STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075320	A. Building B. Wing	04/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ark Healthcare & Rehabilitation at St. Camillus	494 Elm St Stamford, CT 06902

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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 clinical record review, observations, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #23) reviewed for Activities of Daily Living (ADLs), the facility failed to ensure a resident was provided and or offered showers. The findings include: Resident #23 was admitted on [DATE] with diagnoses that included depression and schizophrenia.The admission MDS assessment dated [DATE] identified Resident #23 had moderately impaired cognition, had not exhibited refusal of care, and required moderate assistance with bathing. The MDS assessment further identified it was very important for the resident to choose her/his preferred bathing method including a shower, tub bath, bed bath, or sponge bath.The RCP dated 3/4/2026 identified Resident #23 required assistance with activities of daily living (ADLs). Interventions included providing supervision for bathing and dressing. An undated nurse aide care card also indicated the resident required supervision for bathing and dressing.Review of nurse aide bathing flowsheets from 2/26/2026 through 4/21/2026 identified since admission, Resident #23's bathing task was signed off and documented on only three occasions on 3/31/2026, 4/7/2026, and 4/10/2026. The flowsheets did not specify whether bathing provided was a shower or a sponge bath.Review of nursing progress notes from 2/26/2026 through 4/21/2026 failed to identify any documented refusal of care or refusal of showers by Resident #23.Review of the undated facility shower schedule identified Resident #23 was scheduled to receive showers twice weekly, every Tuesday and Friday on the 3:00 PM to 11:00 PM shift.Observation on 4/20/2026 at 2:15 PM noted Resident #23 was dressed in a grey sweatshirt and sweatpants, with hair noted to be uncombed and raised upward. Resident #23 identified he/she had been admitted to the facility approximately six weeks prior. Resident #23 stated he/she had been receiving sponge baths and had only received one shower approximately three weeks ago, with none since. Resident #23 identified he/she would prefer showers and would accept them if offered.Interview with LPN #11 on 4/23/2026 at 12:28 PM identified Resident #23 required the assistance of one for showers. LPN#11 indicated Resident #23 was scheduled to receive showers on Tuesday and Friday evenings during the 3:00 PM to 11:00 PM shift and was not aware of any care refusals.Interview with NA #10 on 4/23/2026 at 2:24 PM identified she regularly is assigned to care for Resident #23 on the evening shift. NA#10 indicated she thinks Resident #23's shower day was Tuesdays. NA #10 indicated she could not recall the last time she assisted Resident #23 with a shower. NA identified approximately 2 weeks ago Resident #23's shower schedule was changed from the day shift to evening shift, but she was unable to recall the specific day or reason for the change. NA#10 indicated she documents showers in the electronic medical record but does not typically document sponge baths. NA #10 stated Resident #23 has not refused care.Interview with the Director of Nursing Services (DNS) on 4/24/2026 at 10:33 AM identified the nurse aides are expected to document showers and baths in the nurse aide flowsheets in the resident's electronic medical record. The DNS identified the documentation in the flowsheets does not distinguish between a shower or sponge bath, so it is not possible to determine from the record what type of bathing was provided on a given day to Resident #23.Review of the undated facility Bathing/Shower Policy identified that each resident would be offered a full bath/shower at least weekly.Review of the undated facility ADLs Policy identified that staff should document all care given as well as document care refusals in the electronic medical record.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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, observations, review of facility documentation, facility policy, and interviews the facility failed to ensure food temperatures were consistently obtained and logged prior to serving meals, refrigerator and freezer temperatures were consistently monitored and documented, dishwasher temperatures were consistently monitored and documented prior to washing dishes, sanitizer solution was consistently tested and logged prior to use to disinfect pots and pans and kitchen surfaces per manufacturer recommendations, and dietary staff wore a beard guard when preparing and serving food. The findings include: A tour of the Dietary Department on 4/20/26 at 8:00 AM with the Food Service Director (FSD) identified the following:1. Food temperature for breakfast, lunch, and dinner meal log sheets for 2025 were not completed. 2. Refrigerator and freezer log sheets for 2025 were not completed. 3. Dishwasher temperature log sheets for 2025 were not completed.4. Sanitizer parts per million (PPM) log sheets for 2025 were not completed.Interview with the FSD on 4/20/26 at 8:10 AM identified he did not have any log sheets for 2025. The FSD indicated the only daily log available were from 1/1/2026 to 4/20/2026. The FSD indicated he is new to the facility and is working with staff to ensure all compliance with food service and kitchen protocols. On 4/22/26 at 8:02 AM, the Administrator provided completed daily log sheets for January through April 2026 for food temperatures, refrigeration/freezer temperatures, dishwasher temperatures, and sanitizer concentrations.Interview with the Administrator on 4/22/26 at 10:32 AM identified she was aware that the daily log sheets for food temperatures, refrigerator/freezer temperatures, dishwasher temperatures, and sanitizer PPM levels were not consistently completed during 2025. The Administrator indicated a Quality Assurance and Performance Improvement (QAPI) plan was implemented on 2/17/2026 to address the concerns and completed on 3/17/2026. 