STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105072	A. Building B. Wing	07/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Healthcare and Rehabilitation Center	6300 46th Ave N Saint Petersburg, FL 33709

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an assessment for self-administration of enteral nutrition was completed for one resident (#125) out of one resident reviewed.Findings included:On 07/16/2025 at 1:11 p.m. Resident #125 was observed in his room administering his enteral nutrition independently into his gastrostomy tube (g-tube). The resident's head of bed was observed to be flat. Resident #125 stated the nurses give him his enteral nutrition during the scheduled meal times. He stated he self-administers the enteral nutrition into his g-tube.Review of the admission record for Resident #125 revealed he was admitted to the facility on [DATE] with diagnoses to include malignant neoplasm of thyroid gland, unspecified severe protein calorie malnutrition, gastroesophageal reflux disease and gastrostomy status.Review of Resident #125's quarterly Minimum Data Set (MDS) dated [DATE] showed Resident #125 had a brief interview for mental status (BIMS) score of 15 out 15 indicating intact cognition.Review of Resident #125's active physician orders summary dated 07/17/2025 showed: Nothing by mouth (NPO) diet, NPO texture, NPO consistency, dated 02/12/2025. House protein one time a day for malnutrition give 30 cubic centimeters (cc) via feeding tube. Enteral feed order five times a day related to gastrostomy status, dysphagia oropharyngeal phase. Jevity 1.5 eight ounces (237 cc) bolus 5 times per day via feeding tube. Flush with 100 cc water pre/post each bolus feeding. dated 02/14/2025. Review of the medical record showed there was no documentation of an assessment for Resident #125 to self-administer enter nutrition. There was no documentation of a physician order for Resident #125 to self-administer his enteral nutrition. Review of the care plan for Resident #125 did not show the resident was care planned to self-administer his enteral nutrition.An interview was conducted on 07/16/2025 at 5:35 p.m. with Staff T, Licensed Practical nurse (LPN)/MDS Coordinator. She stated if a resident was to self-administer his enteral nutrition, there should be an order. She stated the care plan would show a self-administering focus. She reviewed Resident #125's care plans and did not see a self-administering focus. Staff T, LPN/MDS Coordinator reviewed the physician orders and confirmed there were no physician orders for Resident #125 to self administer his enteral nutrition. She stated they would assess the resident and contact the physician to obtain orders and they would update the care plan. Review of a facility policy titled Resident Self- Administration of Medication, dated 12/2020 showed - it is the policy of this facility to support each resident's right to self-administer medication. A resident may only self-administer medications after the facility's interdisciplinary team has determined which medications may be self-administered safely.Policy explanation and compliance guidelines:1. Each resident is offered the opportunity to self-administer medications during the routine assessment by the facility's interdisciplinary team.2. Resident's preference will be documented on the appropriate form and placed in the medical record.3. When determining if self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following:a. The medications appropriate and safe for self-administration.b. The resident's physical capacity to: swallow without difficulty, open medication bottles, administer injections.c. The resident's cognitive status, including their ability to correctly name their medications and know what conditions they are taken for.d. The resident's capability to follow directions and tell time to know when medications need to be taken.e. The resident's comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects, and when to report to facility staff.f. The resident's ability to understand what refusal of medication is, and appropriate steps taken by staff to educate when this occurs.g. The resident's ability to ensure that medication is stored safely and securely.14. The care plan must reflect resident self-administration and storage arrangements for such medications. and devices.Review of a facility policy titled Administering Medications, revised March 2023 showed a policy statement - Medications are administered in a safe and timely manner, as prescribed.Policy interpretation and implementation showed: 21. Resident may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary team has determined that they have decision-making capacity to do so safely.

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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 interviews and record review, the facility failed to report allegations of serious injury of unknown source and neglect for one resident (#56) of two residents sampled.Findings included: A record review for Resident #56 revealed she had an unwitnessed fall on 07/02/2025. Review of the nursing progress note dated 07/02/2025 revealed the resident had attempted to get out of bed without assistance and was found “face on the floor” with a moderate amount of blood on her facial/nose area. The resident was transferred to a local hospital via Emergency Medical Services (EMS) where she was diagnosed with a skull fracture. The resident was care planned for falls with interventions that included “Utilize total mechanical lift with staff assist of 2 for transfers”. “Remind resident to request assistance prior to ambulation/transfers as needed”. “Keep call light within reach. ” Further review of the medical record revealed she was admitted to the facility on [DATE], with diagnoses to include cognitive communication deficit (04/29/2025); Hypertension (04/29/2025); Major Depressive Disorder (04/29/2025); Encephalopathy (06/01/2025); Dementia (06/19/2025); fracture of base of skull (07/03/2025); contusion of scalp (07/03/2025); history of falling (07/03/2025). A review of the Determination of Capacity to Give Informed Consent form dated 05/22/2025, revealed that the Psychiatric Mental Health Nurse Practitioner (PMHNP) attested, “I have assessed [Resident #56] on a consult requested by attending physician and have found he/she”…The PMHNP marked with an “x” “Lacks the capacity to make medical decisions. On 07/16/1025 at 5:07 PM, an interview was conducted with the Director of Nursing (DON). During this interview, she was asked about Resident #56’s fall and if she saw this event as an adverse incident or an injury of unknown source she stated, “No”. She offered that “There was no violation of the care plan” because the resident attempted to get out of bed without calling for assistance and fell. She offered that, since there was no violation of the care plan that she did not have to report this concern to the State Agency because it was out of their control. She stated that the resident had a fall risk score of 10 (out of 20) on admission which was high but not “super high”. She stated that when the resident returned to the facility they put bolsters in her bed (long cushions or pillows that provide support and can be used to prevent falls) and moved her closer to the nursing station. She stated prior to the fall they did not see the need to have any more interventions than those listed on the care plan. Offering that the resident should have called for assistance and she did not so she fell. She further offered that the facility could not protect every resident at all times from falling. She was asked if there should have been more supervision of the resident due to her dementia and confusion she stated the resident was capable of calling for assistance and she did not. She stated that she had investigated this incident but could not find the witness statements but felt the night supervisor would be able to locate them. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/17/2025 at 9:59 AM, an interview was conducted with the PMHNP, during which she stated she last saw the resident on 06/26/2025 and found her to be confused, alert to self only, very confused, garbled speech, dementia with agitation and exit seeking, She was not told the resident had a fall and if she had been she would have seen her for a follow up. In her opinion she was not able to request assistance or call for assistance. She stated she should have been notified of the resident’s fall, the hospital visit would make her “unstable” which would have required her to be seen the next day. On 07/17/2025 at 2:02 PM, a telephone interview was conducted with the son of Resident #56, during which he stated that the facility called him and informed him that the resident was found alongside the bed and was sent to the Emergency Room. He reported that she is always confused and was confused at the time she fell. They called him that morning. He stated that they had given her a special mattress and moved her closer to the nursing station to keep a better eye on her. On 07/17/2025 at 4:38 PM, a telephone interview was conducted with Staff G, Licensed Practical Nurse (LPN) who stated she was working with the resident the morning of her fall. She stated that the patient was very confused and would not have known what the call light was, and would not have be able to use it to call for assistance. She stated that she did rounds every two hours and the resident had been asleep the last she had checked on her. She said the CNAs (Certified Nursing Assistants) are in and out. The resident had not tried to get out of bed before and when she entered the room she was on the floor. Review of a facility policy titled Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating, revised September 2022 showed, all reports of resident abuse (including injuries of unknown origin), neglect… are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management. Findings of all investigations are documented and reported. 1. If resident abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law. 6. Upon receiving any allegations of abuse, neglect, exploitation, misappropriation of resident property or injury of unknown source, the administrator is responsible for determining what actions (if any) are needed for the protection of residents.