with set up as needed, may fluctuate in ability to perform ADLs due to my cognitive status assist as needed. The RCP failed to reflect Resident #41's refusals for ADL care/shaving.Observations on 1/27/26 at 10:40 AM, 1/28/26 at 12:01 PM, and 1/29/26 at 11:23 AM noted Resident #41 to be unshaven with 1/2 inch hair growth on his/her chin and cheeks. In addition, an electric razor was observed on top of Resident #41's bedside dresser in the same location on all 3 observations. Furthermore, Resident #41's hair was oily and unkept. The Resident Care Flowsheet indicated that Resident #41's shower days were scheduled for every Friday on 7:00 AM to 3:00 PM shift. No refusals were documented regarding showers when reviewed for the month of January 2026.Interview with the DNS on 1/29/26 at 11:00 AM indicated that residents were shaved with ADL care and as needed. If a resident refused care, then it would be documented in the resident care flowsheets by the Nurse Aids (NA). An interview and review of Resident #41's RCP with LPN #1 (Corporate MDS Director) on 1/29/26 at 12:05 PM identified that Resident #41 did not have a care plan for refusing shaving. LPN #1 indicated that nursing was responsible to ensure that care plans were comprehensive and individualized. LPN #1 indicated that Resident #41's care plan should reflect refusals if he/she did not allow staff to shave him/her. Furthermore, LPN #1 indicated that it was the facility policy for care plans to be updated quarterly and as needed with changes.Subsequent to surveyor inquiry, observation of Resident #41 on 1/30/26 at 1:30 PM no longer had facial hair and had been shaven.Interview with Nurse Aide (NA) #2 on 2/5/26 at 8:45 AM indicated that Resident #41 often refused to be shaved and could become combative at times. NA #2 stated she had attempted to shave Resident #41, but Resident #41 had refused several times during the week. Furthermore, NA #2 indicated that Resident #41's electric razor was no longer functioning, and she had to use a disposable razor for shaving. NA #2 indicated that when Resident #41 was admitted , he/she had lots of facial hair, and the responsible party had requested that he/she be shaved regularly.2. Resident #58 was admitted to the facility in January 2026 with diagnoses that included dementia, adjustment disorder, and generalized muscle weakness. Physician orders dated 1/12/26 directed to provide assistance of 1 with activities of daily living (ADLs).A 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #58 was severely cognitively impaired and required maximum assistance with ADLs.The Resident Care Plan (RCP) dated 1/20/26 identified Resident #58 required assistance with ADLs related to weakness and deconditioning from a recent hospitalization. Interventions included to assist with toileting and incontinent needs, assistance with oral hygiene, assist with bed mobility, and ensure glasses were clean and available. Additionally, the RCP indicated Resident #58 may fluctuate in ability to perform ADLs due to cognitive status and diagnosis, therapy as ordered and transfers per MD orders. The RCP failed to reflect Resident #58's refusal to have his/her nails trimmed or desire to have extremely long fingernails.Observations on 1/27/26 at 12:00 PM, 1/28/26 at 9:28 AM, and 1/29/26 at 11:25 AM noted Resident #58's fingernails (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were extremely long, sharp and pointed. The Resident Care Flowsheet indicated that Resident #58's shower day was on Mondays on the 7:00 AM to 3:00 PM shift.Interview with the DNS on 1/29/26 at 11:00 AM indicated that fingernails were trimmed on shower days and as needed and that she was unaware that Resident #58's fingernails were extremely long.An interview and review of Resident #58's RCP with LPN #1 (corporate MDS Director) on 1/29/26 at 12:05 PM identified that Resident #58 did not have a care plan for refusing to have fingernails trimmed and/or the desire to have long fingernails. LPN #1 indicated that nursing was responsible to ensure that care plans were comprehensive and individualized. LPN #1 indicated that Resident #58's care plan should reflect refusals if he/she does not allow staff to trim his/her fingernails or that Resident#58 desires to have long fingernails. Furthermore, LPN #1 indicated that it was the facility policy for care plans to be updated quarterly and as needed with changes. Subsequent to surveyor inquiry, Resident #58's care plan was updated to reflect his/her desire to have long fingernails.Interview with Nurse Aide (NA) #2 on 2/5/26 at 8:45 AM indicated that she trimmed Resident #58's fingernails. She indicated that she did not have Resident #58 as her assigned resident and had never provided care to Resident #58 prior to trimming his/her nails. NA #2 indicated that she trimmed Resident #58's fingernails per the nurse's request. NA #2 indicated that she was aware that Resident #58 often refused to have his/her nails trimmed. NA #2 indicated that Resident #58 allowed her to trim his/her nails without difficulty.The Care Planning Policy (undated) directed, in part, a comprehensive and individualized plan of care will guide caregivers to assist residents to achieve or maintain their highest practical level of well-being. The Care Plan is reviewed and updated at least quarterly and as necessary to reflect changes in the residents' status.

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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 2 residents (Resident #15, Resident #104), the facility failed to ensure medication was administered timely. The findings include: 1. Resident #15 had diagnoses that included dementia, pelvis fracture, and anxiety.The Resident Care Plan (RCP) dated 12/29/25 identified Resident #15 was at risk for malnutrition related to variable food intake with requirement for oral nutritional supplements, significant weight change and advanced age. Interventions included to obtain a dietary consultation as needed, monitor weights as ordered, document amount of meal consumed for breakfast, lunch, and dinner, notify the nurse if Resident #15 refused a meal, and offer alternative foods.The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, weighed 127 pounds (lbs.), used a walker and wheelchair for mobility, and had 1 fall with a major injury since the prior assessment. Additionally, the MDS assessment identified Resident #124 required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility, and transfers had not been attempted due to a medical condition or safety concerns.Physician orders dated 1/19/26 directed the following medications were ordered and scheduled for administration at 8:00 AM or 9:00 AM:a. Allopurinol tablet 100 milligrams (mg) give 1/2 tablet by mouth daily for gout (ordered for 9:00 AM).b. Amlodipine Besylate tablet 10 mg give 1 tablet by mouth daily for hypertension (HTN) (ordered for 9:00 AM)c. Cranberry tablet 400 mg give 1 tablet by mouth daily for supplement (ordered for 9:00 AM).d. Ferrous Sulfate tablet 325 mg give 1 tablet by mouth every 2 days for low iron (ordered for 9:00 AM).e. Losartan Potassium tablet 25 mg give 1 tablet by mouth daily for HTN (ordered for 9:00 AM).f. Naloxegol Oxalate tablet 25 mg give 1 tablet by mouth daily for constipation (ordered for 9:00 AM).g. Omeprazole capsule delayed release 20 mg give 1 capsule by mouth daily for gastroesophageal reflux disease (GERD) (ordered for 9:00 AM).h. Vitamin D tablet 400 units give 2 tablets by mouth daily for supplement (ordered for 9:00 AM).i. Polyethylene Glycol 3350 powder 17 gram (GM) per scoop give 1 scoop by mouth 2 times a day for constipation (ordered for 9:00 AM and 5:00 PM).j. Acetaminophen tablet 325 mg give 2 tablets by mouth 3 times a day for pain (ordered for 9:00 AM, 1:00 PM, and 9:00 PM).k. Seroquel tablet (an anti-psychotic) 50mg tablet give 1 tablet by mouth 3 times a day for dementia with behaviors (ordered for 8:00 AM, 12:00 PM, and 8:00 PM).l. Tramadol 50 mg tablet give 1.5 tablets (75 mg) by mouth 3 times a day for severe pain (ordered for 9:00 AM, 1:00 PM, and 5:00 PM).m. Trazodone 50 mg tablet give 1 tablet by mouth 3 times a day for anxiety (ordered for 9:00 AM, 1:00 PM, and 5:00 PM).Observation of Resident #15 on 2/5/26 at 11:30 AM identified he/she was sitting upright in bed.Review of the Medication Admin Audit Report for Resident #15 for medications scheduled for administration on 2/5/26 identified the following medications were signed off as administered between 12:23 PM-12:47 PM: a. Allopurinol tablet 50 mg 9:00 AM dose administered at 12:24 PM (3 hours and 24 minutes late).b. Amlodipine Besylate tablet 10 mg 9:00 AM dose administered at 12:24 PM (3 hours and 24 minutes late).c. Cranberry tablet 400 mg 9:00 AM dose administered at 12:47 PM (3 hours and 47 minutes late).d. Ferrous Sulfate tablet 325 mg 9:00 AM dose administered at 12:25 PM (3 hours and 25 minutes late).e. Losartan potassium tablet 25 mg 9:00 AM dose administered at 12:26 PM (3 hours and 26 minutes late).f. Naloxegol Oxalate tablet 25 mg 9:00 AM dose administered at 12:23 PM (3 hours and 23 minutes late).g. Omeprazole capsule delayed release 20 mg 9:00 AM dose administered at 12:26 PM (3 hours and 26 minutes late).h. Vitamin D tablet 800 units 9:00 AM dose administered at 12:29 PM (3 hours and 29 minutes).i. Polyethylene glycol 3350 powder 17 gram (GM) per scoop give 1 scoop by mouth 2 times a day, 9:00 AM dose administered at 12:23 PM (3 hours and 23 minutes late and 4 hours and 37 minutes before the next dose due at 5:00 PM).j. Acetaminophen tablet 325 mg give 2 tablets by mouth 3 times a day, 9:00 AM dose administered at 12:23 PM (3 hours and 23 minutes late and 37 minutes before the next scheduled dose at 1:00 PM). Additionally, the 1:00 PM dose was signed off as administered at 12:30 PM (7 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minutes after the previous dose administered late at 12:23 PM).k. Seroquel tablet 50mg tablet give 1 tablet by mouth 3 times a day, 8:00 AM dose administered at 12:23 PM (4 hours and 23 minutes late and 23 minutes). Additionally, the 12:00 PM dose was signed out at 12:30 PM (7 minutes after the previous dose administered late at 12:23 PM).l. Tramadol 50 mg tablet give 1.5 tablets (75 mg) by mouth 3 times a day, 9:00 AM dose administered at 12:26 PM (3 hours and 26 minutes late and 34 minutes prior to next scheduled dose). Additionally, the 1:00 PM dose was signed off as administered at 2:18 PM (1 hour and 52 minutes after the previous dose administered at 12:26 PM).m. Trazodone 50 mg tablet give 1 tablet by mouth 3 times a day, 9:00 AM dose administered at 12:40 PM (3 hours and 40 minutes late and 20 minutes before the next scheduled dose). Additionally, the 1:00 PM dose was signed off as administered at 12:30 PM (10 minutes prior to the dose administered at 12:40 PM).2. Resident #104 had diagnoses that included dementia, heart failure, and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #104 was severely cognitively impaired, used a wheelchair for mobility, required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility, and was dependent for bed/chair transfers.The Resident Care Plan (RCP) 11/24/25 identified Resident #104 was at risk for alteration in cardiopulmonary function related to congestive heart failure and interstitial lung disease. Interventions included monitor for edema, assess lung sounds as ordered and administering medications as ordered by the physician/APRN.Review of the physician's orders signed 1/5/26 for Resident #104 directed the following medications were ordered and scheduled for administration at 8:00 AM or 9:00 AM:a. Acetaminophen 500 mg give 2 tablets by mouth 2 times a day for pain (8:00 AM and 5:00 PM).b. Trazodone 25 mg give 1 tablet by mouth daily for anxiety (8:00 AM).c. Vitamin B-12 500 micrograms (mcg) give 1 tablet by mouth daily for weakness (8:00 AM).d. Vitamin D3 1,000 units give 1 tablet by mouth daily for weakness (8:00 AM)e. Artificial tears drops instill 1 drop in both eyes 3 times a day for dry eyes (8:00 AM, 2:00 PM, and 8:00 PM).Observation of Resident #104 on 2/5/26 at 11:30 AM identified he/she was sitting out of bed in a chair between the bed and the window.On 2/5/26 from 11:35 AM to 12:05 PM Registered Nurse (RN) #3 was observed to move from room to room with his medication cart and when the cart was in front of each room, RN #3 was observed to be looking at the computer attached to the medication cart and then placing medications into a small plastic medication cup prior to bringing that medication cup into the residents' rooms. This was the same procedure RN #3 was observed to perform during observation of part of his medication pass on 1/29/26 from 8:38 AM-9:10 AM. Review of the Medication Admin Audit Report for Resident #104 for medications scheduled for administration on 2/5/26 identified the following medications were signed off as administered between 12:17 PM-12:18 PM:a. Acetaminophen 500 mg give 2 tablets (1000mg) by mouth 2 times a day 8:00 AM dose was administered at 12:17 PM (4 hours and 17 minutes late and 4 hours and 43 minutes before the next scheduled dose at 5:00 PM).b. Trazodone 25 mg give 1 tablet by mouth daily 8:00 AM dose was administered at 12:17 PM (4 hours and 17 minutes late).c. Vitamin B-12 500 mcg give 1 tablet by mouth daily 8:00 AM dose was administered at 12:17 PM (4 hours and 17 minutes late).d. Vitamin D3 1,000 units give 1 tablet by mouth daily 8:00 AM dose was administered at 12:18 PM (4 hours and 18 minutes late).e. Artificial tears drops instill 1 drop in both eyes 3 times a day, 8:00 AM dose was administered at 12:17 PM (4 hours and 17 minutes late and 1 hour and 43 minutes before the next scheduled dose at 2:00 PM).Interview and observation on 2/5/26 at 12:20 PM the Director of Nursing Services (DNS) identified the DNS had come to the unit at surveyor request to observe RN #3 still completing morning medication administration pass. RN #3 was observed to be in front of Resident #15 and Resident #104's room which was the last room to receive medications. The DNS did not approach RN #3 to inquire on the reason he was still passing morning medications and she was unable to identify why he would still be passing medications at this time of