STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105283	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Hills Center	610 E Bella Vista Dr Lakeland, FL 33805

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record reviews, and interviews the facility failed to ensure medications were stored in accordance of current professional standards for two (Residents #128 and #57) of 25 sampled residents and in four of four medication carts. Findings included: An observation was made on 3/9/26 at 12:08 p.m. of Resident #57's bedside dresser drawer, which was partially open. The observation revealed a box of Cold & Flu medication. The resident stated no one had told her she couldn't have medications at bedside. The resident reported having a cold the other week and spouse had brought in the medication. On 3/11/26 at 11:13 a.m. Staff M, Registered Nurse (RN) and Staff O, Licensed Practical Nurse (LPN) observed and removed 2 tablets of daytime cold & flu medication and a bottle of antacid tablets from the bedside dresser of Resident #57. The resident informed Staff M of being told about not keeping medications without an order. The staff members stated residents are not allowed to keep meds at bedside. On 3/11/25 at 10:55 a.m. an observation was made with Staff G, Licensed Practical Nurse (LPN) of the 100-hall medication cart. The observation revealed one round blue pill stored in the bottom of the second drawer. The staff member reported not knowing what it was and no, it should not be there. An observation of the bottom drawer revealed topical Lidocaine patches stored in the same compartment with oral medications. The Staff G, LPN stated a divider is needed. On 3/11/25 at 11:03 a.m. an observation of the 200-hall medication cart was conducted with Staff O, LPN. The observation revealed the following: envelopes of no-sting skin protectant stored with envelopes of liquid wound care supplements a latanoprost box, dated 1/31/26 containing a bottle, dated 2/17/26 of latanoprost 0.005% eye drops. The staff member reported not knowing when the bottle was opened. one compartment contained envelopes of topical lidocaine patches stored with a bottle of oral laxative granules and individual packages of the liquid wound care supplement. An insulin glargine box showed an open date of 3/2, the vial held within the box was dated 3/4/26. An insulin lispro box revealed it was opened on 2/24/26, the vial of insulin lispro inside the box (continued on next page)

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed it was opened on 2/8, possibly 2/9. A box of insulin lispro was dated 3/3/26, the opened vial inside the box was undated. One Novolog insulin pen labeled For Emergency Use The pen was not labeled with a resident name. The plastic bag holding the pen was dated ¾ with an unreadable name on the bag. Staff O reviewed the pen and attempted to read name on bag and stated she didn't know who it was for, couldn't read the name. One insulin pen was undated and the plastic bag containing the pen was either dated as opened on 2/25 or 2/28. The staff member was unsure if the last number was a 5 or an 8. Review of the United States Food & Drug Administration (FDA) packaging insert for latanoprost 0.005% ophthalmic solution instructed Once a bottle is opened for use, it may be stored at room temperature up to 25-degree Celsius (C) (77-degree Fahrenheit (F)) for 6 weeks. This information was reviewed at https://www.accessdata.fda.gov/drugsatfda_docs/label/2012/020597s044lbl.pdf. (Photographic evidence was obtained) An observation on 3/9/26 at 11:13 a.m. revealed a box of medication in the unlocked conference room. The box was labeled Employee tubersol 5ml vial. The medication vial was uncapped and the box was open. The box contained a sticker that reads, Refrigerate; the label contained no date opened and no discard date written on the label. An observation on 3/11/26 at 10:40 a.m. of the 400-hall medication cart revealed: 2 lidocaine 5% patches were stored with the bleach wipes in the bottom drawer without a divider. Staff E, LPN said the lidocaine patches should not be stored in with the bleach containers stating, they should be stored separately. An observation on 3/11/26 at 11:10 a.m. of the 300-hall medication cart revealed: An opened bottle of chloraseptic 1.4% spray with a use by date of 2/3/26 revealing the medication was expired. An interview on 3/11/26 at 11:10 a.m. with Staff F, LPN, was conducted. Staff F, LPN said the bottle of chloraseptic expired on 2/3/26 and should have been removed from the cart. An interview on 3/11/26 at 3:00 p.m. with the DON and NHA was conducted. The DON said the lidocaine and bleach should not be stored together and should have at least a divider between the two items. The DON said the chloraseptic spray was expired and should have been removed. The DON said expired medications should be removed from the cart when the medications expires. An interview and observation on 3/12/26 at 11:20 a.m. with Resident #128 was conducted. On the resident's bedside table was a medication cup with a white circular pill inside (photographic evidence obtained). Resident #128 said he did not know there was still a pill in the cup. Resident #128 said he did not know what the pill was for. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview on 3/12/26 at 11:40 a.m. Staff G, LPN was conducted. Staff G, LPN said she did not know a pill was not taken by Resident #128. Staff G, LPN stated, that's a blood pressure pill, I can tell. Staff G, LPN said she put the medications in the cup, gave the cup to Resident #128 and then would be back later to gather the medication cup she did not watch the resident take the medication. An interview on 3/12/26 at 11:45 a.m. with the DON was conducted. The DON said the expectation for the nurses is to remain at bedside until the medications are taken by the residents. A review of the facility's policy dated 1/2026, titled, Storage of Medication revealed The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 11: Medications requiring refrigeration are kept in a refrigerator with a thermometer to all temperature monitoring. 14: Outdated, contaminated, discontinued mediations and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock. A review of the facility's policy dated 1/2026, titled, Medication Administration General Guidelines revealed medication administration 4: medications are to be administered at the time they are prepared. 20: The resident is always observed after administration to ensure that the dose was completely ingested.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observations, record reviews, and interviews the facility failed to provide a private space for the resident council to meet and failed to respond to the council's concerns and/or suggestions during five of six Resident Council Meeting Minutes. Findings included: On 3/10/26 at 2:35 p.m. a resident council meeting was held in the dining room between the 100/200 halls and the 300/400 halls. The dining room was open between the two units with a half wall separating the spaces, across from the screened porch leading to the smoking patio, and a hallway for staff, residents, and visitors between the units. The residents were separated among several tables. A family member of Resident #83 also attended the meeting. The president stated the dining room was the location of resident council meetings. The residents and family member reported the facility does not have a private space for them to meet. On 3/10/26 at approximately 3:00 p.m., during the meeting, a corporate staff member was observed standing behind a portion of the full wall in the 300/400 hall next to the dining room half wall. On 3/10/26 at 3:00 p.m., during the council meeting, observations were made of numerous staff members standing at the 300/400 hall nursing station across from the dining room for the change of shift and walking between the units using the dining room as a hallway. Review of the Resident Council Meeting Minutes and Grievance/Concern logs revealed the following documented issues and/or concerns and corresponding grievances. The Resident Council Meeting Minutes showed Individual grievances or concerns will be written on concern/grievance report. Review of the Resident Council Meeting Minutes dated, 10/8/25 showed: no concerns were raised. One vision impaired would like to see a few games for the blind. We currently play games on Fridays specifically catered to vision impaired residents. Review of the minutes did not identify the vision impaired resident, nor did it include what type of games specifically catered to the vision impaired. Review of the grievance log showed one grievance had been filed by a council attendee on 10/8/25 regarding care. No mention of the concern regarding activities for the visually impaired. Review of the Resident Council Meeting Minutes dated, 11/19/25 showed: previous month's concerns were resolved, yes, without explanation. Residents are frustrated with them not being able to get their money - especially (esp) this week. It was communicated to them that we are working on that situation. Review of the grievance log did not reveal a grievance had been filed on behalf of the resident council. Review of the Resident Council Meeting Minutes dated, 12/20/25 showed: council believed the previous month's concerns were resolved, yes. The minutes did not reveal what the concerns had been or the resolution of the concern. The council would like a way to go out in the community via bus or van. They would also like a new canopy for the smoking area for residents. Review of the grievance log did not show a grievance had been filed on behalf of the resident council. The person who filed grievances on 12/10/25 was not included in the list of council attendees. Review of the Resident Council Meeting Minutes dated, 1/14/26 showed: did the council believe previous month's concerns were resolved did not reveal an answer to the question, the area was blank. The note section did not reveal any concerns or issues had been voiced. Review of the grievance log did not show a grievance being filed on 1/14/26 by an attendee of resident council. Review of the Resident Council Meeting Minutes dated, 2/11/26 showed: the previous month's concerns had been resolved. The note showed the residents enjoyed hearing from the traveling administrator and were saddened by the resignation of the Activity Director. The residents stated the food tasted better and was coming out hot and faster. Review of the policy - Resident Council, effective February 2026, revealed Residents have the right to organize and participate in resident groups in the facility. The council will be provided with a private area to hold the meetings. Staff and/or visitors will attend only at the resident council's invitation. The purpose of the meeting is to engage and empower the residents to bring ideas and concerns to improve person centered care in the facility to increase resident satisfaction. The Activities Director or designee will responsible to: host, organize, take minutes of the meeting, initiate a concern report(s) from individual or group concerns, if indicated during the meeting process, provide (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	information, invite outside organizations if requested by the Resident Council, communicate concerns/recommendations to the Administrator/Director of Nursing (DON), (and) provide a response to resident general concerns. If a resident has a concern and/or grievance, the host is responsible for initiating a concern/grievance report, if indicated. An interview was conducted on 3/12/26 at 12:32 p.m. with the Nursing Home Administrator (NHA). The NHA stated residents should be able to meet in private. The NHA stated if concerns were voiced during the council meeting, staff would write up a grievance, investigate concerns, and an appropriate time for resolution would be a few days. The NHA reported not knowing why resident council had not met yesterday (3/11/26 per activity calendar).

