STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085039	A. Building B. Wing	12/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New Castle Health and Rehabilitation Center	32 Buena Vista Drive New Castle, DE 19720

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy, the facility failed to ensure risk vs benefits was explained to the resident or representative prior to the use of psychotropic medications for four (Residents (R)67, R20, R39, and R4) out of five residents reviewed for unnecessary medication out of a total sample of 35 residents. This facility's failure created the potential for residents to receive medications that were not necessary or desired related to their psychiatric/mental health care. Findings include:1.R67 was admitted to the facility on [DATE], according to the resident's admission Record, dated 12/12/25 and found in the Electronic Medical Record (EMR) under the Profile Tab. The resident's diagnoses included history of Traumatic Brain Injury (TBI) and Dementia with Agitation. Review of R67's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/28/25 and found in the EMR under the MDS Tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition. The assessment indicated the resident had short and long-term memory deficits. The assessment indicated the resident was receiving antidepressant, antianxiety and antipsychotic medications. Review of R67's Physician's Order Report, dated 12/13/25 and found in the EMR under the Orders Tab, revealed orders, all with an initial order date of 12/01/25 for the resident to receive Trazodone (an antidepressant medication) 50 milligrams (MG) three times daily for restlessness and agitation, Risperdal (an antipsychotic medication) 0.5 mg once daily for major depression, Risperdal 1 mg every night at bedtime for dementia with agitation, and Buspirone (an anti-anxiety medication) 30 mg twice daily for anxiety. Review of R67's Medication and Treatment Administration Records (MARs/TARS), dated 12/01/25 through 12/12/25 and found in the EMR under the Orders Tab, revealed the resident was receiving his psychotropic medications per physician's orders. Review of R67's record revealed no documentation that the risk vs. benefits were discussed prior to the administration of any of the resident's psychotropic medications. 2. Review of R20's quarterly MDS located under the RAI tab with an ARD of 11/25/25 revealed a BIMS score of three out of 15 indicating severe cognitive impairment and a diagnosis of emotional lability and Dementia. Review of R20's Orders located in the EMR revealed a physician's order, originally dated 07/27/25, for Trazodone (an antidepressant medication) tablet 50 mg twice a day at 9:00 AM and 9:00 PM with medication monitoring for the antidepressant. (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R20's EMR revealed no documentation that the risk vs benefits were discussed with the resident or representative prior to starting Trazadone. 3. Review of R39's EMR Face Sheet revealed the resident was admitted on [DATE] with a diagnosis of depression. Review of R39's admission MDS located under the RAI tab of the EMR with an ARD of 11/24/25 revealed a BIMS score of 15 out of 15, indicating cognitively intact. Review of R39's Orders located in the EMR revealed a physician's order for sertraline (antidepressant) tablet 25 mg oral give once a day, start date 11/18/25. Review of R39's EMR revealed no documentation that the risk vs benefits were discussed with the resident or representative prior to starting the Sertraline. 4.Review of R4's EMR located under the MDS tab revealed the admission MDS with an ARD of 5/01/24 revealed an admission date of 04/24/24; a BIMS of seven out of 15 indicating a severe cognitive impairment; diagnosis of arthritis, cerebrovascular accident, non-Alzheimer's dementia, hemiplegia, anxiety disorder, psychotic disorder, Senile degeneration of brain, not elsewhere classified; medications received antipsychotic, antianxiety, anticoagulant, antiplatelet; documented GDR as clinically contraindicated dated 05/02/24. Review of R4's EMR located under the Care Plan tab revealed a plan of care for the use of psychotropic medication; indicating that R4 was at risk for adverse reactions related to the use of psychotropic medications received for the diagnosis of dementia with psychosis, anxiety, and a seizure disorder. Review of R4's EMR located under the Orders tab revealed a physician order dated 10/31/24 for the antipsychotic risperidone 0.5 milligrams (mg). Give two tablets by mouth for dementia with severe agitation twice a day. A review of R4's EMR revealed no documentation that the risk vs. benefits were reviewed with the resident's responsible party prior to starting the psychotropic medication. During an interview with the Administrator, Director of Nursing (DON), and the Regional [NAME] President of Operations on 12/12/25 at 1:52 PM, they confirmed risk vs benefits had not been discussed for the administration of psychotropic medication for R67. The DON stated her expectation was for the risk and benefits to be discussed for each psychotropic medication being administered to any resident residing in the facility in order to ensure residents and/or their representatives were aware of the risks and benefits related to the medication. Review of the facility's undated Nursing Home Resident Rights Document indicated, The Resident has the right to be fully informed of the type of care provided, and risks and benefits of proposed treatments.

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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 - Some	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 record review, interviews, and review of facility policy, the facility failed to ensure timely reporting of allegations of potential abuse/neglect for four (Residents (R) R67, R126, R134, and R39) out of seven residents reviewed for abuse out of a total sample of 35 residents. The facility's failure to ensure timely reporting of the allegation of abuse created the potential for these and other residents to experience ongoing effects related to abuse.Findings include:1.Review of the resident's admission Record, dated 12/12/25 and found in the Electronic Medical Record (EMR) under the Profile tab revealed R67 was admitted to the facility on [DATE] with diagnoses that included history of Traumatic Brain Injury (TBI) and Dementia with Agitation. Review of R67's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/28/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition. The assessment indicated the resident had short and long-term memory deficits. Review of R67's Progress Notes, dated 09/03/25 and found in the EMR under the Notes tab, revealed This nurse was notified by CNA (Certified Nursing Assistant) staff that the resident [R67] attempted to enter the room of two [unnamed] female residents. One [unnamed] resident reported that he [R67] tried to get into bed with her and stated she would call 911 if the behavior recurs. Upon assessment, no injuries were noted, and both residents were assessed to be WNL [within normal limits]. DON [Director of Nursing] was notified. A room change was recommended to prevent further incidents. Review of the facility's Incident and Accident Report Log, dated 06/09/25 through 12/09/25 and provided directly to the survey team, revealed no entry on the log related to the 09/03/25 incident of potential abuse of the two unidentified females by R67. Nothing could be found in facility or R67's records to indicate the 09/03/25 incident of potential abuse of the unidentified female residents by R67 had ever been reported by staff to the Administrator or DON or by Administration to the appropriate Agencies (including the State Agency (SA). During an interview with the Administrator and DON on 12/10/25 at 12:49 PM, they confirmed incidents of potential resident to resident abuse were expected to be entered into the Incident and Accident Log and confirmed the 09/03/25 incident of potential resident to resident abuse should have been reported to Administration by staff immediately after it occurred and should have been reported by administration to the SA within two hours of staff becoming aware of the incident. The DON denied being notified as documented in the 09/03/25 nurse's note. 2. A review of R134's EMR titled Resident Face Sheet, located on the resident's dashboard, indicated the facility admitted the resident on 09/05/25. A review of R134's EMR titled admission MDS with an ARD of 09/11/25 indicated the resident had a BIMS score of 15 out of 15 which indicated the resident was cognitively intact. The assessment indicated the resident had no behaviors directed towards others. The assessment indicated R134 was ambulatory. A review of R134's EMR titled nursing Progress Notes located under the Resident tab dated 09/27/25 (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed R134 attempted to propel his wheelchair around R126. R126 then refused. R134 grabbed R126's wheelchair handles and pulled R126 back. This action caused R126 to fall to the ground. 