the day. The DNS identified that medications scheduled for 9:00 AM should not routinely be administered this late in the day. Interview with RN #7 on 2/5/26 at 12:25 PM identified he had thought RN #3 was passing his 12:00 PM medications and was not aware that RN #3 had not finished his morning medication pass (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(8:00 AM and 9:00 AM medications). RN #7 identified that there was a 1 hour window before and after the physician ordered administration time in which medications were permitted to be administered and considered on time. RN #7 identified that RN #3 had not approached him with concerns related to his medication pass. RN #7 further identified that he would speak with RN #3 about ensuring his medications were administered on time.Interview with RN #3 on 2/5/26 at 1:20 PM identified he was late in finishing the morning medication pass because it was a heavy medication pass with many medications to be administered for over 30 residents. RN #3 identified he had notified the Unit Manager (Licensed Practical Nurse (LPN) #8) before and that she was aware of how long the medication pass took because she had done it herself before. RN #3 identified he had received no feed back or seen any change since he reported the difficulty with completing the medication pass on time, so he had not brought it up again. RN #3 identified his biggest concern was to ensure all residents received the medications that they were supposed to get and he did it as quickly as possible to maintain accuracy.Interview with the DNS on 2/5/26 at 3:15 PM identified that she was not aware of the medication pass on RN #3's unit specifically as being heavy with medications given late due to inability to complete the medication pass timely, but she had heard in general that some medication passes were difficult. The DNS identified that the administrative staff were looking at staggering the medication administration times, moving some one time a day administration medications to a different shift, and having the physicians review medication for unnecessary medications that can be discontinued. The DNS identified it was in preliminary discussions but there had been no formal plan or quality improvement initiative started yet to address the medication passes.Review of the Medication Administration policy directed, in part, all medications will be administered safely and accurately per physician orders, facility policy and state and federal regulations. The policy directed medications can only be administered with a valid physician order. The policy directed physician orders shall include the resident's name, medication name, dosage, route, frequency and duration of order. The policy directed to ensure the right resident, right medication, right dose, right route, and right time were verified. The policy directed to document the administration of medication in the medication administration record immediately after administration. The policy directed to ensure administration of medication is within 1 hour before or 1 hour after the ordered time. The policy further directed that staff must demonstrate competency in medication administration via skills assessments and to conduct regular audits of administration records and practices.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility policy for 1 of 3 residents observed for dining (Resident #15), the facility failed to provide cueing and assistance with meals. The findings include:Resident #15 had diagnoses that included dementia, pelvic fracture, and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, weighed 127 pounds (lbs.), used a walker and wheelchair for mobility, and had 2 or more falls with no injury since the prior assessment. Additionally, the MDS assessment identified Resident #124 required setup or clean-up assistance with eating, supervision or touching assistance with bed mobility, and partial/moderate assistance with transfers.The Resident Care Plan (RCP) dated 12/29/25 identified Resident #15 was at risk for malnutrition related to variable food intake with requirement for oral nutritional supplements, significant weight change and advanced age. Interventions included obtaining a dietary consult as needed, monitor weights as ordered, document amount of meal consumed for breakfast, lunch/dinner, notify the nurse if Resident #15 refused a meal, and offer alternative foods.The RCP dated 12/29/25 further identified Resident #15 had a left pelvic fracture. Interventions included pain assessments per policy, report unrelieved pain to the medical doctor (MD)/Advanced Practice Registered Nurse (APRN), rehab therapy as ordered to increase function and mobility, and transfers per MD orders. A Dietary note written by Dietician #1 dated 12/29/25 at 11:11 AM identified Resident #15 was seen for readmission evaluation. The note identified Resident #15 had been readmitted from the hospital following a fall with acute left superior and inferior pubic rami fractures. The note identified Resident #15's overall oral food intake was good with 51-100% of food consumed at the majority of meals. Resident #15's feeding ability was setup or clean-up assistance and Resident #15 received an oral nutritional supplement of Boost 237 ml daily. The note identified Resident #15's weight was 123.4 lbs. which had been stable for 6 months and recommendations were to provide the diet as ordered, continue Boost 237 ml daily, and monitor weights as ordered. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, weighed 127 pounds (lbs.), and used a walker and wheelchair for mobility, had 1 fall with a major injury since the prior assessment. Additionally, the MDS assessment identified Resident #124 required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility, and transfers had not been attempted due to a medical condition or safety concerns.A Comprehensive Nutritional assessment dated [DATE] at 1:48 PM identified Resident #15 received a Boost 237 ml supplement daily and snacks 2 times a day. The assessment identified Resident #15's weight was 123.4 (taken 12/24/25) and there were no recent weight changes. The assessment identified Resident #15's oral intake percentages ranged from 25-100%. The assessment identified Resident #15 was independent with feeding and had no swallowing difficulties. The assessment identified Resident #15 was seen for a significant change review and the diet remained appropriate, Resident #15's appetite remained fair overall, that an updated weight was pending with weight trends stable over the last 6 months with no decrease in food intake.A nursing note written by Licensed Practical Nurse (LPN) #8 on 1/9/26 at 8:50 AM identified that due to Resident #15's left hip fracture, Resident #15 had been refusing to get out of bed, and Resident #15 was refusing to have weights taken. The note identified multiple attempts had been made to obtain weights without success and the dietician and APRN were notified. The note identified there were no new orders at that time.A physician order signed 1/19/26 directed to provide a regular diet of regular texture with thin liquids (for drinking).a. Observation of Resident #15 in 2nd floor dining room on 1/27/26 at 12:19 PM identified Resident #15 sitting at a table with 2 other residents. Resident #15 was observed to have a full bowl of soup placed in front of him/her and a covered plate placed down on the left side of Resident #15.Observation of Resident #15 in 2nd floor dining room on 1/27/26 at 12:25 PM identified Resident #15 picked up a spoon from the bowl of soup (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and placed it back down inside bowl of soup multiple times in a row, but no attempt was made to bring the soup up to his/her mouth to take a bite of the soup. The plate of food remained covered on the left side of Resident #15.Observation of Resident #15 in 2nd floor dining room on 1/27/26 at 12:30 PM identified a staff member uncovered the plate of food and placed it in front of Resident #15 while moving the soup away from him/her. The staff member was observed to cut a bite of chicken, and she fed it to Resident #15. The staff member was then observed to walk away from Resident #15 to sit down and feed a different resident. Resident #15 was left to self-feed and was observed to refrain from attempts to self-feed. Observation of Resident #15 in 2nd floor dining room on 1/27/26 at 12:46 PM identified a staff member sat down next to Resident #15 to assist with the meal. The staff member was overheard asking Resident #15 if he/she wanted anything else to eat and then the staff member offered Resident #15 his/her ice cream and after it was opened, handed the ice cream to Resident #15. Resident #15 did not take any bites of ice cream. Observation of Resident #15 in 2nd floor dining room on 1/27/26 at 12:50 PM identified the ice cream was removed from Resident #15's hand by a Nurse Aide (NA) and Resident #15 was transported out of dining room in his/her wheelchair by the staff member without Resident #15 eating any more food (observation from 12:19 PM to 12:50 PM Resident #15 was observed to have consumed only 1 bite of food).b. Observation of Resident #15 on 1/28/26 at 8:43 AM identified Resident #15 sitting in bed with a breakfast plate containing scrambled eggs and a coffee cake on the overbed table in front of him/her. No visible silverware was observed on the plate or next to the plate (it may have been inside the napkin). No bites of food were observed missing from coffee cake which appears fully intact. No noticeable bites of scrambled eggs missing. When Resident #15 was asked by the surveyor the reason he/she hadn't eaten, he/she replied No show. Observation of Resident #15 on 1/28/26 at 8:45 AM identified a NA (who was observed going room to room collecting plates with Resident #15's room being the last room remaining) entered Resident #15's room and asked Resident #15 if he/she was finished eating, the NA then left the plate in front of the Resident #15, and after collecting the empty dishes from the roommate the NA exited the room (without cueing or prompting Resident #15 to eat).c. Observation of Resident #15 on 1/29/26 at 12:11 PM identified Resident #15 sitting in bed with the head of bed (HOB) elevated. A plate containing 2 stuffed shells and mixed vegetables was on the overbed table in front of Resident #15. The stuffed shells were observed to be whole and not cut up. A cupcake was observed next to the right side of plate on top of the placemat. A glass of dark colored liquid with a straw was observed on the table next to the plate and cupcake. Resident #15 was observed sitting with both hands placed on a corner of the overbed table and eyes looking down at his/her hands. No attempts to touch the food or self-feed by Resident #15 was observed.Observation of Resident #15 on 1/29/26 at 12:36 PM identified Resident #15 sitting in bed with the HOB elevated and the same plate of food was on the overbed table in front of him/her, but the stuffed shells were observed to be cut up. Resident #15 was observed holding a cup and drinking fluids from a straw.Observation of Resident #15 on 1/29/26 at 1:03 PM identified Resident #15 sitting in bed with the HOB elevated and the same plate of food was on the overbed table in front of him/her, with no missing pieces of stuffed shells observed since the last observation. A cupcake still present next to plate with no bites missing.Observation of Resident #15 on 1/29/26 at 1:21 PM (1 hour and 10 minutes after Resident #15's meal was initially provided) identified Resident #15 sitting in bed with the HOB elevated and a NA sitting on the end of the bed trying to assist Resident #15 with eating his/her meal. The NA stated that Resident #15 only ate a couple bites of the food even with her assistance.d. Observation of Resident #15 on 1/30/26 at 7:55 AM identified Resident #15 sitting in bed with the HOB elevated with breakfast served by a staff member. An uncovered plate was on the overbed table in front of Resident #15 with an uncut croissant and an omelet cut into 4 pieces. Observation of Resident #15 on 1/30/26 at 8:16 AM identified Resident #15 sitting in bed with the HOB elevated with the same untouched plate of food containing an uncut croissant and 4 pieces of omelet. Resident #15 was observed sitting with hands resting on his/her stomach and eyes closed. No attempts to self-feed were observed. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation of Resident #15 on 1/30/26 at 8:39 AM identified Resident #15 sitting in bed with the HOB elevated with the same plate of food that had 1/2 of one piece of omelet missing, but no other bites missing. A NA was observed to take the plate away without attempting to cue Resident #15 to eat and she approached the unit manager (LPN #8) and said Resident #15 didn't eat and didn't want anymore. LPN #8 responded that Resident #15 slept more in the morning since his/her fall (on 12/27/25) and he/she might ask for something to eat later. A Dietary note written by Dietician #2 on 1/30/26 at 8:53 AM identified Resident #15 had a significant weight change. The note identified Resident #15's oral food intake was poor with intact ranging from 26-100% mixed with intermittent refusals to eat. The note identified Resident #15's acceptance of the oral nutritional supplement was good overall with the intake mostly 50-100% and the current supplement order was for Boost 237ml daily. The note identified Resident #15's feeding ability was setup or clean-up assistance. The note identified Resident #15's weight was 108.6 lbs. obtained on 1/29/26 and the weight triggered for an unplanned significant weight loss over 1 month (prior weight on 12/24/25 of 123.4 lbs. (12.0% significant weight loss) and 3 months (prior weight on 10/9/25 of 125.4 lbs. (13.4% significant weight loss). The note identified Dietician #2's recommendations were to provide the diet as ordered, increase the supplement to Boost 237 ml twice per day, and monitor weights as ordered. The note further identified that a reweight was requested for verification of the weight loss and that the interdisciplinary team and APRN were updated.e. Observation of Resident #15 on 2/5/26 at 8:16 AM identified Resident #15 sitting upright in bed with a plate of food on the overbed table in front of him/her. Scrambled eggs were observed with no visible bites missing, oatmeal was observed untouched with no visible bites missing, apple sauce remained unopened and untouched in front of Resident #15. Silverware was observed to still be wrapped up on the placemat next to the plate. Resident #15 was observed sitting with hands folded and eyes closed.Interview and clinical record review with LPN #8 on 2/5/26 at 8:35 AM identified that the nurses and/or nurse aides needed to update her when a resident was not eating or had poor oral food intake, and she indicated that the nurses and NAs had not told her Resident #15 was not eating, but that on 2/4/26 when she became aware Resident #15 was not eating well and had a significant weight loss, she had requested a speech evaluation and she had updated the MD/APRN. Interview with Dietician #1 on 2/5/26 at 9:02 AM identified he had been notified this week of a possible need to feed Resident #15 and he had spoken with LPN #8 about obtaining a speech screen. Dietician #1 further identified that he had not been aware of any concerns related to Resident #15's oral food intake prior to yesterday.