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were comfortable for one (400 hall) of four hallways sampled. Findings included: An interview on 3/9/2026 at 4:15 P.M. with Resident #52 was conducted. Resident #52 said the water does not get hot even if it's left on. Resident #52 said she frequently washes up with cold water. An observation on 3/12/2026 at 10:40 A.M., of the back hall hot water heater revealed a temperature gauge beyond the mixing valve was 108 degrees Fahrenheit. To enter the room Staff B, Maintenance Director (DM) used a flathead screwdriver to break the lock into the water heater room. During an observation on 3/12/2026 at approximately 10:40 A.M.,in two resident rooms, water was left running for five minutes, water temperature in room [ROOM NUMBER]'s room sink was 102.3 degrees Fahrenheit and the water temperature in room [ROOM NUMBER]'s bathroom sink was 101.8 degrees Fahrenheit. When placing fingers in the water the water was not cold but was not warm either. An interview on 3/12/2026 at 11:35 A.M., with Staff B, DM was conducted. Staff B, DM said he did not have a key to the water heater room. Staff B, DM said the temperature should be between 110-112 degrees Fahrenheit. Staff B, DM said he had not checked the temperature because he did not have a key to open the door. Staff B, DM confirmed the temperature was 108 degrees Fahrenheit. Staff B, DM said the resident bathroom sinks and sinks in the room should be at least 105 degrees. Staff B, DM said he does not know why the temperatures are reading low. Staff B, DM said he does not know why the front hot water heaters do not have a mixing valve or temperature gauges. Staff B, DM said the hot water heaters in the front hall are for the kitchen, laundry, and residents. Staff B, DM said he does not have a calendar or schedule of when the hot water heater's need to be flushed, it's just something I remember to do. Staff B, DM said he does not know the manufacture specifications of the water heaters. Staff B, DM said if the facility had a water boil notice, the residents could still be showered, just no water can touch their faces. An interview on 3/12/2026 at 12:55 P.M., with the Nursing Home Administrator (NHA) was conducted. The NHA stated her expectation is for the rooms to have hot water, and she does not know the temperature range. She said she would expect the water on the back hall to be at a higher temperature for residents to be comfortable. She said there should be thermometers and mixing valves on all the water heaters in the facility. A review of a policy effective 2017 titled, Legionella Assessment criteria will include control measures of: Physical controls and temperature management. The legionella testing/safety procedures include: 3: Hot water temperatures will be heated to 140 degrees Fahrenheit (F) before reaching the mixing valve supplying water to the fixtures inside the facility. 5: Water heaters will be flushed per manufacture specifications.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to obtain Preadmission Screening and Resident Review (PASARR) Level II evaluations for (#8 and #9) of thirty-five initially sampled residents prior to facility admission.Findings included: Review of Resident #8's admission Record showed the resident was admitted on [DATE] and 11/12/25. The record included diagnoses not limited to not elsewhere classified anoxic brain damage, unspecified depression, bipolar-type schizoaffective disorder, and cognitive communication deficit. Review of Resident #8's PASARR Level I screening, dated 12/18/25, revealed mental illness diagnoses of depressive disorder, schizoaffective disorder, and insomnia with the findings based on documented history and medications. The PASARR had been completed by the facility's current Director of Nursing (DON). The screening showed the resident did not have or may have had a disorder resulting in functional limitations of major life activities that would be otherwise be appropriate for the individual's developmental stage, did not have or may have had on a continuing or intermittent basis interpersonal functioning, concentration, persistence, and pace, and/or adaptation to change, had not received recent inpatient or partial hospitalization psychiatric treatment, and had no significant disruption of a normal living situation due to the mental illness. The screening completion showed the resident did not have a diagnosis or suspicion of serious mental illness or intellectual disability and a Level II PASARR evaluation was not required. Review of a psychiatry note, dated 2/26/26, showed Resident #8 had a past psychiatric (psych) history of insomnia, major depressive disorder (MDD), bipolar disorder, and bipolar-type schizoaffective disorder. The resident had denied any major disturbance in mental health, sleep was okay, but appetite was poor. Review of Resident #8's care plan revealed the resident was at risk for hurting self and/or with suicidal ideation, had a history of suicidal attempts, but was not currently suicidal. The focus was initiated on 11/16/25 and revised on 11/24/25. An interview on 3/10/26 at 5:02 p.m. was conducted with the Social Service Director (SSD). The SSD stated she assists with sending information to the State Mental Health Authority for review. The SSD said completing the audit sheets and the DON reviewed them. The SSD stated a Level II was determined on Mental Illness (MI) or Intellectual Disability (ID), based on orientation, changes in orientation, change in harming self or others, and schizophrenia are what requires a Level II, (and) any diagnosis that changes level of functioning and personal relationships. An interview on 3/12/26 at 10:00 a.m. was conducted with the DON. The DON provided quality assurance audits of Level I and II PASARRs, dated 2/7/26 and 3/2/26. The DON stated she was reviewing all PASARRs in the building, but it was only her and she also had DON responsibilities. The DON stated Resident #8 had been audited but a Level II had not been requested yet. Review of the audit provided revealed it had been completed by the SSD on dated 2/7/26 (one month prior to the interview), and Resident #8's Level 1 PASARR had been reviewed, and the initiation of a Level II was n/a (not applicable). A record review for Resident #9's admission record revealed the resident was admitted with a diagnosis of post-traumatic stress disorder (PTSD), chronic, other seizures, major depressive (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	disorder, recurrent, unspecified generalized anxiety disorder, and other specified disorders of the brain. A review of Resident #9's minimum data set (MDS), dated [DATE], section D., mood revealed Resident #9 sometimes feels lonely or isolated from those around. Section N., medications revealed the resident was prescribed antidepressant, antianxiety, opioid, and anticonvulsant. A review of the State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASARR) level I screen electronically signed by a Registered Nurse on 10/21/24 for Resident #9 revealed the resident has confirmed or suspected mental illness of anxiety disorder, schizoaffective disorder, substance abuse, and post-traumatic stress disorder, chronic. Resident #9 was receiving services for mental illness at the time of the PASARR level I screen. The findings were based on documented history, medications, behavioral observations, and individual, legal representative or family report. The review showed a level II screen was not submitted for consideration. An interview was conducted on 03/10/26 at 3:38 p.m. with Staff H, Registered Nurse/Clinical Reimbursement Director (RN/CRD). Staff H said sudden acute episodes of behavioral changes, hallucinations, or delusions can trigger a PASARR level II for PTSD. An interview was conducted on 03/10/26 at 2:40 p.m. with the SSD. The SSD said when speaking with Resident #9 upon admission, the resident was vague about his PTSD triggers but self-reported a history of PTSD. The SSD said all residents are referred to psychiatric and psychological services and the clinical team reviews the facility's PASARRs. The SSD said a PASARR level II would be triggered if a resident is a danger to themselves or others, have an intellectual disability, schizophrenia, or a sudden change in cognition. The SSD said PTSD would not trigger a PASARR level II screening unless there are accompanying symptoms or diagnoses such as being a threat to themselves or others. An interview was conducted with the DON on 03/12/26 at 9:22 a.m. The DON said a primary diagnosis of dementia accompanying any mental disability such as schizophrenia or bipolar disorder as well as suicidal ideations would trigger a request for a PASARR level II screening. The DON stated the SSD did not have the mandated master's degree or higher in social work or other related field and was not able to assist in performing level II PASARR evaluations, therefore the DON was the only staff member auditing and evaluating residents for level II PASARR along with other DON responsibilities. When the DON began employment at the facility, there was a realization that appropriate PASARR screenings were not completed for residents. The DON said PTSD would require a level II PASARR screening, and the DON was not familiar with Resident #9's mental health conditions or status. Review of a facility policy titled Pre-admission Screening and Resident Requirements Level I and Level II, effective August 2025, revealed a level II PASARR must be completed if the criteria below are identified: there is an indication the resident has, or may have had a disorder resulting in functional limitations in major life activities that would otherwise be appropriate for the individual's developmental stage; the resident has a primary or secondary diagnosis of dementia or related neurocognitive disorder and a suspicion or diagnosis of serious mental illness (SMI), intellectual disability (ID), or both, and is currently exhibiting interpersonal issues. The policy also showed level II PASARR must be completed if the resident's record indicates that the resident has received treatment for a mental illness.