5. Observation on 4/22/26 at 8:18 AM during breakfast meal service in the first-floor kitchenette identified [NAME] #1 was at the steam table preparing and serving food with visible facial hair and was not wearing a beard guard. Foods observed on the steam table included scrambled eggs, bacon, sausage, toast, and bread.Interview with the Admissions Director on 4/22/26 at 8:22 AM identified she was the manager assigned to the meal service in the dining room. The Admissions Director identified that all dietary staff are required to wear hair restraints, including beard guards, at all times while preparing or serving food. The Admissions Director indicated [NAME] #1 must have taken his beard guard off and forgot to put a new one on. Subsequent to surveyor inquiry, [NAME] #1 exited the kitchenette and returned wearing a beard guard. Review of the undated facility Food Temperature Check Policy, directed in part, prior to delivery focuses on ensuring time/temperature control for safety foods are safe adhering to the FDA Food Code and CMS regulations. Policies require checking food temperatures before placing them into the transportation carts or on the tray line.Review of the undated facility Refrigeration Temperature Recording Policy, directed in part, record keeping for temperature control refrigeration equipment is necessary to ensure foods are maintained at optimum quality and to prevent spoiling and/or foodborne illness. It is the FSD responsibility to have protocols in place where temperatures are monitored and logged.Review of the undated facility Storage of Frozen and Refrigerated Foods Policy, directed in part, the Food and Nutrition Service Department would adhere to all guidelines and regulations concerning the refrigeration and freezing of foods. Keep temperatures for freezers at 0 degrees Fahrenheit or below, record all unit temperatures daily on the refrigerator/freezer temperature record and retain per state regulation.Review of facility Sanitizer Bucket Policy dated 3/27/20, directed in part, the proper sanitizer bucket use in order to maintain sanitary conditions of work areas and equipment. Prepare sanitizer solution using QUAT and follow manufacture instructions and levels of chemicals. Test PPM using a test strip made for QUAT ensure test strips are in good condition (not previously wet) and not expired. After checking sanitizer level is accurate, log and verify level on PPM log. Review of facility Dish Machine Policy dated 5/8/20, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	directed in part, ensure proper sanitary dishwashing with hi-temp and low temp dish machines. Dietary staff will record dish machine temperatures on a dish machine temperature log before they begin the dishes from each meal service. Any unusual or substandard readings should be reported immediately to the FSD or Maintenance Department.Review of facility Hair Restraint Policy dated 1/20/17, directed in part, anyone within the kitchen, who will have close contact with the preparation or service of food, food storage areas, equipment will keep hair effectively/appropriately restrained to include facial hair. The purpose of the hair restraint is to prevent hair from contacting food and food equipment surfaces and to deter food service employees from touching their hair.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on clinical record reviews, review of the facility Infection Control Program, facility documents facility policy and interviews, the facility failed to provide education regarding the Covid Vaccine to staff members offering to provide the vaccine or inform where staff could obtain a Covid vaccination, and the facility failed to ensure documentation of screening residents for the eligibility to receive the Covid vaccine was completed, and residents and responsible parties received copies of Covid Vaccination educational materials prior to deciding to vaccinate or decline vaccination. The findings include: An interview and facility document review with the Assistant Director of Nursing Services (ADNS/Infection Preventionist(IP) on 4/23/2026 at 10:15 AM identified she/he was unable to locate specific staff education regarding the Covid Vaccine and offering the vaccine or indicate where they could receive the vaccine. The Staff Development Nurse, RN#2 identified she/he provided staff training on the Covid infection and staff members roles within the facility as it pertains to the infection control process. However, she/he indicated she/he was not specific with education regarding the Covid 19 vaccine and did not offer it to the staff. An interview with the Assistant Director of Nursing Services (ADNS)/Infection Preventionist on 4/23/2026 at 10:15 identified Resident #63's refusal to consent to vaccination form dated 8/15/2024 was signed to indicate the receipt and review of the CDC Vaccination statement but the IP could not provide evidence of what educational materials were provided and who obtained the verbal consent. A review of Resident # 1's clinical record identified on 10/23/2024 a verbal consent was provided by the Conservator of Person for Resident #1 to receive the influenza and Covid 19. However, a review of the consent form identified no page 2 which identified the conservators signature attesting to the receipt of the vaccination information sheet. Additionally, the form noted no documentation of the screening process to determine eligibility to receive the vaccine. The ADNS / IP further indicated