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility policy and interviews for 2 of 2 residents observed utilizing an air mattress (Resident #14 and Resident #124), the facility failed to ensure the air mattresses were set according to physician orders and for 1 of 2 residents (Resident #186) reviewed for hospitalization, the facility failed to follow physician orders regarding obtaining vital signs. The findings include: 1. Resident #14 had diagnoses that included Alzheimer's disease, chronic obstructive pulmonary disease, and anxiety. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #14 was severely cognitively impaired, had 1 unhealed Stage 4 pressure ulcer, had a pressure reducing device for the bed, was dependent for eating and transfers, and required substantial/maximal assistance with bed mobility. Additionally, the MDS identified Resident #14 weighed 87 pounds. The Resident Care Plan (RCP) dated 11/17/25 identified Resident #14 had a Stage 4 pressure ulcer to the coccyx. Interventions included application of a specialized mattress per physician orders, check function and setting of the air mattress every shift (7:00 AM-3:00 PM, 3:00 PM-11:00 PM, and 11:00 PM-7:00 AM), and offload heels while in bed. A physician order dated 12/11/25 directed every shift to check the function and setting of Resident #14's air mattress at the setting of 80 and alternating (the number 80 represented the resident weight and the term alternating, represented the alternating inflation/deflation of parallel chambers within the interior of the air mattress). Observation of Resident #14's air mattress on 1/27/26 at 11:00 AM identified Resident #14 was lying supine in bed, on the air mattress with the head of the bed (HOB) elevated at 30 degrees. The air mattress pump hanging from the footboard of the bed was observed to be functioning, the knob on the left side of the pump pointed at the shaded area of 120 (and not 80 as per physician order), and the light within the button indicating the static setting was lit a discrepancy with the physician order that directed alternating inflation (the static setting represented the stationary unchanging inflation of the parallel chambers within the interior of the air mattress). Observation of Resident #14's air mattress on 1/28/26 at 12:56 PM identified Resident #14 was lying supine in bed on the air mattress with the head of the bed (HOB) elevated greater than 45 degrees. The air mattress pump hanging from the footboard of the bed was observed to be functioning, the knob on the left side of the pump pointed at the line located between the shaded area labeled 80 and the shaded area labeled 120, and the light within the button indicating the static setting was lit (and not alternating inflation as per physician order). Observation of Resident #14's air mattress on 1/30/26 at 6:40 AM identified Resident #14 was lying supine in bed on the air mattress with the head of the bed (HOB) elevated 30 degrees. The air mattress pump hanging from the footboard of the bed was observed to be functioning, the knob on the left side of the pump pointed at the line located between the shaded area labeled 80 and the shaded area labeled 120, and the light within the button indicating the static setting was lit. Observation, review of the clinical record and interview with Licensed Practical Nurse (LPN) #6 on 1/30/26 at 7:43 AM identified when she signed off the physician order for the air mattress setting in the Resident #14's electronic medical record (EMR) she checked that the air mattress was on and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	functioning, the plug was connected, and then she verified that the settings on the pump matched the settings in the physician order. LPN #6 identified she had verified Resident #14's air mattress settings when she signed off in the EMR during her shift of 11:00 PM-7:00 AM on 1/30/26. Upon looking at the air mattress pump with the surveyor and comparing it to the physician order within the EMR, LPN #6 verbally indicated the setting on the air mattress pump was correct even though the observed air mattress setting matched the surveyor observation on 1/30/26 at 6:40 AM, and both observations differed from Resident #14's physician order for the air mattress which directed a setting of 80 and alternating. LPN #6 failed to identify that the setting on the air mattress pump was incorrect with the knob pointing at the line between the shaded area labeled 80 and the shaded area labeled 120 instead of within the shaded area labeled 80 and with the static button lit up instead of turned off to indicate alternating. Subsequent to surveyor inquiry, observation with the Unit Manager, Licensed Practical Nurse (LPN) #8, on 2/5/26 at 8:05 AM identified Resident #14's air mattress was set at 80 and alternating (static button light was off). 2. Resident #124 had diagnoses that included diabetes, dementia, and congestive heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #124 was severely cognitively impaired and was dependent for eating, bed mobility, and chair/bed transfers. The Resident Care Plan (RCP) 12/15/25 identified Resident #124 had the potential for alteration in skin integrity related to decreased mobility and incontinence. Interventions included placement of an air mattress with settings at 2 and alternating and check settings every shift, inspect skin for signs and symptoms of breakdown when providing care. A physician order in effect 1/30/26 directed every shift to check the function and setting of Resident #124's air mattress at the setting of 2 and alternating (the number 2 represented the number of lights lit for the firmness setting and the term alternating, represented the alternating inflation/deflation of parallel chambers within the interior of the air mattress). Observation of Resident #124's air mattress on 1/27/26 at 1:09 PM identified Resident #124 was lying supine in bed on the air mattress with the head of the bed (HOB) elevated at 30 degrees. The air mattress pump hanging from the footboard of the bed was observed to be functioning with 3 lights lit (not 2 per physician order) for the firmness setting, and the light indicating the alternating setting was lit. Observation of Resident #124's air mattress on 1/30/26 at 6:35 AM identified Resident #124 was lying supine in bed on the air mattress with the HOB elevated at 30 degrees. The air mattress pump hanging from the footboard of the bed was observed to be functioning with 3 lights lit (not 2 per physician order) for the firmness setting, and the light indicating the alternating setting was lit. Observation, review of the clinical record and interview with Licensed Practical Nurse (LPN) #6 on 1/30/26 at 7:38 AM identified when she signed off for the air mattress setting in the Resident #124's electronic medical record (EMR) she checked that the air mattress was on and functioning, the plug was connected, and then she verified that the settings on the pump matched the settings in the physician order. Upon looking at the air mattress pump with the surveyor and comparing it to the physician order within the EMR, LPN #6 verbally indicated the setting on the air mattress pump was correct even though the observed air mattress setting matched the surveyor observation on 1/30/26 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 6:35 AM, and both observations differed from Resident #124's physician order for the air mattress which directed a setting of 2 (lights lit for firmness) and alternating. LPN #6 failed to identify that the setting on the air mattress pump was incorrect with the 3 lights lit up for the firmness setting. Interview and observation with the Unit Manager, Licensed Practical Nurse (LPN) #8, on 2/5/26 at 8:06 AM identified Resident #124's air mattress was set at 3 lights lit (not 2 lights lit) and alternating. LPN #8 identified the charge nurse should verify the settings each shift. Subsequent to surveyor inquiry, observation on 2/5/26 at 8:10 AM identified LPN #8 verified Resident #124's air mattress settings in the EMR and then instructed the charge nurse to adjust the setting on the pump to 2 lights lit for the firmness setting. Subsequent to surveyor inquiry, observation of Resident #124's air mattress on 2/5/26 at 11:55 AM identified Resident #124 was lying supine in bed on the air mattress with the HOB elevated at 30 degrees. The air mattress pump hanging from the footboard of the bed was observed to be functioning with 2 lights lit for the firmness setting, and the light indicating the alternating setting was lit. Interview with the Nursing Supervisor, Registered Nurse (RN) #7, on 2/5/26 at 12:25 PM identified the charge nurse should check the air mattress pump settings and verify it against the physician order, and if the setting on the air mattress pump is incorrect, the charge nurse should adjust the pump to reflect the proper settings. Review of the Pressure Relieving Mattress Policy directed, in part, the facility would provide a pressure relieving mattress to all resident regardless of their Braden score. The policy directed for a resident that triggered as high risk for pressure ulcer development a low air loss or alternating pressure mattress may be recommended. The policy directed to verify physician orders and settings according to manufacturer recommendations, place mattress directly on the bed frame, hang the motor unit (pump) on the frame in a safe location, and allow the mattress to inflate per manufacturer recommendations. The policy directed to check the settings and function every shift and verify the settings on the pump, and to take immediate action by removing the resident if the mattress was observed to be malfunctioning. 3. Resident #186's diagnosis included dementia, chronic thrombocytopenia, and chronic obstructive pulmonary disease. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #186 was moderately cognitively impaired and required maximal assistance with showering and transfers. Additionally, the MDS identified Resident #186 required set up for eating, and partial moderate assistance for personal hygiene and dressing. The Resident Care Plan dated 8/5/25 identified Resident #186 was at risk for respiratory distress-ineffective breathing patterns, nutritional deficits, activity intolerance and adverse effects from medications. Interventions included providing medications per physician's orders, vital signs as ordered per the facility policy and elevating the head of the bed to prevent shortness of breath. An Advanced Practice Registered Nurse (APRN) #1's progress note dated 10/13/25 at 3:09 PM identified Resident #186 had a new large, red, raised area to his/her abdomen and right flank. Resident #186 reported the area had been present for a few days and reported associated discomfort. APRN #1 further identified Resident #186 was noted with an elevated temperature of 100.2 degrees (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Fahrenheit the night before, 98.1 degrees Fahrenheit on recheck. The resident was unsure if the area had changed in size since it started, denying any additional associated symptoms. A new order directed to monitor the area every shift for 5 days, vital signs every shift for 3 days and notify the provider of any new or worsening symptoms. Physician orders dated 10/13/25 directed obtaining vital signs every shift for 3 days. Treatment Administration Record and Medication Administration Record for October 2025 failed to identify a vital signs order for 3 days every shift. The Vital Signs Summary log for October 2025 identified from 10/13/25 through 10/16/25 vital signs were only obtained 3 of 9 shifts. Nursing notes dated 10/16/25 written by Registered Nurse (RN) #7 identified labs were reviewed by the APRN noting a decreased platelet count with orders to transfer Resident #186 to the emergency room APRN 1's progress note dated 10/16/25 at 3:49 PM identified a new order to transfer Resident #186 to the emergency room for evaluation. Progress notes dated 10/24/25 at 10:38 PM and written by the Licensed Practice Nurse identified Resident #186 arrived back at the facility at approximately 6:30 PM via stretcher accompanied by 2 attendants with an admitting diagnosis of septic shock. Interview on 1/30/26 at 11:11 AM with Registered Nurse (RN) #2 identified an APRN order was written on 10/13/25 for Resident #186 to have his/her vital signs taken every shift for 3 days and the order was placed in the electronic medical record. Additionally, RN #2 indicated Resident #186's vital signs were not completed every shift as per physician's order and was only completed a few times. RN #2 further, identified the floor nurse on each shift was responsible for ensuring the physician's orders were completed, documented, and she was responsible for the oversight. Review of the Vital Signs/Blood Pressure policy dated 12/6/23 identified vital signs will be taken on admission and at least monthly, unless otherwise ordered by practitioner and are to be recorded.

