STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105269	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Groves Center	512 S 11th St Lake Wales, FL 33853

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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 0585 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 policy review, the facility failed to ensure a grievance was filed and investigated and resolved for one resident (#9) of seven sampled residents.Findings included: Review of Resident #9's admission record revealed an admission date of 08/18/2025. Resident #9 was admitted to the facility with diagnosis to include muscle wasting and atrophy, need for assistance with personal care, methicillin resistant staphylococcus aureus infection, and osteomyelitis.During an interview on 10/28/2025 at 12:03 p.m., Resident #9 stated, I am not happy because I have a blanket and a couple of blouses missing. The resident reported a family member came to the facility on [DATE] and the facility let them look in the laundry room for the missing items. The family member did not find the items.During an interview on 10/28/2025 at 2:15 p.m. the Social Services Director (SSD) reviewed the grievance log and stated there were no current open grievances for Resident #9. The SSD stated staff should file a grievance when resident is missing items. SSD was not aware of Resident #9's missing items.Review of Resident #9's Medicare 5-day quarterly Minimum Data Set (MDS) dated [DATE] revealed in section C - Cognitive Patterns, a Brief Interview Mental Status (BIMS) of 15 out of 15, showing intact cognition with no cognitive impairment.During an interview on 10/28/2025 at 2:30 p.m., the Admissions Director (AD) stated a grievance is when a resident has a concern or is missing items. The AD spoke with Resident #9 and the family member on 10/27/2025. The resident spoke about a missing blanket and some clothes. The AD stated the family member went to the laundry room to see if any of the missing items were there. The AD was unsure if the blanket was found, and stated they did not file a grievance for the missing items. The AD reported thinking the missing items were being worked on already, since Resident #9 had brought up the missing items a few different times. The AD stated when a resident is talking about something a lot it usually means SSD was already working on it. During an interview on 10/28/2025 at 3:21 p.m., the Housekeeping Director reported Resident #9 and the family member reported missing items on 10/27/2025. The Housekeeping Director stated Resident #9 and family member wanted to go to the laundry room to search for the missing items. The Housekeeping Director stated the family member went to the laundry room and found most of the items, but Resident #9 reported still missing a dress and blanket. The Housekeeping Director stated a grievance was not filed.During an interview on 10/28/2025 at 3:45 p.m.with Staff M, Certified Nursing Assistant (CNA) reported Resident #9 had complained about missing items. Staff M stated the missing items were not reported to social services. Staff M asked, When residents are missing items, is this something you report?.During an interview on 10/28/2025 at 4:00 p.m., the Nursing Home Administrator (NHA) stated he does the onboarding with all new staff and reviews the process for grievances. The NHA stated he told staff, If it is something you can fix right away, then you don't need a grievance. He reported for missing items, a grievance should be filed for the paper trail. The NHA stated there should have been a grievance filed for Resident #9 since there were missing clothes.Review of the facility policy titled The Grievance/ Concern Management Policy, effective May 2025, showed residents and their representative have the right to present concerns on behalf of themselves, and/or others to the staff and /or administrator of the facility to work for improvements in resident care, free from restraint, interference, coercion discrimination, or reprisal.The procedure showed:-Residents and their representatives who are unable to complete a written concern will be assisted by staff to prepare and submit the form-The Social Services representatives/ Grievances Official in collaboration with the NHA will be responsible for assigning the concern to the appropriate department for investigation. Social Service will monitor and document resident/ representative satisfaction up completion of the investigation and the summary of findings/conclusion-The department involved will document the concern and record the resident/ resident representative's satisfaction with the resolution to the concern-Complete a concern report investigation with summary and conclusion-Social Services staff will provide information regarding compliance line information for unresolved concerns

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to provide necessary care and services to prevent Urinary Tract Infections (UTIs) from developing or worsening by 1.) Failing to follow physician's orders for a silver coated foley catheter, failed to order labs, and change the foley catheter per orders for one resident (#2) out of four residents reviewed, resulting in Resident #2 developing a urinary tract infection that progressed to Fournier's gangrene and sepsis. 2.) Failed to give antibiotics for UTI as ordered for one resident (#13) out of four residents reviewed with catheters. This failure placed Resident #13 at risk for worsening infection or delayed recovery.Findings included: 1.) Review of the admission records showed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but are not limited to type 2 diabetes mellitus without complications, muscle wasting and atrophy, need for assistance with personal care, sepsis, unspecified organism, obstructive and reflux uropathy, unspecified. Review of Resident #2's May 2025 Medical Administration Record (MAR)/Treatment Administration Record (TAR) revealed the resident had an appointment with a urologist on 5/13/25. The appointment was checked off on 5/12/25. There were no notes regarding this appointment in the electronic medical record or the chart. Review of Resident #2's May 2025 orders showed the resident's primary care provider (PCP) ordered the facility to use a #16 French silver coated foley catheter and change the catheter every 3-4 weeks during night shift, starting on 5/19/25. The order was to start doing this every month for neurogenic bladder and recurring Urinary Tract Infections (UTIs). He placed the order again on 5/22/25 with an order summary of using the #16 French silver coated foley catheter and change on a every 3-4 weeks schedule once foley is received. There were no records of the resident ever receiving the silver coated foley catheter after these orders were placed. Review of Resident #2's June 2025 MAR/TAR revealed the resident was last treated for UTI, with Rocephin 1 GM, on 6/10/25 at 8:29 p.m. The resident had an order for a urinalysis, with a urine culture and sensitivity test on 6/9/25. The resident had an order for additional labs on 6/10/25. The testing results of the urine polymerase chain reaction (PCR) panel were positive for pathogens. The resident had an order for enhanced barrier precautions related to foley catheter care every shift for infection prevention and control. Review of Resident #2's June 2025 MAR/TAR showed the resident had a pain level of 7 out of 10 on 6/9/25 and a pain level of 8 out of 10 on 6/10/25, during the evening when the resident was diagnosed with the previous UTI. (The pain scale is a tool used to measure and assess the intensity of pain on a scale of 0-10 where 0 represents no pain and 10 represents the worst possible pain). Review of Resident #2's progress notes completed on 7/2/25 at 10:51 a.m., by Staff D, Licensed Practical Nurse (LPN), revealed the resident had complaints of severe pain in pelvic area, hard and swollen pelvic area, and the area was tender to touch. Staff D contacted the providers answering service and spoke with the primary care providers Advanced Registered Nurse Practitioner (ARNP). The ARNP instructed Staff D to order a kidney, ureter, bladder (KUB) and pelvic ultrasound. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's July 2025 MAR/TAR, revealed a KUB and pelvic ultrasound were ordered for lower pelvic pain. The documentation showed the order was, discontinued due to clarification. On 7/3/25, another order for the pelvic ultrasound was discontinued due to, No directions specified for order. Review of Resident #2's July 2025 MAR/TAR showed a completed order for KUB and pelvic ultrasound on 7/2/25 at 3:40 p.m. and an abdominal x-ray was taken at 4:00 p.m. Review of Resident #2's ultrasound results, dated 7/2/25 showed the reproductive organs were not visualized, the urinary bladder was empty, and it was a nondiagnostic study. Review of Resident #2's x-ray results, dated 7/2/25 showed there was no evidence of pneumoperitoneum or abnormal calcifications. Resident #2's record did not show any orders for labs to establish if there was an infection during July 2025. The last labs order for the resident were the labs on 6/10/25. Review of Resident #2's July 2025 MAR showed a documented pain level of 8 out of 10 on the day shift of 7/2/25, and the pain level was documented at 10 out of 10 during the evening shift of 7/2/25. On 7/3/25, the resident's pain levels were listed as N/A (not applicable) for day and evening shifts. The pain level was documented as 7 out of 10 during the evening shift on 7/4/25. The pain level was documented as 0 out of 10 during the day shift and N/A during the evening shifts for 7/5/25 to 7/6/25. All the pain levels for the night shifts were documented as 0 out of 10 for 7/1/25 through 7/6/25. Review of Resident #2's progress notes showed documentation of her pain level being 10 out of 10 on 7/7/25. The notes showed the resident's temperature was last checked on 6/27/25. Review of Resident #2's May, June, and July 2025 MAR/TAR's revealed the resident's catheter was changed on 5/25/25 but was not changed again until the resident complained of pain on 7/2/25. The weekly skin checks in the electronic medical record, from 5/14/25 to 7/2/25 revealed, No new area of skin impairment. Review of Resident #2's progress notes completed on 7/4/25 at 11:39 a.m., by the Assistant Director of Nursing (ADON) at that time, revealed a skin assessment was completed. She noted Resident #2 had skin redness in the coccyx/buttock area. No open areas were observed, with only scant, pinpoint dot-like size amount of sanguineous drainage seen on brief from hemorrhoids irritation. She noted a small nickel-sized reddened area observed directly above the excoriated area on the coccyx. She noted that peri-care and foley care had been provided. No documentation was completed about wounds in the perineal area. The ADON documented the resident complained of high pain sensitivity to the wound area on palpation and movement. The ADON repositioned the resident and noted that she would continue to monitor and follow the plan of care. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's care plans showed a focus area of indwelling catheter. Interventions included observing for signs of discomfort, observe and document for pain or discomfort due to the catheter, and to document and report any signs and symptoms of UTI. There was an additional focus area of Wound Risk. Interventions included obtaining vital signs per order. Documented under the focus area of pain, interventions included administering pain medication as ordered and observe for effectiveness, and to observe and anticipate the residents need for pain relief. There was an additional focus area of skin integrity risk. Interventions included monitoring and documenting location, size, and treatment of skin. Report abnormalities, failure to heal and signs and symptoms of infection. Review of Resident #2's Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section H, Bladder and Bowel, revealed the resident had an indwelling catheter and no toileting program had been attempted at that time. Section M, skin conditions, noted the resident was at risk of developing pressure ulcers or injuries. The MDS information provided did not contain any documented pressure injuries. Review of Resident #2's hospital record, dated 7/7/25 showed: Resident #2 reported for the past few weeks they have been asking the facility to send them to the emergency room for not feeling well. Upon examination, the resident had purulent drainage from their peritoneal area with foul smelling odor. They also had a large necrotic area appearing in their genital region. The foley catheter was in place with purulent drainage. The resident reported to the hospital that they had been smelling this foul odor for the past few weeks. Review of Resident #2's hospital lab records, dated 7/7/25 at 2:34 p.m. showed elevated white blood cell (WBC) results: WBC 30.85 (units 10*3/uL) [Microliter]. Review of Resident #2's hospital general surgery plan, dated 7/7/25 showed: Fournier's gangrene with a necrotizing soft tissue infection of the lower abdominal wall as well as peritoneum with purulence draining from indwelling catheter. Patient is in septic shock at this time and is being actively resuscitated with volume. Patient will need emergent debridement for source control, and I have discussed this with the patient. I discussed the procedure in detail including significant disfigurement from the removal of the necrotic tissue and that further operations we will need to be undertaken for either reconstruction or further debridement of necrotic tissue. We also discussed possible need for an ostomy in the future. On 10/27/25 at 3:50 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). She stated if there were signs of infection in residents with catheters, she would let the nurse know immediately. She would document what was observed in the electronic medical record, under catheter care tasks. Staff B said the last training she received was an in-service in July 2025 where they discussed catheter procedures. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/27/25 at 3:57 p.m., an interview was conducted with Staff E, Registered Nurse (RN). Staff E stated the care provided depended on the type of catheter a resident had. She noted nurses flushed and cleaned foley catheters and CNAs emptied the catheter bags throughout the day. Staff E stated the care was provided every shift, but it also depended on the resident's condition at that time. If signs of infection were observed, she would check vitals, notify the provider to get orders for a urinalysis and culture, and call the resident's representative. Staff E said a change of condition evaluation would have been completed as well. She stated she had not received training on resident's change of condition but did receive education on documenting last week. On 10/27/25 at 4:05 p.m., an interview was conducted with Staff A, LPN. He stated the CNAs and nurses cleaned the catheters. Staff A said the nurses and CNAs must assess if the catheter was intact and draining and observe for urine color. Staff A said, If the line is cloudy, the nurses change it. He stated if he suspected an infection, he would call the doctor to ask for a culture. Staff A stated there was a section in the chart for change of condition and progress notes. he stated any change of condition should be documented in those sections of the record and should also be shared in shift-to-shift report. Staff A stated the staff had been trained in catheter care and change in condition, upon hire and continued with occasional in-service trainings. He stated the training instructed, If an infection is discovered, then the clinical nursing staff would go and review all the foleys in the facility. As part of this review, leadership would provide training with demonstration and education. On 10/28/25 at 11:45 p.m., an interview was conducted with Staff D, LPN. She stated Resident #2 had pelvic pain on 7/2/25, and she was told to give the resident medication. On 7/2/25, Staff D changed the resident's catheter. Staff D thought she changed the catheter after resident reported the pain, but she was not sure. She stated she could not remember anything else ordered for the resident. She was not sure; it was a long time ago. Staff D said she did not remember if there were any signs of infection. She stated one of the CNAs saw discharge coming out of the adult brief on 7/7/25. Staff D noted the CNA called someone to have the resident sent out to the emergency room (ER). On 10/28/25 at 12:49 p.m., a telephone interview was conducted with Staff C, LPN. Staff C said 7/7/25 was the first time she had worked with Resident #2. The resident presented with a large amount of perineal discharge, and Staff C notified the provider. She stated the resident was then sent to the ER. Staff C said she believed that during discussions they mentioned the resident having pain. Staff C stated she believed the resident had an ultrasound and followed with urology. Staff C said she was not sure because she only found out about Resident #2's treatment through conversations with other staff. Staff C stated she was told the staff had noticed a foul odor. Staff C said a CNA notified her about the discharge and asked her to assess. Staff C stated the event was a long time ago and she was not exactly sure who the CNA was that day, on 7/7/25. On 10/28/25 at 12:54 p.m. a telephone interview was conducted with Staff G, RN. She did not remember much about the resident. She stated, If there were labs ordered, then they would be placed in the system. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	On 10/29/25 at 2:09 p.m., an interview was conducted with the Director of Nursing (DON). She stated it was common to call physicians for new orders. She confirmed she knew there had been discrepancies with provider notifications for labs or changes in conditions. The DON said, If the resident is presenting with signs of infection, then the CNA should report it to the nurse. The nurse will assess and perform interventions if the resident has orders. They will check for recent antibiotics use due to UTIs. They will call the provider if it is a new onset of infection. She stated the staff have had in-service training for catheter care since she began working at the facility. The DON stated they had not implemented a demonstration training, but they were going to soon. Review of a facility policy titled General Procedures and Treatment Modalities, pages 783-785 revealed the catheter care procedures. Review of page 785 shows to call the health care provider if there are signs of fever, or cloudy, bloody, odoriferous urine develops. 2.) Review of admission Records showed Resident #13 was admitted to the facility on [DATE] with diagnoses including but are not limited to chronic systolic (congestive) heart failure, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, and obstructive and reflux uropathy, unspecified. Review of Resident #13's August 2025 and September 2025 MAR showed an order was placed for Ertapenem Sodium Injection Solution Reconstituted 1GM. One application was to be given every day at bedtime for Proteus Mirabillis in urine for five days starting on 8/29/25. Review of Resident #13's August 2025 and September 2025 MARs showed the doses administered to the resident were on 9/1/25, 9/2/25, and 9/3/25. The resident received three doses of the five ordered doses. Review of Resident #13's progress note did not show any documentation detailing why the doses were missed, or if the provider was notified that the resident did not receive all doses of the prescribed antibiotic for the UTI. Review of a facility policy titled Lab/Radiology Process Guidelines, undated, showed: 5. Upon receiving the results, notify the physician and resident/resident representative of the results, and file the results in the medical record under Labs/Radiology tab. 6. Document in a progress note the labs/radiology tests you received and who the results were reported to. Include any additional follow up or new physician orders received in the progress. 