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 record review and interviews, the facility failed to notify a resident and the resident's representative of a hospital transfer in writing prior to the transfer for one resident (#149) out of four residents reviewed.Findings included: During an interview on 07/14/2025 at 12:10 p.m., Resident #149 stated she just returned from a hospital stay. “The hospital wanted me to stay until Saturday, but I told them I had to be back to the facility on Friday so that my bed at the facility was not given away. I don’t remember being given anything explaining my options for holding my bed before I went to the hospital.” Review of Resident #149's Minimum Data Set (MDS), dated [DATE], revealed a brief interview for mental status (BIMS) score of 15 out of 15 indicating intact cognition. Review of Resident #149’s admission record revealed a readmission date of 07/11/2025 from an acute care facility. Resident #149 was admitted to the facility with diagnosis to include chronic obstructive pulmonary disease (COPD) with (Acute) exacerbation, primary insomnia, anemia, and type 2 diabetes mellitus with diabetic neuropathy. Review of Resident #149’s physician orders revealed as follows: Transfer to emergency room (ER) evaluate and treat; one time only for shortness of breath and chest pain for 1 day, dated 07/08/2025. Review of Resident #149’s Nursing Home Transfer and Discharge Notice form revealed notice of date given 07/14/2025. Physician/Designee Name and signature were blank. Resident or Representative Name and signature were blank. During an interview on 07/16/2025 at 10:14 a.m., Staff Z, Licensed Practical Nurse (LPN), Unit Manager stated if a resident needs to be transferred out the nurse would evaluate the resident, do a change of condition, call the physician for the order and go over the bed hold policy with the residents. I let the social services know when a resident transfers to the hospital and they complete the AHCA [Agency for Healthcare Administration] transfer form. During an interview on 07/16/2025 at 3:03 p.m., the Director of Nursing (DON) stated the Business Office and Nursing completes the AHCA Transfer form. The form should be filled out the same day the resident goes out. She reviewed the AHCA transfer form for Resident #149 and stated it is missing the physician and resident’s signature. Review of a facility policy dated 2/2025 showed - it is the policy of this facility to develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. Procedure: (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The facility will support each resident in the exercise of his or her right to participate in his or her care and treatment, including planning for discharge. 2. The facility will determine the resident's expected goals and outcomes regarding discharge upon admission, routinely in accordance with the MDS assessment cycle, and as needed. a. Initial information and discharge goals will be included in the resident's baseline care plan. b. Subsequent assessment information and discharge goals will be included in the resident's comprehensive plan of care. 3. If discharge to community is determined to not be feasible, the facility will document in the clinical record who made the determination and why. 4. In cases where the resident wishes to be discharged to a setting that does not appear to meet his or her post-discharge needs, or appears unsafe, the interdisciplinary team will treat this situation similarly to refusal of care: a. Discuss with the resident, (and/or his or her representative, if applicable) and document the implications and/or risks of being discharged to a location that is not equipped to meet his/her needs and attempt to ascertain why the resident is choosing that location. b. Offer other, more suitable, options of locations that are equipped to meet the needs of the resident. Document any discussions related to the options presented. c. Document refusals of other options that could meet the resident's needs. d. At time of discharge, follow policies regarding discharges Against Medical Advice, and refer to Adult Protective Services (or other state entity charged with investigating abuse and neglect), as necessary.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. Based on interviews and record reviews, the facility failed to notify the state mental health authority/state intellectual disability authority after a significant change in the mental or physical condition of a resident who has mental illness for one resident (#3) of nine residents reviewed.Findings included:Review of Resident #3's electronic medical record revealed an original admission date of 02/10/2021 and a Preadmission Screening and Resident Review (PASRR) dated 02/08/2021 provided by the hospital pre-admission. In section 3, this is documented as a non-provisional admission, and section 4 is documented as no diagnosis or suspicion of serious mental illness or intellectual disability indicated. Level II PASRR not required. A PASRR Resident Review- Evaluation Request, dated 04/23/2023, was present with no signatures and no evidence of a level II request for evaluation from the state agency.Review of Resident #3's diagnoses list revealed a diagnosis of major depressive disorder on 10/29/2024. Further review revealed a request for a psychiatric meeting dated 10/29/2024, with diagnosis of major depressive disorder, recurrent, moderate. During an interview with the Director of Nursing (DON) on 7/16/2025 at 10:34 AM regarding the facility's PASRR process, when asked how the facility identifies residents with new mental disorders or intellectual disorder diagnoses, she stated the provider lets them know of any changes, and the Assistant Director of Nursing (ADON) arranges for a new PASRR. Additionally, she stated the Psychiatry and Psychology providers communicate directly with the ADON, DON, and Social Services Director. When asked who is responsible for making the referral to the appropriate state (designated) authority when a resident is identified as having an evident or possible mental disorders (MD), intellectual disability (ID) or related condition, the DON stated that the ADON makes that referral. When asked for a copy of the completed PASRR Resident Review Evaluation Request for Resident #3, the DON stated she would get it.During an interview on 7/16/2025 at 2:05 PM, the DON stated Resident #3 does have a completed PASRR Resident Review Evaluation Request completed after the major depression disorder diagnosis. The DON said it would be in the electronic medical record. The surveyor relayed lack of copy in electronic medical record. The DON stated she will get a copy. Resident #3's PASRR Resident Review Evaluation Request, dated 04/23/2023, was not signed by the preparer nor the resident's legal representative. No evidence of submission was provided. Additionally, a document was provided with no signature, letterhead, patient identification, source, or evidence of transmission (such as fax or email.)The facility did not provide a level II (evaluation and determination) for Resident #3 by the end of the survey. Review of the facility policy titled, Pre-admission Screening and Resident Review revised March 2019 revealed a policy statement, It is the policy of this facility to assure that all residents admitted to the facility receive a Pre-Admissions Screening and Resident Review, in accordance with State and Federal Regulations.Policy Interpretation and Implementation1. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process.b: If the level I screen indicates that the individual meets the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the level II (evaluation and determination) screening process.d: The state PASARR representative provides a copy of the report to the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to implement patient-centered interventions related to adaptive dining equipment to promote independence while eating per occupational therapy and physician order for one resident (#13) out of one resident reviewed. Findings included: On 07/16/2025 at 12:29 p.m. Resident #13 was observed in the room wearing a clothing protector with an opened meal tray on the overbed table in front of the resident. The resident was observed holding a regular everyday eating fork. The resident stated a staff member was supposed to get weighted silverware, but they hadn't been sending one with the meals. Review of Resident #13s admission Record showed the resident was admitted on [DATE] and 02/05/2025. The record included diagnoses not limited to Parkinson's disease without dyskinesia without mention of fluctuations, unspecified convulsions, and type 2 diabetes mellitus with hyperglycemia. The resident's annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview of Mental Status score of 15/15, indicating an intact cognition. Review of Resident #13s physician orders revealed an order created by Staff N, Occupational Therapist (OT) on 6/24/25 and signed by the resident's primary care Physician on 07/04/2025 for the resident to receive Built-up handle utensils provided for all meals to promote independence with feeding tasks. Review of Resident #13's care plan with an initiated date of 07/25/2023 and a revision date of 06/18/2025 revealed the resident was at risk for an alteration in nutrition and/or hydration related to (r/t): receives a therapeutic diet, food intolerance/allergy: tomato products, Body Mass Index (BMI) indicates obesity, diagnosis (dx) myocardial infarction (MI), chronic obstructive pulmonary disease (COPD), sepsis, urinary tract infection (UTI)/ extended-spectrum beta-lactamase (ESBL), fall, left (L) tibia/ankle fracture (fx), ileostomy, gastrointestinal (GI) hemorrhage, diabetes mellitus (DM), anemia, Parkinsons, pain, gastroesophageal reflux disease (GERD), depression, bipolar, anxiety, genitourinary system surgery. Controlled carbohydrate diet (CCHO) added to dietary restrictions; 06/2025 weight stable, BMI 34.7. The goal revealed the resident would consume 75-100% of most meals through the next review date. The interventions showed dietary, Certified Nursing Assistants (CNAs), and nursing were to Provide adaptive equipment as ordered. An interview was conducted on 7/16/25 at 12:34 p.m. with Staff K, Licensed Practical Nurse (LPN) and Staff M, Certified Nursing Assistant (CNA). The staff members reported having never seen Resident #13 with built-up or weighted silverware. On 7/16/125 at 12:35 p.m. Staff K, LPN observed Resident #13 in the room eating with regular-style silverware. The staff member confirmed the silverware was not weighted or built-up. The resident reported spilling a lot of food. The staff member returned to the nursing station and reviewed Resident #13's physician orders and confirmed an order was revised on 06/24/2025 for the resident to have built-up silverware to promote independence. An interview was conducted on 07/16/2025 at 2:03 p.m. with Staff N, Occupational Therapist (OT) and the Director of Rehab (DoR). Staff N, OT stated Resident #13 had complaints of not being able to hold onto standard (eating) utensils and cut food, built-up utensils were trialed in two sessions, and an order was placed in the electronic record. Staff N, OT stated the expectation was to include (built-up) utensils with meals and was unaware the resident was not getting the utensils. Staff N, OT reported Resident #13 had not said anything about not getting them and Staff N, OT saw Resident #13 three times a week. The DoR provided an Occupational Therapy treatment note dated 6/24/25, written by Staff N, OT which read Therapist trialed use of built-up eating utensils to promote independence with feeding tasks. Patient (Pt) demonstrated increased ability to cut food and bring it to mouth without spilling/dropping utensils using built-up eating utensils. Review of the policy - Comprehensive Person-Centered Care Plans, revised December 2016, revealed A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The policy included the following:- 1. The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident.- 2. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.- . 8. The comprehensive, person-centered care plan will:a. Include measurable objectives and timeframes;b. Describe the services that are to be furnished to attain or maintain their resident's highest practicable physical, mental, and psychosocial well-being;.m. Aid in preventing or reducing decline in the residence functional status and/or functional leveln. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; [NAME]. Reflect currently