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview the facility failed to create a resident centered care plan for two (Resident #8 and #36) related to medications out of five residents sampled. Findings included: Review of Resident #36's diagnosis includes Alzheimer's disease, schizoaffective disorder, bipolar type, bipolar disorder, depression, and generalized anxiety disorder. Review of Resident #36's Minimum Data Set (MDS) dated [DATE] revealed section N. Medications, antipsychotic, antidepressant, anti-anxiety and anticonvulsant medications. Review of Resident #36's care plan dated 11/26/25 revealed no care plan for antipsychotic, antidepressant, anti-anxiety or anticonvulsant medications. During an interview on 3/11/26 at 5:20 p.m., Staff H, Registered Nurse/Clinical Reimbursement Director (RN/CRD), stated residents should have care plans for medication they are taking. She reviewed Resident #36's care plan and stated she did not see a care plan for anti-anxiety, depression medication and psychotropic medications. I will go update her care plan now. Resident #36 should be care planned for taking anti-anxiety, depression and antipsychotic medications. Social services is responsible for care planning behaviors or moods. During an interview on 3/11/26 at 5:26 p.m., the Social Services Director (SSD) stated, being responsible for care planning behaviors. The SSD reviewed Resident #36's care plan and stated the care plan is missing her schizoaffective diagnosis, depression and her anxiety diagnosis. I have never put a care plan for diagnosis of schizophrenia or bipolar. During an interview on 3/11/26 at 5:30 p.m., the Director of Nursing (DON) stated residents' care plans usually include when they are falls, advance directives medications, and cognition level. She would expect Resident 36 to be care planned for her diagnosis of bipolar, schizoaffective disorder, depression and anxiety. There should be a psychotropic care plan that would include all those diagnoses. On 3/9/26 at 10:50 a.m. an observation revealed Resident #8 was lying in bed and did not respond to introduction. Review of Resident #8's admission Record showed the resident was admitted [DATE] and on 11/12/25. The record included diagnoses not limited to: not elsewhere classified anoxic brain damage, unspecified depression, bipolar-type schizoaffective disorder, and cognitive communication deficit. Review of Resident #8's psychiatry progress note, dated 2/26/26 revealed the resident had a past psychiatric (psych) history of insomnia, major depression disorder (MDD), bipolar disorder, and bipolar-type schizoaffective disorder. The note revealed to continue the current medication regiment as the patient was more stable. Review of Resident #8's physician orders showed the resident was being administered the following psychotropic medications: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Mirtazapine 7.5 milligram (mg) oral tablet – Give 1 tablet by mouth every night shift for depression, dated 2/13/26. Trazodone 50 mg oral tablet – Give 1 tablet by mouth one time a day for depression, dated 2/18/26. Depakote Extended Release (ER) 250 mg – Give 1 tablet by mouth three times a day for bipolar disorder, dated 2/18/26. Review of Resident #8's care plan focus, initiated and revised on 3/11/26, revealed the resident used psychotropic medications: antidepressant for depression, potential for adverse effects (and) anticonvulsant for bipolar disorder. The goal dated 3/11/26 with a target date of 3/9/26 showed the resident would not have side effects of psychotropic medications. The interventions were initiated on 3/11/26. Review of the facility policy titled Care Plan, dated February 2024, revealed Policy: The facility shall support that each resident must receive, and the facility must provide the necessary caring services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment in plan of care. This facility shall assess and address care issues that are relevant to individual residents, to include, but may not be limited to, monitoring resident condition and responding with appropriate interventions.

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Lakeland Hills Center	610 E Bella Vista Dr Lakeland, FL 33805

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record reviews and interviews, the facility failed to ensure residents received activities of daily living (ADL) care timely, for one (Resident #139) out of two residents reviewed for ADL care.Findings Included: During an interview on 03/09/2026 at 09:39 AM, Resident #139 stated having used a call light earlier in the day. Resident #139 stated staff answered the call light, and she told them she had urinated and had a bowel movement. Resident #139 stated she was changed two hours later. Resident #139 explained having again urinated and was waiting to be changed by staff at the time of the interview. The resident explained being upset about having to wait two hours to be changed by staff. During an interview on 03/11/2026 at 12:57 PM, Resident #139 stated at 11:00 AM, the Social Services Director (SSD), asked if assistance was needed. Resident #139 stated she told the SSD she had made a bowel and bladder movement and needed to be changed. Resident #139 stated having heard the SSD asking two Certified Nursing Assistants (CNA), to assist Resident #139 with being changed. Resident #139 stated the two CNAs did not come in and provide the care needed. Resident #139 stated Staff I, CNA, provided the care, after lunch. During an interview on 03/11/2026 at 02:57 PM, the SSD, explained having spoken to Resident #139. The SSD stated she asked the resident if assistance was needed and the resident explained she needed to be changed. The SSD stated Staff I, CNA, was asked to assist Resident #139. The SSD stated Staff I mentioned being unable to assist Resident #139, due to assisting another resident with a shower at the time. The SSD stated Staff J, CNA and Staff K, CNA, were then approached and asked to assist Resident #139 with being changed. The SSD confirmed not seeing any staff members go into Resident #139's room to assist. During an interview on 03/11/2026 at 03:02 PM, Staff J, CNA, explained being asked by the SSD to assist Resident #139 with being changed. Staff J explained not assisting Resident #139 with being changed. Staff J described having walked off, after seeing Staff K, CNA, go into Resident #139's room. Staff J stated not knowing if Staff K changed Resident #139. Staff J stated the situation happened before lunch. During an interview on 03/11/2026 at 03:17 PM, Staff K, CNA, stated she and Staff J, CNA, were asked by the SSD, to change Resident #139. Staff K stated having approached Staff I, CNA, about assisting Resident #139 with being changed. Staff K stated Staff I explained being unable to assist Resident #139, due to assisting another resident at the time. Staff K explained not having assisted Resident #139. During an interview on 03/11/2026 at 03:36 PM, Staff I, CNA stated Staff J, CNA and Staff K, CNA, asked her to change Resident #139. Staff I explained being unable to do so, due to assisting a resident with a shower at the time of the request. Staff I stated she assisted Resident #139 after lunch. Staff I stated when she changed Resident #139, it was red down there. Staff I stated not knowing how long Resident #139 had been waiting, and that it had been more than 30 minutes since the SSD approached her. Staff I stated Resident #139 had a lot of bowel movements that morning. Review of Resident #139's medical records revealed an admission date of 03/06/2026. The medical diagnosis included: spinal stenosis, lumbar region with neurogenic claudication and low back pain. Review of Resident #139's orders revealed: Bisacodyl 10 milligrams (mg) daily as needed for constipation, dated 03/06/2026; Sodium Phosphates insert 1 application every 24 hours as needed for constipation, dated 03/06/2026; Magnesium Hydroxide 30 milliliters (m)l every 24 hours as needed for constipation, dated 03/06/2026; Polyethylene Powder give 17 grams every 24 hours as needed for constipation, dated 03/06/2026 and Nystatin (Bulk), apply to perineum topically two times a day for Erythema [redness], dated 03/11/2026 to start 03/12/2026. Review of a Situation Background Assessment and Recommendation (SBAR), form for Resident #139 revealed a change in skin color that started on 03/11/2026 at 4:37 PM and the condition had not occurred before. Review of Resident #139's CNA Kardex, revealed on 03/09/2026 at 05:55 AM bladder incontinence had been provided. The next entry for incontinence care wasn't documented until 12:20 PM. Review of incontinence care for 03/11/2026 revealed Resident #139 was changed at 10:00 AM and not assisted again until 12:29 PM. Review of Resident #139's nurse progress notes revealed a note dated (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/11/2026 at 07:06 PM, Resident was observed to have redness in the perineal area during routine care. A note dated 03/09/2026 revealed Resident #139 had a surgical wound on the lower back. Review of Resident #139's care plan focus revised 03/09/2026, revealed: ADL: The Resident has an ADL Self Care Performance Deficit r/t impaired physical mobility, weakness, decreased endurance, deconditioning, unsteady gait/balance, recent laminectomy, advancing disease process. Interventions included for toileting to require an assist of 2. Another intervention was to use a bedpan for toileting. A focus wound risk revealed Resident #139 was at risk for developing a wound, fragile skin, edema, impaired physical mobility, susceptible to bruising, medication in use, advancing disease process, surgical wound to lower mid-back/spine, revised 03/09/2026. An intervention was to observe for any new areas of skin breakdown: redness, blisters, bruises, discoloration noted during bath or daily care; report to nurse if noted, nurse will report to MD if notified. During an interview on 03/12/2026 at 11:03 AM, the Director of Nursing (DON), stated if staff become aware a resident in need of care such as being changed, someone from staff should be able to go into the room to provide care. The DON stated ancillary staff should be able to notify nursing staff to change residents. The DON stated if the assigned staff member is in the middle of providing care to another resident, then another staff should provide care. The DON stated the time it takes for staff to assist a resident, once notified, should not exceed 10 minutes. The DON stated the two CNAs that were available to assist Resident #139, should have provided care. The DON stated they should not have asked Resident #139's assigned CNA to assist the resident. The DON stated staff received education on customer service, answering call lights, and using the term that's not my patient. The DON stated a skin documentation for Resident #139, from 03/09/2026, showed redness on coccyx and heels. The DON stated on 03/11/2026 a skin evaluation revealed redness in the peri area. The DON stated Resident #139 sitting in stool for a long period of time could have caused irritation to the skin. The DON stated Resident #139 was provided assistance and it took a little longer than necessary. The DON stated the nurse should have been made aware of the situation. A facility policy and Resident #139's skin assessments were requested from the Nursing Home Administrator (NHA) and were not provided.