3. A review of R126's EMR titled Resident Face Sheet, located on the resident's dashboard, indicated the facility admitted the resident on 08/29/25. A review of R126's EMR titled admission MDS with an ARD of 11 out of 15 which indicated the resident was moderately cognitively impaired. The assessment indicated the resident had no behaviors directed towards others. The assessment indicated R126 used a front wheeled walker. A review of R126's EMR titled nursing Progress Notes located under the Resident tab dated 09/27/25 revealed R134 attempted to propel himself around R126 and when R126 refused to move R134 grabbed the wheelchair handles to R126's wheelchair and pulled back. R126 fell and sustained a skin tear on his right elbow during the incident. Nursing immediately assessed R126 for injuries and pain. Nursing administered the resident Tylenol. A review of a document provided by the facility titled Incident Online Submission Form indicated the facility reported the resident-to-resident, which involved R134 and R126 to the State Survey Agency (SSA) on 09/29/25. The facility reported incident (FRI) revealed on 09/27/25 that R134 attempted to propel himself around R126. R126 did not move and R134 then grabbed R126's wheelchair handles and pulled R126 back. R126 fell to the ground. Nursing assessed R126 and the resident sustained a skin tear on his right elbow. An investigation ensued. Staff and other residents' statements were included. R134 denied that he had deliberately caused R126 to fall out of his wheelchair and hurt R126. During an interview on 12/11/25 at 10:17 PM, the Administrator stated Registered Nurse (RN)4 failed to report the resident-to-resident which involved R134 and R126 immediately to her. The Administrator stated staff were to notify her immediately of any resident-to-resident alleged abuse. 4. Review of R39's admission MDS located under the RAI tab of the EMR with an ARD of 11/24/25 revealed a BIMS revealed the resident had a score of 15 out of 15 which indicated the resident was cognitively intact. Review of R39's Facility Reported Incident (FRI) dated 12/01/25 revealed, Description of Incident:[R39] who is a short-term care resident at the facility has a past medical history of sepsis, muscle weakness, other abnormalities of gait and mobility, other specified chronic obstructive pulmonary disease (COPD), chronic pain syndrome, depression, hyperlipidemia, pain in left knee, vitamin deficiency, diabetes mellitus. R39 is alert and oriented, able to make her needs known, requires assistance with activities of daily living (ADL), and uses wheelchair for locomotion. [R39]'s BIMs of 15. On 11/30/25 at approximately 1:00 PM Certified Nurse Assistant (CNA) began assessing the residents' brief. Resident stated to CNA, 'I'm not wet. If I am, I will let you know.' The CNA continued to checking the brief, at which point the resident struck the CNA on the arm and stated, 'Stop, you're being too rough and you're hurting me.' The CNA responded, 'Please don't put your hands on me.' Resident continue to report knee pain despite scheduled and as needed (PRN) pain medication. Bedside table, call bell, and personal belongings placed within reach for safety and comfort. A head-to-toe assessment was completed; no obvious signs of injury were noted. RP [Responsible Party] and NP [Nurse Practitioner] were made aware. Date of violation: 11/30/25 Time of violation: 7-3On November 30, 2025, writer entered the resident's room to apply icy hot. CNA was present in the room. While the writer was applying the topical medication, the CNA began assessing the resident's brief. Resident stated to the CNA, 'I'm not wet. If I am, I will let you know.' The CNA continued checking the brief, and told (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	writer to look at the resident brief, because its soil and needs to be changed. At which time the resident struck the CNA on the arm and stated, 'Stop, you're being too rough and you're hurting me.' The CNA responded, 'Please don't put your hands on me, thank you,' and then exited the room. Writer apologized to the resident and informed her that staff would return in approximately 30 minutes to allow time for her pain medication to take effect. Resident agreed, then stated, 'I'm going to call my kids so they can get me out of here. That CNA is rough, has an attitude, and she doesn't realize she'll get old one day.' Writer apologized again and informed the resident that the social worker would be available Monday morning and that a message would be forwarded for follow-up. The Administrator was notified on 12/01/25 which was a delay in notification. Review of the facility's Delaware Resident Abuse Policy dated last revised/reviewed on 09/28/22 indicated, This Facility will not tolerate abuse, neglect, mistreatment, exploitation of residents, and misappropriation of resident property by anyone; and Facility staff must immediately report all such altercations to the Administrator/Abuse Coordinator. The Administrator/Abuse Coordinator will immediately initiate an investigation and notify the applicable local and state agencies in accordance with the procedures in the policy; and Timing: All allegations of abuse, neglect, involuntary seclusion, injuries of unknown source, and misappropriation of resident property must be reported immediately to the Administrator, Director of Nursing (DON) and to the applicable State Agency. If the event that caused the allegation involves an allegation of Abuse or serious bodily injury, it should be reported to the DOH (Department of Health) immediately, but not later than 2 hours after the allegation is made.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, the facility failed to complete a thorough investigation of an allegation of abuse for three (Residents (R) 134, R126, and R67) of seven residents reviewed for abuse out of 35 sampled residents. The facility's failure to complete a thorough investigation placed residents at risk of being unprotected from Abuse. Findings include:1. A review of R134's electronic medical record (EMR) titled Resident Face Sheet, located on the resident's dashboard, indicated the facility admitted the resident on 09/05/25. 2. A review of R126's EMR titled Resident Face Sheet, located on the resident's dashboard, indicated the facility admitted the resident on 08/29/25. A review of a document provided by the facility titled Incident Online Submission Form was completed. The facility reported the incident involving R134 and R126 to the State Survey Agency (SSA) on 09/29/25, as documented in the 'Incident Online Submission Form'. The facility reported incident (FRI) revealed on 09/27/25 that R134 attempted to propel himself around R126. R126 did not move and R134 then grabbed R126's wheelchair handles and pulled R126 back. R126 fell to the ground. Nursing assessed R126 and the resident sustained a skin tear on his right elbow. An investigation ensued. The facility's investigation included staff and resident interviews. R134 denied that he had deliberately caused R126 to fall out of his wheelchair and hurt R126. Staff were asked if they have ever witnessed R134 redirecting other residents who use wheelchairs, instead of asking staff if they had witnessed R134 attempting to hurt other residents. During an interview on 12/11/25 at 5:07 PM, the Administrator confirmed the resident-to-resident incident which involved R134 and R126 was incomplete since she did not ask staff about abuse. 3.Review of the resident's admission Record, dated 12/12/25 and found in the electronic medical record (EMR) under the Profile tab revealed R67 was admitted to the facility on [DATE], according to the. The resident's diagnoses included history of Traumatic Brain Injury (TBI) and Dementia with Agitation. R67's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/28/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition. The assessment indicated the resident had short and long-term memory deficits. Review of R67's Progress Notes, dated 09/03/25 and found in the EMR under the Notes tab, revealed This nurse was notified by CNA [Certified Nursing Assistant] staff that the resident [R67] attempted to enter the room of two [unnamed] female residents. One [unnamed] resident reported that he [R67] tried to get into bed with her and stated she would call 911 if the behavior recurs. Upon assessment, no injuries were noted, and both residents were assessed to be WNL [within normal limits]. DON [Director of Nursing] was notified. A room change was recommended to prevent further incidents. Review of the facility's Incident and Accident Report Log, dated 06/09/25 through 12/09/25 and provided directly to the survey team, revealed no documentation on the log related to the 09/03/25 incident of potential abuse of the two unidentified females by R67. Review of facility records and R67's records revealed no documentation to indicate an investigation (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	had been initiated/completed related to the 09/03/25 incident of potential abuse of the unidentified female residents by R67. During an interview with the Administrator and DON on 12/10/25 at 1:49 PM, they confirmed an investigation of potential abuse was expected to be initiated and completed related any incident of potential abuse/neglect, including the 09/03/25 incident of potential resident to resident abuse of the two unidentified female residents by R67. Review of a facility policy titled Abuse, Neglect and Exploitation dated 09/28/22 indicated . Investigation protocol. The person investigating the incident should generally take the following actions: Interview the resident, the accused, and all witnesses. witnesses generally include anyone who: witnessed or heard the incident; came in close contact with the resident the day of the incident (including other residents, family members); and employees who worked closely with the accused employee(s) and/or alleged victim the day of the incident.If there are no direct witnesses, then the interviews may be expanded. For example, to cover employees on the unit, or, as appropriate, the shift. For injuries of unknown source, the investigation will generally involve talking with both the shift on duty when the injury was discovered and prior shifts as well.