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, interviews and record review, the facility failed to ensure dependent residents received assistance with activities of daily living (ADLs) for five residents (#107, #86, #18, #43 and #102) of seven residents sampled.Findings included: 1. On 07/16/2025 at 9:13 a.m. Resident #107 was observed with long fingernails and hair on her chin. She stated she would like to be assisted with trimming her nails and shaving her face. She stated she preferred her nails short and clean. She stated the Certified Nursing Assistants (CNA’s) say they will help, but then they do not. Review of the admission record for Resident #107 revealed she was admitted to the facility on [DATE] with diagnoses to include dementia. Review of Resident #107’s quarterly Minimum Data Set (MDS) dated [DATE] revealed in section C the resident had a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating moderate cognitive impairment. Section GG - showed the resident required partial/moderate assistance (Helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). Review of a care plan for Resident #107 dated 03/11/2024 showed the resident has a self-care deficit with dressing, grooming, and bathing related to generalized weakness. Resident participates with ADLs with cues from staff. Interventions included gather and set up supplies for cares. Cue or encourage resident to participate in ADL tasks. Allow resident ample time to attempt or complete ADL tasks before intervening. Encourage/remind the resident to ask for assistance as needed and observe for decline in ADL function; report to the physician as indicated. 2. On 07/16/2025 at 9:18 a.m. Resident #86 was observed in his room. He was observed with long fingernails, embedded with black colored substances underneath the nails. The resident stated there used to be a nurse who used to trim his nails, but she does not trim his nails anymore. Resident #86 said, “I think they are just busy.” He stated he preferred his nails trimmed short. Review of the admission record for Resident #86 revealed he was admitted to the facility on [DATE] with diagnoses to include hemiplegia and hemiparesis following cerebral infarction, affecting left dominant side and need for assistance with personal care. Review of Resident #86’s comprehensive MDS dated [DATE] revealed in section C the resident had a BIMS score of 15 out of 15 indicating intact cognition. Section GG- showed the resident required partial/moderate assistance (Helper does less than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). Review of a care plan for Resident #86 dated 12/09/2021 showed the resident has a self-care deficit with ADLs related to CVA (stroke), hemiplegia, impaired balance, limited mobility, and weakness. Interventions included - provide hands on assistance with dressing, grooming, bathing as needed. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Healthcare and Rehabilitation Center	6300 46th Ave N Saint Petersburg, FL 33709

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 07/16/2025 at 9:21 a.m. with Staff X, Licensed Practical Nurse (LPN)/ Unit Manager (UM). She stated the residents should be assisted with shaving on a daily basis, mostly during showers/baths. She stated the nail care should be done at the same time. She stated if a resident was refusing any type of care, the nurse should be notified. She stated the nurse would document, and interdisciplinary team (IDT) would discuss, and the care plan would be updated. 3. On 07/15/2025 at 10:46 a.m. Resident #18 was observed in her room, noted with facial hair on her chin. She stated it was a long time ago since she was shaved. On 07/16/2025 at 9:16 a.m. Resident #18 was observed in her room. She stated she still needed to be assisted with shaving. She stated it was “not lady like. Review of the admission record revealed Resident #18 was readmitted to the facility on [DATE] with a primary diagnosis of Parkinson’s disease without dyskinesia, without mention of fluctuations. Review of Resident #18’s quarterly Minimum Data Set (MDS) dated [DATE] revealed in section C the resident had a BIMS score of 7 out of 15 indicating severe impairment. Section GG- showed the resident required substantial to maximal assistance (Helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort). Review of Resident #18’s care plan dated 02/08/2023 revealed the resident has a self-care deficit with dressing, grooming, bathing related to generalized weakness. Interventions included - gather and set up supplies for care, cue/encourage resident to participate in ADL tasks, allow resident ample time to attempt/complete ADL tasks before intervening, encourage/remind the resident to ask for assistance as needed, and to provide hands on assistance with dressing, grooming, and bathing. On 07/16/2025 at 11:50 a.m. an interview was conducted with Staff Y, CNA. She stated the residents are to be shaved during showers. She stated if a resident refuses, she would let the nurse know. She stated if they asked to have their nails trimmed, she would check if it was okay. She stated most of the time it is not a problem. On 07/16/2025 at 11:54 a.m. an interview was conducted with Staff S, Registered Nurse (RN). Staff S, RN stated if a resident had facial hair, the CNAs would shave the resident per preference during their shower. She stated she sometimes helps trim resident's nails. She stated if she got through her assignments today, she would assist the residents who needed to have their nails trimmed. 4. On 07/14/2025 at 11:32 a.m., an interview was conducted with Resident #43. The resident stated he had a bowel movement and had been waiting for an hour and a half to be assisted to the toilet. The resident stated he used the call light, and a nurse told him that they would get the CNA, responsible for his area. The resident stated staff came into the room and turned off the call light approximately an hour ago. Review of Resident #43’s medical records revealed he was re-admitted to the facility on [DATE], with diagnosis to include encephalopathy, need for personal care, epilepsy, and other specified disease of spinal cord. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #43’s quarterly Minimum Data Set (MDS) Section C revealed the resident had a Brief Interview for Mental Status (BIMS) score of 15 that means intact cognition. Section H revealed the resident is always incontinent with bowel and bladder. Section GG showed for Toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment, the resident requires Substantial/Maximal Assistance. Review of a care plan initiated on 06/08/2022, showed a focus of Resident #43, has a self care deficit with dressing, grooming, bathing r/t (related to), TBI (traumatic brain injury), spinal cord injury and seizures. Interventions included: provide total staff assistance with dressing, grooming, and bathing, and staff to anticipate resident needs with ADLs (activities of daily living). Review of a CNA Kardex (a document used by nursing staff describing a resident’s level of care), dated 07/04/2025 through 07/17/2025 revealed the resident did not receive toileting care consistently with the following dates missing documentation: 07/05/2025, 07/12/2025, 07/13/2025, 07/14/2025, 07/15/2025, 07/16/2025 and 07/17/2025. 5. On 07/14/2025 at 11:13 a.m., an interview was conducted with Resident #102. The resident explained that she had used her call light earlier, and the staff did not respond until over an hour later. During this time, the resident was left soiled in stool. She explained that she had not received a shower since 07/12/2025. She stated she would like showers at least three times a week, but she would like to shower more often if she could. On 07/15/2025 at 10:17 a.m. an interview was conducted with Resident #102 she said she had not received another shower since 07/12/2025. Review of Resident #102’s medical records revealed she was admitted to the facility on [DATE], with diagnosis to include unspecified heart failure, hyperlipidemia, unspecified, morbid (severe) obesity due to excess calories, essential (primary) hypertension, peripheral vascular disease, unspecified, lymphedema, and chronic obstructive pulmonary disease, unspecified. Review of Resident #102’s quarterly Minimum Data Set (MDS) Section C revealed the resident had a BIMS score of 15 out of 15, which means intact cognition. Section H revealed the resident was always incontinent with bowel and bladder. Section GG showed for toileting hygiene: The ability to maintain perineal hygiene, adjust clothes before and after voiding or having a bowel movement. If managing an ostomy, include wiping the opening but not managing equipment, the resident requires Substantial/Maximal Assistance. Review of a care plan initiated on 03/26/2021, showed a focus – Resident #102, has a self-care deficit with ADLs r/t: impaired mobility r/t lymphedema/morbid obesity diagnosis (dx) of; chronic pain. Interventions included: resident usually prefers a shower, however some days chooses to have a bed bath instead. Provide hands-on assistance with dressing, grooming, and bathing as needed. Review of a care plan dated 03/26/2021, showed a focus of Resident #102, is at risk for complications r/t alteration in health maintenance with a dx of: anemia, GERD, hypothyroidism. Interventions revealed, provide increased assist with ADLs as needed for c/o (complaints of) increased fatigue/weakness. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of a care plan initiated 03/26/2021, showed a focus - Resident #102, has an alteration in elimination AEB (as evidenced by): is incontinent of bowel and bladder. The interventions were: provide hands-on assistance with toileting upon resident request and as needed. Check resident upon arising, before/after meals and at HS (hours of sleep) for incontinence; perform incontinence care prn (as needed). Initiate bowel protocol as needed. Review of a CNA Kardex, dates 07/04/2025 through 07/17/2025 revealed the resident did not receive toileting care consistently with the following dates missing documentation: 07/04/2025, 07/06/2025, 07/09/2025, 07/10/2025, 07/12/2025, 07/14/2025, 07/15/2025, and 07/16/2025. On 07/16/2025 at 2:32 P. M., an interview was conducted with Staff X, Licensed Practical Nurse who was the Unit Manager (UM), for the South Wing. Staff X, UM stated residents should be changed every two hours or less. She stated, charting should be documented in the electronic medical record. She stated the charting should be completed before leaving the building; otherwise, staff would be called back to the facility to complete the charting in the residents’ records. On 07/17/2025 at 1:41 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that residents should be changed every two hours. The DON stated charting should be done at the time assistance is provided to a resident. Review of an undated facility policy titled, Activities of Daily Living (ADLs), Supporting, showed: Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. Policy Interpretation and Implementation showed: 1. Residents will be provided with care, treatment and services to ensure that their activities of daily living (ADLs) do not diminish unless the circumstances of their clinical condition(s) demonstrate that diminishing ADLs are unavoidable… 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care); b. mobility (transfer and ambulation, including walking); c. elimination (toileting)…