s/he screens every resident before providing the Covid 19 vaccine but does not document it. S/he further indicated obtaining verbal consent for the Covid 19 vaccines and education of the vaccine over the phone from the resident's responsible party is done by the party responding yes or no to the understanding of education. The ADNS/IP further indicated that there was a check-off in the electronic vaccination system for each resident, the nurse can check yes or no if education was provided and they all are checked yes. The ADNS/IP could not provide any information of any type of educational source that's/he provided, reading material over the phone or faxed to responsible parties or to residents. On 4/27/2026 at 10:40AM an interview and facility document review with ADNS/IP identified she/he utilized an education form from the Centers for Disease Control and Prevention that was provided by the previous IP. The ADNS/IP further indicated she/he would be using the CDC educational sheets in the future to educate residents and responsible parties. The facility policy labeled Covid 19 Vaccine given onsite indicated all residents who have no medical contraindications to the vaccine will be offered the Covid 19 vaccine based upon CDC guidance and the facility would provide the Vaccination Information Sheet outlining the benefits and risks to the resident or legal representative in conjunction with obtaining the consent for the vaccination.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, facility documentation, facility policy, and interviews for 1 of 6 residents (Resident #3) reviewed for dining, the facility failed to ensure a dignified dining experience. The findings include:Resident #3 had diagnoses that included dementia and end-stage renal disease. The physician's order dated 3/1/26 directed a regular renal diet and thin liquids. The annual Minimum Data Set (MDS) dated [DATE] identified Resident #3 had severely impaired cognition and required setup or cleanup assistance for eating.The Resident Care Plan (RCP) dated 3/19/26 identified Resident #3 was at risk for further decline in ADL self-care related to increased weakness, fatigue, and continuous deconditioning. Interventions included the use of adaptive equipment, built-up utensils, scoop plate, double- handled sippy cup, and assistance of one with eating.Observation on 4/22/26 at 8:50 AM noted Resident #3 seated in a wheelchair at a round table in the lounge while Nurse Aide (NA) #1 fed him/her breakfast. NA #1 stood to the left side of the wheelchair, standing over Resident #3 while feeding him/her. NA #1 fed Resident #3 scrambled eggs with a spoon from a scoop dish, followed by fortified cereal, and periodically offered sips of liquid from a two-handled cup between bites. No chair was available for NA #1 to sit.Interview with NA #1 on 4/22/26 at 9:00 AM identified she had worked at the facility for approximately one year. NA #1 indicated she fed Resident #3 while standing because the resident would be out for several hours and needed to eat beforehand. NA #1 stated she remained standing because no chairs were available and she needed to monitor the area.Observation on 4/22/26 at 9:04 AM noted Licensed Practical Nurse (LPN) #1 (MDS Coordinator) exit the elevator, enter the lounge, and retrieved a wheeled chair from the nurse's station. LPN #1 brought the chair into the lounge and instructed NA #1 to sit. NA #1 stated she did not need to sit. LPN #1 again directed NA #1 to sit while feeding Resident #3. NA #1 responded that she was almost finished. LPN #1 then left the lounge. At 9:06 AM, NA #1 sat down and offered Resident #3 the remaining liquid from the two-handled cup. At 9:09 AM, NA #1 completed feeding Resident #3.Interview with LPN #1 on 4/22/26 at 9:09 AM identified she had just arrived on the unit and observed NA #1 standing while feeding Resident #3. LPN #1 indicated she retrieved a chair for NA #1 so she could sit while feeding Resident #3. LPN #1 identified nurse aides should sit while feeding a resident to promote dignity.Interview with the Director of Nursing (DNS) on 4/22/26 at 9:22 AM identified that nurse aides must sit while feeding residents, maintain eye contact, and engage in conversation to promote a dignified dining experience. The DNS stated that NA #1 should not have stood while feeding Resident #3.Review of facility Feeding Policy (undated) identified the purpose was to provide adequate nutrition to residents unable to feed themselves. The procedure is to wash hands, explain procedure to the resident, and assist resident to a comfortable position. While feeding the resident make sure assistance is provided in a dignified and respectful manner during feeding. Staff are to talk to the resident, alternate bites of food with types of food on the plate, feed the resident slowly, and do not stand while feeding a resident.

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F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews for 1 of 1 resident (Resident #52) reviewed for personal funds, the facility failed to ensure quarterly statements were consistently provided to the resident. The findings include: Resident #52 diagnosis included ulcerative colitis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #52 was cognitively intact. An interview, clinical record review, and facility document review with Business Office Manager (BOM) #1 on 4/27/2026 at 11:51 AM identified she was covering the position due to a vacancy and that Business Office Managers from sister facilities were assisting. BOM #1 identified Resident #52 had a personal account with the facility and was responsible for himself/herself. BOM #1 indicated Resident #52 would be the person to receive quarterly account statements from the facility. BOM #1 identified the procedure was quarterly statements