STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075358	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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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 0686 Level of Harm - 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 observation, clinical record review, facility policy review and interviews, the facility failed to ensure residents at high risk for pressure ulcer development were promptly assessed and provided timely preventative interventions. Specifically, for one sampled resident (Resident #7), the facility failed to implement turning and repositioning, and other preventive measures despite known risk factors and an existing pressure injury and failed to develop and implement a care plan to prevent pressure ulcers. These failures resulted in the development of a new pressure injury to the coccyx that progressed to an unstageable wound and ultimately to a Stage 4 pressure ulcer, causing actual harm. Resident #7 was admitted on [DATE] with diagnoses that included dementia, nutritional deficiency, stage 4 pressure ulcer wound, and osteoarthritis.The W-10 (inter-agency patient referral form) dated 8/1/24 identified Resident #7 required assistance with Activities of Daily Living (ADL's), assistance of 2 staff for transfers, and had the presence of a stage 3 pressure wound to the left heel.RN #1's nurse's note dated 8/1/24 at 3:16 PM identified Resident #7 was admitted to the facility in stable condition and was adjusting to his/her room. Resident #7's lower extremity was dry, peeling and had a stage 3 pressure ulcer to the left heel. The left heel pressure ulcer wound measured 1.0 centimeters (cm) in length and 1.0 cm in width and had good granulation tissue in the wound bed. The physician was at the facility and admitted the resident.Review of the clinical record on 8/1/24 failed to reflect that a Braden Scale assessment (used to predict the risk of pressure ulcer development) had been completed upon admission for Resident #7.The wound physician's initial evaluation dated 8/8/24 identified Resident #7 had an unstageable wound to the left heel related to pressure. The wound size was documented as 0.6 centimeters (cm) in length by 0.5 centimeters (cm) in width by 0.1 centimeters (cm) in depth. The treatment plan directed: cleanse the wound followed by the application of calcium alginate to the base of the wound and secure with a dry clean dressing daily and as needed when soiled/saturated. It further recommended to follow the facility pressure ulcer prevention protocol to include a pressure redistribution mattress, wheelchair pressure redistribution cushion per facility policy, offload heel, and turn and reposition every two hours.The admission MDS assessment dated [DATE] identified Resident #7 had severe cognitive impairment, required extensive assistance for bed mobility, personal hygiene, toileting, dressing, transfers, and was non-ambulatory. The assessment further identified Resident #7 was always incontinent of bladder and bowel and was at risk for the development of pressure ulcers and had one unstageable pressure wound.RN #1's nurse's note dated 8/14/24 at 8:11 PM identified Resident #7 had an open area to the coccyx. The coccyx area was cleansed with wound cleanser and border dressing was applied. The physician was notified and recommended a wound consultation.Resident #7's care plan dated 8/14/24 identified Resident #7 had an unstageable coccyx wound. Care plan interventions directed to observe the area for worsening, increased redness and report to the physician, provide treatment as ordered, provide incontinent care approximately every 2 hours and as needed, turn and re-position every 2 hours and air mattress set according to the resident's weight. Further review of Resident #7's care plan from 8/1/24 to 8/13/24 failed to identify that a care plan was developed and implemented to minimize the risk of developing a pressure ulcer until he/she developed a second pressure wound to the (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	coccyx.The wound physician's progress notes dated 8/15/24 identified Resident #7 was seen for follow up evaluation of the unstageable wound to the left heel. The left heel wound was stable. In addition, the wound progress notes identified a new Deep Tissue Pressure Injury (DTPI) to the coccyx related to pressure was evaluated. The wound size was documented as 3 cm in length by 0.5 cm in width by 0.1 cm in depth and non-blanchable ecchymosis. The treatment plan identified: cleanse the wound and apply calcium alginate to the wound bed and secure with border foam daily and change as needed if dislodged or soiled.Review of nurses' notes from 8/1/24 to 8/15/24 failed to identify that Resident #7 was turned and repositioned every two hours as directed by the wound physician on 8/8/24.The nurse's note dated 8/16/24 at 6:43 PM identified Resident #7 was transferred out of bed to the wheelchair with the assistance of two people. The treatments to the left heel and coccyx wound were administered, and Resident #7 was turned and repositioned in bed. The wound physician's progress note dated 8/22/24 identified the unstageable left heel wound was improving without complications. The coccyx had become an unstageable wound and had worsened. The coccyx wound size was documented as 4.5 cm in length by 3.4 cm in length by 0.8 cm in depth. The treatment plan was to cleanse the wound, apply 1/4 strength Dakin's moist gauze to the wound base and change twice per day and as needed when soiled or dislodged.The wound physician's progress notes dated 9/5/24 identified that the unstageable wound to the left heel was resolved. The unstageable coccyx wound continues to worsen. The physician manually pulled a copious amount of necrotic (dead tissue) tissue from the wound bed, and a large amount of purulent drainage was noted. The coccyx wound was documented as 6 cm in length by 7 cm in width by 2.5 cm in depth with undermining 4.3 cm in depth from 12 o'clock to 12 o'clock. The coccyx wound was noted to increase in overall dimension size and depth to the wound bed. The treatment plan directed to cleanse the wound, apply 1/4 strength Dakin's moist gauze to the base of the wound and secure with border foam and change twice a day.The wound physician's progress note dated 9/12/24 identified that the unstageable wound to the coccyx had become a stage 4 coccyx pressure wound. The wound was documented as 7 cm in length by 7 cm in width by 3 cm in depth with undermining of 5.5 cm in depth from 12 o'clock to 12 o'clock. The treatment plan directed to cleanse the wound, apply 1/4 Dakin's moist gauze to the wound base and secure with border foam twice a day and as needed when soil or dislodge.The Braden Scale assessment dated [DATE] identified Resident #7 had a score of 13 which indicated a moderate risk of developing a pressure ulcer.Review of the wound physician's weekly progress notes from 9/19/24 to 1/5/26 identified Resident #7 continued to have a stage 4 wound to the coccyx. The physician continues to monitor and provide the treatment plan for the stage 4 coccyx wound.The current wound physician's progress note dated 1/12/26 identified that the stage 4 coccyx wound was evaluated. The wound was documented as 7.4 cm in length by 2.1 cm in width by 1.5 cm in depth with undermining measurement of 1.1 cm in depth from 12 o'clock to 12 o'clock. The wound healing was stalled. The treatment plan was to cleanse with 1/2 strength of Dakin's solution, apply crushed metronidazole (anti-bacterial) then calcium alginate with silver, secure with gauze and dry clean dressing twice per day and change as needed when soiled soil or dislodged.Observation on 1/7/25 at 9:45 AM identified Resident #7 was in his/her room lying on his/her back on a low air loss mattress with a positioning wedge device noted to his/her side, but the positioning wedge was not properly tucked in to put the resident on his/her side. Interview with RN #1 (per diem nursing supervisor) on 1/7/26 at 12:15 PM identified that she was responsible for assessing the resident when admitted to the facility. She identified that Resident #7 was admitted with a stage 3 pressure ulcer wound to the left heel and she called the physician to obtain a treatment order. She identified that she would complete a Braden Scale assessment on admission to assess the resident's risk for developing a pressure ulcer. She also identified that Resident #7 would be a high risk for developing a pressure ulcer because of the limited mobility, incontinence, and admitted with a stage 3 pressure ulcer wound to the left heel. She further identified that any resident admitted to the facility with a high risk of developing a pressure ulcer wound would have a care plan for turning and repositioning (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	program, treatment to the wound as ordered by the physician, recommended for an air mattress and these interventions would be implemented immediately on admission. She could not recall whether she assessed Resident #7 for risk for developing a pressure ulcer or developed a care plan to minimize the risk of developing; however, she identified that it would be indicated in the physician's order for the turning and repositioning and/or it would be documented in the nursing progress notes that the resident was being turn and repositioned. In addition, she identified that there was a new open wound on the coccyx that was reported on 8/14/24 and she had provided a treatment and updated the physician and recommended for a wound consult.Interview with MD #2 (wound specialist) on 1/7/26 at 1:35PM identified that he had been following Resident #7's stage 4 coccyx wound that was related to a pressure. He identified that Resident #7 was at high risk of developing a pressure ulcer due to limited mobility, incontinence and presence and/or history of pressure ulcer. Additionally, MD #2 identified that the facility should determine the resident's risk of developing a pressure ulcer and immediately implement interventions such as low air loss mattress, develop a repositioning plan, provide timely incontinent care to minimize the risk of developing a pressure ulcer wound. He further identified that Resident #7 stage 4 to the coccyx wound healing had stalled because of decline in medical condition such as total dependent for staff, poor nutrition and he/she was in the hospice care program due to decline in medical condition.Observation of wound care with LPN #1 on 1/8/25 at 10:30 AM identified Resident #7 was in his/her room lying on his/her back on a low air loss mattress. LPN #1 removed the old dressing, which had a small amount of drainage noted on the old foam dressing. Resident #7 noted with a stage 4 wound on his/her coccyx.Interview with LPN #1 on 1/8/25 at 11:00 AM identified that the nurse aides are responsible for turning and repositioning the resident. She identified that she is responsible for ensuring that the resident is being turned and repositioned frequently. She identified Resident #7 required total assistance from the staff for turning and repositioning. She further identified that she documents in the nurses' notes whether a resident is being turned and repositioned and the care plan would indicate whether he/she needed to be turned and repositioned frequently.Interview with the DNS on 1/12/26 at 9:10 AM identified that the registered nurses are responsible for assessing the resident on admission. She noted that she expects the resident to be assessed comprehensively such as but not limited to completing the Braden Scale assessment, fall risk assessment, elopement, and head to toe assessment. She identified that the Braden Scale assessment is used to assess the resident's risk of developing pressure ulcers. She also identified that any residents who are at risk of developing a pressure ulcer would be in a turning and repositioning program, air mattress maybe added, wound consultation and provide a timely treatment to the wound. She identified that the care plan should be implemented immediately to minimize the risk of developing a pressure ulcer wound. She identified that she was not DNS at that time and she could not provide a reason why there was no care plan implemented until Resident #7 developed another pressure injury to the coccyx. Although she identified that she was not the DNS when Resident #7 was admitted to the facility, she would expect the nursing staff to assess the resident for risk of developing a pressure ulcer and immediately implement a care plan to minimize the risk of developing a pressure ulcer. She further identified that Resident #7 would be at high risk of developing a pressure ulcer because he/she was admitted with pressure wound, limited mobility, impaired cognition. The Pressure Ulcer Prevention/Assessment Plan policy identified the purpose of the policy was to minimize the development of pressure ulcers. The policy indicates on the day of admission that a Braden Scale assessment will be completed on all residents. The pressure ulcer prevention plan indicated that any residents admitted with a DTI should be considered a high risk for pressure ulcers and facility interventions should include mild to moderate interventions, spenco boots while in bed, and every 1 hour turning and repositioning. The facility would initiate these interventions upon admission and written in the physician's orders.The facility failed to assess the resident's risk for pressure ulcer development and failed to implement measures to prevent the development of the pressure ulcer to the coccyx resulting in the development and progression of the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	pressure ulcer to a stage 4 to the coccyx. With appropriate assessments and interventions, the development of the pressure wound was avoidable.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on review of facility documentation, review of facility policy, and interviews, reviewed for infection surveillance and water management, the facility failed to ensure that the infection control surveillance data collected monthly was analyzed for trends and was included into the quarterly infection control report, and the facility failed to provide documentation that the water management plan was implemented to identify an established flushing program logs of low flow areas, eyewash station protocol, and annual water management committee meetings were held. The findings include:Review of the infection control program for the period of April 2024 to January 2026 with the Infection Preventionist (RN #4) on 1/7/26 at 11:48 AM failed to provide documentation that reflects analysis of trends identified in the monthly infection surveillance data collected for the period of April 2024 to January 2026. Review of the Quarterly Infection Control Report provided for the period of April 2024 to January 2026 with the Infection Preventionist (RN #4) on 1/7/26 at 11:48 AM failed to reflect analyzed monthly infection trends that were obtained from the infection surveillance data collection.Interview with RN #4 on 1/7/26 at 11:48 AM identified she was responsible for analysis of the infection surveillance data collected monthly. She further identified the analysis would include the monthly infection control rate, the number of infections and type of infections identified during the month, which is then included in the quarterly infection control report that is presented at the quarterly Medical Staff Meeting. RN #4 identified the monthly infection rate or resolution rate as specified in the policy should have being completed and she has no excuse as she knows that the infection surveillance data should have been analyzed as she had done it in the past but not in recent years.Review of the Infection Surveillance Data Collection policy identified an Infection Surveillance Data Collection Form shall be completed by the Infection Control Nurse for each resident who has an infection. The data collected shall be analyzed monthly for trends and incorporated into the quarterly Infection Control Report.Review of the facility Water Management Plan/Program for the period of April 2024 to January 2026 with the Administrator and the Director of Maintenance on 1/12/26 at 11:49 AM failed to identify an establish flushing log, eyewash station protocol and annual water management meeting.Interview with Infection Preventionist (RN #4) in the presence of the Administrator on 1/8/26 at 10:31 AM identified she was only responsible for checking the ice machine filter and maintenance was responsible for the testing. RN #4 identified that there was no formal water management meeting as information she provided to the Director of Maintenance regarding water management would be as a result of the environmental rounds such as if the water filter on the ice machine needed changing and the legionella water testing completion.Interview on 1/12/26 at 11:49 AM with the Administrator and the Director of Maintenance identified the facility's water management plan program is the responsibility of the Director of Maintenance and the Infection Preventionist. The Director of Maintenance identified that the plan was developed by an outside contracted company who handles the water management plan program for they complete the annual Legionella water testing, provides the facility with a report, the cleaning of the ice machine which is completed by an outside vendor, and water temperature checks are completed daily at different faucets. The Administrator and the Director of Maintenance identified the water management plan binder was possibly destroyed during the leak and they would have to request another copy from the vendor. The Administrator and the Director of Maintenance identified they have not had a formal meeting to discuss and review the water management plan annually. The Administrator identified that the housekeeping director indicated that she turns on the eyewash station in her area to ensure it is running and if the water turns on and is brown, she will then run the water until it becomes clear, however, they have no documentation to such. The Director of Maintenance identified they have no eyewash protocol for flushing and no established flushing program as some of the dead legs were removed during the construction but has not updated the plan to reflect such. However, they have identified areas such as the bathtub which are not being used frequently. Although a request was made on 1/12/26 at 11:49 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	AM for their contracted company water management binder in which the Annual Water Management Plan Revision and Update dated 10/12/24 made reference to, the facility failed to provide the water management plan binder provided by their contracted company. Review of the Annual Water Management Plan Revision and Updates dated 10/30/25, the Director of Maintenance identified this as the current revision of the water management plan identifies the water committee shall meet and review the water management plan, recording the topics discussed, and record meeting minutes with the signatures of attendees, meet annually. The plan revision and updates further recommend a flushing program to be established following mitigation steps from the assessment form and areas noted to be included in the flush program are low flow area (areas with minimum usage) purging of storage tanks, other desired locations. The plan further recommends to develop and assign water committee members and review plan and protocol on a more regular/routine basis, document areas of compliance such as water flushing program, eye wash station protocol, and cleaning of medical equipment cleaning programs.