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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, interviews, and record review, the facility failed to implement interventions and provide supervision to prevent accidents/injuries to residents related to: 1) failure to prevent a fall with injuries for one resident (#56) out of four residents reviewed for falls; and 2) failure to ensure a safe environment for residents to smoke for two residents (#21, #41) out of two residents who required the use of a wheelchair. Residents were expected to sign a leave of absence (LOA) form and then navigate off facility grounds, unassisted, through the parking lot approximately 350 feet, over a large speed bump, and across large potholes, despite being assessed to require supervision during ambulation or requiring the use of a wheelchair. Findings included: 1. A review of the medical record for Resident #56 revealed a progress note dated 07/02/2025 at 6:35 a.m. “Resident attempted to get oob (out of bed) without assistance, found with left leg stuck inside rail and face on the floor, noted moderate amount of blood to resident's facial/nose area, resident remained on floor, positioned on right side, pending arrival of emergency services, MD (Medical Doctor) made aware of resident's state, attempts to reach residents son unsuccessful, no answer at this time will attempt at a later time” Further review of the medical record revealed she was admitted to the facility on [DATE], with diagnoses to include cognitive communication deficit (4/29/25); hypertension (4/29/25); major depressive disorder (4/29/25); encephalopathy (6/1/25); dementia (6/19/25); fracture of base of skull (7/3/25); contusion of scalp (7/3/25); history of falling (7/3/25). A review of the resident’s care plan dated 05/07/2025 to 07/28/2025, revealed the “Resident is at risk for falls and/or fall related injury r/t [related to]: generalized weakness. Resident will minimize risk of fall related injuries with staff intervention thru next review date.” Interventions included, “Observe for unsteadiness/dizziness when changing positions; provide assist as needed”. “Utilize total mechanical lift with staff assist of 2 for transfers”. “Remind resident to request assistance prior to ambulation/transfers as needed”. “Keep call light within reach. ” A review of the Determination of Capacity to Give Informed Consent form dated 5/22/25, revealed that the Psychiatric Mental Health Nurse Practitioner (PMHNP) attested “I have assessed [Resident #56] on a consult requested by attending physician and have found he/she”…The PMHNP marked with an “x” “Lacks the capacity to make medical decisions.” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Further review of the record revealed an encounter note dated 06/19/2025 by the PMHNP that stated This is an [AGE] years old patient with a past psychiatric history of depression and dementia. Prior to last visit, patient had symptoms of depression. During last visit, patient was confused. Patient had symptoms of dementia. Patient stated no history of depression or anxiety. Patient denied any mood swings or behavioral outbursts. Sleep and eating habits were noted as good. No medication changes were done. Facility is requiring a detail cognitive assessment as patient is showing behaviors related to memory problems and there has been change in patient baseline requiring recommendation on the care plan. Today, I saw this patient to perform that cognitive assessment and form the care plan. As per collected information the patient is very confused with repetitive speech. Staff reports no concerns at this time. Patient can not tell me her birthday or where she currently is. No other psychiatric symptoms observed. Staff report patient has gotten agitated during hygiene care. No side effects to current psych medications reported.” The note documented a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment. On 6/26/25 the PMHNP documented on an encounter note, “Dementia with agitation: The history suggests that the patient had a gradual decline in memory, executive function, language, concentration, and fund of knowledge. These symptoms have caused distress and have affected the quality of life and activities of daily living. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition. The memory loss has been followed by significant behavioral agitation as well.” The note documented a BIMS score of 7, indicating severe cognitive impairment. Review of the interdisciplinary team (IDT) notes dated 07/02/2025 at 9:03 a.m., “IDT reviewed 07/02/2025 with new intervention to apply bed bolsters to reduce the risk of future falls and enhance resident safety while in bed. This intervention will be added to the resident’s care plan and monitored for effectiveness.” A progress note dated 07/02/2025 at 2:16 p.m. This wroter [sic] called [Hospital] to get update on resident per Nurse[sic] she is admitted for non displaced skull FX [fracture], family notified. A review of the hospital speech-language pathology (SLP) evaluation note dated 07/02/25, “Assessment/Plan SLP Assessment Pt [patient] was cleared by nursing for SLP evaluation. Pt is A+OX1 [alert and oriented to self only], confused but cooperative. Pt presents from SNF [Skilled Nursing Facility], following GLF [ground level fall], with skull fx [fracture] and C-collar [cervical neck brace] in place. Strong and foul urine smell is noted in pt.'s room. Oral-facial examination is remarkable for reduced mandibular depression due to the presence of C-collar.” “Severe cognitive deficits are noted, however, pt is baseline mentation per notes.” On 7/16/25 at 5:07 p.m., an interview was conducted with the Director of Nursing (DON). She stated that the resident had a fall risk score of 10 (out of 20) on admission which was high but not “super high” She stated that when the resident returned to the facility they put bolsters in her bed (long cushions or pillows that provide support and can be used to prevent falls) and moved her closer to the nursing station. She stated prior to the fall they did not see the need to have any more interventions than those listed on the care plan. Offering that the resident should have called for assistance and she did not, so she fell. She further offered that the facility could not protect every resident at all times from falling. She was asked if there should have been more supervision of the resident due to her dementia and confusion she stated the resident was capable of calling for assistance and she did not. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/17/2025 at 9:59 a.m., an interview was conducted with the PMHNP, during which she stated she last saw the resident on 06/26/2025 and found her to be confused, alert to self only, very confused, garbled speech, dementia with agitation and exit seeking, She was not told the resident had a fall and if she had been she would have seen her for a follow up. In her opinion she was not able to request assistance or call for assistance. She stated she should have been notified of the resident’s fall, the hospital visit would make her “unstable” which would have required her to be seen the next day. On 07/17/2025 at 2:02 p.m., a telephone interview was conducted with the son of Resident #56, during which he stated that the facility called him and informed him that the resident was found alongside the bed and was sent to the Emergency Room. He reported that she is always confused and was confused at the time she fell. They called him that morning. He stated that they have given her a special mattress and moved her closer to the nursing station to keep a better eye on her. On 07/17/2025 at 4:38 p.m., a telephone interview was conducted with Staff G, Licensed Practical Nurse (LPN) who stated she was working with the resident the morning of her fall. She stated that the patient was very confused and would not have known what the call light was and would not have be able to use it to call for assistance. She stated that she did rounds every two hours and that the resident had been asleep the last she had checked on her. She said the CNAs (Certified Nursing Assistants) are in and out. The resident had not tried to get out of bed before and when she entered the room she was on the floor. 