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to provide life enriching activities for one (#2) of one dependent resident sampled for activities. Findings included: On 3/9/26 at 10:53 a.m. an observation was made of Resident #2 lying in bed. The resident did not respond verbally or physically when writer introduced self. The room contained four residents with variable responses. The observation showed resident #2 had a tracheostomy, gastrostomy tube, and an indwelling urinary catheter. The observation did not reveal music was playing for the resident. On 3/10/26 at 10:26 a.m. an observation was made of Resident #2 lying in bed, eyes partially open, non-responsive to verbalization. The observation showed urinary drainage bag leaking on floor. Staff L, Licensed Practical Nurse (LPN) was notified of the issue and confirmed the leaking of the bag. The observation did not reveal music was playing for the resident. On 3/11/26 at 3:38 p.m. an observation of Resident #2 lying in bed with eyes open. The resident had three roommates. The resident and roommates were observed lying in bed, two of the three televisions were off, and one had a solid blue screen, no music was playing. Review of Resident #2's admission Record showed the resident was admitted on [DATE] and re-admitted [DATE]. The record revealed diagnoses not limited to unspecified sequelae of cerebral infarction, aphasia, unspecified obstructive and reflux uropathy, hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, other seizures, dysphagia following cerebral infarction, tracheostomy status, and gastrostomy status. Review of Resident #2's care plan revealed the resident had the following focuses:potential for pain related to impaired mobility and inability to make needs known.Has a problem with communication, is non-verbal.Has impaired cognitive function/dementia or impaired thought processes related to (r/t) status post (s/p) cerebrovascular accident (CVA).Activities of daily living (ADL) dependent secondary to CVA with multiple co-morbidities, does not make any needs known.Requires staff assistance with involvement of activities related to cognitive deficits, prefers to stay in room, requires physical assistance to and from activities. The interventions showed the resident preferred participating in outdoor activities, caring for personal belongings, choosing clothes to wear, receiving showers, to participate with activities of choice, would benefit from in room, preferred activity time: morning, enjoys the outdoors/nature, likes to do word finds/sudoku and read, listens to R and B, hip hop, jazz, and the oldies. The resident also enjoys dramas, crime, mysteries, and comedies on television. The resident needed assistance/escort to and/or from activity functions. Review of Resident #2's admission Minimum Data Set (MDS) dated [DATE] showed the Brief Interview of Mental Status (BIMS) was not conducted as the resident was rarely/never understood. The functional abilities assessment (Section GG) showed the resident had bilateral lower and upper extremities impairments and were dependent upon staff for all hygiene and care needs. The resident was dependent on bed mobility and transferring from bed and/or chair was not applicable, tub/shower transferring showed the resident was dependent. The preferences for routine and activities section (F) completed by a family member and/or significant other. The reported preferences revealed the following activity preferences were very important to the resident: listening to music, going outside to get fresh air, and participating in religious services or practices. The family member reported the following activities were somewhat important: Having books newspapers and magazines to read, keeping up with the news, doing things with groups of people, and doing favorite activity. Review of Resident #2's Certified Nursing Assistant (CNA) task documentation for a the 30-day lookback showed: self-directed activities No Data Found, individual activity No Data Found, and group activities No Data Found. The documentation showed the resident had not been involved with any activities with included but not limited to audio books, spa, beauty/barber, cultural events, current events, discussion group, indoor/outdoor gardening, music listening, movie/comedy, sensory stimulation, sing along, and spiritual guidance/reflection. During an interview on 3/11/26 at 4:12 p.m. Staff A, Medical Records reported transitioning into the Activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director role on 3/29/26, I am currently completing the course for National Certificate Council for Activity Director (NCCAD). Staff A stated currently there is not an Activity Director. Staff A stated she was helping with activities here and there and unsure who did the in-room visits (listed on activity calendar) on 3/9 and 3/10/26. Staff A stated she only helps with bingo, games, movies, and popcorn right now. The staff member reported not documenting participation in group activities, doesn't have access to the electronic record. An interview was conducted on 3/12/26 at 9:00 a.m. with Staff N, CNA. Staff N reported usual assignment included Resident #2's room. Staff N stated the activities provided included getting residents up in bed, putting them in a chair to get ready for breakfast. Staff N reported activities were provided in the dining room. The staff member stated Resident #2 requires total care and sometimes therapy visits the resident and the resident doesn't listen to the television or music. During an interview on 3/12/26 at 12:43 p.m. the Nursing Home Administrator (NHA) stated not having an answer regarding in-room activities, in the Dining Room activities were provided by Staff A and CNAs. The NHA stated activities for low cognitive and bedbound residents should be provided per resident and/or family preference, something should be occurring for Resident #2, even some music. Review of the Resident Handbook revealed the Activities Director would meet with the resident shortly after your admission and help you select programs and activities in which you would like to participate. The activities director is responsible for setting up and supervising a full range of programs to make life more active and interesting for all of our residents.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to ensure two (Resident #2 and #122) of two residents reviewed were managed with professional standards and facility policy. Findings included: On 3/9/26 at 10:53 a.m. an observation was made of Resident #2 lying in bed, eyes open and was not responsive to verbal stimuli. The observation showed a nutrition pump next to the bed without a bottle of liquid nutrition hanging revealing the resident was not receiving nutrition at the time of the observation. On 3/10/26 at 2:00 p.m. an observation was made with Staff L, Licensed Practical Nurse (LPN) of the staff member connecting Resident #2's liquid nutrition to the gastronomy tube. The observation showed the bottle of nutrition was hanging with tubing already primed. The staff member stated Resident #2 was flushed with 320 milliliters (mL) every four (4) hours. Staff L used a 60 cubic centimeter (cc) syringe and plunger to push the contents of tubing into the stomach, removed the plunger from syringe and placed 60 cc of water into the syringe, replaced the plunger and pushed the water through the tubing. The staff member removed the syringe and connected the nutrition tubing and gastrostomy tube, turning on the pump. Immediately following the observation, Staff L reported being a brand-new nurse and didn't know what gravity (without plunger) or push meant. The staff member stated gravity was used when doing a bolus and had been told she could do both gravity and push. On 3/11/26 at 10:46 a.m. Staff M, Registered Nurse/Unit Manager (RN/UM) stated policy was to gravity feed not push, you can't see what you are pushing into and explained resident may have an abscess or placement (issue), never push. Review of Resident #2's admission Record showed the resident was admitted on [DATE] and re-admitted on [DATE]. The record included diagnoses not limited to unspecified sequelae of cerebral infarction, aphasia, dysphagia following cerebral infarction, encounter for attention to gastrostomy, tracheostomy status, and gastrostomy status. 