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F 0584 Level of Harm - Minimal harm or potential for actual 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of the clinical record, review of facility documentation, review of facility policy and procedures and interviews for the facility and one resident (Resident #24) investigated for environment, the facility failed to ensure resident rooms were kept at comfortable and safe temperature levels between the regulatory recommended temperatures of 71 degrees to 81 degrees. The findings included:Resident #24 was admitted to the facility in January 2024 with diagnoses that included dementia, psychotic disturbance, mood disturbance and anxiety.The annual MDS assessment dated [DATE] identified Resident #24 had moderately impaired cognition, did not exhibit any behaviors or rejection of care, was independent with self-care and utilized a rolling walker with supervision.The care plan dated 1/8/26 failed to identify any concerns with Resident #24's room being cold to the resident.Interview with Resident #24 on 1/5/26 at 11:45 AM identified Resident #24 had reported to the facility that the resident room was cold most days and not comfortable for Resident #24 without multiple layers of clothing and extra blankets. Resident #24 indicated that the facility was working to resolve the issue but that it wasn't getting resolved. Resident #24 identified that he/she preferred to keep the room door closed because he/she enjoyed the quiet. The baseboard heater in the room was cold to the touch.Observation on 1/7/26 at 11:21 AM identified room temperatures taken in Resident #24's room as temperature near the window was 65.8 degrees Fahrenheit (F), temperature at the foot of the bed was 67.8 degrees F, temperature at the doorway of the room with the door closed is 69 degrees F. There is a thermostat in the hallway across from Resident #24's room that reads 75 degrees F. Observed in Resident #24's room was a thermometer that was affixed with Velcro to the top of the wardrobe within 2 feet of the 8-foot ceiling that read 71 degrees F. The baseboard heater was cold to touch. Temperature outside was 35 degrees F. Resident #24 was dressed in a turtleneck sweater and seated in a recliner with a blanket covering him/her.Observation of Resident #24's room thermometer on 1/8/26 at 9:35 AM identified the temperature was 69 degrees F. Temperature outside was 33 degrees F. Resident #24 identified he/she was moving slowly this am because it was too cold to change clothes.Interview with the Director of Maintenance on 1/8/26 at 2:15 PM identified that he was aware of the heat discrepancies in the residents' rooms. The Director indicated that the facility was checking the temperatures in the residents' rooms. When asked for the temperature logs, the Director identified he doesn't document the temperatures unless they are below 70 degrees and didn't have any documentation because none of the temperatures were below 70 degrees. The Director indicated that there was hot water baseboard heat in the resident rooms and one zone for the whole building for the boiler hot water baseboard system. The Director identified there was one thermostat in the basement that monitored two sensors on either end (east and west) of the hallway. The Director additionally indicated that there was a secondary heat source that supplied forced hot air to the hallway and that he needed to keep the baseboard heat thermostat a little higher than the hallway so it would kick in. The Director identified that residents are required to keep the resident room doors open for safety and so the hallway heat will go into the rooms. The Director could not identify why all temperatures were not documented and why 70 degrees was the threshold for documentation. The Director did identify that residents did complain of rooms being chilly.Observation of Resident #24's room on 1/12/26 at 9:33 AM identified the thermometer, moved to waist height in the room, read 70 degrees F. The baseboard heater in the room was cold to the touch.Observation of 6 resident rooms on the west nursing wing on 1/13/26 at 9:13 AM identified room temperatures below 70 degrees on thermometers placed high in the rooms, within 2 feet of the 8-foot ceilings. The thermometer in the hallway identified at 75 degrees F.Interview and observations with the Director of Maintenance on 1/13/26 at 9:15 AM identified that the placement of the thermometers (sized 1 inch x 2 inches) was up and out of the way (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	so that residents would not trip on them. The thermometers were moved down to waist level in the rooms, where the residents were, and temperature readings dropped. Resident #24's room was 66 degrees F and other rooms temped were 68 degrees F. The Director indicated that taking temperatures nearer to the ceilings of the resident rooms, when the residents were all located within the lower 4 to 5 feet of the room was not the most accurate placement for thermometers.Interviews with residents in these observed rooms on 1/13/26 at the time of observation with the Director of Maintenance identified that residents had additional blankets and layered clothing in the rooms because of the temperatures.Additional observations with the Director of Maintenance on 1/13/26 at 9:30 AM identified temperatures on the west addition of the facility that were under 70 degrees F. The Director of Maintenance identified he had an infrared temperature gun, referred to as the heat gun, which he uses to take ambient temperatures by standing at the doorway of the resident room and aiming the gun toward the resident bed, or other items in the room, to record the temperature. The Director of Maintenance could not identify how this gun was calibrated and indicated that if it was near the temperature displayed on the thermometer, then he considered it valid.The resident rights policy for the facility identified that residents have the right to a clean, safe, comfortable environment in which to live.The facility policy for Temperature Monitoring identified the facility will monitor temperatures in resident care areas to maintain comfort, infection control, and material integrity. The policy indicated that maintenance was responsible for monitoring ambient and water temperatures and that temperature standards for resident rooms/common areas should be between 71 degrees F and 81 degrees F and indicated that if temperatures were out of range, they should be documented, the supervisor notified and corrective action taken.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 clinical records, review of facility documentation, review of facility policy/procedures, and interviews for 3 of 5 sampled residents (Resident #11, Resident #39, and Resident #42) reviewed for (PASRR), the facility failed to ensure the recommendations from a level II PASRR determination were included in the resident's care plan. The findings include:Resident #11 was admitted to the facility in December of 2025 and had diagnoses that included Down syndrome, adjustment disorder with anxiety, and nontraumatic intracerebral hemorrhage.The PASRR level II screening dated 12/17/2025 identified Resident #11 had a positive level II PASRR and identified recommendations that should be addressed by the facility. The admission MDS assessment dated [DATE] identified Resident #11 had moderately impaired cognition, had no behaviors. The assessment further identified Resident #11 was dependent on care for personal hygiene, oral hygiene, dressing, transfers, bed mobility and was non-ambulatory. The care plan dated 12/31/25 identified Resident #11 had psychotropic drug use related to a history of anxiety with interventions that included encourage resident to see psych (psychiatry) as recommended and observe resident for lethargy, mood or behavior changes and report to MD (physician). However, the care plan failed to reflect that the resident was admitted to the facility with a positive PASRR with interventions that included to follow PASRR recommendations: review PASRR as indicated. Interview and review of the resident care plan on 1/12/26 at 2:55 PM with the MDS coordinator (LPN #4) identified the current plan of care failed to reflect a care plan indicating the resident had a positive level II and the recommendations provided by the PASRR. LPN #4 identified it was the responsibility of SW #1 to update the resident's care plan with the PASRR information, as the social worker deals with PASRR screening and review. She further identified she is in the process of gaining access to the PASRR screening site to gain access to residents PASRR information but has yet to receive access. Interview with the social worker (SW#1) on 1/13/26 at 9:40 AM identified the residents with a positive level II PASRR care plan should have being completed to reflect the positive level II and the recommendations provided. Interview on 1/12/26 at 9:56 AM with LPN #4 in the presence of SW #1 identified the care plan should have been completed once PASRR level 2 was received with the interventions from the recommendations. Interview with the DNS on 1/13/26 at 11:17 AM identifies that she expects if a resident had a positive level II PASRR that the resident's care plan be revised to reflect the positive level II PASRR. Review of the Care Plans policy and procedure identifies the Resident Care Plan (RCP) of each resident is completed and reviewed by the 21st day after admission and quarterly thereafter at the Resident Care Conference and can also be revised as needed at any time on an interim basis. The policy further identifies the RCP will include physical, cognitive and psycho-social problems and will address the residents' needs on an individual basis. Review of the PASARR policy and procedures identifies residents identified through PASARR receive required specialized services and care plan interventions and all PASARR documentation is maintained in the resident medical record. Resident #39's diagnoses included schizoaffective disorder, bipolar, and generalized anxiety disorderThe PASRR level II screening dated 9/26/2024 identified Resident #39 had a positive level II PASRR approved without specialized services and identified recommendations that should be addressed by the facility. The quarterly MDS assessment dated [DATE] identified Resident #39 was cognitively intact, had verbal behavioral symptoms directed towards others, no hallucinations or delusion behavior. The assessment further identified Resident #39 required maximal assistance with toileting hygiene, personal hygiene, lower body dressing, and moderate assistance with bed mobility and transfers. The care plan dated from 8/20/24 through 10/22/25 identified Resident #39 had psychosocial well-being related to dementia with interventions that included encourage resident to see psych (psychiatry) as recommended and observe resident for lethargy, mood or behavior changes and report to MD (physician). However, the (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan failed to reflect that the resident was admitted to the facility with a positive PASRR with interventions that included to follow PASRR recommendations: review PASRR as indicated. Interview and review of the resident care plan on 1/12/26 at 2:55 PM with the MDS coordinator (LPN #4) identified the current plan of care failed to reflect a care plan indicating the resident had a positive level II and the recommendations provided by the PASRR. LPN #4 identified it was the responsibility of SW #1 to update the resident's care plan with the PASRR information, as the social worker deals with PASRR screening and review. She further identified she is in the process of gaining access to the PASRR screening site to gain access to residents PASRR information but has yet to receive access. Interview with the social worker (SW#1) on 1/13/26 at 9:40 AM identified the residents with a positive level II PASRR care plan should have being completed to reflect the positive level II and the recommendations provided. Interview on 1/12/26 at 9:56 AM with LPN #4 in the presence of SW #1 identified the care plan should have been completed once PASRR level 2 was received with the interventions from the recommendations. Interview with the DNS on 1/13/26 at 11:17 AM identifies that she expects if a resident had a positive level II PASRR that the resident's care plan be revised to reflect the positive level II PASRR. Review of the Care Plans policy and procedure identifies the Resident Care Plan (RCP) of each resident is completed and reviewed by the 21st day after admission and quarterly thereafter at the Resident Care Conference and can also be revised as needed at any time on an interim basis. The policy further identifies the RCP will include physical, cognitive and psycho-social problems and will address the residents' needs on an individual basis. Review of the PASARR policy and procedures identifies residents identified through PASARR receive required specialized services and care plan interventions and all PASARR documentation is maintained in the resident medical record. Resident #42 was admitted to the facility in November of 2025 and had diagnoses that included bipolar disorder, psychotic disorder, and generalized anxiety disorder. The PASRR level II screening dated 11/18/2025 identified Resident #42 had a positive level II PASRR short term approval without specialized services and identified recommendations that should be addressed by the facility. The admission MDS assessment dated [DATE] identified Resident #42 was cognitively intact, had behaviors of delusion and rejection of care. The assessment further identified Resident #42 required maximal assistance with toileting hygiene, personal hygiene dressing, bed mobility and dependent on the use of a manual wheelchair. The care plan dated 12/3/25 identified Resident #42 had psychotropic drug use related to history of bipolar, getting anxious and history of attention deficit disorder (ADD) with interventions that included encourage resident to see psych (psychiatry) as recommended and observe resident for lethargy, mood or behavior changes and report to MD (physician). However, the care plan failed to reflect that the resident was admitted to the facility with a positive PASRR with interventions that included to follow PASRR recommendations: review PASRR as indicated. Interview and review of the resident care plan on 1/12/26 at 2:55 PM with the MDS coordinator (LPN #4) identified the current plan of care failed to reflect a care plan indicating the resident had a positive level II and the recommendations provided by the PASRR. LPN #4 identified it was the responsibility of SW #1 to update the resident's care plan with the PASRR information, as the social worker deals with PASRR screening and review. She further identified she is in the process of gaining access to the PASRR screening site to gain access to residents PASRR information but has yet to receive access. Interview with the social worker (SW#1) on 1/13/26 at 9:40 AM identified the residents with a positive level II PASRR care plan should have being completed to reflect the positive level II and the recommendations provided. Interview on 1/12/26 at 9:56 AM with LPN #4 in the presence of SW #1 identified the care plan should have been completed once PASRR level 2 was received with the interventions from the recommendations. Interview with the DNS on 1/13/26 at 11:17 AM identifies that she expects if a resident had a positive level II PASRR that the resident's care plan be revised to reflect the positive level II PASRR. Review of the Care Plans policy and procedure identifies the Resident Care Plan (RCP) of each resident is completed and reviewed by the 21st day after admission and quarterly thereafter at the Resident Care Conference (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and can also be revised as needed at any time on an interim basis. The policy further identifies the RCP will include physical, cognitive and psycho-social problems and will address the residents' needs on an individual basis. Review of the PASARR policy and procedures identifies residents identified through PASARR receive required specialized services and care plan interventions and all PASARR documentation is maintained in the resident medical record.