2. During an interview on 07/14/2025 at 5:05 p.m., Resident #41 was observed in a wheelchair in the parking lot of the facility. Resident #41 stated he was smoking. I have to sign out on a Leave of Absence (LOA) and go past the fence to smoke. Sometimes I go and hide in the cover patio area. I put my butts out in my pile. The lady at the front desk keeps my lighter and cigarettes.” No staff or smoking receptacles were observed in the area where Resident #41 was smoking. Review of Resident #41's admission record revealed an admission date of 04/21/2025. Resident #41 was admitted to the facility with diagnoses of muscle weakness (generalized), other abnormalities of gait and mobility, unsteadiness on feet, and nicotine dependence, unspecified, uncomplicated. Review of Resident #41's Quarterly MDS dated [DATE] revealed, Section C. Cognitive Patterns a Brief Interview Mental Status (BIMS) of 15 out of 15 showing intact cognition. Review of Resident #41’s Care Plan dated 04/22/2025 revealed: Focus: “[Resident #41] desires to smoke. [Resident #41] has been assessed as able to smoke: independently. Goal: [Resident #41] will adhere to the smoking policy daily thru the next review date. Resident will demonstrate safe smoking practices thru the next review date. Interventions: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Monitor for signs of unsafe smoking practices; Return smoking material to designated staff upon re-entry to the facility from LOA; Maintain smoking materials in designated area; Provide redirection if resident is observed in any unsafe smoking practices. Seek the assistance of managers/supervisors if needed; Observe for decline in hand dexterity; decline in cognition; decreased alertness while smoking; inability to safely dispose of ashes, butts; new or worsening vision impairments; and decreased ability to safely hold cigarette, as needed.” Review of Resident #41’s smoking assessment dated [DATE] revealed: Does the resident use, or have a desire to use, tobacco products/e-cigarettes? Yes 3. Observation a. does the resident remain alert during smoking? Yes Can the resident safely light a cigarette or smoking product, or ignite an e-cigarette device? Yes c. Is the resident able to safely hold a cigarette/smoking product/e- cigarette device? Yes d. Can the resident dispose of ashes, butts, and e- cigarette devices properly? Yes Is the resident free of visible upper extremity tremors? Yes f. Is the resident free from contractures in their hands, wrist, or elbows that impair their ability to smoke? Yes g. Is the resident free from loss of mobility, reduced movement, weakness, or paralysis to the dominant upper extremity? Yes h. Is the resident free from vision issues that impair their ability to smoke? Yes i. Total score for observation 0. During an interview on 07/15/2025 at 3:59 p.m., Staff Z, Unit Manager, stated she completed the smoking assessment for Resident #41 at his admission in April. “I answer the questions on the smoking assessment by marking yes to the questions. I did not observe Resident #41 smoking. I see him smoking when I leave for the day and see him out on the sidewalk smoking. I was told to make sure that all the residents who smoke have a smoking assessment completed and created new smoking assessments for all the residents today (07/15/2025). She had not seen the smoking policy/guideline form and was unsure where it came from. 3. During an interview and observation on 07/14/2025 at 5:15 p.m., Resident #21 was observed on the edge of the facility driveway in between the main street and a yellow speed bump on the facility driveway. Resident #21 was observed holding onto her wheelchair, trying to move it across the speed bump. Resident #21 stated I am being punished because I am a smoker. We have to come all the way out here, off property to the sidewalk to smoke. I don’t understand why I can’t go right here underneath this tree. No staff or smoking receptacles were observed in the area where Resident #21 was smoking. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #21's admission record revealed an admission date of 07/08/2025. Resident #21 was admitted to the facility with diagnosis to include other abnormalities of gait and mobility, unsteadiness on feet, other specified disorders of bone density and structure, and nicotine dependence, unspecified, uncomplicated. Review of Resident #21's physician orders revealed an order dated 07/10/2025, resident may go on LOA unsupervised. Review of Resident #21's Medicare 5 Day MDS dated [DATE] revealed Section C. Cognitive Patterns, a Brief Interview Mental Status (BIMS) of 14 out of 15 showing intact cognition. Review of section GG. Functional Abilities revealed, for mobility, Resident #21 requires partial/moderate assistance for sit to stand, chair/bed-to-chair transfer, walk 10 feet 1 step (curb). Resident #21 uses manual wheelchair for mobility. Review of Resident #21's care plan dated 07/09/2025 revealed: “Focus: [Resident #21] desires to smoke. [Resident #21] has been assessed as able to smoke: Resident /responsible party have been informed of the facility smoking policy. Goal: [Resident #21] will adhere to the smoking policy daily thru the next review date; Resident will demonstrate safe smoking practices thru the next review date. Interventions: Monitor for signs of unsafe smoking practices; Provide redirection if resident is observed in any unsafe smoking practices; Seek the assistance of managers/supervisors if needed; Observe for decline in hand dexterity; decline in cognition; decreased alertness while smoking; inability to safely dispose of ashes, butts; new or worsening vision impairments; and decreased ability to safely hold cigarette, as needed; Inform resident of smoking cessation options upon resident request prn[as needed].” Review of Resident #21’s smoking assessment dated [DATE] revealed: Does the resident use, or have a desire to use, tobacco products/e-cigarettes? Yes …3. Observation a. does the resident remain alert during smoking? Yes b. Can the resident safely light a cigarette or smoking product, or ignite an e-cigarrete device? Yes c. Is the resident able to safely hold a cigarette/smoking product/e-cigarette device? Yes (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	d. Can the resident dispose of ashes, butts, and e- cigarette devices properly? Yes Is the resident free of visible upper extremity tremors? Yes f. Is the resident free from contractures in their hands, wrist, or elbows that impair their ability to smoke? Yes g. Is the resident free from loss of mobility, reduced movement, weakness, or paralysis to the dominant upper extremity? Yes h. Is the resident free from vision issues that impair their ability to smoke? Yes i. Total score for observation 0. During an interview on 07/16/2025 at 11:15 a.m., the Director of Therapy stated Resident #21 is in Physical Therapy (PT) and Occupational Therapy (OT) as of 07/08/2025. PT is working with her on bed mobility, transfers and ambulation. Resident #21 is a standby assist which is close supervision or contact guarding to make sure she is safe when standing. “She should have someone standing next to her when she is out of her wheelchair. Resident would not be considered safe to ambulate on her own.” During an interview on 7/15/2025 at 4:05 p.m., the Director of Nursing (DON) stated the policy is we are a nonsmoking facility. Residents are assessed to see if they are a safe smoker, “I would assume they are watching the resident smoke if they are documenting on the observation of the smoking assessment. I don’t have to see someone physically smoking to assess if they have a tremor. There are a couple of things on the smoking assessment under the observation that do not require them to watch the resident smoking.” During an interview on 07/17/2025 at 3:25 p.m., the Nursing Home Administrator (NHA) stated “We are a non-smoking facility and if residents want to smoke, they sign out LOA and go off the premises to smoke. No there are no smoking receptacles or anywhere for cigarettes to be discarded outside. The nurses do a smoking assessment with the residents. I have never looked at the smoking assessment. If it says observation I would expect there to be an observation of the residents smoking. I have never watched any residents travel through the parking lot to the sidewalk so I cannot say if the parking lot is safe. There are speed bumps, and holes in the parking lot.” (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the facility’s undated policy titled Safety and Supervision of Residents, undated, revealed “Policy Statement: Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision, and assistance to prevent accidents are facility-wide priorities…Facility-Oriented Approach to Safety: 1. Our facility-oriented approach to safety addresses risks for groups of residents. 2. Safety risks and environmental hazards are identified on an ongoing basis through our combination of employee training, employee monitoring, and reporting processes; reviews of safety and incident/accident data; in a facility wide commitment to safety at all levels of the organization. 3. When accident hazards are identified, the QAPI [Quality Assurance and Performance Improvement]/safety committee shall evaluate and analyze the cause of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards, and try to prevent avoidable accidents. 5. The QAPI committee and staff shall monitor interventions to mitigate accident hazards in the facility and modify as necessary. Individualized, Resident Centered Approach to Safety: 1. Our individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents. 2. The interdisciplinary care team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for individual residents. 3. The care team shall target interventions to reduce individual risks related to hazards in the facility environment including adequate supervision and assistive devices…6. The facility-oriented and resident-oriented approaches to safety are used together to implement a systems approach for safety, which considers the hazards identified in the facility environment and individual resident risk factors, and then adjust interventions accordingly. 7. Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual residents assessed needs and physician order. 8. The type and frequency of resident supervision may vary among residents and over time for the same resident. 9. Due to their complexity and scope, certain resident risk factors environmental hazards are addressed and dedicated policy and procedures.”