8. Stat and critical labs must be called to the physician as soon as they have resulted, with the nurse documenting the communication and follow-up in the electronic medical record. Review of a facility policy titled, Physician Notification, dated October 2021 revealed, The facility strives to ensure each resident's health is supervised by a qualified attending physician. The attending physician in the facility is ultimately responsible for supervision and management of the care of the resident/patient. Review of a facility policy titled Abuse Prevention Program, reviewed September 2025, showed: (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Policy: The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff bum out, or resident behavior which may increase the likelihood of such events. Definitions: Neglect -Failure of the facility, its employees, or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

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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. (continued on next page)

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F 0609 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 interviews and record reviews the facility did not ensure reporting of an allegation of neglect for one resident (#1) out of three residents reviewed. Findings Included: A facility policy titled Abuse Prevention Program, reviewed September 2025, showed: Policy: - The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property.These policies guide the identification, management, and reporting of suspected, or alleged, abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff bum out, or resident behavior which may increase the likelihood of such events.Definitions: Neglect -Failure of the facility, its employees, or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.Reporting:-The facility will identify person(s) responsible for the reporting and investigating. -The facility will follow Federal regulations and State specific reporting requirements. -DCF will be notified promptly. -The administrator of the facility and/or designee will be notified immediately. -An Immediate report will be filed with AHCA for alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source that is suspicious of abuse or neglect, and misappropriation of resident property:-Not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury; or o not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.-Notify Law Enforcement if a crime is suspected such as with actual or alleged physical or sexual abuse, misappropriation of resident property, and in the event of unexplained death (please see State and -Federal Reporting: Medical Examiner Reporting).-Should the resident be [AGE] years of age, or older, and local Law Enforcement identify the allegation as a crime and take the issue for investigation, the facility will file a Suspected Crime Report within 2 hours of the alleged event if there is a serious bodily injury, or within 24 hours of the alleged event if there is no serious bodily injury. Refer to the Elder Justice Policy & Procedure. -At the conclusion of the investigation, and within 5 business days of the event, a final report will be submitted, detailing the facility findings, to include whether the allegation is substantiated. -Should there be a perpetrator involved and identified, this will be indicated on all reporting. -A 15 Day State Adverse Report may be required (please reference Adverse Incident Reporting). -The facility reports alleged violations & substantiated incidents to the state agency & to other agencies as required & takes necessary corrective actions depending on the results of the investigation. -Allegation of sexual abuse against a licensed employee will be reported to the Board regardless of the investigation outcome per Florida Statute. -Report will be made to the licensing board/authority or other licensing agency, as appropriate if the facility has any knowledge of any actions by a court of law which would indicate an employee is unfit for service. -Resident's responsible party is notified if the resident lacks capacity; if the resident has capacity the facility will request resident permission prior to notification of resident representative. -Resident's physician is notified. An interview was conducted on 10/28/25 at 10:10 a.m. with the Resident Representative (RR) for Resident #1. The RR said on 9/27/25 he was at the facility with Resident #1, and she was not herself. He said the resident was very lethargic, wanted to sleep and was in pain. The RR said, I let the nurse and Certified Nursing Assistant (CNA) know my concern. He said at one point neither he nor the staff could find Resident #1's assigned nurse, Staff H, Licensed Practical Nurse (LPN) for over an hour. The RR said he was trying to find the nurse because the resident's medications were late, and she was in pain. He said a CNA he talked to didn't know where the nurse was nor did the other nurse working. He said when Staff H finally returned to the unit, she was very short and asked what he wanted. The RR said he told Staff H his concerns about [Resident #1's] medications, her pain, and the fact the resident had seizures the previous night. He said Staff H responded by saying, So what's the problem. She's had seizures before, right? The RR stated feeling like Resident #1 needed to go to the hospital because she was not her normal self and was not well. He said the resident had labs drawn earlier that morning and asked about the results of those as well. The RR said Staff H told him the results would be looked at on Monday when the doctor returned and that Resident #1 could not go to the hospital because the doctor was not on call on the weekend. The RR said he went to see the Nursing Home Administrator (NHA) on Monday morning, 9/29/25 and reported that he felt like Resident #1

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on record review and interview, the facility failed to thoroughly investigate an allegation of neglect, by failing to conduct interviews with all relevant staff related to a reportable event for one resident (#2) of five sampled residents. Findings included: On 10/29/25 at 2:47 p.m., a meeting was held to discuss a sample of State Agency reportable cases. The staff attendees included the Nursing Home Administrator (NHA), Regional Nurse Consultant (RNC), Director of Risk Management Consultant (DRMC), and the Senior Regional Nurse Consultant (SRNC). The NHA stated he became aware of the allegation for Resident #2 when the Department of Children and Families (DCF) agent arrived at the facility on 9/2/25. He stated DCF told him the allegation was from Resident #2's family. He was told the family said that the facility did not replace the resident's foley catheter and didn't provide catheter care. The NHA stated he was told the family believed this caused infection. The NHA stated not knowing the name of the family member. He stated he did not contact the family after the allegation. The NHA stated there was an order for a foley catheter with a special coating that had to be placed by a urologist. The NHA said the staff were not sure why the coated catheter had to be placed by a urologist. The NHA confirmed Resident #2 was admitted to the facility with a catheter. When asked if May 2025 was the date the coated foley catheter was ordered, the facility attendees were unsure. They stated they had to look up the information. On 10/29/25 at 3:50 p.m. the interview continued regarding Resident #2. The NHA stated a thorough investigation had been conducted, and he found the allegation of neglect was unfounded. The NHA stated he interviewed Staff C, Licensed Practical Nurse (LPN) on 9/3/25. The NHA reading of the interview included: Staff C sent the resident to the ER, following a doctor's order, on 7/7/25. The NHA reading stated Staff C reported the resident had perfuse discharge and a foul odor. He stated Staff C had never cared for this resident before that night. The RNC stated the resident's last urology appointment was on 5/13/25. She confirmed she did not see any notes in the electronic medical record and stated she would have to look in the resident's chart. The interview revealed the facility did not contact the urologist during their investigation. The NHA stated he attempted to interview Staff G, Registered Nurse (RN) on 9/3/25 by telephone. He stated Staff G, RN did not give him any information and that they had resigned before the allegation. The NHA stated the allegation was not substantiated because Resident #2 had complained of pain on the morning of 7/7/25, and everything was done properly that day. The NHA stated he was unaware the resident had begun complaining of severe pain on 7/2/25 and was not sent to the ER until 7/7/25. The DRNC while reviewing Resident #2's record stated, From a clinical standpoint, I would have ordered labs. The NHA stated he interviewed other staff, such as CNAs, from that night. The NHA did not have any other interviews in the investigation folder. The NHA left to find interview records and returned at 4:21 p.m., unable to locate the records. The NHA stated they did not receive records from the hospital. He stated, it is difficult to obtain the records sometimes because the hospital will not provide them. He stated that the DCF agent did not mention anything about the resident having wounds. The attendees at the meeting were not aware of the perineal wound or the unstageable pressure injury to Resident #2's left thigh where foley catheter would lay. The SRNC stated she had read the report from the hospital and knew about the gangrene. No further information was provided from the investigation. Review of the facility's policy titled Abuse Prevention Program, with a review date of September 2025 revealed the following: once an event report is initiated, the NHA is notified and will conclude a complete and thorough investigation within the specified timeframe. The policy showed: The investigation may include but may not be limited to obtaining statements or interviews from residents, employees and visitors. The investigation may also include observation of resident(s), staff, and environment. As well as document review and possible re-enactment of the event.