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 review of the clinical records, review of facility documentation review of facility policy and interviews for one sampled resident (Resident #48) reviewed for death, the facility failed to ensure resident's care plan was revised to reflect hospice services and recommendations, and for one of five residents (Resident #3) reviewed for (PASRR), the facility failed to ensure the recommendations from a level II PASRR determination were included in the resident's care plan and for one sampled resident (Resident #38) reviewed for Hospice services, the facility failed to ensure the care plan was reviewed and revised to include the Hospice recommendations. The findings include: Resident #48 was admitted to the facility in August of 2025 and had diagnoses that included chronic systolic congestive heart failure, dementia, type 2 diabetes mellitus, and chronic kidney disease stage 3. The admission MDS assessment dated [DATE] identified Resident #48 had moderately impaired cognition, required maximal assistance with toileting hygiene, personal hygiene, bed mobility and was non-ambulatory. The care plan dated 8/27/25 identified Resident #48 had advanced directives related to DNR (do not resuscitate)/DNI (do not intubate)/DNH (do not hospitalized /RNP (Registered Nurse may pronounce)/no feeding tube with interventions to review the resident's advance directives quarterly and as needed with family. Physician's order dated 9/11/25 directed for hospice evaluation and treatment. The nurse's note dated 9/13/25 at 2:39 PM identified Resident #48 was admitted to hospice effective 9/13/25. The physician was notified; and all orders were reinstated. Interview on 1/13/25 at 9:14 AM with the MDS Coordinator (LPN #4) identified it was her responsibility to review and revise the resident care plan when they are admitted to hospice. LPN #4 identified the care plan would typically be updated when she completes the significant change in status MDS assessment but noted that she had not completed the assessment and had not updated the care plan following the resident's admission to hospice care. Review of the Care Plans policy and procedure identifies the Resident Care Plan (RCP) of each resident is completed and reviewed by the 21st day after admission and quarterly thereafter at the Resident Care Conference and can also be revised as needed at any time on an interim basis. The policy further identifies the RCP will include physical, cognitive and psycho-social problems and will address the residents' needs on an individual basis. Resident #3's diagnoses included schizoaffective disorder, depression, and insomnia. The PASRR level II screening dated 12/9/2022 identified Resident #3 had a positive level II PASRR approved without specialized services. The quarterly MDS assessment dated [DATE] identified Resident #3 had severely impaired cognition, behaviors of hallucination and delusions, required total dependence with personal hygiene, toileting (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hygiene, dressing, transfers and was non-ambulatory. The care plan dated 12/30/25 identified Resident #3 had psychotropic drug use related to a history of schizophrenia, depression dementia and lack of psychological development as a child with interventions that included administer medication as ordered encourage resident to see psych (psychiatry) as recommended and observe resident for lethargy, mood or behavior changes and report to MD (physician); however, the care plan failed to reflect that the resident was admitted to the facility with a positive level 2 PASRR with interventions that included following PASRR recommendations. Interview with SW#1 on 1/13/26 at 9:40 AM identified the residents with a positive level II PASRR care plan should have been completed to reflect the positive level II and the recommendations made. Interview on 1/12/26 at 9:56 AM with LPN #4 in the presence of SW #1 identified the care plan should have been completed once PASRR level 2 was received with the recommendations. Interview with the DNS on 1/13/26 at 11:17 AM identified that she expects that if a resident has a positive level II PASRR the resident's care plan should reflect the positive level II PASRR and the recommendations identified. Review of the Care Plan policy and procedure identifies the Resident Care Plan (RCP) of each resident is completed and reviewed by the 21st day after admission and quarterly thereafter at the Resident Care Conference and can also be revised as needed at any time on an interim basis. The policy further identifies the RCP will include physical, cognitive and psycho-social problems and will address the residents' needs on an individual basis. Review of the PASRR policy and procedures identifies residents identified through PASRR receive required specialized services and care plan interventions and all PASRR documentation is maintained in the resident medical record. Resident #38 was admitted to the facility in May 2024 with a diagnosis of protein calorie malnutrition. Physician's orders dated 12/3/25 directed Resident #38 to receive Hospice care related to terminal diagnosis of protein calorie malnutrition. The significant change MDS assessment dated [DATE] identified Resident #38 had severely impaired cognition, required substantial to maximal assistance with self-care, rolling left to right, was always incontinent of bowel and bladder, had scheduled and as needed pain medication, and received Hospice care. The care plan dated 12/16/25 identified Resident #38 was receiving Hospice services with interventions to follow Hospice care plan for care and pain management. Review of Resident #38's clinical record on 1/8/26 at 2:30 PM identified a section for Hospice paperwork that only contained one communication page with documentation from 12/3/25. Interview with the RN Supervisor (RN #2) on 1/8/26 at 2:37 PM identified that the Hospice staff communicated with the facility via the physical clinical record under the section labeled Hospice tab. RN#2 reviewed Resident #38's clinical record and identified that there was no Hospice paperwork or (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hospice care plan. RN#2 identified that care plans were completed by the MDS Coordinator. Interview with the MDS Coordinator on 1/12/26 at 10:14 AM identified that she entered the care plan that indicated Resident #38 was on Hospice and directed the staff to follow the Hospice care plan. The MDS Coordinator indicated that the care plan should be in the clinical record and that she wasn't sure if she should list the recommendations from Hospice in the facility care plan. Interview with the Director of Hospice Operations (RN #6) on 1/12/26 at 10:20 AM identified that documentation of staff visits is documented in the hospice computer system and all visits should be documented on the recommendation sheets in the clinical record at the facility. RN #6 indicated that there is a report provided to the facility every other week and placed in the clinical records by the nurse that is visiting the facility or the facility liaison. RN #6 identified that all consents and care plans should be present in the clinical record for continuity of care and care is directed by the plan of care. Interview with RN#2 on 1/12/26 at 11:00 AM identified there was no Hospice information located in Resident #38's clinical record and indicated that the hospice contract, the care plan and communication log should be present in the clinical record but was unsure who was responsible for ensuring it was complete. RN#2 reviewed the facility's care plan for Resident #38 and indicated that it directed to refer to the hospice plan of care but could not locate the hospice plan of care. Interview with the MDS Coordinator on 1/12/26 at 11:20 AM identified that all Hospice paperwork should be present in the resident's clinical record. She further identified that she entered the hospice care plan for the resident but was unaware that she should include hospice recommendations in the care plan. Interview with the DNS on 1/12/26 at 11:46 AM identified it was the responsibility of the nursing supervisors to ensure the clinical records have everything they are supposed to have. The DNS indicated the plan of care should be collaborative and the recommendations from hospice should be included in the care plan and should specify what the hospice recommendations are for the resident. The care plan policy identified that the resident care plan will include the resident's needs, realistic goals, and the care and services needed to meet these goals and will include physical, cognitive and psycho-social problems and will address the residents' needs on an individualized basis. The facility policy for Hospice plan of care identified that the plan of care is reviewed and revised as often as necessary but no less frequently than every 15 calendar days and should include interventions to manage pain and symptoms, scope and frequency of all services necessary to meet the needs of the patient, patient/caregivers goals for hospice services, Measurable outcomes anticipated from implementing and coordinating the POC, Drugs and treatments necessary to meet the needs of the patient including the dose for medications, frequency and duration, and the IDT's documentation of the patients or representative's understanding, involvement, and agreement with the plan of care (POC). The Hospice POC is established and maintained in consultation with the facility staff. All care provided must be in accordance with the hospice POC and shall identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice POC. The hospice POC reflects the participation of the hospice, the nursing facility and the patient/family to the extent possible and indicated any changes in the hospice POC must be discussed with the patient or representative, a nursing facility representative and must be approved by the hospice prior to (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	implementation. Review of the facility contract with the hospice agency identified that hospice shall document in the patient's record that the plan of care has been provided to the facility and specify the inpatient services that the facility will furnish and that hospice shall periodically review Hospice patients' records to verify that these requirements are met.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:Number of residents cited:Resident #2's diagnoses included dementia, muscle weakness, and chronic obstructive pulmonary disease. The quarterly MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition, required maximal assistance with toileting hygiene, lower body dressing, personal hygiene, transfers, and bed mobility. The assessment further identified the resident was non-ambulatory, did not exhibit behaviors, utilized a wheelchair, and had skin tears. The care plan dated 10/21/25 identified Resident #2 was at risk for skin tears and bruising related to fragile skin, history of skin tears and history of bumping arms with interventions that included, check skin weekly and provide daily moisturizing lotion to extremities. The reportable event report dated 12/14/25 at 2:30 PM identified Resident #2 had a skin tear to the left lower leg that measured 3.0 centimeters (cm) in length by 1.0 cm in width. The nurse's note dated 12/14/25 at 2:51 PM written by the charge nurse (LPN #2) identified that at approximately 2:30 PM NA #5 stated she was putting on Resident #2's shoes when her finger slid with the resident's skin. The note further identified that upon assessment Resident #2 had a 3cm by 1cm skin tear to the left shin per the supervisor. The supervisor asked LPN #2 to apply steri-strips and gauze. Review of Resident #2's physician's order for December 14, 2025, through December 15, 2025, including discontinued orders both in the physical and electronic record failed to direct a treatment order for the skin tear to the left lower leg that was sustained on 12/14/25. Review of Resident #2 clinical records from December 14, 2025, through December 16, 2025, failed to reflect a RN assessment note after the resident had sustained a skin tear. Review of the Weekly Wound Documentation for the month of December 2025 failed to identify a skin tear for Resident #2. The physician order dated 12/18/25 directed left lower extremity skin tear to cover with steri-stripes followed by non-adherent dressing followed by gauze and to change daily for 7 days. Physician's order dated 12/31/25 directed cleanse left extremity wound to xeroform dressing and change daily for 7 days then evaluate. The nurse's note dated 1/1/26 at 12:25 PM written by RN #2 identified a skin tear to left lower extremity presenting with signs and symptoms of infection and slight foul odor. The note further identified the physician was notified and ordered Keflex (antibiotic) 500 milligram (mg) four times daily for 10 days Interview with the Charge Nurse (LPN #2) on 1/7/26 at 12:41 PM identified the supervisor was made aware of the skin tear. LPN #2 identified when a skin tear occurs it is the responsibility of the supervisor to assess the area, to obtain treatment orders, to write their notes, to call the physician and to update the family. An attempt was made to interview the supervisor responsible for obtaining a treatment order and completing the RN assessment note on 1/7/26 but was unsuccessful. Interview on 1/7/26 at 1:16 PM with the day shift Nursing Supervisor (RN #2) identified that when an accident or incident occurs it is the responsibility of the nursing supervisor to complete an RN assessment, write a note, call the family, notify the physician and obtain orders. RN #2 identified that she had seen Resident #2 with an old dressing hanging off his/her leg, so she looked at the area and identified it was getting infected and smelly and had notified the physician. Interview on 1/7/25 at 2:26 PM with the DNS identified after she reviewed the reportable event and investigation, she noticed that the RN assessment note and the treatment orders were missing. The DNS indicated that she then contacted the supervisor responsible for the reportable event report regarding the note, and she had also told the day shift supervisor about the lack of treatment orders, who indicated to her that it was in the records, however, she did not follow up to ensure it was completed. The DNS identified that an RN assessment note should have been completed and a treatment order obtained at the time of the incident.Interview on 1/8/26 at 3:05 PM with the wound nurse (LPN #6) identified that all open wounds including skin tears are monitored weekly by the wound physician. She further identified that once a new wound/open area is identified it should be written in the wound-log book for the resident to be seen by the wound physician weekly. She identified that Resident #2 was first seen in January 2026 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because that was when the resident was added to the wound book. The Skin Tear Protocol identified to notify the supervisor and the supervisor will notify the physician and verify treatment, the supervisor will write orders for treatment in MD orders, and the supervisor and/or charge nurse will fill out incident reports.Review of the Wound Care and Documentation policy identified that documentation of all skin injuries should include a description of condition, size, and treatment required, how the accident happened, reports completed, and notification of family and physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure it had an established system of audit and reconciliation for controlled substances. The findings include:Interview with the DNS on 1/6/26 at 12:18 pm identified the narcotic audit process involved going through the two medication carts on the units and counting the narcotics and checking the expiration dates. The DNS indicated that when a narcotic medication comes into the facility the white controlled substance disposition record is placed on the cart with the medication and the yellow/pink CSDR sheets are placed in a binder that is kept in the IP nurse's office. The DNS identified that the audits are signed off for November and December 2025 when she first came to work at the facility but failed to identify any audit paperwork from November 2025 back to September 2024. The DNS indicated that the yellow/pink CSDR sheets kept in the binders were not used to complete the audits in the facility. When asked how the DNS ensured that all controlled substances brought into the facility were accounted for, she did not answer.Interview with RN#4 (IP, ADNS, staff education) on 1/6/26 at 12:27 PM identified she is responsible for keeping track of the controlled substance records located in two binders kept in her office, one for east nursing unit and one for west nursing unit. RN#4 indicated that the only thing she does with the binders is match a completed white CSDR (if the medication was completed or destroyed) to the yellow/pink CSDRs in the binders. RN#4 identified she did not do the facility audits.On 1/6/26 at 12:30 PM this surveyor flagged 12 controlled substances for audit. 10 of the 12 controlled substances were in the facility. 2 of the 12 controlled substances were not in use, and not in the destroyed medication logs in the facility, thus they could not be reconciled.Interview with the DNS on 1/7/26 at 2:59 PM identified that the 2 medications missing were brought into the facility prior to her taking the DNS position. Additionally, upon taking the DNS position, the audits completed did not include reconciling all controlled substances brought into the facility. The DNS indicated that the audits were just counts on the carts.The facility policy for Medication Storage in the Facility: Controlled Substance storage identified the director of nursing, in collaboration with the consultant pharmacist, maintains the facility's compliance with federal and state laws and regulations in the handling of controlled substances. The policy identified that controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and documentation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure expired medications were removed from active circulation and failed to ensure medications were stored according to manufacturer guidelines and failed to ensure controlled substances were monitored correctly and had corresponding administration sign off sheets. The findings include:Observation of the East Medication cart on 1/6/25 at 11:20 AM with LPN#5 identified the following medications in active circulation in the cart that were expired:Methocarbamol tab 750 mg (10 pills remaining) expired 9/24/25Hycosamine tab 1.25 mg (1 pill remaining) expired 9/5/25Lorazepam 2mg/ml (10 ml left in the bottle) This medication should be refrigerated and did not have a corresponding white controlled substance disposition record to record administrations.Interview with LPN #5 on 1/6/26 at 11:30 AM identified expired medications should be removed from the cart and discarded. Additionally, LPN#5 identified that liquid Lorazepam should be refrigerated and all controlled substances should have a white CSDR to document administrations.Interview with RN Supervisor (RN#2) on 1/6/26 at 11:58 AM identified that expired medications should be discarded or turned into the supervisor. Additionally, RN#2 indicated that all narcotics (controlled substances) in the medication cart should have a corresponding sign off sheet for inventory control, and Lorazepam liquid should be refrigerated. Interview with the DNS on 1/6/26 at 12:18 PM identified expired medications should be taken out of the cart to be discarded. The DNS identified all controlled substances should have a corresponding sign off sheet and noted Lorazepam liquid should be stored in the refrigerator.The medication storage policy identified Controlled substances that require refrigeration are stored within a box attached to the inside of the refrigerator.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based clinical record reviews, review of facility documentation, review of facility policy and interview for 3 of 5 residents (Resident #20, Resident #39, and Resident #41) reviewed for immunizations, the facility to ensure that the COVID-19 booster vaccine was offered and administered when requested by residents. The findings included:1.Resident #20's diagnoses included dementia, history of transient ischemic attack (TIA), and hypertension.The quarterly MDS assessment dated [DATE] identified Resident #20 had severely impaired cognition.Review of the Vaccine Administration Record/Informed Consent for Vaccination at Long Term Care Facility and Vaccine Consent form identified Resident #20's Power of Attorney (POA) had signed the forms on 7/3/25 given the facility consent for the administration of the annual COVID-19 vaccine booster.Review of Resident #20's clinical records, immunization consents and Preventative Health Care Report records with the Infection Preventionist (RN #4) on 1/7/26 at 11:20 AM failed to reflect Resident #20 was administered the COVID-19 2025-2026 booster vaccine as requested or the resident had refused the vaccine.2.Resident #39's diagnoses included schizoaffective disorder, bipolar, chronic obstructive pulmonary disease, and generalized anxiety disorder.The quarterly MDS assessment dated [DATE] identified Resident #39 was cognitively intact.Review of the Vaccine Administration Record/Informed Consent for Vaccination at Long Term Care Facility and Vaccine Consent forms identified Resident #39's Power of Attorney (POA) had signed the forms on 8/15/24 given the facility consent for the administration of the COVID-19 vaccine booster.Review of Resident #39's clinical records, immunization consents and Preventative Health Care Report records with the Infection Preventionist (RN #4) on 1/7/26 at 11:20 AM failed to reflect that Resident #39 was administered the COVID-19 2025-2026 booster vaccine as requested or the resident had refused the vaccine. RN #4 further identified the consent signed on 8/15/24 should have indicated annually Covid-19 vaccine booster as that was requested.Interview on 1/7/26 at 11:20 AM with RN #4 identified she would review the resident's vaccination history on admission to identify what vaccines the resident needed, then consents would be obtained for such vaccines. RN #4 identified after consents are obtained, she would then obtain physician's order, order the vaccine from pharmacy, then administer to the resident by herself or by the night shift nursing supervisor. RN #4 further identified that residents who sign consents for annual vaccine administration, would be approached annual to see if they still wanted the vaccine, and if they refused a declination form would be signed by the resident or responsible party. She further identified both Resident #20 and Resident #39 should have had received the vaccine already, as the facility started to administer the COVID-19 2025-2026 booster vaccine to the residents in October of 2025 and she had no records of them refusing the vaccine. 