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide incontinence care and prevent a Urinary Tract Infection (UTI) for one resident (#150) out of three residents sampled.Findings Included: During a phone interview on 07/15/2025 at 5:15 p.m., Resident #150 Family Member (FM) stated Resident #150 has been in and out of the hospital related to UTI's, multiple times. When she picks up Resident #150's laundry it is soaking wet. Maybe if they changed her more often, she would not have so many UTI's. When she goes to the hospital and they do lab work it shows E. coli [Escherichia coli] in her urine. Review of Resident #150's admission record revealed an admission date of 06/01/2022. Resident #150 was admitted to the facility with diagnosis to include Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, Urinary Tract Infection, Site Not Specified, Major Depressive Disorder, Recurrent, Moderate, Parkinson's Disease Without Dyskinesia, Without Mention of Fluctuations History of Falling. Review of Resident #150's Quarterly MDS, dated [DATE], revealed, Section C. Cognitive Patterns, a Brief interview Mental Status (BIMS) of 01 out of 15 showing severe cognitive impairment. Review of Section GG. Functional Abilities revealed Resident #150 was dependent for all self-care and mobility. Review of Section H. Bladder and Bowel revealed, Resident #150 was always incontinent for bladder and bowel. Review of Resident #150's Orders revealed:7/11/2025, Nitrofurantoin Macrocrystal Capsule 100 milligrams (MG) Give 1 capsule by mouth every 12 hours for UTI for 5 Days. the medication was administered as ordered. 7/5/2025, Urinalysis (UA) Culture and Sensitivity (C&S) may straight catheter. one time only for increasing confusion, restlessness for UTI 6/25/2025-6/29/2025 Ertapenem Sodium Injection Solution Reconstituted 1 gram (GM) (Ertapenem Sodium) Inject 1 gram intramuscularly one time a day for UTI. 6/21/2025-6/24/2025 Bactrim DS Oral Tablet 800-160 MG (Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth two times a day for uti for 3 Days 6/20/2025-6/21/2025 Lab: UA with C & S ok straight cath every shift for 3 Days OK discontinue once UA collected and sent 6/3/2025-6/8/2025 Cefuroxime Axetil Tablet 500 MG Give 1 tablet by mouth two times a day for UTI for 5 Days 5/30/2025-5/30/2025 UA C&S may straight catheter. every shift for 3 Days May discontinue order once completed 5/31/2025-5/30/2025 UA C&S may straight catheter. one time only for anxiety for 2 Days discontinue when complete. Review of Resident #150's Care Plan dated 03/16/2019 revealed:Focus:Resident #150 has potential for complications related to has active infection as follows: UTI Goal:Resident #150 will be free of infection by completion of antibiotic therapy. Interventions: Vital signs as ordered and as needed; Observe site of infection for increased swelling, inflammation, tenderness, drainage, or necrosis; update physician if noted; Maintain isolation precautions as indicated/ ordered; Observe for signs/symptoms of recurring infection; notify physician if noted. Focus:Resident #150 has an alteration in elimination as evidence by (AEB): is incontinent of bowel and bladder related diagnosis: dementia Goal: Resident #150 will be clean, dry, and odor free daily thru the next review date.; Resident will remain free from sign/symptoms of UTI thru the next review date; Resident will have a regular bowel movement at least every 3 days thru the next review date. InterventionsAdminister medications as ordered; observe for effectiveness; Provide hands on assistance with toileting upon resident request and as needed; Check resident upon arising, before/after meals and at HS for incontinence; perform incontinence care as needed; Keep urinal readily accessible; empty and clean as needed; Maintain closed drainage system and keep drainage bag below level of the bladder. Provide a catheter privacy bag. Observe for sign/symptoms of UTI; report to physician if noted; observe for the presence of stool , amount of stool, color and consistency that might indicate constipation/infection; Encourage adequate fluid intake; Labs as ordered; report results to physician; Initiate bowel protocol as needed;;OT screen as indicated; Observe for changes in bowel/bladder function; update physician if noted Review of Resident #150's Labs Results revealed: 06/21/2025 Urine Culture Organism: Escherichia coli (E.coli) Review of Resident #150's task for Toileting Hygiene revealed no documentation for toileting hygiene for the 7 a.m.- 3:00 p.m., shift on 06/18/2025, 06/27/2025, 6/29/2025, 6/30/2025, 07/04/2025, 07/08/2025, 07/09/2025, 07/10/2025, 07/11/2025, 07/13/2025, and 07/16/2025. No documentation for toileting hygiene for the 3:00 p.m.- 11:00 p.m., shift on 06/21/2025, 06/22/2025, 06/28/2025, and 07/06/2025. No documentation for toileting hygiene for the 11:00 p.m.- 7:00 a.m., shift on 06/24/2025, 07/06/2025,07/11/2025 and 07/16/2025. Review of Resident #150's hospital records revealed:05/31/2025- Brought in by Emergency Medical Services (EMS) for altered mental status. Per EMS called in for concern for UTI. The patient family wanted her evaluated in the Emergency Department (ED)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on observations, record reviews, and interviews the medical physician failed to provide the facility with written, signed and dated progress notes following each visit for one (#13) of 34 sampled residents. Findings included:On 7/14/24 at 2:54 p.m. Resident #13 was observed and interviewed in the resident room. The resident was sitting in wheelchair and answered questions appropriately. The resident reported falling two weeks ago and required stitches and a second fall while using the door to maneuver in wheelchair. Review of Resident #13s electronic progress notes and the uploaded documents revealed the most recent Palliative Care - Follow up note was written for a service performed on 2/14/25. Review of the electronic practitioner notes showed psychiatry notes. The electronic Advanced Registered Nurse Practitioner (ARNP) notes revealed the last note was written 8/21/23. The electronic record did not include any specified MD Note and the last Physician Progress Note was dated 4/2/25 by the Physical Medicine and Rehabilitation physician for a service date of 2/27/25. An interview was conducted with Staff K, Licensed Practical Nurse (LPN) on 7/16/25 at 12:39 p.m. The staff member reviewed Resident #13s medical record, saying the physician's document in the electronic record. Staff K reviewed the resident's progress notes (encounter and standard) stating all that was seen was psych notes. An interview and record review was conducted with the Director of Nursing (DON) on 7/16/25 at 1:55 p.m. A review was conducted showing a Summary of Episode with the physician name listed. The DON asked if writer still wanted 3 months of physician notes as Attending Physician had a note for April (uploaded) in the electronic record. The DON stated not having physician notes for 3 months was not optimal and the notes were probably sitting in a pile somewhere not here, then asked if she should ask the doctor to type faster. An interview was conducted with the DON on 7/17/25 at 12:37 p.m. The previously requested physician notes were received. The DON stated the notes were found in Medical Records and the facility had a vacancy in that area. Review of another resident's Summary of Episode was reviewed and the DON confirmed there was no assessment information and the summary was not a physician note. When asked if it was acceptable for there not being a physician note in the medical record for 5 months, the DON stated no. The DON stated staff know the plan of care through (physician) orders. Review of the 10 physician notes received from the DON showed the physician and/or designated medical provider visited Resident #13 on 4/7, 4/21, 5/9, 5/19, 6/2, 6/9, 6/16, 6/23, 6/30, and 7/7/25. Review of Resident #13s uploaded documents on 7/17/25 at 1:02 p.m. revealed on 7/17/25 MD Progress notes April - July 2025 had been uploaded. Review of the policy - Physician Progress Notes, revised February 2008, showed Physician progress notes must be maintained for each resident. The interpretation and implementation revealed:1. Physician progress notes are maintained for each resident residing in this facility. 2. Physician progress notes reflect the residents progress and response to his or her care plan, medications, etcetera (etc).3. The residents attending physician must write, sign, and date the physician progress notes reflecting each visit.4. Inquiries concerning physician progress notes should be referred to the attending physician, medical director, or director of nursing services. Review of the policy - Physician Visits, implemented 1/2025, revealed It is the policy of this facility to ensure the physician takes an active role in supervising the care of the residents. The compliance guidelines include the facility was to write a note to reflect the physician visit, an indication as to whether new orders were written or no new orders were received and any special discussions between the resident and/or family and physician during the visit. The Physician should: b. The resident must be seen at least once every 30 calendar days for the 1st 90 to calendar days after admission and at least every 60 days thereafter by physician or physician delegate as appropriate by state law. d. Date, write, and sign 12a progress note reflecting each visit.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure medications were administered per physician orders and failed to document physician notification for missed medications for one resident (#110) of one dialysis residents reviewed.Findings included:Review of Resident #110's admission record revealed she was originally admitted to the facility on [DATE] with diagnoses to include end stage renal disease (ESRD) and dependence on renal dialysis.Review of Resident #110's Medication Administration Record (MAR) for the months of June and July 2025 revealed the resident was not receiving medications as ordered. The MAR showed numerous notes of a number 1 documented indicating Refused medications. The review showed the medications were not administered as prescribed in the months of June and July 2025 as follows: Lactobacillus capsule, Give 1 capsule by mouth one time a day for prophylactic was missed 31 times.House protein, one time a day, for at risk for malnutrition related to dialysis, offer 30 cc (cubic centimeters) was missed five times.Atorvastatin calcium 20mg (milligrams) one time a day for hyperlipidemia was missed one time.Ferrous sulfate 325 mg, one time a day for anemia was missed one time.Multivitamin one time a day for ARVD (Arrhythmogenic Right Ventricular Dysplasia) was missed one time.On 07/17/2025 at 12:11 p.m. an interview was conducted with Resident #110. The resident stated sometimes she did not receive her medications because she was at dialysis. The resident denied refusing medications.An interview was conducted on 07/17/2025 at 1:38 p.m. with Staff U, Licensed Practical Nurse (LPN). She stated a 1 meant the resident refused the medications. She stated the physician should be notified. She stated the nurse would input a progress note and also document educating the resident on the importance of taking their medications. Staff U, LPN stated the physician and responsible party/family should be notified.On 07/17/2025 at 1:41 p.m. an interview was conducted with the Director of Nursing (DON). She stated any refusals should be followed by physician notification and a progress note. She stated she would follow up. Review of a facility policy titled Administering Medications, revised March 2023 showed a policy statement - Medications are administered in a safe and timely manner, as prescribed.Policy Interpretation and Implementation showed:.4. Medications are administered in accordance with prescriber orders, including any required time frame.5. Medication administration times are determined by resident need and benefit, not staff convenience. Factors that are considered include:a. enhancing optimal therapeutic effect of the medication. b. preventing potential medication or food interactions; andc. honoring resident choices and preferences, consistent with his or her care plan.6. Medication errors are documented, reported, and reviewed by the QAPI (Quality Assurance Performance Improvement) committee to inform process changes and or the need for additional staff training.