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and review of facility policy, the facility failed to ensure a splint was applied routinely for one (Resident (R) R2) out of five residents reviewed for position and mobility out of a total sample of 35 residents. The facility's failure to ensure R2's splint was routinely applied created the potential for this and other residents to experience an unnecessary decline in Range of Motion (ROM). Findings include:Review of the resident's admission Record, dated 12/12/25 and found in the electronic medical record (EMR) under the Profile tab revealed R2 was admitted to the facility on [DATE]., according to the. The resident's diagnoses included Anoxic Brain Damage and Persistent Vegetative State. Review of R2's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/06/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition and inability to communicate. The assessment indicated a brace/splint was not being applied for the resident. Review of R2's Physician's Order Report, dated 12/13/25 and found in the EMR under the Orders tab, revealed no orders for the resident's use of a splint/brace. Review of R2's Splint/Brace Care Plan, dated 10/01/25 and found in the EMR under the Care Plan tab, revealed R2 required the use of a splint/brace related to a contracture of her right hand. The care plan indicated the resident's splint/brace was to be applied every day and removed at night. Review of R2's record revealed no documentation to indicate her splint/brace was being applied per her plan of care. Observations of R2 lying in her bed in a vegetative state and unable to move her body were conducted on 12/09/25 at 2:38 PM, on 12/10/25 at 9:04 AM, 10:03 AM and 11:59 AM. The resident's splint/brace was not applied to her right hand during any of the observations. The brace was observed lying on the bedside table next to the resident's bed. During an observation along with Certified Nursing Assistant (CNA2) on 12/11/25 at 10:31 AM, CNA2 confirmed the care planned splint/brace was not applied to R2's right hand at the time of the observation and confirmed R2's brace/splint was supposed to be applied during the day every day. During an interview with the Director of Nursing (DON) on 12/11/25 at 10:55 AM, she stated her expectation was R2's splint was to be applied according to her plan of care in order to prevent further decline in the resident's ROM. Review of the facility's Splint Issuance Policy dated last revised/reviewed on 03/24/25 indicated, Splints shall be issued or fabricated with a provider's order and therapist must evaluate patient to determine need for splint, fit and issuance; and Patient splint schedule will be communicated to the multidisciplinary team and documented in the care plan.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews, and review of facility policy, the facility failed to ensure consistent implementation of interventions to prevent falls for one (Resident (R) 67) out of 11 residents reviewed for accidents out of total sample of 35 residents. The facility's failure to ensure consistent interventions were implemented to prevent falls for R67 resulted in harm when R67 experienced a fall with major injury (a hip fracture). This failure increased the risk of other residents falling with major injury. and resulted in the potential for this and other residents to experience additional falls with injury. Findings include:Review of the resident's admission Record, dated 12/12/25 and found in the electronic medical record (EMR) under the Profile tab revealed R67 was admitted to the facility on [DATE]. The resident's diagnoses included history of Traumatic Brain Injury (TBI) and Dementia with Agitation. Review of R67's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/28/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition. The assessment indicated the resident had a history of falls since his prior MDS assessment, that the resident experienced two or more falls with no or minor injury since his prior assessment, and that the resident had not experienced any falls with major injury prior to the assessment. The assessment indicated R67 was dependent upon staff to transfer in and out of his bed and indicated the resident did not use a wheelchair during the assessment reference period. Review of R67's Fall Risk Assessment, dated 10/11/25 and found in the EMR under the Observations tab, revealed a fall risk score of 19, which indicated the resident was at high risk for falls. Review of R67's Falls/Risks for Falls Risk Care Plan, dated 12/10/25 and found in the EMR under the Care Plan tab, revealed the resident had experienced multiple falls since his admission to the facility on [DATE], and a fall with a major injury (hip fracture) on 11/26/25. The care plan indicated the resident was a high risk for experiencing falls and indicated the following interventions to prevent further falls including: . close supervision when wheelchair is being serviced, . frequent monitoring when resident is in bed . get resident out of bed to his Broda chair, get out of bed and to common area when awake at night . Review of R67's post fall therapy screening documentation, found in the EMR under the Notes tab, revealed the following recommendations: On 10/13/25 recommend continue with Broda chair in reclined position, (Keep resident) in supervised area; on 10/14/25 Resident (R67) requires assistance for transfer and supervision for safety related to high fall risk due to dementia related behaviors; on 10/22/25 (R67) remains high fall risk requiring redirection with verbal and tactile cues assist of (one staff member) for transfers for safety; and on 10/24/25 Continue with Broda chair and continue with (staff) monitoring and nursing safety interventions. Review of R67's Medication and Treatment Administration Records (MARs and TARs), dated 10/01/25 through 12/12/25 and found in the EMR under the Reports tab, revealed no documentation to indicate R67 was being monitored by staff to prevent falls. Further review revealed monitoring was not listed as a fall intervention. Review of R67's Certified Nurse Aide (CNA) Documentation, dated 10/01/25 through 12/12/25 and provided directly to the survey team, revealed no documentation to indicate R67 was being monitored to prevent falls. Further review of the CNA documentation revealed monitoring was not listed as a fall (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	intervention. Review of the facility's Incident/Accident Reports, provided directly to the survey team, revealed unwitnessed/unsupervised falls experienced by R67 on the following dates: a. On 08/06/25 at 6:00 AM R67 was found on the floor next to the nurse's station after a fall from his Broda chair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. b.On 08/07/25 at 7:41 PM R67 was found lying on his right side on the floor in the hallway. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. c.On 08/13/25 at 4:19 AM R67 was found on the floor next to his wheelchair near the nurse's station after a nurse heard a loud thump. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. d.On 08/18/25 at 10:00 PM R67 was found on the floor by a staff member after slipping out of his wheelchair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. e.On 09/08/25 at 2:45 PM R67 was found by a housekeeper on the floor in the middle of the hall. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. f.On 10/12/25 at 5:36 PM R67 was found on the floor in front of the nurse's station after falling out of his chair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. g.On 10/14/25 at 2:15 PM, R67 was found on the floor in the hallway lying on his right side next to his wheelchair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. h.On 10/21/25 at 10:30 PM, R67 was found on the floor in the hallway next to his wheelchair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. i.On 10/23/25 at 8:30 PM, R67 was found lying on the floor next to his wheelchair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. j.On 11/07/25 at 5:15 PM, R67 was found lying on the floor in the hallway and next to his wheelchair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. k.On 11/28/25 at 10:35 PM, R67 was found on his bottom on the floor in his room. The fall was unwitnessed. The resident complained of pain after the fall and was sent to the local Emergency Department for evaluation and treatment. R67 was found to have a left hip fracture as a result of the fall. The resident was sent back to the facility on [DATE] after his hospitalization related to the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fracture. Surgical intervention was not provided for the resident due to his frail health status and the resident was placed on comfort interventions related to the fall, such as pain control medications, prescribed positioning while in bed and in his Broda chair, and