are provided to residents or responsible parties with personal funds account. BOM #1 indicated residents residing in the facility who are responsible for themselves are expected to receive statements in person and sign to acknowledge receipt, while statements for individuals not residing in the facility are mailed. BOM #1 indicated she was unaware of the prior process used by the previous Business Office Managers and would contact the regional BOM to determine if documentation existed to verify whether Resident #52 had received prior quarterly statements. A follow-up interview and facility document review with BOM #1 on 4/27/2026 at 12:58 PM identified because Resident #52 indicated he/she had not received prior quarterly account statements she provided a copy of the current January 2026 through March 2026 quarterly statement to Resident #52. Resident #52 signed the statement at that time to acknowledge receipt. BOM #1 was unable to provide documentation demonstrating that Resident #52 received quarterly account statements prior to this date.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, review of facility policy and staff interviews for 1 of 4 residents (Resident #6) reviewed for abuse, the facility failed to keep the resident safe from physical and verbal abuse. The findings include:Resident #6 a conserved resident was admitted with diagnoses of bipolar disorder and anxiety disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #6 had moderately impaired cognition and exhibited verbal behaviors directed towards others. Resident #6 required substantial/maximal assistance for toileting, was independent in standing from a sitting position, and used a wheelchair for mobility. The MDS assessment further identified Resident #6 did not have any skin problems or wounds.The Resident Care Plan (RCP) dated 1/21/2025 identified Resident #6 was at risk for alteration in mood and behaviors as evidenced by yelling at staff. Interventions included leaving the resident alone and returning later if the resident was being abusive towards staff.A psychiatric evaluation dated 1/21/2025 identified Resident #6 exhibited baseline confusion, delusional thinking, and disorganized thought process with a tendency toward impulsiveness when irritable. Recommendations included close monitoring and behavioral documentation.A weekly skin observation tool dated 1/25/2025 identified no skin issues.A nursing note dated 1/29/2025 identified Resident #6 refused care and refused staff to enter her/his room, even to care for her/his roommate.A nursing note dated 1/31/2025 identified an ongoing investigation of abuse, and a full body audit was performed. The note identified an abrasion to the left arm measuring 4.0 Centimeters (CM) by 2.0 CM, and an abrasion to the right leg measuring 7.0 CM by 0.5 CM. The Advanced Practice Registered Nurse (APRN) was informed and reviewed, no treatment orders, leave abrasion open to air. Additionally, noted Resident # 6 was referred to psychiatry for a telehealth consult which was conducted by an APRN and staff were directed to administer a stat (one time dose) of Seroquel (medication used to treat mood disorders) 50 milligrams (mg) Seroquel to the resident for mood and behavior and escalation. A review of the facility Reportable Incident report dated 1/31/2025 identified that a Nursing Assistant student (Person #1) reported on 1/31/2025, Resident #6 came out of the bathroom when Nurse Aide (NA#11) and Person #1 were going to provide care to Resident #6's roommate. Person #1's statement indicated Resident #6 began to kick NA#11, and NA#11 kicked Resident #6 back on the legs. Person #1 reported that NA# 11 called Resident #6 a crazy bitch. The statement further identified NA#11 pushed the resident's wheelchair and scratched the resident's left arm. A statement by NA#11 identified that when NA#11 and Person #1 were providing care to Resident #6's roommate, Resident #6 entered the room and told NA#11 to leave. NA#11 told Resident #6 she was almost done and then would leave. The statement then indicated Resident #6 threw a soiled brief at NA#11, at which point NA#11asked Person #1 to move Resident #6's wheelchair so NA#11 could leave; however, Person #1 was scared, at which time NA#11 moved Resident #6's wheelchair to leave the room. Additionally, the report indicated that on 1-31-25 NA #11 was immediately placed on administrative leave.A statement by NA#13 and NA#14 identified that they took care of Resident #6 on 1/30/2026 and noted no skin impairment. The facility's Reportable Incident report further indicated after completion of the facility's investigation, NA#11 was terminated.A police report dated 1/31/25 identified NA#11 was interviewed with the help of an interpreter by the police and indicated Resident #6 threw a soiled diaper at NA#11and asked NA#11 to leave. NA #11 continued cleaning Resident #6's roommate after Resident #6 had asked NA#11 to leave and Resident #6 kicked NA#11 on the left and right legs. The report identified NA#11 indicated that it was Person #1 who moved Resident #6's wheelchair out of the way so NA#11 could leave. The police report identified that officers were unable to communicate with Resident #6. The police report further indicated that photographs of the scratches on Resident #6's arm were submitted to the appropriate department by the officers.The social worker note dated 1/31/25 12:30 PM (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified the Social Worker (SW) and Administrator met with Resident # 6 regarding reported allegation of abuse. The resident was inconsistent with her/his thoughts and could not recall alleged reported incident. Emotional support was provided and Resident # 6 was encouraged to reach out to staff with any issues /concerns. Appropriate departments were made aware. The