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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 observations, interviews, review of the clinical record and facility policy, for 1 of 3 residents (Resident #144) reviewed for pressure ulcers, the facility failed to ensure a treatment was ordered timely when a pressure ulcer was identified. The findings include:Resident #144 was admitted to the facility in November 2025 with diagnoses that included elevated white blood cells, a terminal condition of the colon and depression. A Braden Scale (a tool to determine the risk for developing a pressure ulcer) completed on 11/2/25 identified Resident #144 was at risk for a pressure ulcer with a score of 17 (Braden scores- at risk 15-18, moderate risk 13-14, high risk 10-12, and very high risk 9 or below). Physician orders dated 11/2/25 directed to perform skin checks weekly on Thursdays to check skin integrity. The Resident Care Plan (RCP) dated 11/5/25 identified Resident #144 was a risk for alteration in skin related to decreased mobility. Interventions included to complete a Braden Scale on admission and readmission, incontinent care, inspection of skin when providing care, turn and position per standards of nursing practice, pressure reducing mattress, and transfer/ambulation per MD orders. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #144 was cognitively intact and required moderate assistance of 1 staff member with activities of daily living (ADLs) including bed mobility. The MDS identified that Resident #144 was at risk for pressure ulcers but did not have a pressure ulcer on admission.A Weekly Skin Assessment form identified Resident #144 developed a skin issue on 11/13/25. Registered Nurse (RN) #1 documented that Resident #144 had an area on his/her coccyx measuring 1.0 centimeters (cm) length by 0.3 cm width by 0.1 cm depth but did not stage the pressure area. A review of physician orders identified that there was no treatment order put in place on 11/13/25 when the area on coccyx was identified.A review of skin assessments, nursing notes and physician orders with the Assistant Director of Nursing (ADNS) on 1/29/26 at 11:30 AM identified that RN #1 completed a skin assessment on 11/13/25 which indicated that Resident #144 had an area on his/her coccyx that measured 1.0cm by 0.3cm by 0.1 cm, but not stage the pressure ulcer or obtain a physician order for a treatment. Further review of skin assessments and nursing notes identified LPN #10 completed a nursing note on 11/15/25 at 2:49 PM that indicated she was asked by a NA to look at an open area on Resident #144's coccyx. Resident #144's coccyx was noted by LPN #10 to have an open area measuring 0.5cm by 0.5cm by 0.1cm with a small amount of serous (clear or yellow fluid) drainage with surrounding area red and intact. A treatment order was obtained at that time for Triad Paste (zinc-based barrier cream to protect the skin) with a dry, clean dressing once a day and as needed if soiling (a treatment was not put in place to the coccyx until 2 days after the area was identified). Interview with RN #1 on 1/29/26 at 2:53 PM identified that if she documented on the skin assessment form when Resident #144 had a skin issue. She stated she would have documented in a nursing note on Resident 144's shower day after performing the weekly skin assessment or if staff had identified an area while giving Resident #144 care. RN #1 could not state the reason there was not a treatment order in place or corresponding nursing note on 11/13/25 as this was her normal procedure per facility policy when a skin issue was identified. An interview with the wound physician (MD#1) on 1/30/26 at 2:14 PM identified that if an area was noted on Resident #144's coccyx on 11/13/25 then a treatment order should have been put in place at the time it was identified. MD #1 stated that a treatment order could have been changed later if needed but nursing should have initiated treatment to the coccyx. MD #1 stated nursing staff have been educated on staging wounds and appropriate treatments for pressure ulcers. In addition, MD#1 indicated that Resident #144 had an overall decline in his/her health status and had experienced a significant weight loss despite interventions being in place. MD #1 indicated that Resident #144's comorbidities placed him/her at significant risk in delayed wound healing and weight loss. The Skin Assessment and Pressure Ulcer Prevention Policy dated 1/2025 directed, in part, to prevent a resident from developing a pressure ulcer, if clinically possible, to identify skin (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	issues and report them to the MD/practitioner, identify problem areas promptly for treatment and prevention. If an alternation in skin is found, complete the skin observation tool in PCC which includes notifying the dietitian, the wound skin nurse, and APRN, start a skin/wound tracking record, and notify the MD/APRN for orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility policy, record review, and interviews for 1 of 1 sampled resident (Resident #95) observed with medication at the bedside, the facility failed to properly secure the medication and for 6 residents interviewed (Resident #5, Resident #32, Resident #33, Resident #40, Resident #93, and Resident #106), the facility failed to ensure the wheels on the bed were in the locked position, causing one of the residents (Resident #33) to sustain a laceration during an independent transfer. The findings include: 1. Resident #95's diagnosis included chronic obstructive pulmonary disease (COPD), bipolar disorder and anxiety. The quarterly Minimum Data Set (MDS) assessment dated 1/26/26 identified Resident #95 was cognitively intact and was dependent on toileting.^ The MDS further identified Resident #95 required assistance for eating, substantial maximal assistance for oral hygiene, bathing and partial moderate assistance for upper body dressing. The Resident Care Plan dated 1/27/26 identified Resident #95 was non-compliant/resistive to care and medication.^ Interventions included for nursing to check the resident's mouth after administration of medications to be sure that the medication had been taken, provide consistency in the resident's daily care routine, and provide the same caregiver as much as possible. Physician orders dated 127/26 directed Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puffs inhale orally four times a day for wheezing/shortness of breath (SOB) while awake and Albuterol Sulfate Inhalation Nebulization Solution (2.5 MG/3ML) (Albuterol Sulfate) 3 ml inhaled orally via nebulizer every 4 hours as needed for shortness of breath (SOB)/Wheeze. On 1/27/2026 at 11:15AM during initial tour, Resident #95 was observed to have an inhaler (Albuterol Sulfate) unsecured, at the bedside without orders for self-administration. The inhaler had was from the facility contracted pharmacy and labeled accordingly. Resident reported she has had the inhaler at the bedside for a while but doesn't remember how long. Interview on 1/27/26 at 11:20AM with Licensed Practical Nurse (LPN) #2 identified Resident #95 was not administered her Albuterol Sulfate this morning because the resident was sleeping.^ Also, identifying Resident #95 has had the order for a long time and was unable to identify if Resident #95 had an order for self-administration of medication. Interview on 1/27/27 at 11:25 AM with Registered Nurse (RN)#2 identified Resident #95 did not have an order for self-administration of medication and should not have medication at his/her bedside per the facility policy.^^ Facility policy for Medication Administration: to ensure safe, accurate, and effective administration of medications to residents, promoting optimal health outcomes while minimizing medications errors. Also, identified all medication should be stored in a secure, locked area accessible only to authorized personnel. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2a. Resident #5 was admitted to the facility in December 2024 with diagnoses that included non-traumatic brain dysfunction, diabetes, dementia, and depression. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was cognitively intact and was dependent for lower body dressing and toilet hygiene. Additionally, the MDS identified Resident #5 required substantial assistance with upper body dressing and personal hygiene. The MDS also identified Resident #5 relied on a walker or wheelchair for ambulation and had no falls since admission. b. Resident #32 was admitted to the facility in March 2024 with diagnoses that included chronic obstructive pulmonary disease, diabetes, mild cognitive impairment, and absence of several toes. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 had intact cognition and required partial to moderate assistance with transfers and ambulation. Additionally, the MDS identified Resident #32 relied on a walker or wheelchair for ambulation and had a fall within the last 2 to 6 months. On 1/30/26 at 12:30 PM, observation of Resident #32's room identified Resident #32 was out of bed in the wheelchair and the bed wheels were in the locked position, however on 2/5/26 at 9:00 AM, observation of Resident #32's room with Registered Nurse (RN) #3 identified Resident #32 was washing him/herself in the bathroom, and 1 of the 2 wheels at the foot of the bed that had the capability to lock, was in the unlocked position, which allowed the bed to freely move. Interview with Resident #32 on 2/5/26 at 9:00 AM identified that housekeeping unlocks the wheels. c. Resident #33 was admitted to the facility in June 2025 with diagnoses that included overactive bladder, high blood pressure and cirrhosis of the liver. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #33 had intact cognition and was independent with activities of daily living. Additionally, the MDS identified Resident #33 had no falls in the last 2 to 6 months. A Resident Care Plan dated 10/10/25 identified Resident #33 was at risk for falls related to an unstable health condition. Interventions included to encourage and remind Resident #33 to call for assistance if feeling unwell, adjust the height of the bed to promote safe transfers out of bed, and keep call bell within reach. A Morse Fall Scale assessment dated [DATE] identified Resident # 33 as a high risk for falls. A nursing note dated 12/17/25 at 3:11 AM identified Resident #33's bed was in a low position and locked. A nursing note dated 12/17/26 at 7:53 AM indicated Resident #33 reported sustaining a skin tear after hitting the left forearm on the top of the footboard but did not allow the nurse to complete a full assessment of the wound. A facility Reportable Event Form dated 12/17/25 identified Resident # 33's report of falling at 4:40 AM when attempting to get up out of bed on his/her own to get dressed. The report did not identify if the wheels of the resident's bed were locked or unlocked but noted that the resident was educated to (continued on next page)

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Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Road Branford, CT 06405

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	keep his/her wheels locked. An Advanced Practice Registered Nurse (APRN) note dated 12/18/25 at 12:41 PM identified that Resident #33 had fallen the previous day (12/17/25) and sustained a large skin tear on the left forearm but did not originally report the fall to staff. The injury was noted during a doctor's appointment on 12/17/25, when the skin tear was observed to be bleeding and the resident was sent to the emergency department for further evaluation (from the doctor's office). The Resident Care Plan (RCP) was revised on 12/17/25 to include an interventions to encourage Resident #33 to keep the wheels of the bed locked. The RCP also identified the resident was independent with bed mobility, transfers and ambulation with a walker. A physician's order dated 12/18/25 directed staff to ensure resident's bed was locked every shift. Interview with Resident #33 on 1/27/26 at 3:45 PM identified on 12/17/25 when he/she was getting out of bed around 4:40 AM, his/her bed wheels were unlocked, causing him/her to fall into the wooden footboard and sustain a large skin tear on his/her left forearm. Interview with Resident # 33 on 2/5/26 at 1:15 PM identified that he/she did not know how to lock or unlock the wheels on his/her bed. He/she indicated that he/she realized the bed was unlocked because, when attempting to get up, the bed moved and he/she fell into the footboard with his/her left arm. The resident stated he/she did not know how the bed became unlocked but noted that he/she had observed the bed was in the unlocked position multiple times before. d. Resident #40 was admitted to the facility in May 2020 with diagnoses that included osteoarthritis, abnormal gait and mobility, and muscle weakness. An annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had intact cognition and was independent with toileting and upper body dressing. The MDS further identified Resident #40 required supervision with personal hygiene and lower body dressing. Additionally, the MDS identified Resident #40 relied on a walker or wheelchair for ambulation and had 2 falls since the last MDS assessment. On 1/30/26 at 12:53 PM, observation of Resident #40's room with LPN #9 identified Resident #40 was out of bed in a wheelchair, in his/her room. The 2 bed wheels at the foot of the bed were in the unlocked position (the 2 wheels at the head of the bed do not have the capability to lock), causing the bed to be freely movable. On 2/5/26 at 9:27 AM, observation of Resident #40's room with LPN #8 identified Resident #40 was out of bed in a wheelchair, in his/her room. 1 of the 2 wheels at the footboard was only partially locked, rendering the bed to be freely movable. e. Resident #93 was admitted to the facility in February 2025 with diagnoses that included bipolar disorder, muscle weakness, difficulty walking and unsteady gait. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #40 had intact cognition and was independent with toileting hygiene and required set-up with upper/lower body dressing and personal hygiene. Additionally, the MDS identified Resident #40 was independent with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ambulation and had 1 fall since admission. On 1/30/26 at 12:45 PM, observation of Resident #93's room identified Resident #93 was out of bed, in a wheelchair in his/her room. Initially, the 2 wheels at the footboard were in the unlocked position, and Nurse Aide (NA) #4 entered the room, and locked the wheels at the foot of the bed, however, the bed remained freely movable. On 2/5/26 at 9:05 AM, interview with Resident #93 identified that Maintenance fixed the wheels at the foot of the bed which stopped the bed from moving. f. Resident #106 was admitted to the facility in September 2023 with diagnoses that included muscle weakness, adjustment disorder and a history of falling. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #106 had intact cognition and was dependent with toilet hygiene. Additionally, the MDS identified Resident #106 required partial/moderate assistance with personal hygiene, relied on a wheelchair for ambulation and had no falls since admission. On 1/30/26 at 12:50 PM, observation of Resident #106's room with Licensed Practical Nurse (LPN) #9 identified Resident #106 was out of bed in the wheelchair and the bed wheels were in the unlocked position and the bed was able to be moved with ease. On 2/5/26 at 8:15 AM, observation of Resident #106's room with LPN #8 identified Resident #106 was in bed, 1 bed wheel was broken, and 1 wheel was in the locked position. Although 1 bed wheel was in the locked position, the bed was easily able to be moved due to the broken wheel. During the Resident Council Meeting on 1/29/26 at 2:25 PM, Resident #32, Resident #40, Resident #93 and Resident #106 stated they often notice their beds were in the unlocked position and have nearly fallen because their beds were unlocked and moved. Resident #5 reported that he/she used the bed rail for transfers but had noticed at times that when he/she grabbed the rail, the entire bed moved because the wheels were not locked. All residents stated they were unaware of how the bed wheels became unlocked. Although requested, the facility was unable to provide a policy specifically addressing bed locks. Instead, the facility provided an undated policy titled Fall Prevention and Management, which directs staff to identify residents at risk for falls and develop individualized fall and/or injury prevention strategies.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility policy, facility documentation, and interviews for 1 of 5 residents (Resident #15) reviewed for nutrition the facility failed to ensure a re-weight was obtained timely to identify a significant weight loss The findings include: Resident #15 had diagnoses that included dementia, pelvis fracture, and anxiety.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, weighed 127 pounds (lbs.), used a walker and wheelchair for mobility, and had 2 or more falls with no injury since the prior assessment. Additionally, the MDS assessment identified Resident #124 required setup or clean-up assistance with eating, supervision or touching assistance with bed mobility, and partial/moderate assistance with transfers.The Resident Care Plan (RCP) 12/29/25 identified Resident #15 was at risk for malnutrition related to variable food intake with requirement for oral nutritional supplements, significant weight change and advanced age. Interventions included obtain a dietary consult as needed, monitor weights as ordered, document amount of meal consumed for breakfast, lunch, and dinner, notify the nurse if Resident #15 refused a meal, and offer alternative foods. The RCP further identified Resident #15 had a left pelvis fracture. Interventions included pain assessments per policy, report unrelieved pain to the medical doctor (MD)/Advanced Practice Registered Nurse (APRN), rehab therapy as ordered to increase function and mobility, and transfers per MD orders. A dietary note written by Dietician #1 dated 12/29/25 at 11:11 AM identified Resident #15 was seen for readmission evaluation. The note identified Resident #15's overall oral food intake was good with 51-100% of food consumed at the majority of meals. The note identified Resident #15's feeding ability was setup or clean-up assistance and Resident # received an oral nutritional supplement of Boost 237 ml daily. The note identified Resident #15's weight was 123.4 lbs. which had been stable for 6 months and recommended to provide the diet as ordered, continue Boost 237 ml daily, and monitor weights as ordered. Review of the Medication Administration Record (MAR) dated 12/1/25-12/31/25 identified Resident #15's weights were: 127.2 lbs. on 12/4/25, 124.6 lbs. on 12/11/25, 127.8 lbs. on 12/18/25, and 123.4 lbs. on 12/25/25. The significant change in status Minimum Data Set (MDS) assessment dated [DATE] identified Resident #15 was severely cognitively impaired, weighed 127 pounds (lbs.), and used a walker and wheelchair for mobility, had 1 fall with a major injury since the prior assessment. Additionally, the MDS assessment identified Resident #124 required setup or clean-up assistance with eating, partial/moderate assistance with bed mobility, and transfers had not been attempted due to a medical condition or safety concerns.A Comprehensive Nutritional assessment dated [DATE] at 1:48 PM identified Resident #15 received a Boost 237 ml supplement daily and snacks 2 times a day. The assessment identified Resident #15's weight was 123.4 (taken 12/24/25) and there were no recent weight changes. The assessment identified Resident #15's oral intake percentages ranged from 25-100%. The assessment identified Resident #15 was independent with feeding and had no swallowing difficulties. The assessment identified Resident #15 was seen for a significant change review and the diet remained appropriate, Resident #15's appetite remained fair overall, that an updated weight was pending with weight trends stable over the last 6 months with no decrease in food intake.A nursing note written by Licensed Practical Nurse (LPN) #8 on 1/9/26 at 8:50 AM identified that due to Resident #15's left hip fracture, Resident #15 had been refusing to get out of bed and was refusing to have weights taken. The note identified multiple attempts had been made to obtain weights without success, the dietician and APRN were notified and there were no new orders at that time.A physician order signed 1/19/26 and 2/4/26 directed to provide a regular diet of regular texture with thin liquids (for drinking).Interview and clinical record review with LPN #8 on 2/5/26 at 8:35 AM identified when a resident refused a weekly weight the staff were expected to try and obtain the weight again and if unsuccessful, notify the MD/APRN. LPN #8 identified that Resident #15 had frequently refused to have weights obtained since (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his/her fall with major injury on 12/27/25, and that the APRN had been updated on the refusals. LPN #8 was unable to identify how long was an acceptable length of time for the facility to go without documentation of a weight. LPN #8 identified that there had been a weight obtained for Resident #15 on 1/29/26 of 108.6 lbs.(a 14.8 lb/11.9% loss in 35 days) but she had struck that weight out on 1/30/26 because she didn't think it was accurate since the prior weight on 1/8/26 was 123.4 lbs. LPN #8 identified a reweight of 104.6 lbs. had been obtained on Tuesday 2/3/26 (a 18.8 lb/15.2% loss in 26 days) but she had forgotten to document that weight in the clinical record. LPN #8 was unable to identify why a reweight had not been obtained on 1/30/26 prior to her striking out the weight, and she indicated that she probably shouldn't have struck that weight out because the reweight was even lower. LPN #8 was unable to identify the reason it had taken 6 days (1/29/26-2/4/26) before Resident #15's weight loss was identified. LPN #8 identified that the nurses and/or nurse aides needed to update her when a resident was not eating or had poor oral food intake, and she indicated that the nurses and NAs had not told her Resident #15 was not eating, but that on 2/4/26 when she became aware Resident #15 was not eating well, had a significant weight loss, she had requested a speech evaluation and had updated the MD/APRN. LPN #8 identified that she had not entered Resident #15's reweight because she had forgotten, and she had not written a nursing note that identified Resident #15 had a significant weight loss and the interventions she had taken to manage that weight loss, nor that speech therapy, the dietician, MD/APRN, and Resident #15's responsible party had been notified of the weight loss and interventions initiated to manage it because it was late yesterday and she would put the note in today.Interview with Dietician #1 on 2/5/26 at 9:02 AM identified he provided a list of residents that needed weekly weights every Monday that he would get back the following Monday. Dietician #1 identified his weekly weight list contained the names of residents, their previous weeks weight, and a space for the current week's weight. Dietician #1 identified that missing weekly weights and weight losses were brought forward by him in morning report attended by nurses. Dietician #1 identified Resident #15 had been seen by Dietician #2 the previous week for potential weight loss triggered by the weight entered on 1/29/26, and he indicated that Dietician #2 had requested nursing to obtain a reweight to verify the weight loss. Dietician #1 identified he had been notified this week of a possible need to feed Resident #15 and he had spoken with LPN #8 about obtaining a speech screen.Subsequent to surveyor inquiry a late entry nursing note written by LPN #8 on 2/5/26 at 9:33 AM for date 2/4/26 at 2:17 PM identified she was notified that Resident #15's oral intake had been poor even with staff attempting to cue, encourage, and feed Resident #15. The note identified a reweight of 104.6 lbs. indicated Resident #15 had a weight loss. The note identified the physician assistant (PA), dietician, and rehabilitation therapy had been notified. The note identified a therapy screen was performed and Resident #15's diet was downgraded and he/she was to be fed by staff at mealtimes.Interview with APRN #2 on 2/5/26 at 10:00 AM identified that he had not been notified Resident #15 was refusing weights since 1/9/26. APRN #2 identified that Resident #15 was seen by the MD on 12/29/25 following his/her fall on 12/27/25, and APRN #2 indicated that he had not been notified of any concerns for Resident #15 since 12/29/25. APRN #2 further identified that he had not been notified of a significant weight loss until 2/5/26 when he saw the documentation in Resident #15's clinical record.Interview with Registered Nurse (RN) #3 on 2/5/26 at 1:20 PM identified he had not been aware Resident #15 had a weight loss until today, and the nurse aides had not informed him that Resident #15 had been exhibiting poor oral food/meal intake. RN #3 identified Resident #15's weights had not been ordered for a day that he worked, so he had not looked at the weights and therefore was not aware that there was a missing weight nor that Resident #15 had a weight loss. RN #3 identified that if he had obtained a weight for Resident #15 and seen that there was a weight loss, he would have checked Resident #15's meal intake, but because he had not been aware of a weight loss, he had not looked at the meal intake. RN #3 identified he relied on the nurse aides to tell him when a resident had poor food/meal intake.Interview with Dietician #1 on 2/5/26 at 1:30 PM identified that he was made aware on 2/5/26 that LPN #8 had (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	struck out Resident #15's weight obtained on 1/29/26. Dietician #2 was waiting for the nurses to obtain a reweight to verify Resident #15's weight loss. Dietician #1 further identified he doesn't know what the delay was in getting a reweight because Dietician #2 had requested a reweight on 1/30/26.Subsequent to surveyor inquiry an RN note was identified that blood work was ordered by APRN #2 related to Resident #15's weight loss. Review of the Weight Monitoring policy directed, in part, the purpose was to monitor and communicate weight changes. The policy directed an initial nutritional assessment will be conducted by the registered dietitian to establish a baseline body weight to use for future reference. The policy directed accurate and timely measurements of weights for weight changes is important for all residents for assessment of nutritional status. The policy directed residents will be weighed per physician recommendations daily, weekly, or monthly. The policy directed when a weight change is identified a nutritional assessment by the registered dietitian will be obtained. The policy directed it is the responsibility of the charge nurse to ensure weights are obtained as ordered. The policy directed if there was a 5 lb weight discrepancy a reweight should be obtained and the charge nurse should determine if this weight identified a change of 5% in 30 days or 10% in 180 days. The policy directed a significant change in weight will be reported to the physician/APRN, responsible party, dietician, director of nursing, and care plan coordinator. The policy further directed residents with significant weight loss will be reviewed by the dietician to determine the need for changes to the plan of care.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and facility policy for 1 of 2 residents (Resident #124) reviewed for tube feeding, the facility failed to ensure a tube feeding was initiated on time and failed to ensure gastric-tube (g-tube) length was verified prior to administration of tube feeding per physician orders. The findings include: Resident #124 had diagnoses that included diabetes, dementia, and congestive heart failure.