2. On 3/9/26 at 5:10 p.m., Resident #122 was observed in bed with pillows and fans nearby, while sleeping. A nutrition bottle was observed dated 3/10/26. The time stamp for the bag hanging was 2:00 p.m. The rate on the bottle was 85 and the bottle amounted to 1700 ml. The pump showed a flow rate of 60 as it flashed on and off. The feed line from the nutrition bottle and pump had visible air bubbles and gaps of nutrition formula. On 3/11/26 at 9:54 a.m., Resident #122 was observed in bed with pillows and fans nearby, and awake, but unable to respond. The nutrition bottle was not connected to the resident and dated 3/10/26 at 2:00 p.m. The flow rate was 85 on the nutrition bottle with approximately 650 ml remaining out of 1700 ml. The nutrition pump was observed off, with no text displayed. On 3/11/26 at 1:28 p.m., Resident #122 was observed in bed with pillows and fans nearby, resting, and unable to respond. A nutrition bottle connected to the resident showed it had been hung on (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/10/26 at 2:00 p.m. The flow rate was 85 on the nutrition bottle with approximately 320 ml remaining out of 1700 ml. The nutrition pump was observed on, with a flow rate of 85. The Pump showed 1394 ml of nutrition had been administered to the resident. On 3/11/26 at 4:11 p.m., Resident #122 was observed in bed, resting, and unable to respond. A nutrition bottle connected to the resident showed it had been hung on 3/11/26 at 2:00 p.m. The flow rate was 85 on the nutrition bottle with approximately 1700 ml remaining out of 1700 ml. The nutrition pump was observed off, with no light on the screen. Air bubbles were visible in the tube feed line. During an interview on 3/10/26 at 5:10 p.m., Staff P, LPN, stated something was wrong with Resident #122's tube feed line. Staff P stated the nurse from the previous shift had experienced issues with the pump, that had been recurring. Staff P stated she had last checked on the resident at 4:00 p.m. During an interview on 3/10/26 at 5:25 p.m., Staff P, LPN, stated Resident #122 received not much, of the nutrition from the nutrition bottle. Staff P stated Resident #122 had received 11 cc from the nutrition bottle. Staff P stated 60 cc an hour was needed for the resident. Staff P stated the tube feeding pump would run and then stop. During an interview on 3/11/26 at 10:07 a.m., Staff G, LPN, stated Resident #122 had received 1134 cc since the nutrition bottle was hung up. Staff G described having no issues with the nutrition pump. Staff G stated the pump would not turn on again for the resident until between 2:00 p.m. and 3:00 p.m. Staff G, LPN stated a progress note should have been added to Resident #122's medical chart by the end of each work day, that showed how much nutrition the resident received for the day. During an interview on 3/11/26 at 3:51 p.m., Staff D, LPN, stated Resident #122's tube feed line had a kink in it. Staff D stated the line was connected to the resident. Staff D stated the resident needed a whole new setup. Staff D stated Resident #122 could not use the call light, due to the resident's condition. Staff D stated the contents of the nutrition bottle was above 1500 ml. Staff D stated the line should have been flushed at 4:00 p.m. Staff D, LPN stated the pump was not working. Staff D stated the pump had been switched out on 3/10/26. During an interview on 3/11/26 at 4:25 p.m., Staff G, LPN, stated Staff M, RN/UM, had switched the nutrition bottle out at 2:00 p.m. Staff G stated having checked Resident #122's nutrition bottle at 10:00 a.m., and not again until 2:45 p.m. Staff G stated not having checked on Resident #122 since 2:45 p.m. During an interview on 3/11/26 at 4:25 p.m., Staff M, RN/UM, stated every hour to an hour and a half, Resident #122 was checked on. Staff M stated if the tube feeding pump wasn't working, the pump should have been changed, and the line should have been changed if it was the line not working. Staff M stated the tube feeding pump for Resident #122 had not been changed. Staff M stated the 7:00 a.m. to 3:00 p.m., nurse should have changed out the tube feed pump if it was not working. Staff M explained knowing Resident #122 received 11 cc, the day prior after being hung at 2:00 p.m., until being rehung. Staff M stated not knowing the flow rate and stated the amount Resident #122 received was not acceptable. Review of Resident #122's medical record revealed the resident had admitted into the facility on 2/12/26. Resident #122's medical diagnosis revealed: anoxic brain damage and gastrostomy status. Review of Resident #122's orders revealed: Jevity 1.5 cal continuous via tube to infuse at a rate of 85 ml/hr. Total volume of 1700 ml infused in 24 hour time. Verify infusing Q [every] shift, dated 3/2/26. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Orders revealed flush enteral tube with 200 ml of water every 4 hours. Weights and vitals for Resident #122 revealed on 1/27/26, the resident's weight was 176.4 pounds. Weight revealed on 3/2/26 Resident #122's weight was 170.2 pounds. Review of the Minimum Data Set for Resident #122, revealed a Brief Interview Minimum Status of 00, meaning severe cognitive impairment, dated 2/18/26. Nutritional section revealed the resident used a feeding tube. Review of Resident #122's progress notes revealed: 3/10/2026 17:43 Progress Note (general) Note Text: Resident's enteral feeding pump was noted to not be infusing after it had been started. Upon assessment, a kink was identified in the feeding tubing, preventing the feeding from running properly. The feeding was stopped and the tubing was replaced with new tubing to ensure proper flow. A progress note for Resident #122 revealed: 3/11/2026 19:12 Progress Note (general), Resident observed with abdominal distention during assessment. Abdomen noted to be rounded and distended on inspection. Review of Resident #122's care plan revealed: NUTRITIONAL: [Resident #122] has a potential nutritional problem r/t [related to] Res [resident] receives TF [tube feeding], revised 3/2/26. Interventions were to monitor weight changes. A focus of the care plan was: TUBE FEEDING: The resident is receiving enteral nutrition, dated 2/13/26. Interventions were, administration of enteral nutrition as ordered and observe/document/report to MD [Medical Doctor] PRN [as needed]: Aspiration- fever, SOB [shortness of breath], Tube dislodged, Infection at tube site, Tube dysfunction or malfunction, Abnormal breath/lung sounds, Abnormal lab values, Abdominal pain, distension, tenderness, Diarrhea, Nausea/vomiting, dated 2/13/26. During an interview on 3/11/26 at 5:37 p.m., the Director of Nursing (DON) stated, Resident #122 had received 3 ml since 2:00 p.m. The DON stated this was the second time the tubing was kinked up. The DON stated the first shift nurse the day prior should have checked the pump, notified the provider, gotten orders for a bolus feeding, and identified how much nutrition from the nutrition bottle the resident hadn't gotten. The DON stated being available to the staff if something was wrong. The DON stated the staff could have asked for assistance. The DON stated the staff should have been checking the flow rate on the pump. The DON stated the staff had just performed a skill fair in February. The DON stated education for tube feedings was provided often. DON stated knowing there was weight loss. The DON stated staff should have identified the issue with the tube feeding. Review of the policy – Medication Administration Enteral Tubes, dated 01/26 revealed The nursing care center assures the safe and effective administration of enteral formulas and medications. Selection of enteral formulas, routes and methods of administration, and the decision to administer medications via enteral tubes are based on a nursing assessment of the residence condition, in consultation with the physician, dietitian, and pharmacist. 3. Enteral formulas, equipment, route of administration, and the rate of flow are selected based on an assessment of the resident's condition and need. 5. In-service training on safety, administration, and monitoring of enteral solutions and medications via the enteral tube is provided by the nursing care center to nursing personnel. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The procedure of Enteral Medication Administration revealed: 8. Verify tube placement per facility protocol. 9. Check the patients gastric contents for residual feeding. Return any residual volume to the stomach. File facility protocol for a prescriber notification of excess residual volume. 12. Remove plunger from syringe and insert syringe into tubing. 14 c. Allow medication to flow down to via gravity or per manufacturer's specifications.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to provide social services to one (Resident #11) out of 25 residents sampled.Findings Included:During an interview on 03/09/2026 at 10:52 a.m., Resident #11 stated he has not received a social security check in over a year. I have talked to several people and they tell me they are working on it and never follow up with me. I have no money to buy anything that I need.Review of Resident #11's minimum data set (MDS) dated [DATE] revealed Section C. Cognition, a brief interview mental status of 15 out of 15 showing intact cognition.Review of Resident #11's progress notes revealed:Social services progress note dated 6/5/2025, social services director (SSD) called the business office manager and inquired about the previous facility.SSD then called (other facility) and spoke with the Social Worker and asked about the belongings and any funds. She agreed to check and call this writer back. SSD will continue to follow.Social services progress note dated 12/26/2025: Resident spoke with this writer (SSD) He states that she is waiting for Social Security to fix a problem with his check. He states that he is working with the Business Manager. SSD will continue to follow.During an interview on 03/10/2026 at 2:32 p.m., the [NAME] Office Manager stated she has been working with Resident #11 to get his social security check since she started with the company in November. The previous business office manager was working with him prior to me. We have tried calling the other facility multiple times and have had no response. We have tried calling the social security office and they keep telling him and us that this facility cannot be the rep payee. Now that we have an administrator I was going to see if she can reach the other facility through the administrator. During an interview on 03/12/2026 at 12:14 p.m., with the Social Services Director she stated one of her roles is to advocate for services and benefits and make referrals for residents as needed. I help residents when they come to me with concern. Resident #11 came to me in June of 2025; he told me he was concerned about his belongings and his funds. We called the old facility to have them check for his belongings and check to see if there was any money owed to him. The business office manager was the one who was following up with the resident about his rep payee and his check. I did talk to the business office, but it is not documented, it was always just a verbal follow up. The resident did not bring it up again until December and I spoke with the business office manager. No, I did not help with his check, but the business office was handling this for him since it was related to money.During an interview on 03/12/2026 at 12:50 p.m., the Nursing Home Administrator stated social services is to advocate for residents and to come to some kind of resolution when they come with problems. I would have expected there to be follow through.Review of the social services director's job description revealed essential duties and responsibilities: Assist residents/patients and or families in obtaining finical services, when needed. Assists residents/patients and families to ensure a satisfactory adjustment to life in the facility, meets with new residents/patients and families to answer questions. Ensures they have been informed of their personal and property rights and obtains information for a social history and assessment.There was no policy related to this cite.