Social Worker will update upon new incident.A weekly skin observation tool dated 2/6/2025 identified fading bruises, yellow in color, to the right leg and a fading abrasion to the right lower leg. The skin observation tool further identified fading abraded spots on the left forearm and a fading bruise on the right upper arm.Review of NA #11 employee file noted the summary of the investigation by completed by administration dated 2/11/25 identified NA #11 had been terminated for allegation of witnessed resident abuse , after the resident was found to have skin alteration consistent with alleged incident.On 4/24/2026 at 2:04 PM, an interview with Person #1in their preferred language indicated that Person #1 and NA#11 entered the room to clean Resident #6's roommate when Resident #6 yelled through the bathroom door, which was slightly open to not come in. Person #1 indicated NA#11 opened the bathroom door and NA#11 and Resident #6 began arguing, and NA#11 called Resident #6 a crazy bitch. Resident #6 then threw a soiled diaper at NA#11. Person #1 indicated NA#11 tried to close the bathroom door on Resident #6 and continued calling Resident #6 a crazy bitch. Resident #6 then started kicking NA#11 on the legs, and NA#11 kicked Resident #6 back on Resident #6's right leg. Person #1 further indicated NA#11 was restraining Resident #6 by holding the resident's arm down against the armrest of the wheelchair. Person #1 indicated the main door of the room was closed and she/he was not aware of anybody hearing the incident.On 4/27/2026 at 9:12 AM, an interview with NA#11 using an interpreter of NA#11's choosing (Person #2) indicated NA#11 and Person #1 were changing another resident when Resident #6 came into the room from the bathroom and told NA#11 to get out. NA#11 indicated that she did not leave, and Resident #6 began fighting, stood up from her/his wheelchair, and threw a soiled diaper at NA#11's face. NA #11 indicated Resident #6 was kicking and cursing and she/he (NA#11) sat Resident #6 back in the wheelchair. NA#11 indicated that she/he brought the wheelchair close to Resident #6's and Resident #6 sat her/himself back down while NA#11 held Resident#6's hand for assistance. NA#11 could not recall which of Resident#6's hands she/he held. NA#6 denied calling Resident #6 a crazy bitch, denied kicking Resident #6 on the legs, and denied pushing Resident #6's arms down against the armrests of the wheelchair. NA#11 further indicated that she/he did not ring the call bell or call for help when Resident #6 was agitated and the main door of the room was closed.On 4/27/2026 at 12:34 PM, an interview with the Director of Nursing Services (DNS) identified Person #1 did not have anything to gain from making a false accusation, and Resident #6's injuries did not have another clear cause. The DNS indicated that, out of an abundance of caution, NA#11 was terminated at the conclusion of the facilities investigation.Attempts to interview Resident #6 were unsuccessful as Resident #6 was on medical leave.Resident #6's roommate at the time of the incident (Resident #117) was unable to be interviewed due to severe cognitive impairment.A review of the facility policy for Abuse/ Resident policy updated on 7/23/23 noted abuse shall be defined as willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Verbal abuse is defined as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families or within their hearing distance, regardless of their age, ability to comprehend or disability. Physical abuse includes hitting, slapping, punching, and kicking. It also includes controlling behavior through corporal punishment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident #21 and Resident# 117) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the state agency was updated subsequent to the residents' new psychiatric diagnoses. The findings include:1. Resident #21 had diagnoses that included anxiety and dementia. a. A PASRR Level 1 screen dated 11/27/24 identified Resident #21 had a diagnosis of dementia with no mental health diagnosis and received a dementia exemption. The outcome identified Resident #21's approval remained valid unless changes occur or additional information suggests a primary mental health illness then rescreening should occur to reassess need for PASRR evaluation.A psychiatric Advanced Practice Registered Nurse (APRN) note dated 12/2/24 identified Resident #21 had diagnoses of anxiety and depression (new diagnoses for Resident #21).A physician's order dated 12/2/24 directed to administer Seroquel (medication used to treat depression or frenzied, abnormally excited or irritated mood) 12.5 milligrams (mg) twice a day as needed for 14 days. The admission MDS dated [DATE] identified Resident #21 had severely impaired cognition, was not currently considered by the state agency as a Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition and had active diagnoses that included dementia and anxiety.The Resident Care Plan (RCP) dated 12/24/24 identified Resident #21 had anxiety and used psychotropic medication. Interventions included monitoring the resident's mood and behaviors.A psychiatric APRN note dated 1/28/25 identified Resident #21 had diagnoses of anxiety, dementia, and bipolar disorder (new diagnoses for Resident #21). A physician's order dated 2/26/25 directed to administer Depakote (mood stabilizer) delayed released 250 mg tablet twice a day related to bipolar disorder.b. The quarterly MDS dated [DATE] identified Resident #21 had active diagnoses of anxiety, hypertension, dementia, and bipolar disorder. The RCP dated 4/18/25 identified Resident #21 was at risk for potential adverse effects related to the use of psychotropic drugs used to treat anxiety and bipolar disorder. Interventions directed to monitor mood and behaviors because they may fluctuate