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #124 was severely cognitively impaired, had a feeding tube, required a therapeutic mechanically altered diet, and received 51% or more of his/her total calories through the feeding tube. The MDS assessment further identified Resident #124 used a wheelchair, and was dependent for eating, bed mobility, and chair/bed transfers.The Resident Care Plan (RCP) 12/15/25 identified Resident #124 had a feeding tube in place to assist with maintaining nutritional status due to inadequate oral intake. Interventions included check placement of tubing as ordered, ensure the head of the bed is elevated per physician order, and provide nutrition and flushes via the feeding tube per physician orders.A physician order dated 1/21/26 directed to administer a water flush (via g-tube) twice per day; 150 milliters (ml) (pre) before initiating the tube feed, and 150 ml (post) after administration of the tube feed (the order administration times were 6:00 AM and 12:00 PM).A physician order dated 1/21/26 directed to administer a 200 ml water flush (via g-tube) every 6 hours (the order administration times were 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM).A physician order dated 1/21/26 directed to check the g-tube for proper placement prior to initiation of each tube feeding, g-tube flushes, or medication administration by measuring the length of the tube (in centimeters (cm)) each shift. The order failed to identify what the proper length of the g-tube should be.A physician order dated 1/22/26 directed to administer enteral feeding of Jevity 1.5 (tube feed solution) at 67 milliliters (ml) per hour (ml/hr) for 18 hours starting at 12:00 PM and ending at 6:00 AM or until the volume goal of 1206 ml was reached.a. Observation of Resident #124 on 1/29/26 at 12:54 PM, and 1:01 PM identified Resident #124 was lying supine in bed with eyes closed, the tube feeding was observed to be missing from the room with an empty pole and pump observed (physician orders directed to start the tube feeding at 12:00 PM).Observation on 1/29/26 at 1:05 PM identified Registered Nurse (RN) #3 coming off the elevator with his coat on and holding multiple cards of medications.Observation of RN #3 on 1/29/26 at 1:10 PM identified RN #3 was observed at the medication cart putting the cards of medications away inside the medication cart.Observation of RN #3 on 1/29/26 at 1:25 PM, 1:28 PM, 1:35 PM, and 1:48 PM identified RN #3 was observed with the medication cart in front of other rooms administering medications (Resident #124's tube feeding was not hung/in place).Observation of RN #3 performing care of g-tube on 1/29/26 at 1:55 PM identified RN #3 collected the supplies (tube feed bottle, tubing, piston syringe, performed hand hygiene with alcohol based hand rub (ABHR), labeled/dated the bottle of tube feed (Jevity 1.5) and brought the bottle of tube feed and additional supplies into Resident #124's room. RN #3 opened the tubing package and spiked the bottle of tube feed with the end of the tubing and hung the bottle on the pole above the tube feeding pump. RN #3 then applied a pair of gloves to his hands, loaded the tubing into the pump, programmed the pump settings to 67 milliliters (ml) per hour. RN #3 then spoke to Resident #124 and explained that he would be connecting the tubing to his/her g-tube so that he could administer the tube feeding. Resident #124 refused to have RN #3 initiate the tube feeding. Resident #124 asked RN #3 to come back later because he/she was tired. RN #3 asked again and Resident #124 refused so RN #3 left the tube feeding and tubing in place on the pump and exited the room to inform LPN #8 that Resident #124 refused his/her tube feed at that time.Interview with RN #3 on 1/29/26 at 3:40 PM identified he attempted to hang the tube feeding late at 1:55 PM (physician order had a start time as 12:00 PM) because he could not do everything he had to do at the exact time it was ordered for. RN #3 identified Resident #124 had allowed him to hang (continued on next page)

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The note identified the tube feeding with Jevity 1.5 was initiated at 3:00 PM and that the evening and night nurses had been informed not to stop the tube feeding until the volume goal of 1206 ml had been achieved.Observation of Resident #124 on 1/30/26 at 6:35 AM identified the tube feed was running with the volume delivered at 1031ml.Interview with LPN #6 on 1/30/26 at 6:45 AM identified that she usually stopped Resident #124's tube feeding at 6:30 AM on the days when she worked. LPN #6 further identified that she had not received any message from the day nurse (RN #3) about leaving the tube feeding on longer before taking it down today.Interview with LPN #6 on 1/30/26 at 7:38 AM identified that she did not check the volume delivered on the tube feeding pump prior to stopping the tube feeding because the previous volume delivered wasn't always cleared and so the reading wasn't reliable. LPN #6 stated that she calculated the amount of tube feeding for intake and output manually to see the total infused and did not go by the amount on the pump.b. Observation of Registered Nurse (RN) #3 performing care of the g-tube on 1/30/26 at 12:15 PM identified RN #3 brought the bottle of tube feed and additional supplies into Resident #124's room. RN #3 opened the tubing package and spiked the bottle of tube feed with the end of the tubing and hung the bottle on the pole above the tube feeding pump. RN #3 then applied a pair of gloves to his hands, loaded the tubing into the pump, programmed the pump settings to 67 milliliters (ml) per hour with a goal of 1206 mls. RN #3 then attached the end of a 30-ml syringe to Resident #124's g-tube stopcock and pulled back on the syringe to aspirate the residual stomach contents. RN #3 indicated there were 10 mls of residual tube feed in the syringe, and then he pushed on the syringe plunger to return the 10mls of residual. RN #3 disconnected the syringe, pulled the plunger out of the syringe and replaced the syringe without the plunger back onto the g-tube stopcock and proceeded to administer a 150ml water flush by filling the syringe with 30ml of water at a time and allowing it to enter the g-tube via gravity. Once the 150ml of water was administered, RN #3 removed the syringe and hooked the end of the tube feed tubing onto the g-tube stopcock and pressed the start button to initiate the tube feed. RN #3 picked up all trash and discarded it, removed his gloves, and performed hand hygiene and exited the room. The observation failed to identify administration of the 200 ml water flush timed for 12:00 PM by RN #3.Interview and clinical record review with RN #3 on 1/30/26 at 12:30 PM identified there were 2 flushes ordered for 12:00 PM (150 ml pre tube feed administration and 200 ml). RN #3 identified he had forgotten to administer the 200 ml flush, but he would administer it later. RN #3 identified that the order referring to measuring the length of the g-tube prior to administration of flushes and tube feeding solution did not contain the known measurement of Resident #124's g-tube, but that it should be 21 centimeters which he measures from the button (securement ring) to the base of the Y (end of tube that divides). RN #3 identified because he had gotten 10 mls of residual he had not needed to check the length of the g-tube prior to the flushes or initiating the tube feed because he knew the g-tube was in the correct position and he would measure the length later. RN #3 was unable to identify if it was possible to obtain residual fluid from a g-tube that was out of position and at least partially dislodged. Additionally, RN #3 failed to identify that he had visualized the g-tube sitting in the proper position without any observed movement of the g-tube out of position.Interview with the Dietician on 2/5/26 at 1:30 PM identified Resident #124 was able to take in food orally for comfort/pleasure, but that all his/her required calories and fluid intake were provided by the Jevity 1.5 solution administration. The Dietician identified whether Resident #124 ate any food by mouth or not at each meal, he/she still received all necessary nutrition when the full 1206 ml of Jevity 1.5 solution was administered in addition to the ordered water flushes. The Dietician identified the volume goal indicated within the Jevity 1.5 order was the goal for the amount of Jevity 1.5 solution administered at 67 ml/hr for 18 hours (67 ml/hr X (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	18 hours = 1206 ml). The Dietician identified although the physician order had a time of 6:00 AM for stopping the tube feed administration, it should only be stopped at 6:00 AM if the full amount of the volume goal of 1206 ml for Resident #124 had been reached. The Dietician was unaware of any education for the nurses that explained how the volume goal should be the determination for stopping the tube feed administration and not only the time of the order.Interview with RN #7 on 2/5/26 at 12:25 PM identified that to check placement of the g-tube the nurse needed to verify that the securement piece on the g-tube hadn't migrated from the skin and to check for residual. RN #7 identified that if there was residual when the nurse checked, then the g-tube was in the stomach as it should be and the visualization of the tube placement wasn't necessary.Review of the Tube Feedings-GT or JT policy directed, in part, the purpose was to provide nutrition to residents who are unable to maintain adequate nutrition through regular feeding methods (eating food by mouth). The policy directed that g-tube feedings were completed by use of a feeding pump or by bolus feeding method (pouring small amounts at a time into a syringe hooked to g-tube). The policy directed the dietician along with the MD will determine the tube feeding amount, frequency/duration, and flush amounts for administration. The policy directed the tube feeding is administered by the licensed nurse. The policy directed the licensed nurse will explain the procedure, assemble the equipment, label the feeding bag/bottle, wash hands, and elevate the HOB. The policy directed the licensed nurse will check the tube placement by examining the length of the tube, tube site and by aspirating stomach contents for residual and then re-instill any residual. The policy directed if the residual is excessive to hold the tube feeding. The policy directed to irrigate/flush the g-tube per physician orders, to assess for tube feed intolerance (abdominal distention, abdominal pain, and loose stools) and to document intake, tolerance, and assessment.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy and interviews for the only sampled resident reviewed for skin conditions (Resident #13), the facility failed to measure a Peripherally Inserted Central Catheter (PICC) line to assess for possible migration. The findings include: Resident #13's diagnoses included osteomyelitis of the left ankle and foot, severe sepsis, and bacteremia. An Inter-Agency referral report (W-10) from the hospital) and dated 12/15/25 identified Resident #13 had a double lumen left basilic vein (medial side of arm) PICC line inserted on 11/28/25. A nursing progress note dated 12/15/25 at 1:47 PM identified Resident #13 was admitted to the long-term care facility with osteomyelitis of the right ankle, had a double lumen PICC line in the left arm and would be receiving Intra Venous (IV) antibiotics. Physician's orders dated 12/15/25 directed a PICC line dressing change one time a day every Sunday, label with initials and date after dressing change. Additional physician's orders dated 12/16/25 directed Vancomycin (an antibiotic) Intravenous Solution use 1.25 gram intravenously one time a day for osteomyelitis until 12/30/25 and Meropenem (an antibiotic) Intravenous Solution Reconstituted 1 gram, use 1 gram intravenously three times a day for osteomyelitis until 1/22/26. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #13 was moderately cognitively impaired and was dependent with toileting, transfers, and bed mobility. The MDS indicated Resident #13 had acute osteomyelitis of the left ankle and foot, was receiving IV medications and had IV access. The MDS failed to indicate Resident #13 had a PICC IV access. The Resident Care Plan (RCP) dated 1/8/26 identified Resident #13 was on IV antibiotics and had a double lumen PICC line to the left upper extremity. Interventions included to measure and note the left arm circumference 3 inches above the PICC line insertion site with dressing changes weekly and to measure and note the external catheter length of the PICC line with dressing changes weekly. Interview, review of the clinical record and facility policy with the DNS on 1/29/26 at 11:40 AM indicated for a resident with a PICC line the catheter length and arm circumference measurements were to be taken weekly and documented in the clinical record. The DNS indicated although she would have expected arm circumference and catheter length measurements to be documented and monitored weekly for Resident #13's left upper arm PICC line, review of clinical record failed to indicate orders were put in place and no documentation of measurements was noted in the health record when reviewed together. The DNS was unsure why it was not done and indicated it would have been the responsibility of the admitting charge nurse or nurse supervisor to obtain the required physicians orders for the PICC line. Further review of the clinical record with the DNS identified Resident #13 was readmitted to the facility on [DATE] with a double lumen PICC to the left upper arm and the PICC line was removed by Advanced Practice Registered Nurse (APRN) #1 on 1/23/26. Interview, review of the clinical record and facility policy with APRN #1 on 2/5/26 at 10:53 AM identified she removed Resident #13's PICC line on 1/23/26 and although she noted the resident had tolerated the procedure well, she failed to take measurements or document that the PICC line was fully intact in her progress note. APRN #1 indicated she typically does not measure PICC lines when removing them, but the facility should have been measuring and documenting the residents arm circumference and catheter length weekly when the dressing change was done. APRN #1 identified the measurements were a standard of practice and necessary to determine the potential migration or infiltration of the PICC line especially while the resident was receiving IV antibiotics multiple times a day. APRN #1 indicated it would have been the responsibility of the admitting nurse to ensure the physician's orders for weekly arm circumference and catheter length measurements were obtained for Resident #13's PICC line and she was unsure why it was not done. Interview with the Staff Development nurse (RN #4) and the Infection Preventionist (LPN #3) on 2/5/26 at 12:28 PM identified the unit manager or supervisor should have obtained physician's orders on admission for the weekly measurement and documentation of arm circumference and catheter length of the PICC line. RN #4 (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated IV education for the nursing staff was provided annually and the training and competencies would go over the site and line maintenance required for PICC lines. LPN #3 identified the facility does have batch physician's orders for PICC lines and she was unsure why the orders were not obtained or implemented for Resident #13's left upper arm double lumen PICC on 12/15/25. LPN #3 indicated the weekly measurements for the PICC line would determine the potential migration or infiltration of the catheter and should have been put in place and she would have reviewed it herself, but just recently took over this position and was trying to get the IV stuff better organized.Review of the facility policy, Overview of IV Therapy, undated, directed peripherally inserted central catheter (PICC) length is specific to the resident and upon removal the catheter length should be measured, and it should be verified that all the catheter has been removed. Upper arm circumference should be measured on admission and weekly to monitor for infiltration and external catheter length should be monitored on admission and weekly to monitor for outward migration of the catheter.