increased monitoring to prevent further falls. I.On 12/07/25/ at 6:30 PM, R67 was found laying on his right side on the floor next to his Broda chair. The fall was unwitnessed and the resident was not able to tell staff how the fall occurred. The resident did not have any injuries related to the fall. R67 was observed in the facility hallway on12/10/25 at 8:58 AM. The resident was seated in his Broda chair and was well positioned in the chair. There was no staff observed to be monitoring the resident at the time of the observation R67 was observed in the facility common area on 12/11/25 at 11:01 AM. The resident was restless and agitated and was observed attempting to get up from his chair multiple times during the observation. Staff was monitoring the resident at the time of the observation and repeatedly assisted the resident to sit back down in his chair to prevent him from falling. R67 was observed unattended in a staff office in his Broda chair on 12/11/25 at 11:45 AM. The resident was stuck in the office and not able to back out of the room independently. The resident was agitated and attempting to back out of the office. There was no staff observed to be monitoring the resident at the time of the observation. The surveyor requested assistance from staff to remove the resident from the office. R67 was observed on 12/12/25 at 10:00 AM in the facility hallway seated in his Broda chair and propelling himself throughout the hallway. R67 was not agitated but was active and occasionally attempting to stand up from his Broda chair. There was no staff observed monitoring the resident at the time of the observation. R67 was observed on 12/12/25 at 2:15 PM wheeling himself about the facility hallway in his Broda chair. R67 was not observed to be monitored by staff at the time of the observation. During an interview with Certified Nurse Aide(CNA5) and CNA6 on 12/12/25 at 2:41 PM, both staff members stated they were familiar with R67. CNA5 stated R67 was at high risk for falls because he constantly wanted to stand up from his chair when he was in his Broda chair and stated R67 was supposed to be monitored and was supposed to be within sight of staff at all times while he was up in his Broda chair due to his impulsivity to prevent falls. During an interview with CNA7 on 12/12/25 at 2:57 PM, she confirmed she was familiar with R67 and stated R67 was to be kept at in direct view of staff at all times due to his fall risk when he was up in his Broda chair. She stated staff usually tried to keep the resident at the nurses station when he was up in his wheelchair. She stated, He [R67] has to stay in line of site. It is a team effort. He [R67] will get up in a heartbeat. CNA7 stated R67's fall/safety monitoring was expected to be documented in his record in CNA documentation. During an interview with the Director of Nursing (DON), the Administrator, the Regional [NAME] President (VP) of Operations and the Regional Nurse on 12/12/25 at 4:43 PM, all confirmed R67 was expected to remain in line of site of staff at all times when up in his Broda chair. The stated he was to be supervised in this manner due to his high fall risk. The Regional VP of Operations confirmed R67 should have been directly monitored by staff when each of the unwitnessed falls occurred from R67's Broda chair and stated R67 needed to be placed formally on 1:1 supervision by staff when up in his chair to prevent falls. Review of the facility's Fall Prevention and Management Policy dated last revised/reviewed on 07/07/25 indicated, Residents will be assessed for fall risk(s) on admission, quarterly, and as needed. If risks are identified, preventative measures will be put in place and care planned. All falls will be reviewed and investigated.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy, the facility failed to ensure consistent and comprehensive management of nutritional services for one Resident (R) R67) out of three residents reviewed for nutrition out of a total sample of 35 resident. The facility's failure to ensure consistent nutritional interventions were provided for R67 created the potential for this and other residents to experience significant/unanticipated weight loss or nutritional deficits.Findings include:Review of the resident's admission Record, dated 12/12/25 and found in the electronic medical record (EMR) under the Profile tab revealed R67 was admitted to the facility on [DATE] The resident's diagnoses included history of Traumatic Brain Injury (TBI) and Dementia with Agitation. Review of R67's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/28/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition. The assessment indicated the resident had short and long-term memory deficits. The assessment indicated the resident had not experienced significant weight loss or gain during the assessment reference period, indicated the resident required set-up assistance from staff to eat his meals and indicated there were no interventions in place to prevent weight loss at the time of the assessment. Review of R67's Nutrition/Hydration Risk Care Plan, dated 12/10/25 and found in the EMR under the Care Plan tab, indicated the resident was at risk for significant weight loss related to his altered mental status and history of being combative with cares/services. Interventions included provide diet per physician's order and weight per physician's order. Review of R67's Physician's Order Report, dated 12/13/25 and found in the EMR under the Orders tab, revealed orders, with an initial order date of 12/03/25 for the resident to receive a regular diet and for weights to be obtained weekly. There were no current orders in the order set for the resident to receive any type of supplement or nutritional intervention to prevent weight loss. Review of R67's Vital Signs Report, dated 12/13/25 and found in the EMR under the Orders tab, revealed the following weights (which indicated a significant weight loss of 10.49% in less than 30 days) : 11/11/25: 162 pounds (LBS) 12/03/25: 145 pounds (LBS) The record did not indicate anything to show a re-weight had been obtained for R67 after his significant weight loss was recorded on 12/03/25. Review of R67's Dietary Progress Notes, dated 12/06/25 and found in the EMR under the Notes tab, revealed Resident [R67] recently readmitted from the hospital. He has experienced significant unintentional weight loss, decreasing from 162 LBS to 145 LBS (BMI (Body Mass Index) 19.66) over approximately one month, which is concerning for malnutrition risk. Resident is on a regular diet with staff assistance and encouragement provided as needed, and oral nutritional supplements (Boost 8 oz twice daily) are being used to support caloric and protein intake. Fluid intake remains below estimated needs, and staff continue to encourage fluids throughout the day. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R67's Medication and Treatment Administration Records (MARs/TARS), dated 12/01/25 through 12/12/25 and found in the EMR under the Orders tab, revealed the resident had not been receiving any type of nutritional supplement during that time period. During an interview with Licensed Practical Nurse (LPN5) on 12/10/25 at 2:23 PM, she confirmed she was responsible for R67's care on that date and confirmed she could not locate anything in the resident's record to show R67 was receiving the supplements indicated per his nutritional progress notes and could not locate anything to show the resident had been re-weighed after his 12/03/25 weight indicated a significant weight loss. She stated R67 had been receiving a supplement but had recently been hospitalized and the supplement order had not been put back in the EMR upon the resident's return from the hospital on [DATE]. During an interview with LPN 4/Unit Manager on 12/10/25 at 2:27 PM, she confirmed she was in charge of the unit where R67 resided and confirmed she was not able to locate anything to show R67 had been re-weighed after his documented 12/02/25 weight loss nor was she able to locate anything to confirm R67 had been receiving his supplement during the month of December 2025 since his return from the hospital. She confirmed it appeared the order for the resident's supplement had not been re-entered after the resident's return from the hospital on [DATE] During an interview with the Registered Dietician (RD) on 12/11/25 at 10:08 AM, he confirmed R67 was expected to receive his recommended nutritional supplement to help prevent unplanned weight loss and stated a re-weight was expected to be obtained within 24 hours with any documented significant weight loss. He stated he was not aware R67 had not been getting his nutritional supplement since his return from the hospital on [DATE]. During an interview with the DON on 12/11/25 at 10:51 AM, she confirmed her expectation was a re-weight should be obtained as soon as possible (within 24 hours) with any documented significant weight loss and confirmed R67 should have been receiving his recommended dietary supplement (Boost 8 ounces twice daily). Review of the facility's Resident Weight Policy dated last revised/reviewed on 03/23/25 indicated, Weights will be obtained routinely in order to monitor nutritional health over time. The facility's policies related to the maintenance of nutritional health were requested by the survey team on 12/11/25 at 5:30 PM, however the policies were not received prior to survey exit on 12/13/25.