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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. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure that the medication error rate was less than 5.00%. Twenty-six medication administration opportunities were observed and two errors were identified for one (#23) of eight residents observed. These errors constituted a 7.69% medication error rate. Findings included:1.On 7/15/25 at 4:26 p.m., an observation of medication administration with Staff I, Licensed Practical Nurse (LPN), was conducted with Resident #23. The staff member removed a glucometer from the top drawer of the medication cart, and placed it in a clear plastic cup with a lancet and glucose testing strip. Staff I entered the resident's room, cleaned left index finger of resident with alcohol pad, lanced the finger and reported to the resident a blood glucose reading of 215. The staff member returned to the medication cart and cleaned the glucometer. Staff I documented in the medication record a blood glucose of 283, which the computer calculated a dose of insulin aspart of 6 units. This writer asked Staff I to review the blood glucose reading and the staff member confirmed from the glucometer memory a blood glucose reading of 215 for Resident #23. The staff member adjusted the blood glucose reading and stated it still showed the resident was to receive 6 units. The staff member was asked to read the order and confirm the dosage. Staff I refreshed the reading and the medication profile changed the dosage to 4 units for a glucose of 215.Staff I removed Resident #23's insulin glargine pen injector and insulin aspart pen injector. The staff member stated the resident was to receive 15 units of glargine and 4 units of aspart per sliding scale. Staff I dialed the dosage selector to 4 units on the insulin aspart pen and placed a needle then the staff member dialed the glargine pen to 15 units before applying the needle. The staff member re-entered the resident's room, verifying the dosages, and injected both insulins into the left lower abdominal quadrant. The staff member returned to the cart and dispensed one 500 milligram tablet of metformin, which was administered to the resident.An interview was conducted with Staff I on 7/15/25 at 4:46 p.m. The staff member stated, regarding not priming the insulin pens, nope, never been taught to prime the insulin pens.Review of Resident #23's admission Record showed the resident was originally admitted on [DATE] and re-admitted on [DATE]. The record included diagnoses not limited to Type 2 Diabetes Mellitus with hyperglycemia.An interview was conducted on 7/17/25 at 9:04 a.m. with the Director of Nursing (DON). The DON reported expecting medication errors. The insulin observation was revealed with findings of not priming the insulin pens prior to administration. The DON stated yes insulin pens were to primed prior to use and Staff I had been taught that (priming) but must have forgotten nerves. The medication error rate was disclosed and the DON nodded head stating ok, I will educate.Review of the undated procedure for Insulin Pen Administration, received by the facility, revealed:Step 1: Prepare your syringe- Take the cover cap off of your syringe.- Open an new needle by removing the paper tab.- Screw the needle onto your (name brand) Pen- Remove both the outer and inner needle caps.- After the needle is in place, do an air shot before taking your injections. Step 2: Do an air shot (Prime the Needle). Expiration: pen should be used within timeframe recommended by manufacturer.- Dial 2 units- Hold syringe with needle pointing up and tap reservoir gently to move air bubbles to top of needle.- Press the push button on syringe as far as it will go until a drop of insulin appears.Step 3: Dial your dose- Make sure your dose selector is set at 0.- Dial the number of units you need to inject. 1 click = 1 unit of insulin.- If you need to correct dose, dial the dose selector either up or down. Be careful not to press the push button while dialing or insulin will come.Step 4: Give the injection- When the needle is under your skin, inject the insulin by pressing the push button all the way in.- Leave the needle under your skin for a least 5 seconds after injecting your insulin. Keep the push button fully depressed until you withdraw the needle.Review of the manufacturer website, located at www. https://www.lantus.com/how-to-use/how-to-inject#solostar-pen, revealed the following instructions regarding the use of an insulin glargine pen.STEP 2. ATTACH THE NEEDLE Wipe the pen tip (rubber seal) with an alcohol swab. Remove the protective seal from the new needle, line the needle up straight with the pen, and screw the needle on. Do not make the needle too tight. If you have a push-on needle, keep it straight as you push it on. After you have attached the needle, take off the outer needle cap and save it (you will need it to remove the needle after your injection). Remove the inner needle cap and throw it away.STEP 3. PERFORM A SAFETY TEST Dial a test dose of 2 Units. Hold pen with the needle pointing up and lightly tap the insulin reservoir so the air bubbles rise to the top of the needle. This will help you get the most accurate dose. Press the injection button all the way in and check to see that insulin comes out of the needle. The dial will automatically go

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews the facility failed to ensure food allergies were accommodated for one resident (#23) of one resident sampled for food allergies. Findings included: An observation and interview was conducted on 7/14/25 at 12:20 p.m. with Resident #23. The observation showed the resident lying in bed and able to answer questions intelligently and appropriately. The resident reported feeling the portion sizes had decreased and felt (pronoun) had lost weight. The resident reported the facility used mayonnaise made with mustard and was allergic to mustard seeds.Review of the admission Record showed Resident #23 was originally admitted on [DATE] and re-admitted on [DATE]. The record included diagnoses not limited to Type 2 Diabetes Mellitus, morbid (severe) obesity due to excess calories, and adult failure to thrive.Review of Resident #23s quarterly Minimum Data Set (MDS), dated [DATE], revealed the resident scored 15 of 15 for a Brief Interview of Mental Status, indicating an intact cognition.Review of Resident #23s Interdisciplinary (IDT) Plan of Care Review Meeting Summary, dated 6/26/25 at 11:00 a.m., revealed lettered issues voiced during the meeting. The note showed letter A concerns related to Certified Nursing Assistant (CNA) scheduling with the UM directed the resident to question the Director of Nursing Services (DNS) and the lack of linens affecting shower/bathing schedule. The note listed letter B Resident notes allergy to mustard seed - facility may has it. The attendees of the meeting included the resident, Unit Manager (UM), MDS Registered Nurse (RN), and Activity Director. The attendees did not include a member of the Social Service (SS) or dietary department. The note showed letter D - SS discussed replacement to (?) cup lid - was broken by accident.Review of the grievance filed on behalf of Resident #23 by the IDT on 6/26/25 showed the residents hydration cups lid was broken and the facility replaced the cup. The grievance did not address the resident's report of being allergic to mustard seed. An interview was conducted on 7/15/25 at 3:31 p.m. with Staff O, Social Service Assistant (SSA). The SSA reported attending long-term care plan meetings. Staff O stated if there was no signature (on meeting summary) did not attend Resident #23s meeting on 6/26/25. The SSA stated if a resident voiced an allergy would definitely approach nursing staff. The meeting summary was reviewed and the SSA stated Staff P, MDS RN had written the meeting summary and dietary should have been notified of the reported allergy.An interview was conducted on 7/16/25 at 9:59 a.m. with the Certified Dietary Manager (CDM). The CDM stated she or assistant attended care plan meeting however for (the past) 2 weeks the facility hasn't had a morning cook so the IDT has a group chat and if she was unable to attend they will let her know if allergies or something significant regarding food service. The IDT will ask her to talk with the resident right then or will follow up with the resident. She stated at time of admission dietary was notified of allergies through the dietary communication forms and the electronic food service speaks with the electronic medical record system so when an allergy is listed it (the allergy) goes to the dietary tray ticket. The CDM stated she completes an audit of all changes done over the weekend. The staff member reviewed Resident #23s medical record and stated according to the record the resident did not have any allergies. The CDM reviewed the care plan meeting note and stated she had visited the resident one day and the resident had refused to speak with her, a second visit was attempted and the resident had not felt like talking. The CDM stated the resident's allergy would have been in a group chat and would have been put into the electronic medical record so the system would have alerted that the resident had voiced an allergy. The CDM stated the facility had been getting food from the same provider and some items have not been able to get because the provider had changed products. An observation was attempted with the CDM of the facility's open and unopened stock of mayonnaise. She looked in dry stock area and no mayonnaise was located, an observation of the refrigerator with condiments did not show any opened mayonnaise. A computer review of previously purchased mayonnaise showed the providers mayo did have mustard seed as an ingredient. The CDM was surprised mayonnaise had mustard in it.An interview was conducted on 7/16/25 at 10:40 a.m. with Staff P, MDS RN. The staff member confirmed being the person who took notes during the care plan meetings. If a concern (voiced), make notice of it and notify the relevant department unless they are in attendance. The staff member stated a concern depended if it could be handled right away would not write a grievance and would notify SS so they could write a grievance. The staff member remembered having a few care plan meetings with Resident #23. The staff member reviewed the care plan meeting note from 6/26/25 and stated he would have referred it to the kitchen and the CDM or Kitchen Manager (KM). He stated he had informed the CDM or KM immediately after the meeting as the kitchen was on the way to the

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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 observation and interviews, the facility failed to ensure the kitchen was maintained in a clean, sanitary manner in one kitchen (Main) of one kitchens observed during survey.Findings included:During the initial tour of the kitchen conducted with the Certified Dietary Manager (CDM) on 07/14/2025 from 9:59 a.m. to 10:25 a.m., concerns were identified related to the following:The filter in the juice machine was observed with dirt and debris. An immediate interview with the CDM revealed she did not know how the filters can be cleaned. She stated they would have to order new filters and the vendor would install.The juice machine equipment was observed with brown - coloring and stains on the surface of the stainless-steel surfaces. The CDM stated the surfaces are rusted and there was no way to clean them.The ceiling filters were observed with stains, dust and dirt, located above food prep and food service areas.The light by the food prep area was observed with brown stains and bio-growth.An observation was made of water leaking close to the light fixture above the food service station. The CDM stated the maintenance department was aware of the issue. An observation was made of the kitchen mixer utensils with dust and sticky substances on the surfaces of the items. The utensils were stored on the top shelf above clean dishes. The CDM said, We do not use those anymore. They should be removed.A tour of the freezer revealed ice frozen on the freezer surfaces and chunks of ice observed on top of the food boxes. The CDM stated she was aware of the concern and maintenance would remove the ice-build up.An observation was made of an insect flying on top of the chicken which was in a mixing bowl. The [NAME] was preparing the chicken for lunch. The CDM stated some staff leave the back door open, which allows insects and flies to fly inside the kitchen. She immediately removed the chicken and threw it in the trash.Outside the back area of the kitchen, an observation was made of trash and standing water, near the kitchen door. The CDM stated they were expected to pick up trash daily. She stated the maintenance department was aware the water was leaking from an A/C (Air Conditioning) unit located on top of the kitchen roof. She stated it had been an ongoing problem, and it was breeding mosquitoes.Further observation of the trash area revealed trash around the dumpster grounds including used gloves, papers, and incontinence pads. The CDM stated the responsibility to clean the area was shared between nursing and maintenance departments. She stated it was hard for her to enforce compliance. She stated the expectation was they should keep the grounds clean.During an interview conducted with the CDM on 07/16/2025 at 11:30 a.m., the CDM stated they had an expectation to maintain the kitchen in a clean manner. She stated they had started cleaning, and the maintenance department would be working on the repairs.Review of a facility policy titled Environment, dated October 2019 showed a policy - It is the center policy that all food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition.Action Steps showed: 1. The Dining Service Director will insure that the physical plant is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation.2. The Dining Services Director will insure that all employees are knowledgeable in the proper procedures for cleaning all food services equipment and surfaces.3. The Dining Services Director will insure that all food contact surfaces are cleaned and sanitized after each use.4. The Dining Service Director will insure that a routine cleaning schedule is in place for all cooking equipment, food storage areas, and surfaces.5. The Dining Service Director will insure that all dining areas are cleaned and sanitized after each use, including table surfaces, chairs, and floors.6. The Dining Services Director will insure that all trash is contained in covered leak proof containers that prevent cross contamination.7. The Dining Services Director will insure that all trash is properly disposed in external receptacles (dumpsters) and that the area is free of debris.