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility policy and interviews for 1 of 3 residents (Resident #13) reviewed for respiratory care, the facility failed to ensure oxygen was set at the appropriate setting per physician orders. The findings include: Resident #13's diagnoses included COPD, respiratory failure with hypercapnia (abnormally elevated level of carbon dioxide in the blood), emphysema, and pneumonia. Physician orders dated 12/15/25 and currently in effect directed Oxygen at 2 liters/minute via nasal cannula. The quarterly Minimum Data Set (MDS) assessment dated [DATE] was moderately cognitively impaired and was dependent with toileting, transfers and bed mobility. The MDS indicated Resident #13 had a diagnosis of COPD and respiratory failure and was receiving oxygen therapy. A Resident Care Plan (RCP) dated 1/8/26 identified Resident #13 had COPD, respiratory failure and was on continuous oxygen (O2). Interventions included to provide O2 at 2 liters via nasal cannula at all times and to administer oxygen as ordered by the physician. Observations on 1/27/26 at 12:26 PM and 1/29/26 at 12:46 PM noted Resident #13 in bed with oxygen on via nasal cannula and the oxygen concentrator running and set at 3 liters/minute. The oxygen concentrator was out of reach of the resident and the front of the oxygen concentrator (gauge setting/dial and power switch side) was facing the wall under the window (out of reach from the resident therefore Resident #13 could not have manipulated the liter flow him/herself). A nursing note dated 1/29/26 at 2:46 PM identified Resident #13 had no respiratory or cardiac distress noted and was receiving oxygen at 2 liters/minute via nasal cannula continuously. Interview, observation, and review of the clinical record with RN #2 on 1/30/26 at 11:05 AM noted Resident #13 in bed with oxygen on via nasal cannula and the oxygen concentrator running and set at 3 liters/minute. The oxygen concentrator was out of reach of the resident and the front of the oxygen concentrator was facing the wall under the window (out of reach from the resident therefore Resident #13 could not have manipulated the liter flow him/herself). Review of the physician's orders with RN #2 identified Resident #13 was supposed to be receiving oxygen at 2 liters/minute via nasal cannula. RN #2 indicated someone must have incorrectly adjusted Resident #13's oxygen concentrator and she proceeded to readjust the resident's oxygen concentrator setting to 2 liters/minute. RN #2 identified it would have been the charge nurse's responsibility to check and make sure Resident #13's oxygen was set correctly according to the physician's order, and she would need to speak to the charge nurse. Interview and review of the clinical record with LPN #7 on 1/30/26 at 11:15 AM identified she was the charge nurse for Resident #13 and although she had signed the Treatment Administration Record (TAR) for 1/30/26 which directed oxygen at 2 liters/minute continuously, she had failed to check the setting on the resident's oxygen concentrator prior to signing it off. LPN #7 indicated she had observed the resident's oxygen concentrator running and assumed it was at the correct setting from the previous shift. LPN #7 stated she should have checked the setting on Resident #13's oxygen concentrator and made the correction herself. Interview and review of the clinical record with the DNS on 2/5/26 at 10:30 AM identified Resident #13's physicians order directed oxygen at 2 liters/minute via nasal cannula. The DNS indicated it would have been the charge nurse's responsibility to check the oxygen concentrator every shift and ensure the correct setting. Review of the facility policy, Oxygen Administration Nasal Cannula, undated, directed oxygen rates and concentration would be delivered per the physician's order with the oxygen liter flow set to the prescribed liter flow per minute and the administered flow rate documented in the medical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and policy review, the facility failed to ensure medications were stored and labeled according to professional standards and failed to ensure controlled narcotic medications were stored under double lock at all times. The findings include, a. Review of the controlled medications with the DNS on 2/5/26 at 11:50 AM identified 3 Morphine Sulfate 100mg/ml bottles containing 4 cc, 9 cc and 24 cc and 2 bottles of Lacosamide 10 mg/ml containing 100 ml and 300 ml. Additionally, 22 separate medication blister packets identified to be Ativan 0.5mg (29 tablets), Ativan 0.5mg (20 tablets), Ativan 0.5 (2 tablets), Morphine 15mg (27 tablets), Tramadol 50 mg 1(0 tablets), Valium 2mg (18 tablets), Ritalin 10 mg (5 tablets), Ritalin 5mg (17 tablets), Oxycodone 5 mg (30 tablets), Oxycodone 5 mg (28 tablets), Oxycodone 5mg (26 tablets), Oxycodone 5mg (18 tablets), Oxycodone 5mg (9 tablets), Oxycodone 5mg (30 tablets), Oxycodone 5mg (22 tablets), Oxycodone 5mg (22 tablets), Oxycodone 15mg (9 tablets), Oxycodone 15 mg (30 tablets), Oxycodone 20 mg (12 tablets), Oxycodone 20mg (30 tablets), Oxycontin 30mg (3 tablets), and Oxycontin 40mg (22 tablets) were stored in the DNS office under one flip type lock in a file cabinet credenza (made of particleboard type material(and a sliding window accessible from the ground level. Additionally, the DNS identified it was facility policy to keep controlled medications under double lock, and she performed destruction monthly with pending controlled substances kept in her office. The DNS identified she considered her office door the second lock, since she was the only one with a key and always locked the office when it was unoccupied, however observation on 2/5/26 at 9:30 AM identified the DNS office door open without the DNS or staff present. Interview with the Administrator on 2/5/26 at 12:40 PM identified that per fire code the maintenance department has extra keys to all offices, including the DNS office and that he was also in possession of the key to the DNS office. Review of the Best Practice for Medication Dispensing: Schedule II Narcotics Policy directed in part that all controlled substances must be secured under double lock and key. b. Observation and interview with Licensed Practical Nurse (LPN) # 8 on 2/5/26 at 1:04 PM identified LPN #8 removing 2 medication cups from the top drawer of the BH [NAME] medication cart containing an unidentified number of medications and discarding them prior to surveyor review of the medication cart. LPN # 8 identified the medications were being discarded due to resident refusals. Further review of the medication cart with LPN #8 identified a third medication cup containing 11 medications, and a recapped syringe containing 20 cc of an unidentified substance (both located in the top drawer of the medication cart without the benefit of a label). LPN #8 identified that she does not pre-pour medications, and the medications were refused by the resident, however she could not identify the substance in the syringe, when it was prepared or who prepared it. LPN #8 could not identify the policy or procedure on resident refusals. Interview with Registered Nurse (RN) #6 identified it was against facility policy to pre-pour medications ahead of time, keep prepared medications in the top drawer of the medication cart and the policy on resident refusals was to reapproach with the medication and notify the supervisor and provider. Review of the Medication Administration Policy identified in part that all medications should be stored in aa secure, locked are with narcotics and controlled substances under double lock. Additionally, all medications are to be administered safely, accurately and in accordance with physician's orders, facility protocols and applicable state and federal regulations with medications prepared for one resident at a time to minimize errors.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 4 residents (Resident #5) reviewed for nutrition, the facility failed to provide adaptive equipment at mealtime per the physician's order. The findings include:Resident #5's diagnoses included dementia, essential tremor, and unspecified lack of coordination. A physician's order dated 11/18/25 and currently in effect directed red foam on utensils during mealtime at all meals. A Comprehensive Nutritional assessment dated [DATE] and completed by the Registered Dietician (RD) identified Resident #5 was at risk of malnutrition related to a therapeutic diet and chronic diseases and to continue to encourage intake of all meals. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #5 was cognitively intact and required substantial/maximal assistance with bed mobility, toileting, and transfers. The MDS indicated Resident #5 required setup or clean-up assistance with eating and was receiving a therapeutic diet. The Resident Care Plan (RCP) dated 11/24/25 identified Resident #5 was at risk for weight loss and malnutrition and required assistance with activities of daily living due to weakness. Interventions included to provide red foam built up utensils, to set up for meals and assist with cutting up foods. Observations on 1/27/26 at 12:44 PM and 1/30/26 at 7:52 AM noted Resident #5 was using a regular utensil/fork to cut and pick up food (uncut chicken cutlet parmesan with pasta and a fried egg) from the plate with difficulty. The resident was observed alone in his/her room and was eating his/her meals without the benefit of red foam built up utensils. Observation, interview, and review of facility documents with Nurse Aide (NA) #1 on 1/30/26 at 12:29 PM identified she served and set up Resident #5 for lunch without the benefit of red foam built up utensils. NA #1 indicated she was aware Resident #5 needed the red foam built up utensils, but she had made a mistake and had forgotten to provide them. NA #1 proceeded to locate the red foam built up utensils packaged and labeled for Resident #5 in a clear bin on the beverage cart and provided them to him/her. Resident #5 began eating his/her macaroni and cheese with the red foam built up utensil/fork. Review of the resident's meal ticket and NA care card with NA #1 identified Resident #5 should be provided red foam built up utensils at mealtime. Interview with the Food Service Director (FSD) on 1/30/26 at 1:30 PM identified adaptive equipment/utensils were sent to the resident units on a separate cart from the Dietary department and were supposed to be passed out by the NAs on the unit prior to meal service. The FSD indicated Resident #5's red foam built up utensils were prepared, packaged, and labeled with the resident's name and room number for every meal service. The FSD proceeded to show the clear bin Resident #5's red built up utensils were in for the next meal service. The FSD identified it was the responsibility of the NA to ensure the resident received the necessary adaptive equipment as was listed on the resident's meal ticket. Interview and review of the clinical record with the Director of Nurses (DNS) on 2/5/26 at 10:30 AM identified it would have been the responsibility of the NA's to pass adaptive equipment/ utensils to the residents. Review of the resident's meal ticket and NA care card with the DNS indicated Resident #5 should be provided red foam built up utensils with meals. The DNS indicated the NA should have read the NA care card or meal ticket for Resident #5 and ensured the resident had the red built up utensils at mealtime. Interview with Occupational Therapist (OT) #1 on 2/5/26 at 11:04 AM identified Resident #5 was currently receiving services and required red foam built up utensils at mealtime due to having hand tremors and weak hand grasps. OT #1 indicated the red foam built up utensils would help improve the resident's hand grasp and without them the resident would have a harder time grasping, managing, and keeping regular utensils in his/her hand which could affect the resident's nutritional intake. OT #1 identified when an order was put in for adaptive equipment, a sheet was sent to the kitchen, the equipment was sent up to the floor and the nursing staff would be responsible for passing it to the resident at mealtime. Review of the facility policy, Adaptive Feeding Equipment, dated (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/20/18, directed adaptive feeding equipment would be implemented per the recommendation of rehab and all adaptive feeding equipment will be sent by the dietary department. The policy further directs if the adaptive equipment is not received with the meal, staff should notify the kitchen before assisting the resident to eat.