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews the facility failed to initiate consulting pharmacist recommendations within the expected 30-day time frame for two (#8 and #57) of five residents sampled for unnecessary medications. Findings included: On 3/9/26 at 10:50 a.m. Resident #8 was observed lying on a low-air loss mattress. The resident did not respond to the writer. Review of Resident #8's admission Record showed the resident was admitted on [DATE] and 11/12/25. The record included diagnoses not limited to essential (primary) hypertension, unspecified atrial fibrillation, and unspecified heart failure. Review of the consultant pharmacist nursing recommendation dated 12/2/25 asked the facility to Please review the following Medication Errors and review with the responsible nursing staff: MIDODRINE 5 milligram (mg) every 8 hours as needed (prn) for systolic blood pressure (SBP) < (less) than 100. *As required by State regulations blood pressure documentation is Not Charted Every 8 Hours to comply with Physician Directions for monitoring Please correct. The follow-through documentation contained hand written initials. Review of Resident #8s March 2026 Medication Administration Record (MAR) revealed a physician order, dated 11/12/25 at 8:56 p.m. for Midodrine hydrochloride (HCL) oral tablet 5 mg - Give 1 tablet by mouth every 8 hours as needed for hypotension, give for SBP <100. The order showed an area for staff to document blood pressure (bp) and pulse daily as needed. The order for Midodrine did not reveal any blood pressure and/or pulse had been obtained during the month of March. The MAR included a physician order for staff to obtain Vitals every (Q) shift every shift, dated 2/1/26 at 7:25 p.m. The order showed staff had administered (checkmark) vital signs every shift however the documentation did not reveal any numerical recording of blood pressure, temperature, pulse, respirations, and/or oxygen saturations (O2 sats) during any shift until the day shift of 3/12/26. Review of Resident #8's blood pressure summary revealed blood pressure readings had been obtained on 1/30/26 at 10:25 p.m., 2/10/26 at 11:02 p.m., 2/23/26 at 8:38 p.m., and 3/10/26 at 1:52 p.m. Review of Resident #8's care plan did not reveal a focus showing the resident's diagnosis of hypertension and/or hypotension episodes. During an interview on 3/12/26 at 2:24 p.m. the Director of Nursing stated if there are parameters (for hypotensive), staff should be getting vital signs every 8 hours. The DON reviewed the resident's MAR and confirmed staff were not obtaining blood pressure every 8 hours. 2.On 3/9/26 at 2:47 p.m. Resident #57 was observed and interviewed in the resident's room. The resident was able to ambulate with a wheeled walker from near the units nursing station to the room. Review of Resident #57s admission Record revealed the resident was admitted on [DATE] and 12/17/25. The record included diagnoses not limited to subsequent encounter for fracture with routine healing right side multiple fractures of ribs, type 2 diabetes mellitus with unspecified complications, and hemiplegia and hemiparesis following cerebral infarction affecting left dominant side. Review of a Medication Regimen Report (MRR) dated 1/5/26 revealed two recommendations: The Maximum recommended chronic dose of acetaminophen is 4G per day without liver impairment. This patient has orders for acetaminophen 650 milligram (mg) every (q) six hours (hrs.) as needed (prn) and Fioricet/Codeine oral capsule 50-300-40-30 mg (Butalbital-Acetaminophen- Caffeine with (w/) codeine). Please consider add daily limit of Acetaminophen from all sources to orders. The recommendation showed handwritten indication it had been acknowledged.Current pain medication orders include ACETAMINOPHEN 650 mg every 6 hours as needed (PRN) pain and Fioricet/Codeine oral capsule 50-300-40-30 mg (Butalbital-Acetaminophen-Caffeine with (w/) codeine every 6 hours PRN headache. Per CMS regulations > Please clarify these orders to include specific for dosing parameters for mild pain, moderate pain or severe pain for each medication. The recommendation showed the physician had agreed. Review of the consultant pharmacist's Pending a Final Response, dated 2/1-2/3/26, showed the recommendations made on 1/5/26 (see above) were pending. Review (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident #8's active physician orders, as of 3/12/26 at 12:57 p.m. showed the following orders contained acetaminophen:11/30/25: Acetaminophen 325 mg - Give 2 tablet by mouth every 6 hours as needed for fever temp greater than 100 degrees Fahrenheit (F).11/30/25: Acetaminophen 325 mg - Give 2 tablet by mouth every 6 hours as needed for pain.12/18/25: Acetaminophen 325 mg - Give 2 tablet by mouth every 6 hours as needed for elevated temperature. Do not exceed 3 gram (GM)/24 hours, for temperature > (greater than) 101 F, call MD over the counter (OTC) medication provided by facility. Pharmacy do not send.2/5/26: Percocet 5-325 mg (Oxycodone w/ Acetaminophen) - Give 1 tablet by mouth every 6 hours for severe pain.3/10/26: Fioricet/Codeine oral capsule 50-300-40-30 mg (Butalbital-Acetaminophen-Caffeine with (w/) codeine) - Give 1 capsule by mouth every 66 hours as needed for headache/moderate pain 4g daily limit of acetaminophen from all sources. Review of Resident #8's February MAR conducted on 3/10/26 at 4:20 p.m. showed the residents Fioricet/Codeine order, dated 12/3/25 and discontinued on 3/10/26 at 1:35 p.m. did not reveal the recommendation to limit the daily amount of acetaminophen from all sources had been added to the order. Review of Resident #8's active physician orders dated 3/12/26 at 12:57 p.m. did not reveal the recommendation to limit the daily amount of acetaminophen to 4 gm's from all sources had been added to one of three current acetaminophen orders, had not been added to the scheduled Percocet (oxycodone/acetaminophen) order, and the limit had been added to the Fioricet order started on 3/10/26. The order to administer acetaminophen for pain and the order for Fioricet did not include parameter to administer for mild, moderate, and or severe pain. A telephone interview was conducted on 3/12/26 at 1:19 p.m. with the Consultant Pharmacist. The pharmacist stated if a recommendation went past 60 days they reported to the facility's corporate office. The pharmacist stated the expectation was to add daily limit on all acetaminophen (orders) and as long as they had it somewhere should follow recommendations. A telephone call was received on 3/12/26 at 2:18 p.m. from the Consultant Pharmacist. The pharmacist reported reviewing Resident #57's record and only asked them to add the limit to the as needed (prn) medications with acetaminophen, the resident's Percocet was scheduled so does not ask them to add the daily limit to scheduled (sources). Review of the United States Food and Drug Administration (FDA) information on Acetaminophen, current as of 8/14/25, showed Acetaminophen is found in hundreds of over-the-counter and prescription drugs. It may be the only active ingredient, or it may be combined with other active ingredients. The ways to safely use acetaminophen included but was not limited to: Know if you are taking drugs that contain acetaminophen. Both over-the-counter and prescription drugs may contain acetaminophen. Do not use more than one acetaminophen-containing product at a time. Acetaminophen is in many products. You could accidentally take too much if you use more than one product containing acetaminophen at a time.The FDA reported The maximum total amount of acetaminophen taken in 24 hours should not be more than 4,000 mg for adults and children [AGE] years of age and older. This information was located at (https://www.fda.gov/drugs/information-drug-class/acetaminophen). Review of the website, Drugs.com, revealed information related to the use of acetaminophen (https://www.drugs.com/acetaminophen.html), updated on 11/27/25. The website described acetaminophen as Acetaminophen is used for the short-term relief of minor aches and pains due to colds, flu, headache, backache, arthritis, toothache, muscle pain, and menstruation. It also temporarily reduces fever. Acetaminophen is also available in combination with many other medications (see below). Always check the label to see if a combination product contains acetaminophen. You should never take two products containing acetaminophen together. The warnings and side effects showed they were rare but could include liver damage with overdose or prolonged high-dose usage. The website recommended a maximum daily limit of 3250 mg in a 24 hour period and severe liver damage could occur if more than 4 gm (4000 mg) was taken in 24 hours and if taken with other drugs also containing the medication. A request was made to the facility for a policy regarding pharmacy recommendations. The facility provided a policy - Consultant Pharmacist Quarterly Report, dated 1/24, The policy revealed The consultant pharmacist prepares for quarterly written reports on the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	status of the nursing care centers pharmaceutical services and nursing staff performance related to medication therapy. The policy did not include procedures regarding monthly Medication Regimen Reports.