3.Resident #41's diagnoses included dementia, type 2 diabetes mellitus, and depression.The annual MDS assessment dated [DATE] identified Resident #41 had severely impaired cognition. The assessment further identified Resident #41 was not up to date with the COVID-19 vaccination.Review of Resident #41's immunization consent records and preventative health care report with the Infection Preventionist (RN #4) on 1/7/26 at 11:20 AM failed to reflect that the COVID-19 2025-2026 booster vaccine was offered to the resident. Interview on 1/7/26 at 11:20 AM with RN #4 further identified that residents who sign consents for annual vaccine administration, would be approached annual to see if they still wanted the vaccine, and if they refused a declination form would be signed by the resident or responsible party.Interview on 1/8/26 at 10:27 AM with RN #4 identified the family indicated they did not want the COVID-19 vaccine in past, however, she should have obtain a consent of their refusal for the COVID-19 2025-2026 booster vaccine.Review of the Vaccine policy and procedure identifies the pneumovax, influenza, and covid vaccines will be administered to residents unless contraindicated or refused by the resident or (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	physician. The policy further identifies a licensed nurse will administer the appropriate vaccines on a timely basis with the physician's order.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on review of facility documentation, review of facility policy and procedure and interviews for the social worker (designee), the facility failed to ensure the employee was appropriately screened prior to employment. The findings include: Review of the Social Worker (designee) employment records on 1/13/25 at 9:40 AM identified SW#1 was hired at the facility as a social worker designee in July of 2020. The employee records did not contain documentation that the facility completed proper screening inclusive of a background check (criminal), reference checks, or employment or education verification.Interview with the Administrator on 1/13/26 at 10:00 AM identified that the employee records did not contain a background check and identified that references are not usually checked and the resume is acceptable for past employment history and noted the facility doesn't normally call to verify references or past employment history. The Administrator further identified that the facility did not have a Human Resources office, but that she and the DNS are responsible for reviewing applicants and hiring. The Administrator indicated that she had a checklist that she follows for the hiring process but identified that SW#1 was hired prior to her working at the facility.Interview with SW#1 on 1/7/26 at 2:33 PM identified that he had not been fingerprinted as part of his hiring process but did have fingerprints done a long time prior to this employment.Review of the general orientation/hiring checklist received by the Administrator at exit identified forms that were to be completed prior to orientation included background checks and license/certification verification.The Abuse Prohibition policy identified that personnel will be screened for a history of abuse and indicated as part of the employee hiring process a criminal background check will be required. The policy further identified the screening would include a minimum of two reference checks and indicated that information will be documented and kept in a separate file in Human Resources.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility policy documentation, review of facility policy and procedures, and interviews for one sampled resident (Resident #16) reviewed for an allegation of neglect, the facility failed to report the allegation of neglect to the State Survey Agency. The findings include:Resident #16's diagnoses included Parkinson's disease, dementia, muscle weakness, and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, no exhibited behaviors, required maximal assistance with toileting, bathing, and lower body dressing. It further identified the resident was dependent for bed mobility, utilized a wheelchair, was non-ambulatory and always incontinent of bladder and bowel. The care plan dated 11/18/25 identified Resident #16 was at risk for pressure injury/ulcer related to a history of healed stage 3 on the coccyx with interventions that included: provide resident with incontinent care approximately every 2 hours and as needed and turn and reposition every two hours and as needed. Review of a complaint emailed to the DNS, Administrator and the Regional Ombudsman by Person #3 (responsible party) on 1/2/26 at 8:08 PM identified that on January 2, 2026, she/he went to the facility to have dinner with Resident #16. She/he identified that upon arrival, she/he was told that Resident #16 had not had his/her afternoon nap and had remained seated in the wheelchair while attending a recreational program. Person#3 further noted that the recreation program had lasted from approximately 2:00 PM to 4:00 PM. The complaint further identified Person #3 was assisted by NA #2 to transfer the resident from the wheelchair to the bed and during the transfer urine and feces leaked through Resident #16's incontinent brief and clothing onto the floor. It further noted that the brief was fully saturated, making it evident that he/she had not been changed for a prolonged period, possibly hours. Interview on 1/5/26 at 1:38 PM with Person #3 identified he/she had arrived at the facility at 4:30 PM and found Resident #16 in the wheelchair, saturated in urine and feces up to his/her belly. Person #3 further noted that, NA #2 assisted him/her to transfer Resident #16 to bed when urine was squirting out over the chair, after which Person #3 cleaned the resident. Person #3 identified that the incident was reported to RN #3, the nursing supervisor and an email was sent to the DNS and the Administrator on 1/2/26. On 1/5/26 a request for accident and incident reports for the month of January 2026 for Resident #16 was made but no reports were provided (there were no reports related to the incident). A review of the State Agency's online reporting portal for the period of 1/2/26 through 1/7/26 failed to identify a report submitted by the facility regarding an alleged allegation of neglect related to Resident #16.Interview on 1/7/26 at 3:35 PM with the DNS and the Administrator identified they had not seen/received the email sent on 1/2/26. After another search the DNS and Administrator indicated there was an email sent on 1/2/26 from Person #3. The DNS reviewed the email and indicated that if she had seen the email she would have initiated an investigation because of the allegation of neglect. She further noted that she would have also reported this incident to the state survey agency. The DNS further identified that when an allegation of neglect is made to the nursing supervisor, the supervisor should initiate the accident and incident report and notify the DNS. Following Surveyor inquiry, the facility completed a reportable event dated 1/7/26 related to an alleged neglect by Resident #16's POA in regard Resident #16 not being provided with incontinent care on a timely basis. The reportable event was submitted to the State Survey Agency as a possible occurrence of neglect. Interview on 1/8/26 at 1:58 PM with the RN #3 identified Person #3 approached her 6:00 PM on 1/2/26 and told her that Resident #16 was very wet and filled with feces and conveyed that the resident was not changed at 4:00 PM and noted that it was neglect. RN #3 further identified that the nurse aide assigned to the resident (NA #3) admitted that she had not changed the resident at 4:00 PM because she had come to work late. RN #3 identified she had not reported the allegation to the DNS, nor had she assessed the resident's skin, or documented (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anywhere concerning the allegation. She further noted that she should have completed an accident and incident report because an allegation of neglect had been made but she had neglected to complete an accident and incident report and she had not reported the incident to the DNS. Interview on 1/12/26 at 8:58 AM with NA #3 identified she arrived on shift close to 3:30 PM on 1/2/26 and Resident #16 was already up in the wheelchair and positioned across from the nursing station. She identified the resident was wet, as were some of the other residents who were in bed and in wheelchairs. NA #3 identified that they were short staffed, and she began to change the residents who required a mechanical lift device for transfer with another first and did not get back to change Resident #16 before dinner. NA #3 identified Person #3 was upset, and she had apologized to him/her for not getting a chance to provide care to Resident #16 in time. NA #3 identified that if the resident was provided with incontinent care at 2:00 PM as stated the resident would not be soaked wet down to his/her pants. NA #3 identified she is usually assigned to care for Resident #16 and provides incontinent care prior to the dinner meal. Review of the Abuse Prohibition policy identifies neglect as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy further identified the Administrator, the Director of Nursing or their designee assumes responsibility for the immediate verbal notification of the incident to the following which includes to the Department of Public health all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24-hours if the events that caused the allegation do not involve abuse and do not result in serious bodily injury, to the Administrator of the facility and to other officials including the State Survey Agency and adult protective services where state law provides for jurisdiction in Long- term care facilities.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, review of facility policy and procedures, and interviews for one sampled resident (Resident #16) reviewed for an allegation of neglect, the facility failed to initiate an investigation of the alleged neglect. The findings include: Resident #16's diagnoses included Parkinson's disease, dementia, muscle weakness, and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, no exhibited behaviors, required maximal assistance with toileting, bathing, and lower body dressing. It further identified the resident was dependent for bed mobility, utilized a wheelchair, was non-ambulatory and always incontinent of bladder and bowel. The care plan dated 11/18/25 identified Resident #16 was at risk for pressure injury/ulcer related to a history of healed stage 3 on the coccyx with interventions that included: provide resident with incontinent care approximately every 2 hours and as needed and turn and reposition every two hours and as needed. Review of a complaint emailed to the DNS, Administrator and the Regional Ombudsman by Person #3 (responsible party) on 1/2/26 at 8:08 PM identified that on January 2, 2026, she/he went to the facility to have dinner with Resident #16. She/he identified that upon arrival, she/he was told that Resident #16 had not had his/her afternoon nap and had remained seated in the wheelchair while attending a recreational program. Person#3 further noted that the recreation program had lasted from approximately 2:00 PM to 4:00 PM. The complaint further identified Person #3 was assisted by NA #2 to transfer the resident from the wheelchair to the bed and during the transfer urine and feces leaked through Resident #16's incontinent brief and clothing onto the floor. It further noted that the brief was fully saturated, making it evident that he/she had not been changed for a prolonged period, possibly hours. Interview on 1/5/26 at 1:38 PM with Person #3 identified he/she had arrived at the facility at 4:30 PM and found Resident #16 in the wheelchair, saturated in urine and feces up to his/her belly. Person #3 further noted that, NA #2 assisted him/her to transfer Resident #16 to bed when urine was squirting out over the chair, after which Person #3 cleaned the resident. Person #3 identified that the incident was reported to RN #3, the nursing supervisor and an email was sent to the DNS and the Administrator on 1/2/26. On 1/5/26 a request for accident and incident reports for the month of January 2026 for Resident #16 was made but no reports were provided (there were no reports related to the incident). A review of the State Agency's online reporting portal for the period of 1/2/26 through 1/7/26 failed to identify a report submitted by the facility regarding an alleged allegation of neglect related to Resident #16.Interview on 1/7/26 at 3:35 PM with the DNS and the Administrator identified that according to the policy, when an allegation of neglect is told to the supervisor; the supervisor should initiate an accident and incident report and notify the DNS.Interview on 1/8/26 at 1:58 PM with the RN #3 identified Person #3 approached her 6:00 PM on 1/2/26 and told her that Resident #16 was very wet and filled with feces and conveyed that the resident was not changed at 4:00 PM and noted that it was neglect. RN #3 further identified that the nurse aide assigned to the resident (NA #3) admitted that she had not changed the resident at 4:00 PM because she had come to work late. RN #3 identified she had not reported the allegation to the DNS, nor had she assessed the resident's skin, or documented anywhere concerning the allegation. She further noted that she should have completed an accident and incident report because an allegation of neglect had been made but she had neglected to complete an accident and incident report and she had not reported the incident to the DNS. Following Surveyor inquiry, the facility completed a reportable event dated 1/7/26 and started the investigation related to an alleged neglect by Resident #16's POA regarding Resident #16 not being provided incontinent care on a timely basis. The Reportable Event policy identified an investigation will be conducted by the facility after the discovery of a resident with an injury or suspicious or unknown origin or receipt of allegation of abuse. The investigation and the findings shall be documented.Review of the Abuse Prohibition policy identified that any incidents of actual or suspected abuse must have (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an incident report completed. In addition to the incident report, the supervisory personnel are responsible for ensuring that the initial investigation regarding the incident occurs timely and appropriate interventions are put in place to ensure the resident's safety or protected from additional harm. The Administrator and DNS or designee should be notified as soon as possible.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and interviews for one of two sampled residents (Resident #7) reviewed for facility acquired pressure ulcers, the facility failed to develop a baseline care plan to prevent pressure ulcer/injury on admission. The findings include: Resident #7 was admitted on [DATE] with diagnoses that included dementia, nutritional deficiency, stage 4 pressure ulcer wound, and osteoarthritis.The nurse's note written by RN #1 dated 8/1/24 at 3:16 PM identified Resident #7 was admitted to the facility in stable condition and was adjusting to his/her room. Resident #7's lower extremity was dry, peeling and had a stage 3 pressure ulcer to the left heel. The left heel pressure ulcer wound measured 1.0 centimeters (cm) in length by 1.0 cm in width with good granulation tissue in the wound bed. Review of the clinical record failed to identify that a Braden Scale assessment (used to predict the risk of pressure ulcer development) had been completed on admission. Resident #7's baseline care plan dated 8/1/24 failed to identify areas of concern and/or goals of care and/or interventions to address the areas of concern. There was no care plan developed to address the resident's risk for pressure ulcers.The admission MDS assessment dated [DATE] identified Resident #7 had severe cognitive impairment, required extensive assistance for bed mobility, personal hygiene, toileting, dressing, transfers, and was non-ambulatory. The assessment further identified Resident #7 was always incontinent of bladder and bowel and was at risk of development pressure ulcers and had one unstageable pressure wound.The nurse's note written by RN #1 dated 8/14/24 at 8:11 PM identified Resident #7 had an open area to the coccyx. The coccyx area was cleanse with wound cleanser and border dressing was applied. The physician was notified and recommended for the wound consultation.Resident #7 care plan dated 8/14/24 identified resident had unstageable coccyx wound. The care plan interventions directed to observe the area for worsening, increased redness and report to the physician, provide treatment as ordered, provide incontinent care approximately every 2 hours and as needed, turn and re-position every 2 hours and air mattress set to resident's weight. Interview with RN #1 (per diem nursing supervisor) on 1/7/26 at 12:15 PM identified she could not recall whether she developed a care plan to address Resident #7's impaired skin integrity due to pressure ulcer. She identified that the care plan should include the turning and repositioning program, wound consultation, and provide treatment per physician orders. She identified that it would be either in the physician's orders or in the resident care plan to identify the interventions provided to the resident. Interview with the DNS on 1/12/26 at 9:10 AM identified that the licensed staff are responsible for developing and implementing a care plan to address any care issue identified on admission. She identified that Resident #7 was admitted with a pressure ulcer wound and should have had a care plan to include turning and repositioning, provide treatment as per physician order and air mattress when applicable. She further identified that the care plan should be implemented immediately on admission. Although requested, a policy for completing the baseline care plan was not provided for review.