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on document review, interviews, and facility policy review, the facility failed to ensure that one of four residents (Residents (R) 133) reviewed for tube feeding was assessed and monitored for nutritional and fluid needs and to intervene when resident (R133) aspirated tube feeding through the nose and mouth multiple times and gained a significant amount of weight. This failure resulted in harm to R133 when he went into cardiac arrest once while aspirating and was hospitalized three times after aspiration of tube feeding. The facility's Administrator and Regional [NAME] President of Operations were informed on 12/12/25 at 6:00 PM that Immediate Jeopardy existed at F693 Tube Feeding Management related to the failure to ensure that tube feedings were assessed, monitored, and interventions implemented when one of four residents reviewed for tube feeding aspirated tube feeding formula through his nose and mouth. The Immediate Jeopardy began on 05/13/25 when R133 e. experienced a change in condition and was sent to the emergency room and admitted to the hospital. The facility provided an Immediate Jeopardy Removal Plan that was accepted on 12/13/25 at 11:05 AM. Upon identification of immediate jeopardy related to tube feeding assessment, monitoring, and aspiration risk, the facility transferred the affected resident to the hospital and immediately assessed all tube-fed residents for tolerance, weights, and aspiration signs, with the Registered Dietitian and clinical leadership reviewing their status and convening an unscheduled QAPI meeting. The facility provided same-day education to the dietitian and nursing staff on the enteral feeding policy with 100% completion, and implemented a structured audit and monitoring process of MARs and progress notes over several weeks to ensure ongoing compliance and early identification of tube feeding intolerance.?The survey team validated implementation of the removal plan through interviews and review of training records. Immediate Jeopardy was removed on 12/13/25 at 12:15 PM. After removal of the Immediate Jeopardy, the deficiency remained at a "G" scope and severity for isolated harm.Findings include:Review of R133s Face Sheet located under the Resident tab in the electronic medical record (EMR) revealed the resident was admitted on [DATE] with a diagnosis of feeding tube (gastrostomy status).Review of R133's Care Plan located under the RAI tab in the EMR revealed administer feeding and hydration via feeding tube as ordered, elevate had of bed 30-45 degrees during feeding and for one hour after, flush tube with 30mls of water before and after medication administration and feeding, maintain the head of the bed elevated at all times when feeding is connected, start date 05/19/2024.Review of R133s Progress Notes located under the Resident tab in the electronic medical record (EMR) dated 02/17/25 at 1:39 PM revealed Dietary Progress Notes: Stable weights overweight by standard tube feeding [TF]. Order remained Nurtren 1.5 at 70 milliliters [ml] per hour [hr./ hrs.] for 18 hours for calories of 1890 and free water flush [FWF] of 65ml per hr. for 18hrs for 1170 ml water a day.Review of R133s Progress Notes located under the Resident tab in the EMR dated 02/20/25 at 3:21 PM revealed a Nurse Practitioner (NP) note, tube feedings .RD [Registered Dietitian] managing nutrition . Review of R133's Progress Notes located under the Resident tab in the EMR revealed Dietary Progress Note, dated 03/18/25 stating that the monthly weight trends were stable , overweight by standard, weighed 211.8 on 03/12/25 and to continue same tube feed and FWF as ordered. Review of R133's May 2025 Medication Administration Record (MAR) located under the Resident tab in the EMR revealed the order for May tube feedings should provide 1260 ml over 18 hours and FWF of 1170 every 24hrs. Review of the MAR revealed the following amounts of TF and FWF documented as provided by staff:05/06 TF of 3080 mls and FWF of 2860 mls. 05/07 TF of 2200 mls and FWF of 2070 mls05/08 TF of 3080 mls and FWF of 2860 mls05/09 TF of 3080 mls and FWF of 2860 mls05/10 TF of 3310 mls and FWF of 1879 (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	mls These amounts were in excess of the order for a total of 1260 mls of tube feeding and 1170 ml of FWF in 24 hours.Review of R133s Progress Notes located under the Resident tab of the EMR dated 05/11/25 at 3:54 PM revealed, Patient sent out to hospital at about 0945. At 0936 patient was found unresponsive patient is full code CPR [Cardiopulmonary Resuscitation] initiated after checking pulse, low oxygen level noted with all abnormal vital signs. Patient's feeding was seen oozing out of the patient's mouth. HOB [Head of Bed] elevated, and head turned to side patient was suctioned, increase noted in O2 [oxygen] levels from 60% to 98%. Paramedics resumed compressions transported to hospital with paramedics.Review of R133's Progress Notes located under the Resident tab in the EMR dated 05/21/25 at 11:30 PM revealed R133 was readmitted to facility with the same tube feeding and water flushes rate as before he was found with tube feed formula oozing out of the patient's mouth. Review of R133's Progress Notes located under the Resident tab in the EMR dated 05/23/25 at 10:46 AM, revealed Medical Director (MD) note, Treated for aspiration pneumonia and completed antibiotics.Review of R133's Order History located under the Resident tab in the EMR dated 06/09/25 revealed orders for free water flush changed from 65 mL per hour to 180 mL per shift. 180ml per three shifts equaled 540ml of FWF a day instead of the previous amount of 1170ml a day.Review of R133's Progress Notes located under the Resident tab in the EMR dated 07/11/25 at 12:54 PM, Dietary Progress Notes revealed weights stable, current weight on 06/10/25 is 214.8 .continues to tolerate TF as ordered. Review of R133's August 2025 MAR located under the RAI tab in the EMR revealed, TF 70mL per hr. over 18 hours and free water 180 mL per shift with a total of 540 with 60mL free water before meals and 30mL between meds. This order provided 1260ml of tube feeding formula a day and 540 ml of FWF and additional 60 ml before tube feeding and 30 ml between medications. Review of the August 2025 MAR revealed the following amounts of TF and FWF documented as provided by staff:08/01: TF1680 ml and FWF 1840 mls08/02 TF 1680ml and FWF 1840ml08/03 TF 540mls and FWF 720 ml08/04 TF 450 mls and FWF 630 ml08/05 TF 920mls and FWF 1080 mls08/06 TF 920 mls and FWF 1080 mls08/07 TF1680 mls and FWF 1840 mlsReview of R133's Progress Notes located under the Resident tab in the EMR dated 08/07/25 at 8:57 PM, revealed, call to resident's room and was told resident has aspirated. Upon assessment resident was observed with labored breathing HOB up, 84% room air nonrebreather mask applied at 15L-noted with crackles to bilateral (b/l) lungs. Milky secretions pooling from both nares and mouth. Suction performed twice. Order obtained to send resident out 911. Review of R133s Progress Notes located under the Resident tab in the EMR dated 08/13/25 at 11:36 AM, revealed History Hospital note: R133 came from nursing facility with shortness of breath with concern of overfeeding and aspiration admitted for septic shock pneumonia and urinary tract infection (UTI).Review of R133s Progress Notes located under the Resident tab in the EMR dated 08/14/25 at 11:09 AM, revealed, dietary note: weights net gain of 22.6% over the past seven months. This abrupt change is being evaluated for accuracy, Nurse Practitioners [NP]/MD notified weekly weight. No nutritional interventions needed at this time.Review of R133s Progress Notes located under the Resident tab in the EMR dated 09/18/25 at 10:40 AM, revealed, Dietary Progress Notes: Most recent weight on 09.05.25 is 230lbs. Weight changes and nutrition status were reviewed on site visit. MD aware. Resident remains NPO and continues on prescribed tube feeding: Nutren/Isosource 1.5 at 70ml/hr. 18 hours with concurrent waster flushes providing 2132ml total fluid a day. Review of October 2025 MAR located under the Resident tab in the EMR revealed an order for TF at 70cc/hr. over 18 hours and 180mL of water every shift for a total of 540mL a day with 60mL of free water before meds and 30mL between meds.Review of R133's Progress Notes located under the Resident tab in the EMR dated 10/14/25 at 3:47 PM, revealed, Resident has coarse crackles in the beginning of the shift and Nutren feed was seen coming out of the mouth. dyspneic [difficulty breathing]. Titrated to four (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	liters (L) on the concentrator with HOB to 90 degrees. Suction