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to ensure 1.) necessary care and services were to prevent Urinary Tract Infections (UTIs) from developing or worsening by, failing to follow physician's orders for a silver coated foley catheter, failed to order labs, and change the foley catheter per orders for one resident (#2) out of four residents reviewed, resulting in Resident #2 developing a urinary tract infection that progressed to Fournier's gangrene and sepsis. Failed to give antibiotics for UTI as ordered for one resident (#13) out of four residents reviewed with catheters. This failure placed Resident #13 at risk for worsening infection or delayed recovery. 2.) The facility did not ensure providers were notified of abnormal lab results for two residents (#1 and #4) out of three residents reviewed for labs and 3.) failed to ensure pain was managed for one resident (#12) out of three residents sampled.Findings included: 1.) Review of the admission records showed Resident #2 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including but are not limited to type 2 diabetes mellitus without complications, muscle wasting and atrophy, need for assistance with personal care, sepsis, unspecified organism, obstructive and reflux uropathy, unspecified. Review of Resident #2's May 2025 Medical Administration Record (MAR)/Treatment Administration Record (TAR) revealed the resident had an appointment with a urologist on 5/13/25. The appointment was checked off on 5/12/25. There were no notes regarding this appointment in the electronic medical record or the chart. Review of Resident #2's May 2025 orders showed the resident's primary care provider (PCP) ordered the facility to use a #16 French silver coated foley catheter and change the catheter every 3-4 weeks during night shift, starting on 5/19/25. The order was to start doing this every month for neurogenic bladder and recurring Urinary Tract Infections (UTIs). He placed the order again on 5/22/25 with an order summary of using the #16 French silver coated foley catheter and change on a every 3-4 weeks schedule once foley is received. There were no records of the resident ever receiving the silver coated foley catheter after these orders were placed. Review of Resident #2's June 2025 MAR/TAR revealed the resident was last treated for UTI, with Rocephin 1 GM, on 6/10/25 at 8:29 p.m. The resident had an order for a urinalysis, with a urine culture and sensitivity test on 6/9/25. The resident had an order for additional labs on 6/10/25. The testing results of the urine polymerase chain reaction (PCR) panel were positive for pathogens. The resident had an order for enhanced barrier precautions related to foley catheter care every shift for infection prevention and control. Review of Resident #2's June 2025 MAR/TAR showed the resident had a pain level of 7 out of 10 on 6/9/25 and a pain level of 8 out of 10 on 6/10/25, during the evening when the resident was diagnosed with the previous UTI. (The pain scale is a tool used to measure and assess the intensity of pain on a scale of 0-10 where 0 represents no pain and 10 represents the worst possible pain). (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's progress notes completed on 7/2/25 at 10:51 a.m., by Staff D, Licensed Practical Nurse (LPN), revealed the resident had complaints of severe pain in pelvic area, hard and swollen pelvic area, and the area was tender to touch. Staff D contacted the providers answering service and spoke with the primary care providers Advanced Registered Nurse Practitioner (ARNP). The ARNP instructed Staff D to order a kidney, ureter, bladder (KUB) and pelvic ultrasound. Review of Resident #2's July 2025 MAR/TAR, revealed a KUB and pelvic ultrasound were ordered for lower pelvic pain. The documentation showed the order was, discontinued due to clarification. On 7/3/25, another order for the pelvic ultrasound was discontinued due to, No directions specified for order. Review of Resident #2's July 2025 MAR/TAR showed a completed order for KUB and pelvic ultrasound on 7/2/25 at 3:40 p.m. and an abdominal x-ray was taken at 4:00 p.m. Review of Resident #2's ultrasound results, dated 7/2/25 showed the reproductive organs were not visualized, the urinary bladder was empty, and it was a nondiagnostic study. Review of Resident #2's x-ray results, dated 7/2/25 showed there was no evidence of pneumoperitoneum or abnormal calcifications. Resident #2's record did not show any orders for labs to establish if there was an infection during July 2025. The last labs order for the resident were the labs on 6/10/25. Review of Resident #2's July 2025 MAR showed a documented pain level of 8 out of 10 on the day shift of 7/2/25, and the pain level was documented at 10 out of 10 during the evening shift of 7/2/25. On 7/3/25, the resident's pain levels were listed as N/A (not applicable) for day and evening shifts. The pain level was documented as 7 out of 10 during the evening shift on 7/4/25. The pain level was documented as 0 out of 10 during the day shift and N/A during the evening shifts for 7/5/25 to 7/6/25. All the pain levels for the night shifts were documented as 0 out of 10 for 7/1/25 through 7/6/25. Review of Resident #2's progress notes showed documentation of her pain level being 10 out of 10 on 7/7/25. The notes showed the resident's temperature was last checked on 6/27/25. Review of Resident #2's May, June, and July 2025 MAR/TAR's revealed the resident's catheter was changed on 5/25/25 but was not changed again until the resident complained of pain on 7/2/25. The weekly skin checks in the electronic medical record, from 5/14/25 to 7/2/25 revealed, No new area of skin impairment. Review of Resident #2's progress notes completed on 7/4/25 at 11:39 a.m., by the Assistant Director of Nursing (ADON) at that time, revealed a skin assessment was completed. She noted Resident #2 had skin redness in the coccyx/buttock area. No open areas were observed, with only scant, pinpoint dot-like size amount of sanguineous drainage seen on brief from hemorrhoids irritation. She noted a small nickel-sized reddened area observed directly above the excoriated area on the coccyx. She noted that peri-care and foley care had been provided. No documentation was completed about wounds in the perineal area. The ADON documented the resident complained of high pain sensitivity to the wound area on palpation and movement. The ADON repositioned the resident and noted that she would continue to monitor and follow the plan of care. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #2's care plans showed a focus area of indwelling catheter. Interventions included observing for signs of discomfort, observe and document for pain or discomfort due to the catheter, and to document and report any signs and symptoms of UTI. There was an additional focus area of Wound Risk. Interventions included obtaining vital signs per order. Documented under the focus area of pain, interventions included administering pain medication as ordered and observe for effectiveness, and to observe and anticipate the residents need for pain relief. There was an additional focus area of skin integrity risk. Interventions included monitoring and documenting location, size, and treatment of skin. Report abnormalities, failure to heal and signs and symptoms of infection. Review of Resident #2's Minimum Data Set (MDS), dated [DATE], Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, which indicated she was cognitively intact. Section H, Bladder and Bowel, revealed the resident had an indwelling catheter and no toileting program had been attempted at that time. Section M, skin conditions, noted the resident was at risk of developing pressure ulcers or injuries. The MDS information provided did not contain any documented pressure injuries. Review of Resident #2's hospital record, dated 7/7/25 showed: Resident #2 reported for the past few weeks they have been asking the facility to send them to the emergency room for not feeling well. Upon examination, the resident had purulent drainage from their peritoneal area with foul smelling odor. They also had a large necrotic area appearing in their genital region. The foley catheter was in place with purulent drainage. The resident reported to the hospital that they had been smelling this foul odor for the past few weeks. Review of Resident #2's hospital lab records, dated 7/7/25 at 2:34 p.m. showed elevated white blood cell (WBC) results: WBC 30.85 (units 10*3/uL) [Microliter]. Review of Resident #2's hospital general surgery plan, dated 7/7/25 showed: Fournier's gangrene with a necrotizing soft tissue infection of the lower abdominal wall as well as peritoneum with purulence draining from indwelling catheter. Patient is in septic shock at this time and is being actively resuscitated with volume. Patient will need emergent debridement for source control, and I have discussed this with the patient. I discussed the procedure in detail including significant disfigurement from the removal of the necrotic tissue and that further operations we will need to be undertaken for either reconstruction or further debridement of necrotic tissue. We also discussed possible need for an ostomy in the future. On 10/27/25 at 3:50 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). She stated if there were signs of infection in residents with catheters, she would let the nurse know immediately. She would document what was observed in the electronic medical record, under catheter care tasks. Staff B said the last training she received was an in-service in July 2025 where they discussed catheter procedures. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/27/25 at 3:57 p.m., an interview was conducted with Staff E, Registered Nurse (RN). Staff E stated the care provided depended on the type of catheter a resident had. She noted nurses flushed and cleaned foley catheters and CNAs emptied the catheter bags throughout the day. Staff E stated the care was provided every shift, but it also depended on the resident's condition at that time. If signs of infection were observed, she would check vitals, notify the provider to get orders for a urinalysis and culture, and call the resident's representative. Staff E said a change of condition evaluation would have been completed as well. She stated she had not received training on resident's change of condition but did receive education on documenting last week. On 10/27/25 at 4:05 p.m., an interview was conducted with Staff A, LPN. He stated the CNAs and nurses cleaned the catheters. Staff A said the nurses and CNAs must assess if the catheter was intact and draining and observe for urine color. Staff A said, If the line is cloudy, the nurses change it. He stated if he suspected an infection, he would call the doctor to ask for a culture. Staff A stated there was a section in the chart for change of condition and progress notes. he stated any change of condition should be documented in those sections of the record and should also be shared in shift-to-shift report. Staff A stated the staff had been trained in catheter care and change in condition, upon hire and continued with occasional in-service trainings. He stated the training instructed, If an infection is discovered, then the clinical nursing staff would go and review all the foleys in the facility. As part of this review, leadership would provide training with demonstration and education. On 10/28/25 at 11:45 p.m., an interview was conducted with Staff D, LPN. She stated Resident #2 had pelvic pain on 7/2/25, and she was told to give the resident medication. On 7/2/25, Staff D changed the resident's catheter. Staff D thought she changed the catheter after resident reported the pain, but she was not sure. She stated she could not remember anything else ordered for the resident. She was not sure; it was a long time ago. Staff D said she did not remember if there were any signs of infection. She stated one of the CNAs saw discharge coming out of the adult brief on 7/7/25. Staff D noted the CNA called someone to have the resident sent out to the emergency room (ER). On 10/28/25 at 12:49 p.m., a telephone interview was conducted with Staff C, LPN. Staff C said 7/7/25 was the first time she had worked with Resident #2. The resident presented with a large amount of perineal discharge, and Staff C notified the provider. She stated the resident was then sent to the ER. Staff C said she believed that during discussions they mentioned the resident having pain. Staff C stated she believed the resident had an ultrasound and followed with urology. Staff C said she was not sure because she only found out about Resident #2's treatment through conversations with other staff. Staff C stated she was told the staff had noticed a foul odor. Staff C said a CNA notified her about the discharge and asked her to assess. Staff C stated the event was a long time ago and she was not exactly sure who the CNA was that day, on 7/7/25. On 10/28/25 at 12:54 p.m. a telephone interview was conducted with Staff G, RN. She did not remember much about the resident. She stated, If there were labs ordered, then they would be placed in the system. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/29/25 at 2:09 p.m., an interview was conducted with the Director of Nursing (DON). She stated it was common to call physicians for new orders. She confirmed she knew there had been discrepancies with provider notifications for labs or changes in conditions. The DON said, If the resident is presenting with signs of infection, then the CNA should report it to the nurse. The nurse will assess and perform interventions if the resident has orders. They will check for recent antibiotics use due to UTIs. They will call the provider if it is a new onset of infection. She stated the staff have had in-service training for catheter care since she began working at the facility. The DON stated they had not implemented a demonstration training, but they were going to soon. Review of a facility policy titled General Procedures and Treatment Modalities, pages 783-785 revealed the catheter care procedures. Review of page 785 shows to call the health care provider if there are signs of fever, or cloudy, bloody, odoriferous urine develops. 2.) Review of admission Records showed Resident #13 was admitted to the facility on [DATE] with diagnoses including but are not limited to chronic systolic (congestive) heart failure, type 2 diabetes mellitus without complications, morbid (severe) obesity due to excess calories, and obstructive and reflux uropathy, unspecified. Review of Resident #13's August 2025 and September 2025 MAR showed an order was placed for Ertapenem Sodium Injection Solution Reconstituted 1GM. One application was to be given every day at bedtime for Proteus Mirabillis in urine for five days starting on 8/29/25. Review of Resident #13's August 2025 and September 2025 MARs showed the doses administered to the resident were on 9/1/25, 9/2/25, and 9/3/25. The resident received three doses of the five ordered doses. Review of Resident #13's progress note did not show any documentation detailing why the doses were missed, or if the provider was notified that the resident did not receive all doses of the prescribed antibiotic for the UTI. Review of a facility policy titled Lab/Radiology Process Guidelines, undated, showed: 5. Upon receiving the results, notify the physician and resident/resident representative of the results, and file the results in the medical record under Labs/Radiology tab. 6. Document in a progress note the labs/radiology tests you received and who the results were reported to. Include any additional follow up or new physician orders received in the progress. 8. Stat and critical labs must be called to the physician as soon as they have resulted, with the nurse documenting the communication and follow-up in the electronic medical record. Review of a facility policy titled, Physician Notification, dated October 2021 revealed, The facility strives to ensure each resident's health is supervised by a qualified attending physician. The attending physician in the facility is ultimately responsible for supervision and management of the care of the resident/patient. Review of a facility policy titled Abuse Prevention Program, reviewed September 2025, showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Policy: The facility has designated and implemented processes, which strive to reduce the risk of abuse, neglect, exploitation, mistreatment, and misappropriation of resident's property. These policies guide the identification, management, and reporting of suspected, or alleged, abuse, neglect, mistreatment, and exploitation. It is expected that these policies will assist the facility with reducing the risk of abuse, neglect, exploitation, and misappropriation of resident's property through education of staff and residents, as well as early identification of staff bum out, or resident behavior which may increase the likelihood of such events. Definitions: Neglect -Failure of the facility, its employees, or service providers to provide good and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. 2.) An interview was conducted on 10/28/25 at 10:10 a.m. with a Resident Representative (RR) for Resident #1. The RR said on 9/27/25 he was at the facility with Resident #1, and she was not herself. He said she was very lethargic, wanted to sleep and was in pain. I let the nurse and Certified Nursing Assistant (CNA) know my concern. He said at one point he nor the staff could find Resident #1's assigned nurse, Staff H, Licensed Practical Nurse (LPN) for over an hour. The RR said he was trying to find the nurse because the resident's medications were late, and she was in pain. He said a CNA he talked to didn't know where the nurse was nor did the other nurse working. He said at one point the staff called Staff H to find her. He said when Staff H finally returned to the unit, she was very short and asked what he wanted. The RR said he told Staff H his concerns about her medications, her pain, and the fact the resident had seizures the previous night. He said Staff H responded by saying so what's the problem. She's had seizures before, right? The RR said he felt like Resident #1 needed to go to the hospital because she was not her normal self and was not well. He said the resident had labs drawn early that morning, so he asked about the results of those as well. He said Staff H told him the results would be looked at on Monday when the doctor returned and that Resident #1 could not go to the hospital because the doctor was not on call on the weekend. Staff H, LPN was unable to be reached for an interview. Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including elevated blood pressure without diagnoses of hypertension, systemic lupus erythematosus, end state renal disease and hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease. Review of Resident #1's Progress Notes from 9/26/25 showed a note at 10:12 p.m. stating The patient experienced two brief episodes of seizures earlier today. Vital signs were obtained and found to be within normal limits: blood pressure 127/73 mmHg, heart rate 86 bpm, temperature 97.7 °F, and blood sugar 107 mg/dL. At the time of evaluation, the patient was alert, oriented, and stable, with no signs of acute distress. Resident #1's Primary care physician was notified of the events and gave instructions to obtain laboratory tests in the morning. The patient remains in her room under observation, accompanied by her father. She continues to be stable and without new symptoms at this time. Monitoring will continue, and the clinical team remains vigilant for any significant changes in the patient's condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #1's lab results showed results drawn on 9/27/25 at 8:17 a.m. and results printed at 1:53 p.m. The results showed the resident had low iron, unsaturated iron-binding capacity (UIBC), glucose, and chloride and had high blood urea nitrogen (BUN), creatinine, BUN/creatinine ratio, and potassium Review of Resident #1's progress notes did not show any documentation the physician was notified of abnormal lab values on 9/27/25. An interview was conducted on 10/29/25 at 1:05 p.m. with Resident #1's primary care provider (PCP). The PCP said he did speak with the nurse on 9/26/25 with Resident #1 had two seizures, but he did not speak to a nurse on 9/27/25 regarding the resident being in pain, having a change in condition, or abnormal lab values. He said Resident #1 was not normally in pain; that would have been new. He said he would have expected to be notified when a resident had pain that was not normal. The PCP reiterated that he did not hear from the nurse that day. Review of Resident #4's admission Records showed the resident was admitted on [DATE] with diagnoses including end stage renal disease, generalized epilepsy, thrombocytopenia (deficiency of platelets in the blood), history of transient ischemic attack, and dependence on renal dialysis. Review of Resident #4's orders showed an order for STAT (immediate) labs for a complete blood count (CBC) and comprehensive metabolic panel (CMP) on 9/28/25 related to tremors and feeling cold. Review of Resident #4's lab results showed the labs ordered were completed on 9/28/25 and results were printed on 9/28/25 at 7:10 p.m. The results showed Resident #4 had abnormal lab results including low red blood cells (RBC), hemoglobin, hematocrit, platelet count, lymphocytes, lymphocyte absolute and had high neutrophils. Review of Resident #4's progress notes did not show any documentation a provider was notified of the abnormal Stat lab results on 9/28/25. An interview was conducted on 10/28/25 at 2:41 p.m. with Resident #4's PCP's assistant. The assistant stated she was returning the phone call on behalf of the PCP. She said the provider would expect to be notified of any abnormal lab results. She said she and the provider did not recall if they were notified on 9/29/25, but the facility would be expected to document that information. She said the PCP did not document every time he received a phone call. An interview was conducted on 10/29/25 at 2:09 p.m. with the Director of Nursing (DON) and the Regional Nurse Consultant (RNC). They said abnormal lab results were faxed to the facility and the nurse called the provider and let them know the results. They stated they expect this to happen within a couple of hours or receiving notification of abnormal lab results, and documentation of the contact should be in the progress notes or on the lab results sheet. They said if there were no new orders from the provider it should have been documented as well. They stated being aware of discrepancies with physician notifications. The RNC and DON reviewed Resident #1's medical record and confirmed there was no documentation prior to her discharge that a provider was notified of abnormal labs. They also reviewed Resident #4's medical record and confirmed there was no documentation a provider was notified of the abnormal Stat lab results. Review of a facility policy titled Lab/Radiology Process Guidelines, undated, showed: (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	5. Upon receiving the results, notify the physician and resident/resident representative of the results, and file the results in the medical record under Labs/Radiology tab. 6. Document in a progress note the labs/radiology tests you received and who the results were reported to. Include any additional follow up or new physician orders received in the progress. 8. Stat and critical labs must be called to the physician as soon as they have resulted, with the nurse documenting the communication and follow-up in the electronic medical record. 3.) On 10/28/2025 at 10:22 a.m., an interview was conducted with Resident #12. Resident #12 stated it took a couple days to get pain medication upon admission to the facility. The resident stated the staff was not ordering the medication. On 10/28/2025 at 2:51 p.m., a follow-up interview was conducted with Resident #12. The resident explained being upset about the pain and stated there was no reason she had to wait was so long to get pain medication. The resident stated the pain increased during the time she was without pain medication. Resident #12 stated when the colostomy bag breaks, the skin becomes very raw like a diaper rash. Resident #12 stated because she sat for long periods, her skin was bad. Resident #12 stated not wanting to sit on feces when left unchanged as it breaks her skin. The resident said it was upsetting and stated it felt like the skin was being torn off, kind of like a hot poker. The resident stated to get the feces off, the nurses had to rub the skin really hard, which was excruciating. Review of Resident #12's admission record revealed the resident was admitted to the facility on [DATE], with diagnoses including: Crohn's disease of large intestines with fistula, other intraoperative complications of the digestive system, acquired absence of other specified parts of the digestive tract, and gastro-esophageal reflux disease without esophagitis. Review of an evaluation titled BIMS (Brief Interview for Mental Status) Evaluation V 2.0, and dated 10/23/2025, revealed Resident #12 had a BIMS, score of 15, which indicated she was cognitively intact. Review of a care plan for Resident #12 dated 10/23/2025 revealed a focus - Resident #2 had an actual wound surgical to abdomen sacral wound, initiated on 10/23/2025. The goal was to promote wound healing and minimize additional wound from developing, initiated on 10/23/2025. Interventions included: observe for pain. Review of a physical therapy evaluation dated 10/23/2025, revealed the resident had pain when resting, with a frequency of constant, and when moving, all at a level of 6 out of 10 in the abdomen. Review of Resident #12's physician orders revealed: -Monitor pain every shift and record pain number on a scale of 0-10 scale, every shift for pain dated 10/21/2025. -Colostomy care every shift and as needed. Ordered 10/23/025. -Acetaminophen 325 milligram (mg), 2 tablets every six hours, as needed for pain. Ordered 10/23/2025. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	-Percocet oral tablet 10-325 mg, (oxycodone with acetaminophen), 1 tablet every 6 hours as needed for sub-acute pain. Ordered 10/24/2025. Review of Resident #12's Medication Administration Record (MAR), showed the resident had a documented pain level of 6 out of 10 on 10/23/2025. The MAR showed no documentation Acetaminophen nor Percocet being given on 10/23/2025 or 10/24/2025. Review of Resident #12's progress notes revealed no documentation as to why pain medication was not provided and no documentation a doctor was notified about the resident's pain levels from 10/23/2025 through 10/24/2025. On 10/28/2025 at 3:02 p.m. an interview was conducted with Staff D, Licensed Practical Nurse (LPN). Staff D stated there was always a Tylenol order in place, and if the Tylenol did not work, then the doctor would need to be called. Staff D stated a pain level of three or higher warranted contacting the doctor. Staff D stated level 6 pain would be considered significant. Staff D reviewed Resident #12's medical record and confirmed the resident had level 6 pain on 10/23/2025, and pain medication was not provided on 10/23/2025. Staff D stated if the resident's primary physician could not be reached, then the Medical Director would need to be contacted. On 10/28/2025 at 3:19 p.m., an interview was conducted with Staff L, LPN. Staff L stated if there was no order for pain medication, the doctor would need to be contacted to provide instructions on what to do. On 10/29/2025 at 1:15 p.m., an interview was conducted with Staff C, LPN. Staff C stated when residents present with pain upon admission, orders would be followed. Staff C stated residents admitted from the hospital with pain and without orders for pain medication, had primary care providers, who would