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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 clinical record review, facility documentation, facility policy review, and interviews for one of two sampled residents (Resident #7) reviewed for facility acquired pressure ulcers, the facility failed to ensure the registered nurse assessed a newly admitted resident in accordance with facility practice. The findings include: Resident #7 was admitted on [DATE] with diagnoses that included dementia, nutritional deficiency, stage 4 pressure ulcer wound, and osteoarthritis.Review of the admission/readmission checklist identified tasks that need to be completed within 24 to 48 hours of admission and it identified that a complete nursing assessment should be completed and the information entered into the electronic health record (EHR), such as admission observations, admission nursing assessment, Braden Scale assessment, fall risk assessment, elopement assessment, and measure all wounds and ensure wound care is provided.Review of the clinical record identified that the following assessments required on admission were either not done or incomplete: observation assessment, admission nursing assessment, Braden Scale assessment, fall risk assessment and the elopement risk assessment. RN #1's nurse's note dated 8/1/24 at 3:16 PM identified Resident #7 was admitted to the facility in stable condition and was adjusting to his/her room. It further identified that the left heel had a stage 3 pressure ulcer that measured 1.0 centimeters (cm) in length by1.0 cm in width, and wound bed contained good granulation tissue. The admission MDS assessment dated [DATE] identified Resident #7 had severe cognitive impairment, required extensive assistance for personal hygiene, toileting, dressing, transfers, and was non-ambulatory. The assessment further identified Resident #7 was always incontinent of bowel and bladder, was at risk of developing pressure ulcers and had one unstageable pressure wound.Interview with RN #1 (per diem nursing supervisor) on 1/7/26 at 12:15 PM identified she is responsible for completing the comprehensive assessment of any resident admitted to the facility. She identified that the assessments include a head-to-toe assessment, fall risk assessment, Braden Scale assessment, and Elopement assessment, all to be completed within 24 to 48 hours. She further identified that she could not recall whether she comprehensively assessed Resident #7, but she identified that all nursing assessments are in the computer. Interview with the DNS on 1/12/26 at 9:10 AM identified that the licensed staff are responsible for completing the comprehensive assessments on all admitted residents. She identified that the assessments include the Braden Scale assessment, fall risk assessment, elopement risk assessment, and the nursing admission assessment. She identified that she is not familiar with the facility electronic medical record computer system, but she would expect that those assessments are completed and available in the resident's EHR. The admission Policy and Procedure identified that all facility personnel would be prepared prior to the new admission arrival. The nursing assessment identified that the nursing admission form for assessing the resident would be carried out in accordance with the nursing process.

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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 observation, review of clinical records, review of facility documentation, review of facility policy and procedures, and interviews for one sampled resident (Resident #16) reviewed for an allegation of neglect, the facility failed to ensure the resident received incontinent care as outlined in the care plan in a timely manner. The findings include:Resident #16's diagnoses included Parkinson's disease, dementia, muscle weakness, and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, did not display behaviors, required maximal assistance with toileting hygiene, bathing, lower body dressing, bed mobility and was dependent with personal hygiene, transfers, and use of a manual wheelchair. The assessment further identified Resident #16 was at risk for pressure ulcers and had pressure reducing devices for chair and bed, was on a turning and repositioning program and was always incontinent of bowel and bladder.The care plan dated 11/18/25 identified Resident #16was at risk for pressure injury/ulcer related to a history of healed stage 3 on the coccyx with interventions that included: provide resident with incontinent care approximately every 2 hours and as needed, turn and reposition approximately every two hours and as needed.The physician orders for the month of January 2026 directed for stand pivot transfer to custom wheelchair (CWC) with assistance of two staff, two nurse aides in the room at all times for care due to accusatory statements, protective foam dressing to coccyx daily and as needed. Review of the nurse aide care card identified Resident #16 required assistance of two staff members for transfers and toileting, two aides at all times with care, toilet the resident per Power of Attorney (POA) after breakfast, after lunch, after supper and before bed and afternoon naps daily.Review of a complaint report emailed to the DNS, Administrator and the Regional Ombudsman by Person #3 on 1/2/26 at 8:08 PM identified that on January 2, 2026, Person #3 was notified when he/she arrived at the facility to have dinner with Resident #16 that he/she did not receive his/her customary afternoon nap in bed and instead remained seated in the wheelchair while attending musical entertainment from approximately 2:00PM to 4:00PM. The complaint further identified the resident's POA was assisted by NA #2 to transfer the resident from wheelchair to bed and during the transfer urine and feces leaked through his/her incontinence product (pull-up) and clothing onto the floor as Resident #16's brief was fully saturated, making it evident that he/she had not been changed for a prolonged period of time, possibly hours. Interview on 1/5/26 at 1:38 PM with Person #3 identified he/she had arrived at the facility at 4:30PM and found Resident #16 in the wheelchair and was saturated in urine and feces up to his/her belly and NA #2 assisted his/her to transfer Resident #16 to bed when urine was squirting out over the chair, after which Person #3 proceeded to clean the resident. Person #3 identified this incident was reported to the RN #3 the evening supervisor and sent an email to the DNS and the Administrator on 1/2/26. A request was made on 1/5/26 for all accident and incident reports for the month of January 2026 for Resident #16 and none was provided.Review of the Point of Care History report for 1/2/2026 failed to reflect specific time in which Resident #16 was provided with incontinent care. The report provides the time in which the documentation was completed by each shift which noted for the 7:00 to 3:00PM shift documentation was done at 2:32 PM and for the 3:00 PM to 11:00PM shift documentation was done at 9:46 PM.Review of Resident #16 the clinical records from January 2, 2026, through January 7, 2026, failed to reflect any incident that had occurred on 1/2/26 involving the resident being observed wearing an incontinent brief that was saturated in urine and feces that leaked through clothing and onto the floor that was reported by Person #3.Interview with the Recreation Director on 1/13/26 at 11:30 AM identified on 1/2/26 there was an entertainment program which started at 2:30 PM in which Resident #16 was in attendance, and it ended at 3:15 PM or 3:20 PM.Interview on 1/8/26 at 8:21 AM with NA #2 identified he had assisted Resident #16's POA in transferring the resident from the wheelchair to the bed after dinner which was about after 6:00PM. He identified he was not assigned to the resident but had still assisted (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the POA. He further identified while transferring the resident he noticed the pants were soaking wet where one could potentially squeeze urine from the pants, but the wheelchair was not wet. He further identified he did not assist the POA in providing care for the resident as he is a male aide and they don't want male aides providing care to the resident, so he left and notified the nursing supervisor. Interview on 1/8/26 at 12:14 PM with NA #1 identified she worked the 7:00 to 3:00PM shift and Resident #16 was a part of her assignment. She identified that she had provided ADL care including peri-care to Resident #16 at around 7:30 AM with NA #4, then she checked on the resident for incontinence again at around 10:30 AM with NA #4 and the resident was not incontinent, so care was not provided. NA #1 identified every day at around 2:00 PM Resident #16 goes back to bed for a nap but on this day, there was entertainment, so she and another aide (NA #4) transferred the resident to the bed and provided incontinent care to the resident and brought the resident to the entertainment. NA #1 identified at 2:00 PM, the resident was incontinent and uses an incontinent brief, but it did not soak through his/her pants, and she added majority of the 2:00 PM incontinent care the resident's pants is not wet. NA #1 identified that she documents usually at the end of the shift but is unable to document each time incontinent care was provided as it is not asked for on the computer documentation, only if care was provided during the shift. Interview on 1/8/26 at 2:40 PM with NA #4 identified she had assisted NA #1 with transferring Resident #16 to bed and when care was provided at 7:30 AM, 10:30 AM and 2:00 PM, as two nurse aides are required to be present when care is provided. She identified during the 2:00PM care resident was transferred to bed when the resident started trying to get back out of the bed as they were about to provide incontinent care. NA #4 indicated they asked the resident if they could continue with providing care and he/she allowed the care, so they continued and after they were completed, the resident was transferred back to the wheelchair to attend the entertainment.Interview on 1/8/26 at 12:48 PM the Charge Nurse (LPN #3) identified when she arrived on shift a little before 4:00 PM she saw Resident #16 seated in his/her wheelchair in front of the nursing station. LPN #3 was approached by Resident #16's POA at about 5:00PM when he/she asked her why Resident #16 did not take his/her 2:00PM nap and she responded that she would find out. LPN #3 identified the daughter was upset after dinner was served as Resident #16 dd not want to eat and was not talking with him/her. She further identified she was unaware of any complaints from the resident POA regarding not receiving care, she was made aware on Monday that Resident #16's POA was upset on Friday because the resident was not provided with incontinent care.Observation on 1/12/26 at 2:40 PM with the DNS identified in Resident #16 room in the bedside table cabinet identified a supply of incontinent brief supply. Interview on 1/8/26 at 1:58 PM with the evening Nursing Supervisor (RN #3) identified that Resident #16's POA reported to her that the resident was sleeping in the dining room as the resident had participated in the activity and did not receive his/her nap which worn the resident out. RN #3 further identified Resident #16's POA returned to the dinner room after 6:00 PM and told her that Resident #16 was so wet and filled with urine and feces which means she was not change at 4:00 PM and this was neglect as the resident was not put back to bed at 2:00 PM, was wet and had feces. The nurse aide assigned to the resident (NA #3) admit that she had not changed the resident at 4:00PM as she had come to work late.Interview on 1/12/26 at 8:58 AM with NA #3 identified she arrived on shift close to 3:30 PM on 1/2/26 and Resident #16 was already up in the wheelchair and positioned across from the nursing station. She identified the resident was wet, as were some of the other residents who were in bed and in wheelchairs. NA #3 identified that they were short staffed, and she began to change the residents who required a mechanical lift device for transfer with another first and did not get back to change Resident #16 before dinner. NA #3 identified Person #3 was upset, and she had apologized to him/her for not getting a chance to provide care to Resident #16 in time. NA #3 identified that if the resident was provided with incontinent care at 2:00 PM as stated the resident would not be soaked wet down to his/her pants. NA #3 identified she is usually assigned to care for Resident #16 and provides incontinent care prior to the dinner meal.Review of the Abuse Prohibition policy identifies the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility has the responsibility to ensure that each resident has the right to be free from abuse, mistreatment, neglect, exploitation and misappropriation. of his or her personal property.Review of the Incontinent Care policy identified incontinent care will be provided to any resident who is incontinent of bowel and/or bladder by the CNA, frequency of incontinent care will be determined by the interdisciplinary team.