(Photographic Evidence Obtained)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain an infection prevention and control program designed to help prevent the transmission of communicable diseases and infections as evidenced by 1) failure of staff to provide appropriate incontinence care by two staff members (Staff A, Staff B); 2) failure to implement policies related to staff use of artificial fingernails and containment of long hair for two staff members (Staff K, Staff S); and 3) failure to ensure staff donned Personal Protective Equipment (PPE) in a contact isolation room for two staff members (Staff AA, Staff AB) out of six staff members observed. The findings included: On 7/16/25 at 9:51 AM, an observation was made of Staff B, Certified Nursing Assistant (CNA), providing incontinence care to Resident #7. The resident had a urinary catheter and had been incontinent of stool. The CNA was observed to use cleansing wipes to clean the resident's peri area, then using the same wipes, she cleaned the resident's penis and the tubing of the catheter. Staff B never changed the wipe, changed her gloves, or sanitized her hands. Staff B then rolled the patient onto the side and provided care to his buttocks to clean up the stool. She was not observed to change her gloves. After wiping a large amount of soft stool and changing the brief, she applied the new brief, changed the sheet under the resident, and covered him with a blanket. She did not change her soiled gloves. A dark soft substance was noted on the gloves, and was the same color and texture of the stool. Staff B, CNA at no point during the care was observed to change her gloves or perform hand hygiene. A review of the Competency Based Orientation CNA Skills Checklist for Staff B revealed the date of employment as 5/18/17, the date orientation was completed as 5/20/22. The form was signed by both the Director of Nursing (DON) and the Mentor. The form revealed there were 5 options: P=previous experience; D=demonstrated and/or instructed by the Dept. head, supervisor, or Mentor/Preceptor; RD=Return demonstration by the orienteer and/or meets performance objective; NE Needs further experience with performance objective; and NA Not Applicable. At the bottom of the page was a Note: All observers are to print their initial in the appropriate boxes and print their full name on the signature page (last page) at the time of their initial observation. Under section F. Specialized Equipment: Utilizes knowledge and skill with: items 3. Care of residents with catheter: i.e. indwelling, suprapubic. a P (previous experience) is indicated with a check mark. On 7/16/25 at 11:00 AM, an observation was made of Staff A, CNA, providing catheter care to the resident in room [ROOM NUMBER]-B. Staff A provided care using one wash cloth that she dipped into a water basin on the tray table next to the bed. She folded the washcloth into four sections and applied liquid soap to the cloth. She provided care to the resident’s penis using a circular motion, then without changing the washcloth she wiped down the catheter tubing. She then folded the corner of the cloth, used the cloth to cleanse the penis and tubing using the previous cleaning method, starting with the head of the penis and down the catheter tubing. She repeated this process two more times until all the corners of the washcloth had been used. She then obtained a new cloth and performed incontinence care. Staff A, CNA was not observed to change her gloves at any point during the care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/16/25 at approximately 11:40 AM, an interview was conducted with Staff A, CNA. She stated she had been with the organization for about 6 years but had been at this location for about 2 years. She stated she received catheter care training during orientation at the other location but had not had additional training at this location. She stated there was on-line training but not really an observation of her providing care. A review of the Competency Based Orientation CNA Skills Checklist for Staff A, revealed the form was blank in the lines next to date of employment, date orientation completed, orientee, and the Director of Nursing. The name [Staff C, CNA] was printed using her first initial and last name, next to Mentor. Under comments was CNA did great. The form revealed there were 5 options: P=previous experience; D=demonstrated and/or instructed by the dept. head, supervisor or Mentor/Preceptor; RD=Return demonstration by the orienteer and/or meets performance objective; NE Needs further experience with performance objective; and NA Not Applicable. At the bottom of the page was a Note: All observers are to print their initial in the appropriate boxes and print their full name on the signature page (last page) at the time of their initial observation. Under section F. Specialized Equipment: Utilizes knowledge and skill with: items 3. Care of residents with catheter: i.e. indwelling, suprapubic. a P (previous experience) is indicated with a check mark. On 7/17/25 at approximately 2:30 PM, an interview was conducted with Staff A, CNA. She stated she did not know who [Staff C] was. She stated she could remember a form similar, but she had signed the form, motioning to the lack of signature on this sheet. She was unable to state when the form was completed for sure but she thought it may have been 6 months ago. On 07/17/25 at 11:42 AM, an interview was conducted with the Infection Preventionist (IP) and the Director of Nursing (DON). During this interview the IP was asked what her role was in staff education, she stated she talks about infection control during orientation but has not done visualization of staff in skills check-offs or return demonstration. The DON stated, We are not there yet. The IP stated she does visualizations of staff throughout the day and will offer spot re-education, but has no documentation of these efforts. She stated she does not observe staff providing care but will do so if asked. She stated their goal is 90% compliance rate, however, they are not able to state where they are at in reaching this goal, as they are not actually documenting their observations. On 7/17/25 at 3:08 PM, an interview was conducted with Staff C, CNA. Staff C stated she was a mentor for the CNAs. She stated anytime gloves become contaminated or soiled, staff are to change them and perform hand hygiene. She stated during catheter care, it is acceptable for the CNAs to use one washcloth as long as they do not contaminate the cloth in the area they are using to clean the catheter. She stated P” on the skills checklist form was for “Pass”, meaning they passed the observation. She said on the day the form is completed, she follows the staff all day, and they perform all items on the list. When shown the checklist and the instruction to initial the boxes and “P” meant previous experience, she stated she had not noticed this before and had not initialed the boxes; she thought she could place a check mark. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the handwashing/hand hygiene policy, revised August 2019, states that the facility considers hand hygiene the primary means to prevent the spread of infections. Under the section Policy Interpretation and Implementation under item #1 it states “All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. Item #2 states all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Item 7 Use and alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:” item e, states “Before and after handling an invasive device (e.g. urinary catheters, IV access sites)”, items h. “Before moving from a contaminated body site to a clean body site during resident care;” Review of the undated Catheter Care, Urinary policy states “The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.” Under Infection Control it states, “Infection control standards maintained.” During a facility tour on 07/16/2025 at 12:37 p.m. two staff members (Staff AA, CNA and Staff AB, CNA) were observed going into room [ROOM NUMBER] (a contact isolation room) during lunch service. The staff members did not don PPE or gloves. Staff AA CNA stated he did not know the resident was on contact precautions. He stated he would make sure to read the sign next time. Staff AB, CNA was observed going into the same room, adjusted the resident in bed B, and taking the resident's tray. Staff AB, CNA did not don PPE. She stated she did not pay attention at the sign on the door. She stated she should have put on full PPE. The two staff members did not perform hand hygiene prior to entering the room. On 7/14/25 at 2:36 p.m. Staff K, Licensed Practical Nurse, (LPN) was observed with almond-shaped fingernails extending approximately ¼-½” past the fingertip. The nails were painted a mauve color with glitter. The staff member reported the nails were fake and the polish was new, “they” put a magnet over it and the glitter follows the magnet. The observation showed other fingernails were painted with larger pieces of glitter. The staff member reported being “addicted” to it and she has had it for a couple of months. The observation showed Staff K, LPN was the primary nurse on the unit multiple days of the 4-day survey. An interview was conducted on 7/17/25 at 3:13 p.m. with the Director of Nursing (DON). The observation of Staff K’s fingernails were described, the DON stated fingernails should be shorter than own (the DON’s fingernails extended minimally past fingertips). She stated fingernails should be nice, clean, short, and trimmed nicely, should not be fake. The DON reported the employee handbook did not identify whether the nails should be fake or real and ½” was not ideal. On 7/16/25 at 9:00 a.m. Staff J, Certified Nursing Assistant (CNA) was asked by Staff S, Registered Nurse (RN) to assist with repositioning Resident #36 prior to the administration of medication. Staff J was observed with untethered blonde braids hanging below buttocks. Staff J’s braids fell onto the resident and the bed linens as the staff member leaned over to lift the resident higher up in the bed. The staff member removed the resident’s teal and white blanket straightening it as the braids fell onto the blanket. Staff J left the area after assisting Staff S. On 7/16/25 at 12:25 p.m. an observation was made of an assignment board on the Rapid hallway showing Staff J had an assignment for the direct care of residents. The assignment was a different hallway than where Resident #36 resided. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/17/25 at 3:13 p.m. the Director of Nursing (DON) was informed of the observation with Staff J’s braids. The DON reported Staff J’s braids are usually tied up. Review of the policy – Employee Appearance, undated, revealed “Employees are expected to be neat and well-groomed at all times.” 1. Your supervisor will tell you what is appropriate attire for your position and department. Uniforms will be neat and clean at all times. 2. For safety reasons, employees, involved with resident care should limit jewelry. 3. Employees may also be instructed to appropriate footwear while on the job. 4. Nails should be clean and trimmed. 5. Nothing in policy is intended to interfere with any religious observance or medical condition requiring special clothing. Review of the Centers of Disease Control and Prevention guidance, dated 2/27/24 – Clinical Safety: Hand Hygiene for Healthcare Workers, located at https://www.cdc.gov/clean-hands/hcp/clinical-safety, revealed the key points were to “Protect yourself and your patients from deadly germs by cleaning your hands.” The CDC recommended: - Natural nails should not extend past the fingertip. - Do not wear artificial fingernails or extensions when having direct contact with hght-risk patients like those at intensive-care units or operating rooms. o Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. - Some studies have shown that skin underneath rings contain more germs than fingers without rings. o Further studies should determine if wearing rings increases the spread of deadly germs.