due to diagnoses.Review of the clinical record identified Resident #21's diagnosis of bipolar disorder was added on 5/19/25 and a diagnosis depression was added on 5/27/25.A psychiatric APRN note dated 5/27/25 identified Resident #21 had diagnoses of anxiety, depression, and bipolar disorder. The physician's order dated 6/9/25 directed to administer Trazodone (medication used to treat depression) 50 mg every day in the afternoon for depression and Valproic Acid (mood stabilizer) oral solution 250 mg/5 milliliter (ml) give 2.5 ml by mouth one time a day and 5.0 ml at bedtime for bipolar disorder. Review of the clinical record failed to identify the PASSR contracted agency was notified of the new psychiatric diagnoses of depression and bipolar disorder from 2/26/25 through 4/22/26 in order to conduct an additional Level 1 and Level 2 screen.Interview with Social Worker (SW) #2 with the Director of Social Services (SW #1) present on 4/22/2026 at 9:40 AM identified she had worked at the facility for approximately a year. SW #2 identified she is responsible for reviewing PASRRs for all new admissions and ensuring updates are submitted to the state agency when a resident receives a new mental health diagnosis. SW #2 indicated she completed an audit of all residents to ensure documented diagnoses matched the PASRRs. SW #2 stated that Resident #21's most recent PASRR, dated 11/27/24, did not include diagnoses of anxiety, depression, or bipolar disorder. SW #2 indicated she must have missed the discrepancy during her audit. Subsequent to surveyor inquiry, a PASRR Level I Screen submission request dated 4/22/26 was made to the PASSR contracted agency to report that Resident #21 had new diagnoses of anxiety, depression, and bipolar disorder. 2. Resident #117 had diagnosis that included dementia, conversion disorder with seizures, major depression disorder, and anxiety.a. A PASRR Level 1 screen dated 11/18/22 identified Resident #117 had no mental health diagnosis known or suspected and not on any medication. The outcome (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	identified Level 2 is not required there is no evidence of a PASRR condition or a serious behavioral health condition. If changes occur or new information refutes these findings a new screen must be submitted. Review of the clinical record identified that Resident #117's diagnosis of major depression was added on 8/8/24, which was a new diagnosis added after completion of the PASRR dated 11/18/22.The quarterly MDS dated [DATE] identified Resident #117 had moderately impaired cognition and active diagnoses that included dementia, seizure disorder, anxiety, depression, and bipolar disorder. A psychiatric APRN note dated 9/5/24 identified Resident #117 had diagnoses of anxiety, depressive disorder, and dementia.b. The quarterly MDS dated [DATE] identified Resident #117 had moderately impaired cognition and active diagnoses that included dementia, seizure disorder, anxiety, depression, and bipolar disorder.The RCP dated 2/24/26 identified Resident #117 used psychotropic medications for anxiety and depression. Interventions directed to administer psychotropic medication and antidepressants as ordered by the physician.A psychiatric APRN note dated 2/20/26 identified Resident #117 had diagnoses of anxiety, depressive disorder, and dementia.A physician's order dated 3/1/26 directed to administer Depakote (mood stabilizer) sprinkles delayed release 500 milligrams (mg) every 12 hours. Interview with SW #2 on 4/22/26 at 9:55 AM identified she was responsible for updated the PASRR contacted agency when there was a new psychiatric diagnosis. SW #2 indicated during recent chart audits she noted Resident #117's most recent PASRR, dated 11/18/22 did not include diagnoses of anxiety, major depressive disorder, or bipolar disorder. SW #2 identified Resident #117's diagnoses of anxiety, major depressive disorder, and bipolar disorder occurred after Resident #117's admission to the facility and had not been communicated to the PASRR state agency. SW #2 identified although she was aware the PASRR state agency should have been updated she was unable to identify the reason why she had not updated the PASRR state agency.Subsequent to surveyor inquiry, a PASRR Level I Screen submission request dated 4/22/26 was made to the PASSR contracted agency to report that Resident #117 had new diagnoses of anxiety, major depression disorder, and bipolar disorder. Although requested, a facility PASRR policy was not provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, review of facility policy and interviews for 1 of 4 residents (Resident #1) reviewed for pressure ulcers, the facility failed to revise the resident plan of care regarding pressure ulcer interventions to prevent skin breakdown. The findings include: Resident #1 was admitted on [DATE] diagnosis includes pneumonia. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was cognitively intact, was at risk for pressure ulcers, and had an unstageable deep tissue injury. The care plan (not dated) indicated Resident #1 had a pressure ulcer classified as a deep tissue injury (DTI) on the right buttock which was present on admission to the facility. Interventions included checking skin at least weekly, providing good nutrition and providing incontinent care. A Health Status Note dated 3/26/2026 at 12:17 PM identified during an observation of Resident # 1's left heel the heel was noted to be boggy with skin intact; no complaints of discomfort and bilateral heel boots were applied. The note further indicated that the Advanced Practice Registered Nurse (APRN) was notified and no new orders . The 3/26/2026 wound consultant documentation identified Resident # 1's left heel was boggy, directed skin prep to the heels leaving heels open to the air and to offload the heels. The