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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 - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one sample resident (Resident #39) reviewed for podiatry services, the facility failed to ensure podiatry consultation visit was reviewed and the recommendation of treatment by the podiatrist was followed through. The findings include:Resident #39's diagnoses included diabetes mellitus with diabetic retinopathy without macular edema.The physician's orders dated 8/14/24 directed: audiology, ophthalmology, psychiatrist, dental, and podiatry consultations as needed.The podiatry consent to treat dated 8/18/24 identified Resident #39 consented for podiatry services.The quarterly MDS assessment dated [DATE] identified Resident #39 had intact cognition, required extensive assistance with personal hygiene, toileting, dressing, and transfers. The assessment further identified the resident was non-ambulatory.The Resident Care Plan (RCP) dated 2/17/25 identified Resident #39 had diabetes mellitus and was at risk for abnormal laboratory values. Care plan interventions directed to administer medication, finger sticks as ordered and observe for lethargy, fruity breath, diaphoresis and report to the physician.Review of the clinical record failed to identify podiatry consults. The consultations were provided after surveyor inquiry. Review of the podiatry consultation reports dated 2/14/25, 4/16/25, 6/16/25, 8/18/25, and 10/27/25 identified Resident # 39 had received podiatry services. The podiatry consultation report dated 6/16/25 identified Resident #39 had an ingrown nail on the right great toe that was tender to palpation, had mild erythema (redness) and no swelling. The recommendation from the podiatrist was for post procedure to address the right ingrown toenail and noted the pain could be controlled with over-the-counter medication (OTC). It further noted that if swelling persists, warm Epsom salt soaks could be applied. In addition, the recommendation identified to monitor signs and symptoms of infection and consider antibiotic medication if infection occurs. The podiatry consultation report dated 8/18/25 identified Resident #39 with bilateral ingrown toenails, tender to palpation, mild erythema (redness) and no swelling. The recommendation identified that the resident could have a post procedure, pain that may be controlled with OTC medication and if swelling persists, consider warm soaks with Epsom salt, monitor for signs and symptoms of infection, apply topical bacitracin once a day for two weeks, and podiatrist will follow-up as routine.Review of the clinical record identified an outpatient podiatry consult dated 10/7/25 that identified that Resident #39 was seen for the ingrown toenail. The outpatient podiatry consultation recommended to soak feet with Epsom salt and warm water for 5 to 10 minutes twice per day and dry feet very well, apply silver sulfadiazine (topical anti-bacterial) 1 percent cream to the toes and apply dry clean dressing and leave open at night, cephalexin (anti-bacterial) 500 milligrams (mg) by mouth twice per day for 10 days.The physician's order dated 10/7/25 directed to soak feet with Epsom salt and warm water for 5 to 10 minutes then rinse and dry feet well and apply silver sulfadiazine cream to the toe and apply dry clean dressing and keep open to air at night, cephalexin 500 mg by mouth twice per day for 10 days.Review of the treatment and the medication administration records for the period of June/2025 through 9/2025 failed to reflect that the recommendations from the house podiatrist were initiated. Treatment to the ingrown toenail was not initiated until after the resident went to the outpatient podiatrist. The podiatry consultation report dated 10/27/25 identified Resident #39 had a right ingrown toenail, tender to palpation, mild erythema(redness) and no swelling. The recommendation identified right ingrown toenail could have a post procedure pain that may be controlled with OTC medication and if swelling persist, consider warm soak Epsom salt, monitor for sign and symptoms of infection, apply topical bacitracin once a day for two weeks, and podiatrist will follow-up as routine. In addition, it appeared that the house podiatrist was unaware that the resident had gone to an outpatient podiatrist outside of the facility and that the nail(s) had been treated and an antibiotic ordered. Interview with the DNS on 1/7/25 at 9:50 AM identified that she obtained all podiatry visits from the computer. She identified that the podiatry reports had not been reviewed by the nursing staff (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or primary physician. She identified that she is not included in the e-mails from the podiatrist and thus does not receive the reports. She further identified that the podiatry consultation reports should be passed on to the nursing supervisor and reviewed if there is a treatment recommendation. She also identified that all podiatry consultation reports should be immediately filed in the resident's clinical record after the review is completed. She further identified that she did not know who received the podiatry consultation reports.Interview with RN #2 (7-3 nursing supervisor) on 1/7/25 at 11:00 AM identified that she was not receiving the podiatry consultation report. She identified that she was unaware Resident #39 was being seen by the in-house podiatrist. She was aware that Resident #39 went out for a podiatry consultation regarding his/her in-grown toenail. She identified that she is responsible for following through with the treatment orders by the podiatrist if she receives the podiatry consultation. She further identified that she was not included in the e-mail who received the report from the in-house podiatry visit.Interview with MD #1 (Medical Director) on 1/7/25 at 1:30 PM identified he had not received the podiatry consultation reports for Resident #39. He identified that the nursing staff should review the podiatry consultation report and follow any new treatment recommendations by the podiatrist. He further identified that he rarely disagreed with the treatment recommendations by the specialist. The facility Ancillary Physician policy identified that routine and emergency podiatry services were available. The policy also identified that all services provided were recorded in the residents' medical record.

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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 clinical record review, review of facility policy, and interviews for one of two sampled residents (Resident #5) reviewed for accidents, the facility failed to provide adequate supervision to prevent the resident from smoking in the courtyard, failed to develop a comprehensive smoking policy and procedures, failed to develop a systems to ensure resident/family aware of the facility's non-smoking status. The findings include: Resident #5's diagnoses included chronic obstruction pulmonary disease (COPD), parkinsonism, chronic back pain, and nicotine dependence.The physician's order dated 8/26/25 directed to administer continuous oxygen at 2 liters per minutes to keep the pulse oximetry above 90 percent.The quarterly MDS assessment dated [DATE] identified Resident #5 had intact cognition, was independent with dressing, hygiene, transfers, ambulated with the assistance of a cane, and was on oxygen therapy.The resident care plan (RCP) dated 11/10/25 identified Resident #5 was observed smoking cigarettes outside in the courtyard. The care plan interventions directed to educate the resident on smoking and identified that the resident was offered a nicotine patch but had refused the patch.The physician's orders dated 11/13/25 with an origination date of 5/1/24 identified Resident #5 was independent with a straight cane in courtyard with instructions to check resident every 15 minutes.A request for an accident and incident report related to the smoking incident was made on 1/8/26 at 10:45 AM, but the facility did not have a documented accident and incident report. The smoking policy education and acknowledgement form was provided on 1/8/26. The form was not signed and it was undated. It contained language that identified resident education regarding smoking and understanding of the smoking policy. This form was supposed to be signed by the resident/resident representative, which would represent an attestation that the resident was provided education and understood the smoking policy. This form was not located in Resident #5's clinical record. Interview with Person #1 (Resident #5's representative) on 1/8/25 at 10:25 AM identified that he/she was aware that the facility was nonsmoking. Person #1 identified that the staff are aware that Resident #5 is an active smoker because he/she smokes when out on leaves of absence. Person #1 identified that he/she did not give Resident #5 cigarettes or lighter because he/she knows that the facility is a nonsmoking facility. Person #1 identified that the facility had not provided education regarding the risks of smoking while using oxygen. Person #1 further identified that he/she was unaware that Resident #5 was observed smoking in the courtyard but would have liked to have been made aware so he/she could ensure that Resident #5 would not bring smoking materials into the facility.Interview with LPN #4 (MDS Coordinator) on 1/8/26 at 10:38 AM identified that she created a care plan for smoking because Resident #5 was observed smoking in the courtyard. She could not identify any details related to the smoking incident because it was only reported in morning report. She further identified that she was unaware that Resident #5 smoked while on leaves of absence. Interview with RN #2 on 1/8/26 at 10:50 AM identified that she was aware that Resident #5 smokes when out with Person #1. She further identified that she was aware the resident had been observed in the courtyard smoking because it was in a shift report. She identified that she could not recall when Resident #5 was observed smoking in the courtyard. Interview with LPN #5 (admission's person) on 1/8/26 at 11:30 AM identified that she is responsible for screening residents for admission and noted that she verbally tells the resident and/or family that the facility is a nonsmoking facility. She further noted that if a resident has a history or is an active smoker, the resident is offered a nicotine patch prior to being admitted to the facility. In addition, she had no knowledge of smoking policy education and acknowledgement form that residents/representatives needed to sign on admission.Interview with the administrator on 1/8/25 at 1:10 PM identified that the facility is listed at the hospital as a nonsmoking facility. She identified that the admission person verbally informs the resident and/or family of the nonsmoking status. She had no knowledge of a smoking assessment and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was unfamiliar with the smoking policy education and acknowledgement form. Interview with the DNS on 1/8/26 at 1:25 PM identified that the facility was a nonsmoking facility. She identified that she could not find a smoking policy prior to Resident #5 smoking in the courtyard except for the smoking policy and education and acknowledgement form. She identified that she was not the DNS at the time that Resident #5 was observed smoking and she could not find any accident and incident reports related to the smoking incident. The Smoking policy revised on 11/2025 identified that the facility is a smoke free facility.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, review of facility documentation and interviews for one sampled resident (Resident #16), reviewed for an allegation of neglect, the facility failed to ensure adequate staffing to meet the needs of the residents. The findings include:Resident #16's diagnoses included Parkinson's disease, dementia, muscle weakness, and type 2 diabetes mellitus. The quarterly MDS assessment dated [DATE] identified Resident #16 had severely impaired cognition, did not display behaviors, required maximal assistance with toileting hygiene, bathing, lower body dressing, bed mobility and was dependent with personal hygiene, transfers, and use of a manual wheelchair. The assessment further identified Resident #16 was at risk for pressure ulcers and had pressure reducing devices for chair and bed, was on a turning and repositioning program and was always incontinent of bowel and bladder. The care plan dated 11/18/25 identified Resident #16was at risk for pressure injury/ulcer related to a history of healed stage 3 on the coccyx with interventions that included: provide resident with incontinent care approximately every 2 hours and as needed, turn and reposition approximately every two hours and as needed.The physician orders for the month of January 2026 directed for stand pivot transfer to custom wheelchair (CWC) with assistance of two staff, two nurse aides in the room at all times for care due to accusatory statements, protective foam dressing to coccyx daily and as needed. Review of the nurse aide care card identified Resident #16 required assistance of two staff members for transfers and toileting, two aides at all times with care, toilet the resident per Power of Attorney (POA) after breakfast, after lunch, after supper and before bed and afternoon naps daily.Review of a complaint report emailed to the DNS, Administrator and the Regional Ombudsman by Person #3 on 1/2/26 at 8:08 PM identified that on January 2, 2026, Person #3 was notified when he/she arrived at the facility to have dinner with Resident #16 that he/she did not receive his/her customary afternoon nap in bed and instead remained seated in the wheelchair while attending musical entertainment from approximately 2:00PM to 4:00PM. The complaint further identified the resident's POA was assisted by NA #2 to transfer the resident from wheelchair to bed and during the transfer urine and feces leaked through his/her incontinence product (pull-up) and clothing onto the floor as Resident #16's brief was fully saturated, making it evident that he/she had not been changed for a prolonged period of time, possibly hours. Interview on 1/5/26 at 1:38 PM with Person #3 identified he/she had arrived at the facility at 4:30 PM and found Resident #16 in the wheelchair and was saturated in urine and feces up to his/her belly and NA #2 assisted his/her to transfer Resident #16 to bed when urine was squirting out over the chair, after which Person #3 proceeded to clean the resident. Person #3 identified this incident was reported to the RN #3 the evening supervisor and sent an email to the DNS and the Administrator on 1/2/26. Review of the nursing staff schedule for 1/2/26 and a resident census of 43 identified the following: For the 7:00 AM to 3:00 PM shift: 3 Licensed staff 4 Nurse aides For the 3:00 PM to 11:00 PM shift: 3 Licensed staff (one Licensed staff scheduled to arrive at 4:15 PM) 5 Nurse aide staff with 2 call outs leaving only 3 nurse aides For the 11:00PM to 7:00 AM shift: 1 Licensed staff 3 Nurse aide staff Interview on 1/8/26 at 8:21 AM with NA #2 identified they were short staffed because one aide was a no call no show and the other aide called out. He identified that by dinner they were down to only 3 nurse aides to work on the unit on 1/2/26 for the 3:00 PM -11:00 PM shift. He further identified he was a male nurse aide, and the family of Resident #16 request that a male does not provide care to the resident.Interview on 1/8/26 at 1:58 PM with the evening Nursing Supervisor (RN #3) identified there were less nurse aides than normal on 1/2/26 on the 3-11 PM shift. She noted that one nurse aide was expected at 4:00 PM, leaving 2 nurse aides prior to 4 PM, another NA called that they were arriving late and the other NA identified she was not supposed to be on the schedule. RN #3 identified that since the schedule was short, she had to cover the dinner in the dining room, no other staff came. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/8/26 at 1:58 PM with NA #6 identified she worked on 1/2/25 on the 3-11 PM shift and noted they only had 3 nurse aides working with the supervisor and two other nurses. She further identified she was not assigned to Resident #16. Interview on 1/12/26 at 8:58 AM with NA #3 identified she arrived on shift close to 3:30 PM on 1/2/26 and Resident #16 was already up in the wheelchair and positioned across from the nursing station. She identified the resident was wet, as were some of the other residents who were in bed and in wheelchairs. NA #3 identified that they were short staffed, and she began to change the residents who required a mechanical lift device for transfer with another first and did not get back to change Resident #16 before dinner. NA #3 identified Person #3 was upset, and she had apologized to him/her for not getting a chance to provide care to Resident #16 in time. NA #3 identified that if the resident was provided with incontinent care at 2:00 PM as stated the resident would not be soaked wet down to his/her pants. NA #3 identified she is usually assigned to care for Resident #16 and provides incontinent care prior to the dinner meal.Interview on 1/13/26 at 8:05 AM with the Scheduler identified she typically schedules the 7:00AM to 3:00 PM and 3:00 PM to 11:00PM shifts depending on census with 5 nurse aides and 3 licensed staff but the lowest she would schedule is 4 aides especially for the 3:00 PM to 11:00PM shifts. She identified that on 1/2/26 the schedule was made for 5 nurse aides, but they had call outs. She added that she was unaware of the call outs as she was off on 1/2/26. The Scheduler identified the facility utilizes agency and the agency was contacted on 1/2/26 at 4:46 PM for staffing that was posted for 5:00 PM to 11:00 PM for 1/2/26, however, nobody picked up the shift. She further identified that to meet the facility's staffing requirement for 1/2/26 they would have to have a minimum of 4 aides. Interview on 1/12/26 at 12:19 PM with the DNS identified the 3:00 PM to 11:00 PM shift was staffed inadequately due to callouts. Review of the Facility Assessment identified the staffing plan as follows: 7:00 AM to 3:00 PM shift an RN (Registered Nurse), 2 LPN's (Licensed Practical Nurse) and 3-6 nurse aides depending on the census; 3:00 PM to 11:00 PM shift 1 RN, 2 LPN's and 3-5 nurse aides depending on census; and for the 11:00 to 7:00 AM shift 1 RN, 2-3 nurse aides depending on census.