be contacted. If the primary care provider contact attempt was ineffective, then the Medical Director would be contacted. Staff C stated any level of pain, such as level 6 out of 10, warranted a call to the provider. Staff C reviewed Resident #12's medical record and confirmed the resident's pain level was documented at a six out of 10 on the pain scale and Acetaminophen was not administered. Resident #12 had no additional orders for pain medication on 10/23/2025. Staff C stated there was no reason not to provide the pain medication and stated, it's kind of cut and dry, right? On 10/28/2025 at 1:48 p.m., an interview was conducted with the Director of Rehab, (DOR). The DOR stated Resident #12 verbalized having constant aching pain in the abdomen at a level of 6 out of 10 with both movement and while at rest. On 10/29/2025 at 2:07 p.m., an interview was conducted with the Director of Nursing, (DON). The DON stated if a resident's primary care provider was contacted, it should have been documented in the resident's medical record. The DON stated if a resident's primary care provider was unreachable, the Medical Director should have been contacted, and if unreachable, the DON should have been contacted. The DON stated a resident's primary care provider should have been contacted for level 6 out of 10 pain. The DON stated pain medication should have been provided for Resident #12's colostomy care. The DON reviewed Resident #12's medical record and confirmed the resident had a pain level of 6 out of 10, on 10/23/2025 and no pain medication was provided until 10/25/2025. The DON confirmed acetaminophen was ordered on 10/23/2025 and was not provided on 10/23/205 and 10/24/2025. The DON confirmed Percocet was ordered on 10/24/2025 and it was not given until 10/25/2025. The DON stated her expectation was something would have been ordered by then. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Review of a facility policy titled Clinical Programs Manual - Pain Management, dated 10/2021 revealed – Overview: The facility is committed to pain management through the following: Interdisciplinary data collection Interdisciplinary approach Resident/patient religious and cultural values Education of residents/patient and caregivers Residents/patients, families and caregivers will be educated on appropriate pain control. The inter disciplinary team will strive to reduce/eliminate the fears of addiction as it relates to pain medication and/or other issues the resident/patient and family may have. The team will encourage the resident/patient and family to report pain since the longer pain goes untreated, the harder it is to relieve. GUIDELINES 1. Collect data on the intensity of the resident/patient's pain. admission Data Collection Monthly, Return & PRN Data Collection 2. Identify the current analgesic regimen (i.e., analgesic usage covering a 24-hour period for several days as applicable.) 3. Analyze the reported pain severity on the current regimen. 4. Include the resident/patient and family in development of the Plan of Care. 6. Develop individualized comfort interventions using collaborative proactive, not reactive, interdisciplinary approach. Obtain physician's orders as needed. d. Identify the sources of pain. e. Maintain prescribed levels. 8. Obtain an order for around-the-cl

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 - Few	Based on observation, interview, and record review the facility failed to ensure proper catheter care was provided to include securing and changing catheter bags per physician orders, for four residents (#15, #16, #4 and #2) of four residents sampled for catheter care. Findings included: On 10/27/25 at 4:05 p.m., an interview was conducted with Staff A, Licensed Practical Nurse (LPN). He stated Certified Nursing Assistants (CNAs) and nurses cleaned the catheters. Staff A stated the staff must assess if the catheter is intact and draining and observe for urine color. Staff A said, If the line is cloudy, the nurses change it. Staff A stated if he suspected an infection, he would, call the doctor to ask for a culture.On 10/27/25 at 4:18 p.m., an observation was made of Resident #15 with a cloudy catheter drainage line.On 10/29/25 at 9:25 a.m., observed Resident #15 lying in bed, alert, with their feet raised on a pillow. The catheter drainage bag was labeled with the date 10/14/25. Observed Resident #15's catheter line was still cloudy. During the observation and interview, Staff A stated the process for a cloudy catheter line would be to irrigate the line. The catheter was observed without an adhesive device or stabilization device for the catheter tubing.On 10/28/25 at 10:56 a.m., an interview was conducted with Staff F, CNA. She stated she performed catheter care every time she drained the catheter bag. She said she would report any signs of infection to the nurse. Staff F stated the facility always had in-service trainings and additional trainings if there are allegations. She believed the training on catheter care was a couple of weeks ago.On 10/29/25 at 9:20 a.m., observed Resident #16 lying in bed, alert, and covered with a blanket. Resident #16 had a foley catheter connected to a drainage bag hanging on the left side of the bed frame. The catheter was observed without an adhesive device or stabilization device for the catheter tubing. The drainage bag was labeled with the date 10/23/25. During a follow -up interview on 10/27/25 at 4:05 p.m., Staff A, LPN stated the date labeled on the bag was the last time the catheter was changed.10/29/25 at 9:27 a.m., observed Resident #14 lying in bed, on their left side. The catheter was hanging on the left side of the bed. The resident stated the catheter was changed yesterday, 10/28/25. Observed sediment in the catheter line. During the observation and interview, Staff A stated the resident had frequent UTIs (Urinary Tract Infections). Staff A stated the process would be to check when their last antibiotic was given. The catheter was observed without an adhesive device or stabilization device for the catheter tubing.Record review revealed Resident #14 was recently treated for a UTI on 10/3/25 through 10/7/25. A urology consult was ordered on 10/29/25. The supra pubic catheter and drainage bag were changed on 10/29/25 at 3:12 p.m.Review of Resident #2's hospital wound consult note, dated 7/8/25 at 11:33 a.m. showed: the resident had an unstageable pressure injury to left medial upper thigh. It is linear and corresponds with where the foley catheter would lay if catheter were not placed in a StatLock. (A StatLock is a stabilization device for the catheter tubing).On 10/29/25 at 2:26 p.m., an interview was conducted with the Director of Nursing (DON). She stated the staff had in-service training for catheter care within the last few weeks but did not specify a date. The DON stated, They plan to start demonstration training soon. The DON stated the facility does not use a StatLock or an adherence method to secure the catheter to the resident's thigh. She said using a method to secure the catheter was not in their policy. Review of an undated facility policy titled, General Procedures and Treatment Modalities, pages 783-785 revealed the catheter care procedures. On page 783, it shows under procedure guidelines: Secure the indwelling catheter to patient's thigh using tape, strap, adhesive anchor, or other securement device. Properly securing the catheter prevents catheter movement and traction on the urethra. On page 785, under Community Care Considerations, it also shows In the male patient, the indwelling catheter is taped to the thigh to straighten the angulation of the penoscrotal junction, thus reducing pressure on the urethra exerted by the catheter.On 10/29/25 at 5:25 p.m., an interview was conducted with the DON. She stated if a resident had wounds from their catheter rubbing and gangrene, then it did not happen overnight. The DON said, I would expect that to be on skin assessments.Review of The Association for Professionals in Infection Control and Epidemiology (APIC) guide titled Guide to Preventing Catheter-Associated Urinary Tract Infections (CAUTI): Best Practices for Prevention, with a date of March 2025, revealed the following on page 16: Ensure securement devices are available and applied appropriately. https://apic.org/wp-content/uploads/2025/07/2025_CAUTI_Implementation_Guide-2.pdfReview of The Joint Commission's article: Managing medical device-related pressure injuries, with an issue date of July 2018, revealed the following: Device care: Ensure that the patient receives the proper size and type of device; that the device is secure, to decrease movement or slippage; that the skin is padded, to reduce friction; and that