physician's orders dated 3/26/2026 directed to offload heels every shift and to apply skin prep to the heels and leave open to air. The physician's orders dated 4/16/2026 directed to check the air mattress for functioning every shift adjusting to the resident's weight or comfort level. An observation on 4/22/2026 at12:20 PM identified Resident #1 in bed with blue booties on both feet. On 4/22/2026 at 12:26 PM an interview and record review with the Registered Nurse (RN) supervisor (RN #2) indicated the Nurse Aide Care cards are on the computer, the nurse aides can access them on the tablets they use to document care. RN#2 indicated the information on the care card flows from the information placed in the care plan. However, upon review of Resident # 1's care plan identified the care plan had not been updated (for 22 days) with the development of a left heel pressure ulcer or the interventions to prevent further skin breakdown which included offloading of the heels. RN#2 indicated the care plan identified a pressure ulcer of the buttock from admission and did not reflect Resident #1's skin status. RN #2 further indicated the physician's orders did flow over to the Treatment Kardex for the licensed nurse to view and sign off after completion. RN #2 also indicated it would be up to the licensed nurse to inform the nurse aides of the need to offload Resident #1's heels. The Assistant Director of Nursing Services (ADNS) approached RN#2 and the surveyor on 4/22/2026 at 12:34 PM to reviewed Resident # 1's care plan. RN #2 further indicated she/he could not find the care plan revised with the left heel ulcer or the need to offload the heels. The facility policy labeled Resident Profile/Care Cards given onsite indicated in part the purpose is to inform staff who assist the residents on a daily basis of the resident plan of care. The policy further indicated the care card will be updated as needed with changes to the resident plan of care. After surveyor inquiry, Resident # 1's care card and care plan was updated on 4/27/2026 at 10:31 AM to include offloading heel boots and the application of heel boots to both feet while in bed and the wheelchair.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, observation, and interviews for 1 of 3 residents (Resident #59) reviewed for pressure ulcers, the facility failed to ensure a physician's order was obtained to included appropriate parameters for as needed wound treatment which resulted in the resident receiving inconsistent wound treatment. The findings include: Resident #59 was admitted with diagnoses of dementia and diabetes mellitus.The admission MDS assessment dated [DATE] identified Resident #59 as severely cognitively impaired and required substantial/maximal assistance for toileting, and supervision/touching assistance for bathing.A physician's order dated 4/17/2026 directed to cleanse the sacral wound with vashe, apply Medi honey gel, and to cover with a dry dressing daily.A review of the Treatment Administration Record from 4/17/2026 through 4/23/2026 identified the sacral dressing had been changed as per order on the 7:00 AM to 3 :00 PM (day) shift.On 4/24/2026 at 1:23 PM, an observation of the sacral dressing change by LPN#3 identified there was no old dressing over Resident #59's sacral wound. Resident #59 was in bed and dressed in white underwear, grey pants, and a grey shirt. LPN#3 looked for the old dressing in the resident's clothes and bed but could not locate the dressing. After the new sacral dressing was applied, a record review was conducted with LPN#3. A review of the physician's orders failed to identify a when needed (PRN) order for dressing changes. LPN#3 indicated that if a dressing fell off, he would notify the nursing supervisor to obtain a PRN order. LPN#3 indicated he was not aware of Resident #59 not having a sacral dressing on and or that the dressing had fallen off.On 4/24/2026 at 1:30 PM, an interview with NA#9 identified she helped Resident #59 wash and dress before breakfast around 8:00 AM or 8:30 AM and did not see a dressing on the resident.On 4/24/2026 at 1:46 PM, an interview with the wound care provider Medical Doctor (MD#1) identified the purpose of the Medi honey for Resident #59 was to provide autolytic debridement, provide moisture, and provide a level of antibacterial protection. MD#1 further indicated the foam dressing over the wound would provide a level of moisture, support, and protection from bacteria. MD#1 indicated that by not having the dressing in place, the wound would be at higher risk for infection and delayed healing.A review of facility policy for Wound and Skin Care indicated that the interdisciplinary plan of care would address goals and interventions directed towards treatment of pressure ulcers consistent with resident goals.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, facility policy and interviews for 1 of 4 Residents (Resident #52) reviewed for nutrition, the facility failed to ensure a resident with a therapeutic diet was provided with food items to meet the needs of the resident. The findings include: Resident #52's diagnoses included ulcerative colitis and diverticulitis.The physician's order dated 10/16/2025 directed a regular diet with regular texture, thin consistency, low fiber, and double portions/double protein with all meals.The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 had intact cognition and was not on a therapeutic diet (despite the physician's order for a low fiber diet).The Resident Care Plan dated 4/28/2026 identified Resident #52 was at risk for malnutrition related to multiple chronic diseases and exacerbation of ulcerative colitis. Interventions included providing supplements as ordered, offering preferred foods, and serving the prescribed low fiber diet with double portions.Observation on 4/21/2026 