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #38) reviewed for Hospice services, the facility failed to ensure Resident #38's medical record was complete and readily accessible and for one sample resident (Resident #39) reviewed for podiatry visits, the facility failed to ensure the podiatry consultations were included in the resident's medical record. The findings included: Resident #38's diagnoses included protein calorie malnutrition and senile degeneration of the brain. The physician's orders dated 12/3/25 directed Resident #38 to receive Hospice care related to terminal diagnosis of protein calorie malnutrition. The significant change MDS assessment dated [DATE] identified Resident #38 had severely impaired cognition, required substantial/maximal assistance with self-care, rolling left to right and was always incontinent of bowel and bladder, had scheduled and as needed pain medication for indicators of pain observed daily and was receiving Hospice care. The care plan dated 12/16/25 identified Resident #38 was receiving Hospice services with interventions to follow the Hospice care plan for care and pain management. Review of Resident #38's nurses' progress notes, in the electronic health record, from 12/1/25 through 1/8/26 identified one progress note dated 12/8/25 that Resident #38 was seen by a hospice representative. Review of Resident #38's physical clinical record on 1/8/26 at 2:30 PM identified a section for Hospice paperwork that only contained documentation from 12/3/25, 12/10/25 and 12/12/25 identifying medication changes. Interview with RN#2 on 1/8/26 at 2:37 PM identified Resident #38's Hospice company communicated with the facility via the physical chart under the Hospice tab. RN#2 reviewed Resident #38's clinical record and identified there was no Hospice paperwork located in the chart and that the particular hospice agency caring for Resident #38 did not have a central communication binder, but communicated via the particular resident's physical chart. RN#2 indicated that much of the communication is verbal but should be documented by the facility nurse in the electronic record as well as the communication by hospice in the physical chart. RN#2 identified that the communication in the physical chart or the recommendations from hospice are how the facility writes the orders based on the recommendations. Interview with the MDS Coordinator on 1/12/26 at 10:14 AM identified that the hospice paperwork, inclusive of consents, care plan and communication, should be in the resident's physical clinical record. None of the identified paperwork was found in the resident's record. Interview with the Director of Hospice Operations (RN#6) on 1/12/26 at 10:20 AM identified Resident #38 had several hospice visits and that documentation of the visit is done in the hospice computer system and that all visits should be documented on the recommendation sheets in the resident's clinical record. RN#6 indicated that there is a report provided to the facility every other week and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	placed in the record by the nurse that is visiting the facility or the facility liaison. RN#6 identified that all consents and care plans should be present in the clinical record for continuity of care. Interview with LPN#1 on 1/12/26 at 10:50 AM identified staff speak with the hospice nurses one on one when they visit residents in the facility. LPN#1 indicated that the hospice nurses have iPads with them but was unsure if their documentation reached the facility's computer system. LPN#1 identified that she does not document interaction with hospice nurses and indicated that she had requested a recliner chair for Resident #38 last week and that the hospice nurse indicated it would have been delivered to the facility over the weekend, but when LPN#1 came to work today, the chair had not arrived. LPN#1 identified that she did not know the hospice nurse's name nor did she document the interaction. When asked how the facility staff would know to check on the status of the recliner chair, LPN#1 indicated she should have documented the interaction in the resident clinical record. Interview with RN#2 on 1/12/26 at 11:00 AM identified there was no Hospice information in Resident #38's chart and indicated that the contract, the care plan and communication should be present in the chart but was not sure who was responsible for ensuring it was complete. RN#2 reviewed the facility care plan for Resident #38 and indicated that it directed to refer to the hospice plan of care but could not locate the hospice plan of care. Interview with the DNS on 1/12/26 at 11:46 AM identified it was the responsibility of the nursing supervisors to ensure the physical charts have everything they are supposed to have and that Hospice paperwork should be present in the resident chart. The facility contract for Hospice services with the company providing services to Resident #38 identified the facility and hospice shall communicate with one another regularly and as needed, via phone, fax, email, and/or in person, for each particular hospice patient and that each party was responsible for documenting such communications in its respective clinical records to ensure that the needs of hospice patients are met 24 hours per day. The contract identified that Hospice shall promote open and frequent communication with facility and provide a plan of care, medications and orders, election form, certifications, contact information and on-call system. Resident #39 with diagnoses included diabetes mellitus due to underlying condition with diabetic retinopathy without macular edema. The physician's orders dated 8/14/24 directed: audiology, ophthalmology, psychiatrist, dental, and podiatry consultation as needed. The podiatry consent to treat dated 8/18/24 identified Resident #39 consented for podiatry services. The quarterly MDS assessment dated [DATE] identified that Resident #39 had intact cognition and required extensive assistance for personal hygiene, toileting, dressing, transfer, and non-ambulatory. The Resident Care Plan (RCP) dated 2/17/25 identified Resident #39 had diabetes mellitus and was at risk for abnormal laboratory. Care plan interventions directed to administer medication, and finger sticks as ordered and observed for lethargy, fruity breath, and diaphoresis and report to the physician. Review of the clinical record failed to identify podiatry consults. The consultations were provided after surveyor inquiry. Review of the podiatry consultation reports dated 2/14/25, 4/16/25, 6/16/25, 8/18/25, and 10/27/25 identified Resident # 39 had received podiatry services. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 1/7/25 at 9:50 AM identified that she obtained all podiatry visits from the computer. She identified that the podiatry reports had not been reviewed by the nursing staff or primary physician. She identified that she is not included in the e-mails from the podiatrist and thus does not receive the reports. She further identified that the podiatry consultation reports should be passed on to the nursing supervisor and reviewed if there is a treatment recommendation. She also identified that all podiatry consultation reports should be immediately filed in the resident's clinical record after the review is completed. She further identified that she did not know who received the podiatry consultation reports. Interview with RN #2 (7-3 nursing supervisor) on 1/7/25 at 11:00 AM identified that she was not receiving the podiatry consultation report. She identified that she was unaware Resident #39 was being seen by the in-house podiatrist. She was aware that Resident #39 went out for a podiatry consultation regarding his/her in-grown toenail. She identified that she is responsible for following through with the treatment orders by the podiatrist if she receives the podiatry consultation. Interview with MD #1 (Medical Director) on 1/7/25 at 1:30 PM identified he had not received the podiatry consultation reports for Resident #39. He identified that the nursing staff should review the podiatry consultation report and follow any new treatment recommendations by the podiatrist. He further identified that he rarely disagreed with the treatment recommendations by the specialist. The facility Ancillary Physician policy identified that routine and emergency podiatry services were available. The policy also identified that all services provided were recorded in the residents' medical record.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for the one sampled resident (Resident #38) reviewed for Hospice services the facility failed to identify and ensure the communication process between the facility and the hospice provider was established, failed to identify the designated facility staff responsible for the coordination of care, failed to ensure the hospice care plan was in place, and failed to ensure other pertinent documentation related to hospice care was in place, and failed to ensure hospice staff was oriented to the facility ?s policies and procedures. The findings include:Resident #38's diagnoses included protein calorie malnutrition and senile degeneration of the brain.The physician's orders dated 12/3/25 directed Resident #38 to receive Hospice care related to terminal diagnosis of protein calorie malnutrition.The significant change MDS assessment dated [DATE] identified Resident #38 had severely impaired cognition, required substantial/maximal assistance with self-care, rolling left to right and was always incontinent of bowel and bladder, had scheduled and as needed pain medication for indicators of pain observed daily and was receiving Hospice care.The care plan dated 12/16/25 identified Resident #38 was receiving Hospice services with interventions to follow the Hospice care plan for care and pain management.Interview with the DNS on 1/7/26 at 2:32 PM identified that hospice paperwork is handled by the social worker.Interview with SW#1 on 1/7/26 at 2:33 PM identified he was not responsible for the hospice paperwork.Review of Resident #38's nurses' progress notes, in the electronic health record, from 12/1/25 through 1/8/26 identified one progress note dated 12/8/25 that Resident #38 was seen by a hospice representative.Review of Resident #38's physical clinical record on 1/8/26 at 2:30 PM identified a section for Hospice paperwork that only contained one communication page with documentation from 12/3/25, 12/10/25 and 12/12/25 identifying medication changes.Interview with the RN Supervisor, RN#2 on 1/8/26 at 2:37 PM identified that Resident #38's Hospice company communicated with the facility via the physical chart under the Hospice tab. RN#2 reviewed Resident #38's chart and identified that there was not any Hospice paperwork located in the chart and that the particular hospice agency caring for Resident #38 did not have a central communication binder, but communicated via the particular resident's physical chart. RN#2 indicated that much of the communication is verbal but should be documented by the facility nurse in the electronic record as well as the communication by hospice in the physical chart. RN#2 identified that the communication in the physical chart or the recommendations from hospice are how the facility writes the orders based on the recommendations.Interview with MDS on 1/12/26 at 10:14 AM identified that she enters the care plan that indicates the resident is on Hospice and directs staff to follow the Hospice care plan. The MDS indicated that the care plan should be in the chart and that she wasn't sure if she should list the recommendations from Hospice in the facility care plan.Interview with Director of Hospice Operations, RN#6, on 1/12/26 at 10:20 AM identified Resident #38 had several hospice visits through this day 1/12 and that documentation of the visit is done in the hospice computer system and that all visits should be documented on the recommendation sheets in the resident chart. RN#6 indicated that there is a report provided to the facility every other week and placed in the resident charts by the nurse that is visiting the facility or the facility liaison. RN#6 identified that all consents and care plans should be present in the resident chart for continuity of care and that patient care is directed by the plan of care.Interview with LPN#1 on 1/12/26 at 10:50 AM identified staff speak with the hospice nurses one on one when they visit residents in the facility. LPN#1 indicated that the hospice nurses have iPad with them but was unsure if their documentation reached the facility's computer system. LPN#1 identified that she does not document interaction with hospice nurses and indicated that she had requested a recliner chair for Resident #38 last week and that the hospice nurse indicated it would have been delivered to the facility over the weekend, but (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when LPN#1 came to work today, the chair had not arrived. LPN#1 identified that she did not know the hospice nurse's name nor did she document the interaction. When asked how facility staff would know to check on the status of the recliner chair, LPN#1 indicated she should have documented the interaction in the resident clinical record.Interview with RN Supervisor, RN#2 on 1/12/26 at 11:00 AM identified there was no Hospice information in Resident #38's chart and indicated that the contract, the care plan and communication should be present in the chart but was not sure who was responsible for ensuring it was complete. RN#2 reviewed the facility care plan for Resident #38 and indicated that it directed to refer to the hospice plan of care but could not locate the hospice plan of care.Interview with MDS on 1/12/26 at 11:20 AM identified that all Hospice paperwork should be present in the resident's physical chart and was able to obtain some of the documentation from the hospice agency. MDS indicated she did not know who was responsible for ensuring the clinical charts were complete.Interview with the DNS on 1/12/26 at 11:46 AM identified it was the responsibility of the nursing supervisors to ensure the physical charts have everything they are supposed to have and that Hospice paperwork should be present in the resident chart.The facility has no established communication with this particular hospice agency caring for Resident #38. Facility staff are unsure who is responsible to verify hospice paperwork is present in the resident chart, how the communication by facility staff and hospice staff should be documented and where and absent the hospice paperwork, the facility care plan directs staff to follow the hospice plan of care which is not accessible to facility staff. There is not effective communication between facility staff and hospice and could affect continuity and quality of care for the resident.The facility policy for Hospice plan of care identified the Hospice POC is established and maintained in consultation with the facility staff. All care provided must be in accordance with the hospice POC and shall identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice POC. The hospice POC reflects the participation of the hospice, the nursing facility and the patient/family to the extent possible and indicated any changes in the hospice POC must be discussed with the patient or representative, a nursing facility representative and must be approved by the hospice prior to implementation.The facility contract for Hospice services with the company providing services to Resident #38 identified the facility and hospice shall communicate with one another regularly and as needed, via phone, fax, email, and/or in person, for each particular hospice patient and that each party was responsible for documenting such communications in its respective clinical records to ensure that the needs of hospice patients are met 24 hours per day. The contract identified that Hospice shall promote open and frequent communication with facility and provide a plan of care, medications and orders, election form, certifications, contact information and on-call system.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical records, review of facility documentation, and interviews for one sampled resident (Resident #6) reviewed for discharge, the facility failed to ensure that the Ombudsman's office was provided with the required notification of the transfer. The findings include:Resident #6's diagnoses included acute respiratory failure with hypoxia, acute kidney failure, and hypertension. The admission MDS assessment dated [DATE] identified Resident #6 had moderate cognitive impairment, required maximal assistance with personal hygiene, toileting hygiene, upper body dressing, bed mobility, transfers and ambulation using a walker.The nurse's note dated 12/23/25 at 2:30 PM identified Resident #6 was discharged home with medications and left the facility at about 1:30 PM with family. The note further indicated Resident #6 was stable, denied pain or discomfort and had no shortness of breath. Interview on 1/6/26 at 3:15 PM with SW #1 identified that he was not routinely sending notification of transfers and discharges to the state ombudsman ?s office. A review of the handwritten report provided by the facility from SW #1 of the facility's discharges, deaths, and admissions in the last three months identified the following:In October 2025, four residents were discharged from the facility.In November 2025, six residents were discharged from the facility.In December 2025 six residents were discharged from the facility.Interview on 1/7/26 at 8:25 AM with SW#1 identified he was aware of the Ombudsman online reporting portal and has access to the site, however, he had not used the portal because he had no need. He further indicated he would only use the portal if the facility had a resident that left the facility Against Medical Advice (AMA), any suspicions of abuse, and anything that was inappropriate. SW #1 further identified he had not sent any notification to the Ombudsman office of discharges in the last 3 months as he was not aware that he had to send the notification. Interview on 1/7/26 at 2:30 PM with the Regional Ombudsman identified she had assisted the facility in the past as it relates to access to the online portal, so they have access to send monthly notification of discharges to the office. She further identified that the facility should have received notices regarding the changes to the reporting in early 2025 that went into effect in fall of 2025. Interview on 1/7/26 at 3:22 PM with the Administrator identified the social worker was responsible for sending notification to the Ombudsman office of transfers and discharges. The Administrator further identified that the notification of hospitalization and discharges should be sent every 30 days, and unplanned discharges are done immediately. She further indicated that the social worker is aware and should have been sending the notification. A request for a transfer/discharge notification to the ombudsman office policy was requested but was not provided. Interview with the DNS on 1/12/26 at 12:19 PM identified the facility does not have such policy but the practice is to send notification of discharges, hospitalization and admission to the Ombudsman office monthly by the social worker.