was done on the resident through the shift as needed during shift and pulse ox went from 88 to 96. Suctioning was provided using yankeur with a total amount of 35 mLs being drawn out. Crackles are still present bilaterally in lung contacted NP and was told to monitor the resident and if any changes to let him know.Review of R133s Progress Notes located under the Resident tab in the EMR dated 10/15/25 at 12:00 AM, revealed resident had course crackles in the beginning of the shift and Nutren feed was seen coming out of the mouth. Crackles still present. Xray ordered and one dose of Lasix [diuretic] ordered. In the afternoon patient noted with swelling on his face. Decision to transfer patient to the hospital.Review of R133's Progress Notes located under the Resident tab in the EMR dated 10/15/25 at 8:03 AM revealed the resident received in bed sleeping. Fluid noted from the mouth and was suctioned. Crackles noted but no respiratory distress noted. Continue to monitor.Review of R133's Progress Notes located under the Resident tab in the EMR dated 10/15/25 revealed nurse assessed resident and observed that resident was aspirating from his mouth, shortness of breath [SOB] and lung crackles. NP was immediately notified and recommended that the resident be sent to the hospital.sent out at 12:50 PM to hospital.During an interview on 12/12/25 at 10:58 AM, the Nurse Practitioner (NP) 1stated he was not aware of a report given from the hospital about potential overfeeding. NP1 revealed that he documented R133 was tolerating the tube feeding after two incidents of aspiration because it depends if the aspiration is based on the tube feeding or if the resident had pneumonia. If not pneumonia, then review the feeding and rates. NP1 revealed that on October 15, 2025, he sent the resident out to the hospital because he was having shortness of breath, increased hypersecretion of saliva not aspiration [despite that three nurses' notes document aspiration of formula feed), and the hospital didn't mention aspiration. NP stated it was high secretions and because of shortness of breath he started medication to lower secretions, oxygen was ordered and the resident was given albuterol treatment and sent out to the hospital because of face swelling.Review of R133's Progress Notes located under the Resident tab in the EMR dated 10/15/25 at 1:54 PM revealed this writer received a call from med student at hospital regarding reason for send out. Updated to change in condition starting yesterday evening, nursing and NP interventions made in house and resident continued, decline despite interventions. No admission diagnosis as yet noted resident still being evaluated.Review of R133s Progress Notes located under the Resident tab in the EMR dated 10/17/25 at 11:51 AM revealed the resident was admitted for sepsis.During a concurrent interview on 12/11/25 at 5:18 PM, the Regional Registered Dietician (RDD) and Registered Dietician (RD) stated that the residual amount of tube feeding in the stomach was mostly zero, but there were times when he had 10, 12 15 or 30 mls. They confirmed in April 2025 the resident tolerated the tube feeding well with no history of vomiting, oozing, or regurgitating tube feeding. The RD revealed he first saw resident in June 2025 as he was the new dietician, and the resident's weight was intact; flushes were good and tolerated feeding well with no complications.They revealed R133 was discussed in IDT meetings because he was a tube feed resident. Regional RD voiced she would provide me with R133's assessments tomorrow but they were not provided before exitDuring a concurrent interview on 12/12/25 at 9:50 AM the RDD and facility RD stated water flush was decreased on 06/09/25 from 65 mL per hr. over 18 hours to 180 mL per shift. The RD confirmed they were not notified in May of R133's aspiration on tube feeding. The RD stated he was not aware of a note on 08/13/25 from the hospital about overfeeding. The RD confirmed he was aware of the weight note on 08/14/25 and aware of risk of overfeeding but did not see documentation of tube feeding oozing out of mouth/ nares. The RD revealed from his assessments while the resident was in the facility he was tolerating his tube feeding. The RD confirmed that an assessment of tube feeding and water flush rate should be (continued on next page)

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F 0693 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	conducted after aspiration incidents.During an interview on 12/12/25 at 12:28 PM, the Director of Nursing (DON), Medical Director, NP1, RDD, and Dietician. Resident has chronic encephalopathy and aspirates off and on. Dietician usually, we work with them, and dietary changes the orders and they keep track of tube feeding, aspiration and labs. We have been monitoring the TF closely. The MD was asked about the resident having TF coming out of his nose and should have he been assessed after this and MD said, people vomit when they are sick. Review of the facility's policy titled, Dietary Enteral Nutrition Care Policy with a revision date of 03/28/25 noted Policy: The use of an enteral nutrition tube has a major impact on a resident and his or her quality of life. Procedure.Upon initiation of enteral feeding, the registered dietician nutritionist (RDN) or designee will perform an assessment that will include a calculation of the individual's energy, protein, fluid requirements, and potential medication interactions. If there is an existing nutrition order, a comparison will be made between the individual's requirements and the physician ordered enteral formula and free fluid flush. The RDN or designee will monitor weight, skin color, labs, physical symptoms, tolerance to feeding, and oral food/ fluid intakes as applicable, periodically, and as needed.The nursing staff will communicate any concerns to the MD, RDN or designee regarding changes in condition such as weight loss, diarrhea, nausea, vomiting, bloating, gas, and high residual levels.Review of facility's policy titled, Dietician, FT with no date noted, Position Summary: The primary purpose of your job is to plan and deliver nutritional care to residents in accordance with the physicians' orders and with current federal, state, and local standards, guidelines and regulations that govern the community. Essential Functions: Determine resident nutritional status by evaluating medical records, observation of resident eating habits, feeding abilities, nutritional needs, and diet compliance to develop individualized nutrition care plans, and adjust as needed. Consult with medical staff evaluate effects of nutritional intervention on individual residents and the need for further intervention or plan revision.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and review of facility policy, the facility failed to ensure bed rails in use were necessary for one (Resident (R) 2) of 11 residents reviewed for accidents out of a total sample of 35 residents. The facility's failure to ensure the necessity of R2's bed rails created the potential for this and other residents to experience accidents related to the use of unnecessary bedrails. Findings include:Review of the resident's admission Record, dated 12/12/25 and found in the electronic medical record (EMR) under the Profile tab revealed R2 was admitted to the facility on [DATE]. The resident's diagnoses included Anoxic Brain Damage and Persistent Vegetative State. Review of R2's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/06/25 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not able to be completed due to the resident's poor cognition and inability to communicate. The assessment indicated the resident was totally dependent upon staff to complete all of her Activities of Daily Living (ADLs) including movement in bed and transfers in and out of bed. The assessment indicated the resident did not have bed rails in place on her bed. Review of R2's Physician's Order Report, dated 12/13/25 and found in the EMR under the Orders tab, revealed no orders for the resident's use of bed rails. Review of R2's comprehensive care plan, most recently dated 09/30/25 and found in the EMR under the Care Plan tab, revealed no care plan to indicate the resident's use of bed rails. R2's record was reviewed comprehensively and no documentation could be found to indicate informed consent had been obtained for the use of bed rails on R2's bed. Observations of R2 lying in her bed in a vegetative state and unable to move her body were conducted on 12/09/25 at 2:38 PM, on 12/10/25 at 9:04 AM, 10:03 AM, 11:59 AM and 1:18 PM, and 12/11/25 at 10:31 AM. Grab bars (short bed rails) were raised on both sides of the resident's bed during all of the observations. During an observation of R2 conducted along with Licensed Practical Nurse (LPN)5 on 12/10/25 at 1:30 PM, LPN5 confirmed 1/4 grab bars were in the raised position on both sides of R2's bed and confirmed R2 was not able to move at all. She stated R2 was unresponsive and was completely dependent upon staff to complete all of her ADLs. She stated the resident's bilateral grab bars were usually in the raised position. During an interview with the Director of Nursing (DON) on 12/10/25 at 2:13 PM, she confirmed R2 was unresponsive and stated R2 was not able to use her grab bars in any way and the grab bars should not have been installed on the resident's bed. Review of the facility's Bed Rail Policy dated last revised/reviewed on 12/03/25 indicated, The use of bed rails will be limited to circumstances where they are used to treat a medical condition and enhance the resident's functional abilities; and If a bed or side rail or bar is used, the facility will: .b. Evaluate the risk versus benefits of using a bed rail and review them with the resident or if applicable, the resident's representative, and c. Obtain informed consent for the installation and use of the bed rails prior to the installation