at 12:16 PM identified Resident #52's lunch tray with a meal ticket that noted a protein shake, and assorted sandwiches were provided, however the protein shake and assorted sandwich were not present on the lunch tray.Interview with the Dietary Manager on 4/22/2026 at 10:30 AM identified staff prepare meal trays based on the meal ticket. The Dietary Manager indicated uncertainty regarding which foods are appropriate for a low fiber diet and stated that staff rely on the menu rather than specific dietary guidance. The Dietary Manager indicated consultation with the dietician would be necessary to determine whether certain foods, such as broccoli, are appropriate for a low fiber diet.Interview with Dietitian #1 on 4/24/2026 at 10:41 AM identified a low fiber diet as a therapeutic diet and described the diet as one that excludes foods containing seeds or skins. Dietitian #1 indicated broccoli could be served because it does not contain seeds, but did not clarify whether preparation modifications, such as removal of the stalk skin, were required. Dietitian #1 identified the electronic diet order system does not include a selectable option for a low fiber diet and must be entered in the comment section.Review of facility Diet Manual dated 2022 identified broccoli is not allowed on a low fiber diet.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on clinical record reviews, review of the facility Infection Control Program, review of facility documentation and interviews for 3 out 3 sampled residents (Residents # 22, #49 and # 63) reviewed for immunization, the facility failed to ensure the screening process for vaccination eligibility consistently documented dates in the facility vaccination consent forms. The facility did not provide evidence of residents or responsible parties receipt of copies of educational materials to assist with deciding to vaccinate or decline the Influenza (Flu) and pneumovax vaccination. The findings included: 1.Resident #22 diagnosis includes diabetes mellitus. Resident #22's Universal Vaccine Consent and Administration Record dated 10/23/2024 identified a verbal consent from the Conservator of Person (COP) obtained for Resident #22 for the Flu. However, the form above the documented verbal consent where screening for eligibility to receive the vaccine remained blank. Page 2 of the consent was missing another consent form without a date to indicated verbal consent for the Flu Vaccine. The Flu consent form obtained from the attorney had no staff signature and screening for eligibility to receive a vaccine was left blank also on page 2 (which indicated acknowledging the receipt of a copy and educational understanding) of the vaccine was not signed by the attorney. 2. Resident #49's diagnosis includes pyelonephritis (kidney infection). Resident #49's Universal Vaccine Consent and Administration Record dated 10/9/2024 indicated verbal consent was obtained from the patient to receive Flu vaccines. The screening area for eligibility to receive the vaccines was not incomplete. On page 2 there was no evidence of receipt of educational materials prior to receiving the vaccines to assist in deciding and the indication of Resident #49's understanding of the forms.Another Universal Vaccine consent form not dated with resident's name was in print in the signature section of the first page of the form indicating Flu vaccine (written in the guardian or representative section) with the same printed name located in the signature section of page 2 without a date. 3. Resident #63's diagnosis includes Parkinson's Disease. The Universal Vaccine Consent and Administration Record for Resident # 63 was not dated but did indicate verbal consent was obtained from a family member. However, the form did not indicate the staff member who obtained the verbal consent. The screening area for eligibility to receive the vaccines was incomplete on page 2. The form also did not indicate receipt of educational materials prior to receiving the vaccines to assist in decision making and Resident #49's understanding of the forms. An interview with the Assistant Director of Nursing Services (ADNS)/Infection Preventionist on 4/23/2026 at 10:15 AM indicated s/he screens every resident before providing the Flu vaccine but does not document the screening. The ADNS further indicated she/he obtains verbal consent for the Flu vaccines and education over the phone from the resident's responsible party education which is acknowledgement of understanding by them responding yes or no. The ADNS/IP further indicated that there was a check-off in the electronic vaccination system for each resident, the nurse can check yes or no if education was provided and they all are checked yes. The ADNS/IP could not provide any information of any type of educational resources that's/he provided over the phone such as reading materials or faxed documents to responsible parties or residents. On 4/27/2026 at 10:40AM an interview and facility document review with ADNS/IP identified he utilized an education form from the Centers for Disease Control and Prevention (CDD) that was provided by the previous IP. The ADNS further indicated she/he would be using the CDC educational sheets in the future to educate residents and responsible parties. The facility policies and procedures labeled Influenza Vaccine and Pneumococcal Vaccine given on site notes both the Flu or Pneumococcal vaccines will only be given with a physician order and a signed consent form. The resident or responsible party will be provided a copy of the Influenza Vaccine Fact Sheet and the Pneumococcal Fact Sheet, education on the vaccines risks and benefits prior to administration and the resident and or responsible party will have the opportunity to ask questions of the Director of Nursing Services (DNS)or his/her designee.