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on review of facility documentation, facility policy, and interviews, the facility failed to provide follow-up to residents in attendance at Resident Council meetings related to resident concerns and failed to attempt alternative measures with a re-occurring issue. The findings include: A Resident Council meeting was conducted as part of the re-certification survey on 1/29/26 at 2:25 PM and attended by 7 residents (Resident #5, Resident #32, Resident #40, Resident #83, Resident #93, Resident #106, and Resident #176). Interviews with the residents in attendance at the meeting on 1/29/26 at 2:25 PM identified if they brought a concern forward to staff at a Resident Council meeting, they would not know if the concern was addressed, and they just assume it wasn't. The meeting identified the concern related to nursing staff being on their phones even during care and often through use of ear buds was so widespread that they no longer speak to the nurses to point out specific staff members who were performing this practice, but that it had been brought forth multiple times in resident council meetings without any noticeable change and without feedback from the facility as to what had been done to address the problem. Resident #40 and Resident #176 identified they had not experienced nursing staff on their phones during actual care, but that they had seen them on their phones on the nursing unit. The other 5 residents (Resident #5, Resident #32, Resident #83, Resident #93, and Resident #106) all stated they had experienced a nursing staff member on their phone via ear buds at least once during care.Review of Resident Council minutes from January 2025 through January 2026 identified a concern related to nursing staff on cell phones and using ear buds had been brought forth in Resident Council in February 2025, March 2025, December 2025, and January 2026.Review of the Resident Council meeting minutes for 2/26/25 identified 12 residents were in attendance. The minutes identified the previous meeting minutes from January 2025 were read and reviewed by the Recreation Director and discussed by the group with no concerns. The minutes identified Resident #32 expressed a concern with the 3:00 PM to 11:00 PM staff wearing ear buds during working hours. A Concern (Grievance) form dated 3/5/25 addressed to the Director of Nursing Services at that time identified a concern was brought forth by Resident #32 at the 2/26/25 resident council meeting related to staff wearing ear buds during the 3:00 PM to 11:00 PM shift. The attached inservicing sheet identified the topic of education was: Resident concern voiced at council meeting that 3;00 PM to 11:00 PM staff were wearing ear buds during the shift. The use of ear buds was not allowed during work time. This practice was disruptive to our residents. Please be mindful of company policy. The education was not dated but there were 20 nursing staff signatures identified that ranged from 3/5/25 to 3/6/25. Review of the Resident Council meeting minutes for 3/27/25 identified 19 residents were in attendance. The minutes identified the previous meeting minutes from February 2025 were read and reviewed by the recreation director and discussed by the group with no concerns. The minutes failed to identify discussion of the actions taken by the facility to address the concern brought forth by Resident #32 at the February 2025 meeting regarding staff wearing ear buds during working hours. The minutes identified Resident #106 and Resident #157 expressed a concern related to Nurse Aides working on the floor with headphones in their ears and talking on their phones while working. The minutes failed to identify if any other residents in attendance agreed with the concern brought forward by Resident #106 and Resident #157. A Concern (Grievance) form dated 4/4/25 addressed to the Director of Nursing Services at that time identified a concern was brought forth at the 2/27/25 Resident Council meeting by Resident #106 and Resident #157 related to Nurse Aides working with headphones (ear buds) and using their phones on the floor. The attached inservicing sheet identified the topic of education was: Concerns from Resident Council, cell phones are to be used on breaks only, off the unit. No staff were allowed to wear ear buds or headphones while on duty. The education was not dated but there were 13 nursing staff signatures identified that were all obtained on 4/8/25. Review of the Resident Council meeting minutes for 4/22/25 identified 16 residents were in attendance. The minutes identified the previous meeting minutes from March (continued on next page)

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F 0565 Level of Harm - Potential for minimal harm Residents Affected - Some	2025 were read and reviewed by the Recreation Director and discussed by the group with no concerns. The minutes failed to identify discussion of the actions taken by the facility to address the concern brought forth by Resident #106 and Resident #157 at the March 2025 meeting.Review of the Resident Council meeting minutes for 12/15/25 identified 13 residents were in attendance. The minutes identified residents expressed concerns that staff members were on their cell phones too often.Although requested, education related to follow-up for December 2025 concerns was not received. Review of the Resident Council meeting minutes for 1/8/26 identified 17 residents were in attendance. The minutes identified residents reported concern that on the 3rd floor unit during the 3:00 PM to 11:00 PM shift, some nursing staff were observed wearing ear buds and using their phones. The minutes failed to identify that the previous meeting minutes were read and failed to identify discussion of actions taken by the facility to address any concerns brought forward at the December 2025 meeting related to staff members who were on their cell phones too much.Education labeled with the 3rd floor unit identified the topic of education was: Wearing ear buds and using cell phones in patient care areas are not allowed. The education was not dated but there were 22 nursing staff signatures identified that ranged from 1/21/26 to 1/23/26.Interview with the Interim Director of Recreation (Dir Rec) on 2/5/26 at 1:00 PM identified he had been in the position for only about 2.5 weeks and he had not held a Resident Council meeting himself but that he would be holding the meeting scheduled 2/19/26 at 2:15 PM. The Dir Rec identified that his process for holding the meeting would be to call the meeting to order, announce attendance, inquire on new business and if someone says something to write it down, for any concerns he would ask if anyone seconds that (agrees), then he would ask about each department specifically to identify concerns, and he would reference the previous meeting minutes. The Dir Rec identified any concerns would be written down, reported to the Administrator, he would follow up during the meeting to ensure concerns had been addressed and to ask for recommendations for activities/recreation. Interview with the Administrator on 2/5/26 at 3:25 PM identified the follow-up to concerns brought forth in Resident Council were in a binder. The Administrator identified there was currently an interim Recreation Director and it was the Recreation Director who typically runs the meetings and then types of the meeting minutes. The Administrator was unable to identify what specifically was reviewed within the Resident Council meetings but that he did receive the meeting minutes each month.Subsequent to surveyor inquiry review of actions taken for resident concerns brought forth in resident council identified 3 times when education had been provided to nursing staff related to the use of cell phones and ear buds but no additional interventions were attempted to resolve the issue of staff using their cell phones/ear buds during work/care.Interview with the Administrator on 2/5/26 at 3:55 PM identified he was unable to identify the reason the education and actions taken by the facility were not discussed with the residents and documented within the Resident Council meeting minutes. Additionally, the Administrator was unable to identify why education related to concerns brought forth in Resident Council was not provided to all staff throughout the building related to the expressed concern, and instead was only provided to the staff on the unit where the resident who expressed the concern was located, considering the residents in attendance at the Resident Council meetings were there to represent all residents in the building.Review of the Resident Council policy directed, in part, the therapeutic recreation department will provide assistance with formation of a Resident Council. The policy directed resident will be given the opportunity to express concerns and/or grievances and contribute their ideas and recommendations regarding facility operations as it is their home. The policy directed that Resident Council will meet monthly, minutes will be maintained which include residents in attendance, opening and adjournment times, discussions and/or actions that take place. The policy directed that department heads should be notified in writing of concerns brought up during the meeting. The policy directed to retain a copy of resolutions that address concerns and to maintain meeting minutes for at least 1 year. The policy further identified resident rights should be reviewed through resident council meetings with a suggestion to cover 1 per month.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075296	A. Building B. Wing	02/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at Branford Hills	189 Alps Road Branford, CT 06405

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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 0584 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and staff interviews for 1 of 6 shower rooms, the facility failed to ensure the shower room was kept in a clean manner. The findings included: An observation during the initial facility tour of the second floor Ledgewood 2 shower room on 1/27/26 at 10:40 AM identified the following:a. The paint on the ceiling was chipping away and cracked.b. There was a black/brown substance on the floors, and walls,c. 1 used white, wet wash cloth was observed on the floor in the shower area.Interview and observation made with Licensed Practical Nurse (LPN) #3 on 1/29/26 at 11:30 AM of the Ledgewood 2 shower room, identified that environmental rounds were completed every other week and that the black substance on the floors/walls was dirt, grout or caulk. LPN #3 further identified the grout or caulk needed to be replaced and the shower was not clean.Interview and observation with the Maintenance Director on 1/29/26 at 11:35 AM identified Ledgewood 2 shower room ceiling needed to be repainted because the paint was peeling. Also, identifying the brown/black substance was glue for the baseboard and it should be cleaned off. Further, identifying Ledgewood 2 shower room was not clean.The Environmental Rounds logs were reviewed and failed to identify any concerns for any of the 6 showers in the facility for the past 6 months.Subsequent to surveyor's inquiry Ledgewood 2 shower room ceiling was scraped, repainted and cleaned. Also, East 2 shower was cleaned of any hair from the drain.