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility policy, record review, observations and interviews, the facility failed to ensure a medication rate of less than five percent when two errors were made out of a total of 25 opportunities, during the administration of (one Resident's (R) 114). The facility's observed medication error rate was eight percent. The facility's failure created the potential for R114 and other residents to experience negative physical and/or psychosocial effects related to the incorrect administration of their medication. A total of 35 residents were reviewed in the sample.Findings include:R114 was admitted to the facility on [DATE], according to the resident's admission Record, found in the Electronic Medical Record (EMR) under the Profile Tab. The resident's diagnoses included Type 2 Diabetes. R114 was observed receiving his medication administered by Licensed Practical Nurse (LPN4) on 12/11/25 at 8:48 AM. LPN4 administered the resident's Basaglar Insulin and Insulin Lispro separately per insulin pen. LPN4 did not prime the insulin pen prior to the administration of the Insulin Basaglar or the Insulin Lispro. Review of R114's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/29/25 and found in the EMR under the MDS Tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15 out of 15. This indicated the resident was cognitively intact. The assessment indicated the resident received insulin on seven of seven days observed during assessment reference period. Review of R114's Physician's Order Report, found in the EMR under the Orders Tab, revealed orders, with an original order date of 11/25/25, for the resident to receive Basaglar KwikPen (Long-Acting Insulin) 10 units Subcutaneously (SC) routinely each morning at 8:00 AM and to receive Insulin Lispro (Short Acting Insulin) 14 units SC routinely three times daily before meals. Review of R114's Medication Administration Record (MAR), dated 12/01/25 through 12/12/25 and found in the EMR under the Orders Tab, revealed the resident was receiving his insulin as ordered. During an interview with LPN4 on 12/11/25 at 9:05 AM, she stated she was not aware the insulin pens needed to be primed and she had never primed the resident's pen prior to the administration of his insulin. During an interview with the Director of Nursing (DON) on 12/11/25 at 10:57 AM, she stated insulin pens were expected to be primed with two units of insulin prior to administration of the insulin to ensure an appropriate dose of the insulin was administered. Review of the facility's undated Using Insulin Pen Delivery Systems Document indicated, Prime (the pen) before each injection, hold upright and prime the pen to remove air bubbles and to ensure the needle is open and working.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and policy review, the facility failed to ensure food was discarded and/or stored according to professional standards for food service safety in one of one kitchen. This failure had the potential to cause the spread of foodborne illness to all 109 residents that receive food from the kitchen.Findings include:During initial observations of the kitchen on 12/09/25 beginning at 9:47 AM, the following was observed:In the dry storage, there were two 19.5-ounce plastic squeeze bottles of chocolate syrup with an expiration date of 5/16/25.In the walk-in refrigerator, there were three 19.5-ounce bottles of chocolate syrup, three 19.5-ounce bottles of vanilla syrup that were opened. The opened bottles of chocolate and vanilla syrup displayed an expiration date of 5/16/25. The Dietary Manager (DM) confirmed that the bottles of chocolate and vanilla syrup were past the expiration date displayed on the bottles. During an interview on 12/09/25 at 11:10AM the DM confirmed that the flavored syrups were past the manufactures use by date and should not be available for use. The DM also stated that those food items were [served during] activities and should have been looked at by the dietary staff. The dietary staff was ultimately responsible for ensuring food items were not expired. During an interview on 12/10/25 at 10:17AM, the Administrator stated that the facility had no policy that directly addressed the manufacture use by date or the expiration displayed on a food item. Review of the facility's policy titled, Equipment Cleaning and Sanitation Policy, dated 08/25/20, revealed The food and nutrition services staff will maintain a clean and sanitary environment in food service areas. The policy did not address food storage policies and procedures.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to 1. have an adequate water management program. The facility's water management program was incomplete and was not consistent with current ASHRAE (American Society of Heating, Refrigerating and Air-Conditioning Engineers) Guideline, which specifically called for design and maintenance procedures for the potential exposure of Legionnaires' disease (a serious pneumonia infection) within a healthcare facility. This failure created the potential for the 105 facility residents, who were either over the age of 65 and/or were autoimmune compromised, to be infected by Legionella and 2. ensure one Licensed Practical Nurse (LPN)4 performed hand hygiene between wound treatments for one (Resident (R) 10) . This has the potential for cross-contamination of pathogens from one wound which can then be transferred to another.Findings include:1.A review was conducted of a facility document titled Premise Plumbing System undated revealed a diagram of the facility's water system. There was no documentation on the diagram that indicated high-risk areas in which water pathogens might develop. During an interview on 12/12/25 at 8:56 AM, the Maintenance Director stated he had not seen a water flow diagram of the facility's water system before and confirmed the diagram did not identify the high-risks areas for pathogen development. Review of website for ASHRAE titled Successfully Managing the Risk of Legionellosis dated 04/07/21 indicated . Legionellae the biological classification name for a [NAME] of bacteria.is the plural, referring to more than one Legionella bacterium.Legionellosis: any illness (disease) caused by the exposure to Legionella. Legionnaires' disease (LD) and Pontiac fever (PF) are the two known types of legionellosis.Potentially fatal, multisystem respiratory illness, accompanied by pneumonia.Symptoms.high fever, chills, muscle pain, headache, dry cough, diarrhea, vomiting, confusion, and delirium common.Immune suppressed.transplant patients, cancer, cardiac, diabetes, steroid/drug therapy.Sick/in poor health. Elderly/infirm.Heavy smokers, lung/COPD diseases.Describe the building water systems using flow diagrams & a written description: Include details such as where the building connects to the (municipal) water supply, how water is distributed and used (processed), where hot tubs, water heaters, cooling towers, etc. are located. 