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on observations, record reviews, and interviews the facility failed to provide laboratory services for one (#8) of five residents sampled for unnecessary medications.Findings included: On 3/9/26 at 10:50 a.m. Resident #8 was observed lying atop a low air loss mattress and did not respond to this writers introduction. Review of Resident #8's handwritten physician telephone orders dated 1/27/26 revealed staff were to obtain a STAT [immediately] urinalysis culture & sensitivity (UA C&S); basic metabolic panel (BMP) (in) 1 week; stool occult x2; administer 1 milligram (mg) salt tablet twice daily (BID), and Potassium 20 milliequivalents (meq) BID x 2 days (d) then daily (qd) after. The order showed a nurse had received the order. Review of Resident #8's February Treatment Administration Record (TAR) showed an order for BMP in one week every night shift for hyponatremia for 1 day. The order was dated 1/27/26 and scheduled for 2/3/26. The TAR did not reveal the order had been administered and did not show the BMP had been obtained or rescheduled. Review of the lab monitoring sheet dated 2/2/26 showed the resident was to obtain a Vitamin B12, folate, and occult stool laboratory test. The lab monitoring sheet dated 2/3/26 showed the staff were to obtain an occult stool sample. The lab sheets did not instruct the laboratory vendor to obtain a BMP on 2/3/26. Review of Resident #8's laboratory results did not include BMP results from 2/3/26. Review of Resident #8's physician orders showed an order for Depakote Extended Release (ER) 250 milligram (mg) three times a day for bipolar disorder. Review of Resident #8's psychiatry note, dated 2/26/26, revealed the medication list included the resident was to receive Depakote 250 mg three times a day. Review of Resident #8's laboratory results, electronic records, and hard copy of chart did not include Depakote level results. An interview was conducted on 3/10/26 at approximately 4:00 p.m. with Staff M, Licensed Practical Nurse (LPN). The staff member reported being unable to locate any Depakote level results for Resident #8. Staff M reviewed the lab monitoring sheets for 2/2 and 2/3/26 and the February TAR confirming the BMP had been obtained. The staff member stated on 3/10/26 the Depakote level should be drawn for baseline and either every 3 or 6 months. An interview was conducted on 3/11/26 at 10:36 a.m. with the Psychiatry Nurse Practitioner (NP). The NP stated when Depakote was started they obtain an ammonia and valproic acid (VPA) (Depakote) after 7 days then every 6 months if prescribed for mood. The NP reported knowing there was a lot of facility turnover and might have dropped off (physician orders). The expectation would be for staff to ask for a level (depakote). During an interview on 3/12/26 at 9:33 a.m., the Director of Nursing (DON) stated a Depakote level was obtained when a resident started on Depakote and every 3 month, the facility didn't have a standing order for psychotropics. The DON reported having to check to why it (Depakote level) wasn't ordered or if it was ordered and what happened. The physician should be notified regarding refusals or not getting the lab drawn. The DON stated lab results are discussed in morning meeting and the expectation was to follow up when the labs came in. The procedure was to put the order in, laboratory techs come in, and staff follow up if refused with the physician, follow the recommendations of the physician, and document why the lab wasn't drawn.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and the Plan of Correction review, the facility did not ensure it had a functioning Quality Assurance Committee. The facility was actively involved in the creation, implementation, and monitoring of the plan of correction for deficient practice identified during a recertification survey ending on 3/12/2026 and was cited F656, F761, F925. The facility had developed a Plan of Correction with a completion date 4/12/2026. The facility had not comprehensively implemented the plan of correction related to 1) implementing resident centered care plans related to prevention of self-harm for one (Resident #3) of three residents; 2) ensuring medications were stored in accordance with current professional standards for four of four medication carts and medications stored at bedside for for one (Resident #3) of twenty-four; and 3) implement an effective pest control program in four of four hallways.cross reference F656, F761 and F925. The findings include:A review of a policy effective January 2025, titled, Quality Assurance Performance Improvement (QAPI) Program revealed The facility QAPI Program will use data driven indicators that focus on the outcomes of care and quality of life for the residents. The program will; 1) track and measure performance; 2) establish goals and thresholds for performance measurement; 3) identify and prioritize deviations for performance and other problems and issues; 4) systematically investigate and analyze to determine underlying causes of systemic problems and adverse events; 5) develop and implement corrective actions or performance improvement activities; 6) monitor / evaluate the effects of corrective actions / performance activities. The Quality Assurance, Assessment, and Compliance Committee (QAA&C) will implement the QAPI Program through individual and committee assignments.1.Review of the facility's plan of correction for the survey ending 3/12/26 with a completion date of 4/12/2026 revealed the following measures would be taken to correct the deficient practice which was identified at F656: . A comprehensive audit of current residents who have a psychiatric diagnosis and use psychotropic medications was completed to ensure they have care plans in place.3. The Director of Nursing or designee provided education to Social Services and Licensed Nurses on completing comprehensive resident- centered care plans specifically for those with psychiatric diagnosis and psychotropic medication use.4. A random weekly audit of new admissions and/ or those residents who take newly prescribed psychotropic medications will be conducted weekly for four weeks, followed by monthly audits for two months to ensure care plans are in place for their psychotropic medication use and associated diagnoses. The results of these audits will be reviewed during the facility's monthly Quality Assessment and Assurance Committee meetings, and additional corrective action will be implemented if necessary.On 4/16/2026 a revisit survey was conducted to ensure compliance with F656. The revisit survey identified the following on-going concerns with F656:An observation on 4/16/2026 at 10:29 A.M. of Resident #3 revealed she had several knives, scissors, disposable razors, and nail care products located on her bedside table in her room.An observation on 4/16/2026 at 11:48 A.M., of Staff K, Certified Nursing Assistant (CNA) revealed she entered Resident #3's room. Staff K, CNA exited Resident #3's room with several knives, scissors, disposable razors, and nail care products.A review of Resident #3's admission Record showed he was admitted to the facility on [DATE], readmitted on [DATE] with diagnoses including but not limited to unspecified mood (affective) disorder, depression, and anxiety disorder. A review of Resident #3's MDS, dated [DATE] revealed a BIMS score of 14 indicating cognitively intact.A review of Resident #3's Care Plan initiated on 4/15/2026 revealed a focus of resident at risk of hurting self with suicidal ideations. Interventions for the focus included: Evaluate resident environment for safety and remove objects which could be used for self-harm.A review of Resident #3's Kardex revealed under the safety category for the use of plastic utensils.An interview on 4/15/2026 at 3:27 P.M. with Staff E, Licensed Practical Nurse (LPN) was conducted. Staff E, LPN (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	said the residents are not supposed to have disposable razors in their room.An interview on 4/15/2026 at 3:29 P.M. with Staff I, CNA was conducted. Staff I, CNA stated, disposable razors should not be in the resident rooms.An interview on 4/15/2026 at 3:36 P.M. with Staff J, CNA was conducted. She said disposable razors are stored in the supply room. Staff J, CNA stated, I ensure there are no disposable razors left in the resident's room.An interview on 4/16/2026 at 9:55 A.M. with the Director of Nursing (DON) was conducted. The DON said there should not be any disposable razors in the residents' rooms.An interview on 4/16/2026 at 9:58 A.M. with the Nursing Home Administrator (NHA) was conducted. The NHA said disposable razors should not be in the residents' rooms and the residents should be supervised while performing self-care. During an interview with the NHA and DON on 4/16/2026 at 4:35 P.M. the DON stated they had only focused on psychotropic medications in the care plan. Audits were only completed on those medications, no other audits related to care plans were completed. 2.Review of the facility's plan of correction for the survey ending 3/12/26 with a completion date of 4/12/2026 revealed the following measures would be taken to correct the deficient practice which was identified at F761: .The Director of Nursing or designee conducted a house-wide audit of resident rooms to ensure no medications were left at bedside and also an audit of the medication carts and medication rooms to ensure no unlabeled, expired, or loose medications were found. Any issues identified during the audit were corrected as indicated.3. The Director of Nursing or designee has provided education to staff on storage of medications, not having medications at bedside and not having loose, unlabeled, expired, or unsecured medications in medication carts, treatment carts, and medication rooms.4. The Director of Nursing or designee will conduct weekly audits of medication carts, treatment carts, and medication rooms, as well as random weekly audits of resident rooms to ensure medications are stored appropriately. This audit will continue weekly for four weeks, followed by monthly for two months. The results of the audits will be reviewed during the facility'smonthly Quality Assessment and Assurance Committee meetings, and additional corrective action will be implemented if necessary.On 4/16/2026 a revisit survey was conducted to ensure compliance with F761. The revisit survey identified the following on-going concerns with F761:On 04/15/ 2026 at 9:35 a.m. Resident #3 was observed in bed, alert and able to answer questions, her bedside table over her bed with miscellaneous personal items on the table. Resident #3 agreed to an interview. Resident #3 stated, I have pain in my shoulder. I have ointment for the shoulder, they say I am supposed to ask to have it put on, but I will forget. I have pain. When asked if she knew the name of the ointment, she