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 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 record review and interviews, the facility failed to ensure pain was managed for one resident (#12), out of three residents sampled.Findings included: On 10/28/2025 at 10:22 a.m., an interview was conducted with Resident #12. Resident #12 stated it took a couple days to get pain medication upon admission to the facility. The resident stated the staff was not ordering the medication. On 10/28/2025 at 2:51 p.m., a follow-up interview was conducted with Resident #12. The resident explained being upset about the pain and stated there was no reason she had to wait was so long to get pain medication. The resident stated the pain increased during the time she was without pain medication. Resident #12 stated when the colostomy bag breaks, the skin becomes very raw like a diaper rash. Resident #12 stated because she sat for long periods, her skin was bad. Resident #12 stated not wanting to sit on feces when left unchanged as it breaks her skin. The resident said it was upsetting and stated it felt like the skin was being torn off, kind of like a hot poker. The resident stated to get the feces off, the nurses had to rub the skin really hard, which was excruciating. Review of Resident #12's admission record revealed the resident was admitted to the facility on [DATE], with diagnoses including: Crohn's disease of large intestines with fistula, other intraoperative complications of the digestive system, acquired absence of other specified parts of the digestive tract, and gastro-esophageal reflux disease without esophagitis. Review of an evaluation titled BIMS (Brief Interview for Mental Status) Evaluation V 2.0, and dated 10/23/2025, revealed Resident #12 had a BIMS, score of 15, which indicated she was cognitively intact. Review of a care plan for Resident #12 dated 10/23/2025 revealed a focus - Resident #2 had an actual wound surgical to abdomen sacral wound, initiated on 10/23/2025. The goal was to promote wound healing and minimize additional wound from developing, initiated on 10/23/2025. Interventions included: observe for pain. Review of a physical therapy evaluation dated 10/23/2025, revealed the resident had pain when resting, with a frequency of constant, and when moving, all at a level of 6 out of 10 in the abdomen. Review of Resident #12's physician orders revealed:-Monitor pain every shift and record pain number on a scale of 0-10 scale, every shift for pain dated 10/21/2025.-Colostomy care every shift and as needed. Ordered 10/23/025.-Acetaminophen 325 milligram (mg), 2 tablets every six hours, as needed for pain. Ordered 10/23/2025.-Percocet oral tablet 10-325 mg, (oxycodone with acetaminophen), 1 tablet every 6 hours as needed for sub-acute pain. Ordered 10/24/2025. Review of Resident #12's Medication Administration Record (MAR), showed the resident had a documented pain level of 6 out of 10 on 10/23/2025. The MAR showed no documentation Acetaminophen nor Percocet being given on 10/23/2025 or 10/24/2025. Review of Resident #12's progress notes revealed no documentation as to why pain medication was not provided and no documentation a doctor was notified about the resident's pain levels from 10/23/2025 through 10/24/2025. On 10/28/2025 at 3:02 p.m. an interview was conducted with Staff D, Licensed Practical Nurse (LPN). Staff D stated there was always a Tylenol order in place, and if the Tylenol did not work, then the doctor would need to be called. Staff D stated a pain level of three or higher warranted contacting the doctor. Staff D stated level 6 pain would be considered significant. Staff D reviewed Resident #12's medical record and confirmed the resident had level 6 pain on 10/23/2025, and pain medication was not provided on 10/23/2025. Staff D stated if the resident's primary physician could not be reached, then the Medical Director would need to be contacted. On 10/28/2025 at 3:19 p.m., an interview was conducted with Staff L, LPN. Staff L stated if there was no order for pain medication, the doctor would need to be contacted to provide instructions on what to do. On 10/29/2025 at 1:15 p.m., an interview was conducted with Staff C, LPN. Staff C stated when residents present with pain upon admission, orders would be followed. Staff C stated residents admitted from the hospital with pain and without orders for pain medication, had primary care providers, who would be contacted. If the primary care provider contact attempt was ineffective, then the Medical Director would be contacted. Staff C stated any level of pain, such as level 6 out of 10, warranted a call to the provider. Staff C reviewed Resident #12's medical record and confirmed the resident's pain level was documented at a six out of 10 on the pain scale and Acetaminophen was not administered. Resident #12 had no additional orders for pain medication on 10/23/2025. Staff C stated there was no reason not to provide the pain medication and stated, it's kind of cut and dry, right? On 10/28/2025 at 1:48 p.m., an interview was conducted with the Director of Rehab, (DOR). The DOR stated Resident #12 verbalized having constant aching pain in the abdomen at a level of 6 out of 10 with both movement and while at rest. On 10/29/2025 at 2:07 p.m., an interview was conducted with the Director of Nursing, (DON). The DON

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F 0777 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results. (continued on next page)

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F 0777 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 record reviews and interviews, the facility did not ensure providers were notified of abnormal lab results for two residents (#1 and #4) out of three residents reviewed for labs.Findings included:1.) An interview was conducted on 10/28/25 at 10:10 a.m. with a Resident Representative (RR) for Resident #1. The RR said on 9/27/25 he was at the facility with Resident #1, and she was not herself. He said she was very lethargic, wanted to sleep and was in pain. I let the nurse and Certified Nursing Assistant (CNA) know my concern. He said at one point he nor the staff could find Resident #1's assigned nurse, Staff H, Licensed Practical Nurse (LPN) for over an hour. The RR said he was trying to find the nurse because the resident's medications were late, and she was in pain. He said a CNA he talked to didn't know where the nurse was nor did the other nurse working. He said at one point the staff called Staff H to find her. He said when Staff H finally returned to the unit, she was very short and asked what he wanted. The RR said he told Staff H his concerns about her medications, her pain, and the fact the resident had seizures the previous night. He said Staff H responded by saying so what's the problem. She's had seizures before, right? The RR said he felt like Resident #1 needed to go to the hospital because she was not her normal self and was not well. He said the resident had labs drawn early that morning, so he asked about the results of those as well. He said Staff H told him the results would be looked at on Monday when the doctor returned and that Resident #1 could not go to the hospital because the doctor was not on call on the weekend. Staff H, LPN was unable to be reached for an interview. Review of admission Records showed Resident #1 was admitted on [DATE] with diagnoses including elevated blood pressure without diagnoses of hypertension, systemic lupus erythematosus, end state renal disease and hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease. Review of Resident #1's Progress Notes from 9/26/25 showed a note at 10:12 p.m. stating The patient experienced two brief episodes of seizures earlier today. Vital signs were obtained and found to be within normal limits: blood pressure 127/73 mmHg, heart rate 86 bpm, temperature 97.7 F, and blood sugar 107 mg/dL. At the time of evaluation, the patient was alert, oriented, and stable, with no signs of acute distress. Resident #1's Primary care physician was notified of the events and gave instructions to obtain laboratory tests in the morning. The patient remains in her room under observation, accompanied by her father. She continues to be stable and without new symptoms at this time. Monitoring will continue, and the clinical team remains vigilant for any significant changes in the patient's condition. Review of Resident #1's lab results showed results drawn on 9/27/25 at 8:17 a.m. and results printed at 1:53 p.m. The results showed the resident had low iron, unsaturated iron-binding capacity (UIBC), glucose, and chloride and had high blood urea nitrogen (BUN), creatinine, BUN/creatinine ratio, and potassium Review of Resident #1's progress notes did not show any documentation the physician was notified of abnormal lab values on 9/27/25. An interview was conducted on 10/29/25 at 1:05 p.m. with Resident #1's primary care provider (PCP). The PCP said he did speak with the nurse on 9/26/25 with Resident #1 had two seizures, but he did not speak to a nurse on 9/27/25 regarding the resident being in pain, having a change in condition, or abnormal lab values. He said Resident #1 was not normally in pain; that would have been new. He said he would have expected to be notified when a resident had pain that was not normal. The PCP reiterated that he did not hear from the nurse that day. 2.) Review of Resident #4's admission Records showed the resident was admitted on [DATE] with diagnoses including end stage renal disease, generalized epilepsy, thrombocytopenia (deficiency of platelets in the blood), history of transient ischemic attack, and dependence on renal dialysis. Review of Resident #4's orders showed an order for STAT (immediate) labs for a complete blood count (CBC) and comprehensive metabolic panel (CMP) on 9/28/25 related to tremors and feeling cold. Review of Resident #4's lab results showed the labs ordered were completed on 9/28/25 and results were printed on 9/28/25 at 7:10 p.m. The results showed Resident #4 had abnormal lab results including low red blood cells (RBC), hemoglobin, hematocrit, platelet count, lymphocytes, lymphocyte absolute and had high neutrophils. Review of Resident #4's progress notes did not show any documentation a provider was notified of the abnormal Stat lab results on 9/28/25. An interview was conducted on 10/28/25 at 2:41 p.m. with Resident #4's PCP's assistant. The assistant stated she was returning the phone call on behalf of the PCP. She said the provider would expect to be notified of any abnormal lab results. She said she and the provider did not recall if they were notified on 9/29/25, but the facility would be expected to document that information. She said the PCP did not document every time he