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F 0637 Level of Harm - Potential for minimal harm Residents Affected - Some	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of clinical record, review of facility documentation, and interviews for one sampled resident (Resident #48) review for death, the facility failed to ensure the Significant Change in Status Assessment (SCSA) was completed for a resident who was admitted to hospice care. The findings include:Resident #48 was admitted to the facility in August of 2025 and had diagnoses that included chronic systolic congestive heart failure, dementia, type 2 diabetes mellitus, and chronic kidney disease stage 3.The admission MDS assessment dated [DATE] identified Resident #48 had moderately impaired cognition, required maximal assistance with toileting hygiene, personal hygiene, bed mobility and non-ambulatory.Physician's order dated 9/11/25 directed for hospice evaluation and treatment.The nurse's note dated 9/13/25 at 2:39 PM identified Resident #48 was admitted to hospice effective 9/13/25. The physician was notified, all orders were reinstated at this time per, the residents' Power of Attorney (POA) request to hospice. The hospice informed consent was obtained and signed on 9/13/25 by Resident #48's POA electing hospice care services.Review of Resident #48's Minimum Data Set (MDS) assessment completed from admission to November 2025 failed to reflect a Significant Change in Status Assessment that was completed after the resident was admitted to hospice services.Interview on 1/13/25 at 9:14 AM with the MDS coordinator (LPN #4) identified that she was responsible for completing the MDS assessment for residents including significant change in Status MDS assessment. LPN #4 identified significant change MDS are completed within 2 weeks of a resident being admitted and/or discharged from hospice services. She further identified Resident #48 MDS assessment should have been scheduled when he/she was admitted to hospice services on 9/13/25 and completed by 9/28/25, she added that it got missed even though the resident was still in the facility for more than a month past his/her admission to hospice care. She identified that she was responsible for scheduling MDS assessments and the DNS was responsible for signing off that the MDS was completed.Interview with the DNS on 1/13/26 at 11:17 AM identified on hire she was informed that she was responsible for signing off MDS assessment. She identified when she signs the MDS assessment, she signs that the sections are completed and not that they were accurately completed. Although requested, a policy for accuracy of MDS assessment was not provided.

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical records, facility policy/procedures and interviews for 3 of 5 sampled residents (Resident #3, Resident #11 and Resident #39) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the comprehensive assessments were accurately coded for residents with a positive Level II PASRR screening. The findings include:Resident #3's diagnoses included schizoaffective disorder, depression, and insomniaThe PASRR level II screening dated 12/9/2022 identified Resident #3 had a positive level II PASRR approved without specialized services.The annual MDS assessment dated [DATE] identified Resident #3 had severe impaired cognition. The assessment further identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response should have been yes because the resident has a positive Level II assessment. Interview on 1/12/26 at 2:55 PM with the MDS coordinator (LPN #4) identified it was the responsibility of the social worker to complete the PASRR section of the comprehensive MDS assessment. She further identified the PASRR assessment in section A of the assessment is only required to be completed on the admission, the annual and the significant change in status MDS assessments. Interview on 1/13/25 at 9:40 AM with the Social Worker (SW #1) identified he was responsible for coding section A 1500 on annual, admission, and significant change in status MDS assessment. He further identified that section A as it relates to PASRR was not completed accurately for Resident #3, Resident #11 and Resident #39 as the residents all had a positive level II screening so section A 1500 should have had a response of yes instead of no. SW #1 further indicated he was not aware that the residents had a positive level II, as he receives resident's PASRR information from the business office and from admission.Although requested, a policy for accuracy of MDS coding was not provided.Resident #11 was admitted to the facility in December of 2025 and had diagnoses that included Down syndrome, adjustment disorder with anxiety, and nontraumatic intracerebral hemorrhage.The PASRR level II screening dated 12/17/2025 identified Resident #11 had a positive level II PASRR.The admission MDS assessment dated [DATE] identified Resident #11 had moderately impaired cognition. The assessment further identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response should have been yes because the resident has a positive Level II assessment.Interview on 1/12/26 at 2:55 PM with the MDS coordinator (LPN #4) identified it was the responsibility of the social worker to complete the PASRR section of the comprehensive MDS assessment. She further identified the PASRR assessment in section A of the assessment is only required to be completed on the admission, the annual and the significant change in status MDS assessments. Interview on 1/13/25 at 9:40 AM with the Social Worker (SW #1) identified he was responsible for coding section A 1500 on annual, admission, and significant change in status MDS assessment. He further identified that section A as it relates to PASRR was not completed accurately for Resident #3, Resident #11 and Resident #39 as the residents all had a positive level II screening so section A 1500 should have had a response of yes instead of no. SW #1 further indicated he was not aware that the residents had a positive level II, as he receives resident's PASARR information from the business office and from admission.Although requested, a policy for accuracy of MDS coding was not provided.Resident #39's diagnoses included schizoaffective disorder, bipolar, and generalized anxiety disorderThe PASRR level II screening dated 9/26/2024 identified Resident #39 had a positive level II PASRR approved without specialized services. The admission MDS assessment dated [DATE] identified Resident #39 as moderately impaired cognition. The assessment further identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that (continued on next page)

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	075358	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bickford Health Care Center	14 Main Street Windsor Locks, CT 06096

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response should have been yes because the resident has a positive Level II assessment.The significant change MDS assessment dated [DATE] identified Resident #39 as cognitively intact. The assessment further identified under the Preadmission Screening and Resident Review (PASRR) section a response of no to the question that asks if the resident was currently considered by the level II PASRR process to have a serious mental illness and or intellectual disability or a related condition. The response should have been yes because the resident has a positive Level II assessment.Interview on 1/12/26 at 2:55 PM with the MDS coordinator (LPN #4) identified it was the responsibility of the social worker to complete the PASRR section of the comprehensive MDS assessment. She further identified the PASRR assessment in section A of the assessment is only required to be completed on the admission, the annual and the significant change in status MDS assessments. Interview on 1/13/25 at 9:40 AM with the Social Worker (SW #1) identified he was responsible for coding section A 1500 on annual, admission, and significant change in status MDS assessment. He further identified that section A as it relates to PASARR was not completed accurately for Resident #3, Resident #11 and Resident #39 as the residents all had a positive level II screening so section A 1500 should have had a response of yes instead of no. SW #1 further indicated he was not aware that the residents had a positive level II, as he receives resident's PASARR information from the business office and from admission.Although requested, a policy for accuracy of MDS coding was not provided.

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F 0645 Level of Harm - Potential for minimal harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of five sampled residents (Resident #4) reviewed for Preadmission Screening and Resident Review (PASRR), the facility failed to ensure the level 1 PASRR screening was accurately completed to determine whether level II PASRR screening needed to be completed. The findings include:The notice of PASRR level 1 screen outcome dated 2/26/24 identified Resident #4 did not require a level II PASRR screening. Further review of PASRR level 1 screening submitted on 2/26/24 identified no medical diagnoses were listed, no behavior was identified, and no medications were identified. The level 1 PASRR screening identified that no level II PASRR screening was required because Resident #4 had no intellectual/developmental disability or serious behavioral health issues. If changes occur or new information refutes these findings, then a new screening must be submitted. Resident #4's was admitted on [DATE] with diagnoses of psychotic disorder with delusions due to known physiological condition, major depression disorder recurrent with severe psychotic symptoms, and anxiety. The physician's order dated 7/11/24 directed: administer sertraline (anti-depressant medication) 25 milligrams (mg) by mouth daily, trazodone (anti-depressant medication) 25 mg by mouth at bedtime, and quetiapine (anti-psychotic medication) 25 mg by mouth daily. The Resident Care Plan (RCP) dated 7/15/24 identified resident had behavioral symptoms, made up wild stories and had delusions due to psychotic disorder and had increased paranoia and accusatory behaviors. Care plan interventions included: see a psychiatrist as needed, 2 staff members for all interactions, provide safe, quiet and low stimuli environment, and focus on reality. The admission MDS assessment dated [DATE] identified Resident #4 had moderate cognitive impairment and required extensive assistance for bed mobility, personal hygiene, toileting, and transfers. The assessment further identified Resident #4 was admitted from the community and had a depression diagnosis. The psychiatrist progress note dated 7/22/24 identified Resident #4 was evaluated for mood and behavior with the diagnosis of anxiety, depression, and delusional. The notes also identified that the nursing staff had been reporting delusional statements from the resident that his/her husband/wife was hurting him/her that cause significant distress, restlessness, and anxiety to the resident. Interview with SW #1 on 1/13/26 at 9:40 AM identified that Resident #4 was admitted from an assisted living facility. He identified that he does not review the PASRR level unless there is a problem presented by the businessperson. He identified that the businessperson was responsible for reviewing the PASRR screening and the businessperson will tell him if there is an issue with the PASRR screening. Upon review of the PASRR level screening that was submitted on 2/26/24 with SW #1, he identified that a new PASRR level screen should have been submitted because there were no medical diagnoses, no behaviors were identified and no medications were listed to identify whether a level II screening is needed or not. Interview with the businessperson on 1/13/26 at 12:00 PM identified that he does not review the PASRR level screening whether the information was accurate or not. He identified that SW #1 is responsible for ensuring that the PASRR assessments are accurate and submit additional information when needed. The facility PASRR policy identified the PASRR review will be initiated with significant change in condition, new diagnosis, and/or behavioral changes. The facility failed to make a referral to the PASRR contractor, to ensure that the resident had a complete and accurate assessment.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of facility documentation, facility policy/procedure, and interviews for 1 of 4 nurse aides (NA #7), the facility failed to ensure performance evaluations were completed 90 days after hire and every year thereafter according to the facility's policy. The findings include: Review of NA #7's personnel file identified that she was hired on 10/25/24 and failed to identify documentation that a performance appraisal (performance evaluation) was completed 90 days after hire, then at one year and annually thereafter in the year of 2024 and the year in 2025. Interview with the Administrator and the DNS on 1/12/26 at 1:50 PM identified it is the responsibility of the department head to complete their staff performance evaluation. The Administrator identified performance evaluation is completed 3 months after hire, then 6 months and one year after. She further identified nursing staff performance evaluation are completed either by the nursing supervisor, the charge nurse or by the ADNS. The Administrator identified NA #7 should have had a performance evaluation completed. Interview with the Administrator on 1/13/25 at 9:00 AM identified that after conducting a search, she was unable to locate performance evaluations for NA#7. The Administrator noted that she receives a list of employees from the human resources department with hire dates and the ADNS then assigns them to be completed. The Employee Performance Appraisal policy and procedure identified that the purpose of the employee performance appraisal is to provide a process by which the job performance of each employee is appraised for the purposes of development, performance review and counseling. Each supervisor is responsible for communicating standards for his or her employees at the beginning of, and throughout, the review period. The policy and procedure further identified the timing is regular employees generally receive performance appraisals annually on their anniversary date and newly hired employees should be appraised first at 90 days, then at 1 year, and annually thereafter.

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F 0947 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on review of facility documentation and interviews for 1 of 4 nurse aides (NA #7), reviewed for required yearly in servicing, the facility failed to provide evidence of the required 12 hours of nurse aide training provided per year that included abuse. The findings include: Review of the staff training records for 2024 and 2025 with the Administrator on 1/12/26 failed to identified NA #7 had received 12 hours of training in the year 2025 which included: resident rights, dementia, proper body mechanics, facility abuse policy and procedure, fire safety, nursing skills review, and hazard communication. The training folder provided only training/in-services provided in the year 2024.Review of the training records provided for NA #7 for the year 2025 failed to reflect 12 hours of education provided with only infection control training listed for the year. Interview on 1/13/26 at 9:00 AM with the Administrator in the presence of the DNS identified she monitors the staff education files which are kept in a shared office space, and education materials are dispersed to department head depending on the education. She then gives staff education to the Infection Control Nurse (RN #4). The DNS identified the facility's policy to provide mandatory education and in-services to the nursing staff annually and to provide other education/in-services as the need arises in the facility.Although requested a policy regarding mandatory education for nurse aides/nursing staff was not provided.