2. Review of the admission Record, dated 12/12/25 and found in the electronic medical record (EMR) under the Profile tab revealed R10 was admitted to the facility on [DATE] with a history of stroke. Review of R10's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/15/25 and found in the EMR under the MDS Tab, revealed a Brief Interview for Mental Status (BIMS) assessment score of zero out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident had a stage four pressure ulcer, and unstageable pressure ulcer, and a venous stasis ulcer at the time of the assessment and indicated the resident was receiving hospice services. Review of R10's Physician's Order Report, dated 12/13/25 and found in the EMR under the Orders tab, revealed orders for wound care to be provided for the resident, including: Cleanse abscess to left ischium, pat dry, apply calcium alginate, cover with dry dressing daily; Cleanse area to left lateral foot with normal saline, pat dry, apply calcium alginate, cover with clean dry dressing daily; Cleanse left groin with normal saline, pat dry, apply collagen and cover with clean dry dressing daily; Cleanse left trochanter with normal saline, apply collagen and cover with clean dry dressing daily; Cleanse right lateral foot with normal saline, pat dry, apply calcium alginate, cover with dry (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dressing daily; and Cleanse sacrum with normal saline, pat dry, apply calcium alginate and cover with clean dry dressing daily. Review of R10's skin and wound care plans, most recently dated 11/18/25 and found in the EMR under the Care Plan Tab, revealed R10 had multiple chronic wounds and indicated orders were to be followed related to the provision of wound care. During an observation on 12/11/25 at 2:52 PM, Licensed Practical Nurse (LPN)4 and the Assistant Director of Nursing (ADON) were observed completing R10's wound care LPN4 removed all of the resident's dressings and then donned a pair of gloves and wore the same pair of gloves while going from wound to wound to clean each of the wounds with normal saline. LPN4 changed her gloves and sanitized her hands and then applied the ordered treatment to each of the resident's wounds while wearing the same pair of gloves. R10 was repositioned while LPN4 wore the gloves she used to apply treatment to all of the resident's wounds. LPN4 then removed the gloves and sanitized her hands before leaving R10's room. During an interview with LPN4 and the ADON on 12/11/25 at 3:19 PM, LPN4 stated she thought she only needed to change her gloves and sanitize her hands between dealing with dirty processes and clean processes. She stated she was not aware she should change her gloves and sanitize her hands when moving from one wound to the next to avoid cross contamination of wounds. The ADON stated she was not sure what the facility's process related to infection control during the provision of wound care was. During an interview with the Director of Nursing (DON) on 12/11/25 at 4:00 PM, she stated her expectation was infection control processes were to be maintained during the provision of wound care to prevent cross contamination of wounds. She confirmed LPN4 should have removed her gloves and sanitized her hands when proceeding from wound to wound while providing treatment to R10. Review of the facility's Clean Dressing Change Policy dated last revised/reviewed on 02/10/25 indicated, Where sterile technique is not ordered or indicated, wounds will be dressed using clean technique which avoids direct contamination of material and supplies.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility policy review, and review of the Centers for Disease Control and Prevention (CDC) guidelines, the facility failed to offer one of five residents (Residents (R) R102) reviewed for flu/pneumonia vaccinations and/or their representatives, the opportunity for the residents to be vaccinated in accordance with nationally recognized standards of 35 sampled residents. The facility failed to offer R102 and/or their representative the opportunity to be vaccinated with one dose of Prevnar 15 (PCV15), PCV20, or PCV21 after the final pneumococcal vaccination. This practice had the potential to increase the risk for this resident to contract pneumonia. Findings include:A review of R102's electronic medical records (EMR) titled Resident Face Sheet, located on the resident's dashboard, indicated the facility admitted the resident on 08/09/23. The resident was over the age of 65 at the time of his admission. A review of R102's EMR titled Preventive Health located under the Resident tab indicated the resident received the PPSV23 on 08/18/23. There was no evidence in the resident's clinical record to document that he shared in clinical decision making for the opportunity to receive the PCV15, PCV20, or the PCV21 vaccination. During an interview on 12/12/25 at 1:45 PM, the Infection Preventionist (IP) verified that she missed offering R102 the PCV15, PVCV20, or the PCV21 vaccination. Review of a facility policy titled Resident Vaccination Policy dated 03/04/25 indicated .Residents and/or their responsible party will be asked about prior vaccinations at admission. Prior doses.pneumococcal.and other vaccines will be documented in the immunization portal in the electronic health record. There was no evidence in the facility's policy that addressed the CDC recommendations for the pneumococcal vaccinations. Review of the CDC website https://www.cdc.gov/pneumococcal/hcp/vaccine-recommendations/index.html, dated 10/26/24 indicated .Based on shared clinical decision- making, adults 65 years or older have the option to get PCV20 or PCV21, or to not get additional pneumococcal vaccines. They can get PCV20 or PCV21 if they have received both .PCV13 (but not PCV15, PCV20, or PCV21) at any age and .PPSV23 [Pneumovax 23]at or after the age of [AGE] years old.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** R2 was admitted to the facility on [DATE], according to the resident's admission Record, found in the Electronic Medical Record (EMR) under the Profile Tab. The resident's diagnoses included Anoxic Brain Damage and Persistent Vegetative State. Observations of R2 on 12/09/25 at 2:38 PM, on 12/10/25 at 9:04 AM, 10:03 AM, 11:59 AM and 1:18 PM, and 12/11/25 at 10:31 AM, revealed grab bars raised on both sides of the resident's bed. The resident was laying in her bed in a vegetative state and unable to move her body. Observations of R2 laying in her bed in a vegetative state and unable to move her body were conducted on 12/09/25 at 2:38 PM, on 12/10/25 at 9:04 AM, 10:03 AM, 11:59 AM and 1:18 PM, and 12/11/25 at 10:31 AM. Grab bars were raised on both sides of the resident's bed during all of the observations. During an observation of R2 conducted along with Licensed Practical Nurse (LPN5) on 12/10/25 at 1:30 PM, LPN5 confirmed 1/4 grab bars were in the raised position on both sides of R2's bed. Review of R2's admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/06/25 and found in the EMR under the MDS Tab, revealed a Brief Interview for Mental Status (BIMS) assessment was not completed due to the resident's poor cognition and inability to communicate. The assessment indicated the resident was totally dependent upon staff to complete all of her Activities of Daily Living (ADLs) including movement in bed and transfers in and out of bed. The assessment indicated the resident did not have bed rails in place on her bed. R2's Physician's Order Report, dated 12/13/25 and found in the EMR under the Orders Tab, revealed no orders for the resident's use of bed rails. Review of the facility documentation revealed no assessment had been conducted prior to the installation of the bed rails. During an interview with the Maintenance Director (MD) on 12/12/25 at 11:00 AM, he stated beds were inspected for overall safety routinely, however rails applied to any given resident's bed were not inspected at the time of installation or routinely thereafter to ensure the physical safety of the bed rails on each resident's bed. During an interview with the Regional Director of Operations on 12/12/25 at 11:05 AM, she confirmed the physical safety of beds with rails applied to them were expected to be assessed when rails were initiated for any resident, and then routinely thereafter to ensure physical safety of the rails and bed. Review of the facility's Bed Rail Policy revised/reviewed on 12/03/25 indicated, The use of bed rails will be limited to circumstances where they are used to treat a medical condition and enhance the resident's functional abilities; and If a bed or side rail or bar is used, the facility will: a. Evaluate the potential risks associated with the use of bed rails including the risk of entrapment, prior to bed rail installation using the Bed Rail Safety Checklist,. d. Ensure appropriate dimensions of the bed, based on the resident's size and weights, e. Ensure correct installation of bed rails, including adherence to manufacturer's recommendations and/or specifications, f. Ensure correct use of an installed bed or side rail, g. Ensure scheduled maintenance of any bed rail in use according to manufacturer's recommendations and specifications.