stated, It is right here. Resident #3 was observed to point to a tube of medication on her bedside table.On 04/15/2026 at 9:38 a.m., Staff A, Licensed Practical Nurse (LPN) was interviewed about the tube of medication on Resident #3's bedside table. Staff A confirmed the tube of medication on Resident #3's bedside table. Staff A was observed to find another full box containing a tube of prescription pain medication in Resident #3's bedside table. Staff A stated medication should not be at the residents' bedside. A review of Resident #3's clinical chart, the face sheet, documented an admission of 07/2023 and readmission on [DATE]. The diagnosis list included but not limited to: Chronic respiratory failure with hypercapnia, chronic pulmonary edema and anxiety disorder. The chart did not reveal a physician order, assessment, or care plan for self-administration of medication. An observation on 4/15/2026 at 1:25 P.M. of the 200-Hall medication cart revealed:two unopened bottles of insulin that required refrigeration before openingone opened bottle of insulin that did not contain an opened or expiration datea bottle of allergy medication with the expiration date worn offseveral medications loose in the top drawera container of micro-kills chemical wipes stored next to medications in the bottom drawerAn observation on 4/15/2026 at 1:50 P.M. of the 400-Hall medication cart revealed:A bottle of fish oil that expired in January 2026An observation on 4/15/2026 at 2:00 P.M. of the 100-Hall medication cart revealed:an inhaler that was opened on 3/11/2026 and expired 3 weeks after openingan open foil package of albuterol inhalation solution that did not contain an opened or expiration datean opened pro air inhaler that did not contain an opened or expiration dateAn observation on 4/15/2026 at 2:10 P.M. of the 300-Hall medication cart (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed:a container of micro-kills chemical wipes stored next to medications in the bottom drawera container of bleach wipes stored next to medications in the bottom drawerAn interview on 4/15/2026 at 1:35 P.M. with Staff D, Licensed Practical Nurse (LPN), regarding 200-Hall medication cart was conducted. Staff D, LPN said the unopened insulin bottles should have been in the refrigerator and the open insulin should have an open and expired date. Staff D, LPN said the expiration date on the allergy bottle was worn and not legible. Staff D, LPN said the loose medications should have been discarded. Staff D, LPN said she did not know where else to store the micro-kills chemical wipes. Staff D, LPN said she had not received any education regarding medication storage.An interview on 4/15/2026 at 1:50 P.M. with Staff A, LPN regarding 400-Hall medication cart was conducted. Staff A, LPN said she did not know who was responsible for removing expired medications. Staff A, LPN said the bottle of fish oil should have been discarded.An interview on 4/15/2026 at 2:00 P.M. with Staff E, LPN, regarding 100-Hall medication cart was conducted. Staff E, LPN said the inhaler had expired and should have been removed from the cart. Staff E, LPN said she did not know when the albuterol or pro air was opened. Staff E, LPN said she had not received any education regarding medication storage.An interview on 4/15/2026 at 2:10 P.M. with Staff F, Registered Nurse (RN), regarding 300-Hall medication cart was conducted. Staff F, RN said she did not know where to store the micro-kill and bleach wipes. Staff F, RN said she had not received any education regarding medication storage.An interview on 4/15/2026 at 3:50 P.M. with the Director of Nursing (DON) was conducted. The DON said the insulin should have been refrigerated. The DON said micro-kill wipes are not allowed to be in the medication carts. The DON said all expired medications should be discarded. The DON said the nurses were responsible for checking the medication carts every shift.During an interview with the NHA and DON on 4/16/2026 at 4:35 P.M. the NHA confirmed the process needs to be reevaluated and improvements made. The NHA stated the medications should be stored according to the policy. 3.Review of the facility's plan of correction for the survey ending 3/12/26 with a completion date of 4/12/2026 revealed the following measures would be taken to correct the deficient practice which was identified at F925: .The Housekeeping Director completed walking rounds and any areas of high concern were deep cleaned and placed on log for Pest Control to address. The Pest Control Vendor continues to treat the facility in two times a week interval to include the drain or more frequently as indicated.3. The NHA educated the Housekeeping Director that once a high area of concern is determined that a deep cleaning of that area needs to be completed. The Maintenance Director was educated by the NHA on maintaining an effective pest control program and ensuring that the pest control vendor is properly addressing areas of concern.4. The Housekeeping Director/designee will randomly audit each hallway for four weeks to ensure areas are free of pest, followed by monthly audits for two months to ensure areas are free of pests. Identified concerns will be placed in Pest Control book. Audit results will be reviewed during the facility's monthly Quality Assessment and Assurance Committee meetings, and additional corrective action will be implemented if necessary.On 4/16/2026 a revisit survey was conducted to ensure compliance with F925. The revisit survey identified the following on-going concerns with F925:An observation on 4/15/2026 at 9:25 A.M. revealed live flies throughout the 100 Hallway.An observation on 4/15/2026 at 9:30 A.M. in room [ROOM NUMBER]D, revealed several live flies around the resident's urinal. An observation on 4/15/2026 at 9:58 A.M. in room [ROOM NUMBER] revealed several live flies throughout the room and on the ceiling.An observation on 4/15/2026 at 10:05 A.M. in the conference room revealed several live flies.An observation on 4/15/2026 at 11:45 A.M. in room [ROOM NUMBER] revealed several live flies on the ceiling.An observation on 4/15/2026 at 12:15 P.M. in room [ROOM NUMBER]B revealed several live flies on the resident's curtain.An interview on 4/15/2026 at 11:22 A.M. with Staff H, Account Services (AS) was conducted. Staff H, AS said the flies are not gone and some of the residents complain about them.An interview on 4/15/2026 at 12:02 P.M. with Resident #3 was conducted. Resident #3 said the flies are bothersome, and has notified the NHA.An interview on 4/15/2026 at 12:15 P.M. with Resident #6 was conducted. Resident #6 said the flies bother him. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105283	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeland Hills Center	610 E Bella Vista Dr Lakeland, FL 33805

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

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6 said the flies are mostly around his curtain.A record review of the [Vendor Name] Pest Control Sighting Log revealed an entry dated 4/13/2026 for a sighting of gnats in the dining room. The entry dated 4/13/2026 revealed issue addressed date of 4/14/2026.An interview on 4/15/2026 at 4:40 P.M. with Social Services Director (SSD) was conducted. The SSD said when she sees gnats/flies, she enters her sighting(s) in the pest control logbook. The SSD said the facility still has a problem with the flies.An interview on 4/15/2026 at 5:00 P.M. with the Nursing Home Administrator (NHA) was conducted. The NHA said the flies were still an issue and the pest control company only treats areas of high concern.During an interview with the NHA and DON on 4/16/2026 at 4:35 P.M. the NHA confirmed the flies are still a problem and needs to be addressed.

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and interviews, the facility failed to ensure its pest control program was effective on four of four hallways.Findings included: On 03/09/2026 at 10:43 A.M., observations were made of three live flying insects on the wall of the headboard in room [ROOM NUMBER]A. On 03/09/2026 at 10:45 A.M., observations were made of a live flying insect on the curtain in room [ROOM NUMBER]A. On 03/10/2026 at 10:48 A.M., observations were made of a live flying insect on the ceiling in room [ROOM NUMBER]B. On 03/10/2026 at 01:08 P.M., observations were made of four live flying insects on the wall of room [ROOM NUMBER]A During an interview on 03/10/2026 at 09:48 A.M., a resident in room [ROOM NUMBER]B stated there was a fly on the ceiling. During an interview on 03/11/2026 at 01:08 P.M., a resident family member in room [ROOM NUMBER]B explained having spoken to facility staff members about flies. The family member pointed at a fly and stated having spoken to the Nursing Home Administrator (NHA), about the flies on 02/04/2026. The family explained having been told that the bug guy would be out during the following week. During an interview on 03/11/2026 at 03:51 P.M., Staff D Licensed Practical Nurse (LPN), stated having seen flies at the facility for at least two months. Staff D stated someone had been visiting the facility at least twice per week. Staff D stated having seen the facility spray bugs three times the prior week. During an interview on 03/10/2026 at 03:23 P.M., the Director of Nursing (DON), stated having seen flies in the facility within the last 6 weeks. The DON stated the facility had been treating flies for the past month. The DON stated the source of the flies was a drain in the building. The DON stated the flies were a one-time thing. Photographic evidence obtained. Findings included: An observation on 3/9/2026 at 9:10 A.M. of the conference room revealed fruit flies flying around the room. An observation on 3/9/2026 at 9:48 A.M. of room [ROOM NUMBER] revealed several fruit flies flying in the resident's room. The bathroom between room [ROOM NUMBER] and 407 revealed fruit flies flying around the sink and the toilet. An observation on 3/9/2026 at 3:45 P.M. of the entrance way to the conference room several fruit (continued on next page)

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	105283	A. Building B. Wing	03/12/2026

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	flies that Staff A, Activities/Medical Records stating, ugh, flies and making a swatting hand motion. An observation on 3/12/2026 at 11:33 A.M. in room [ROOM NUMBER] Bed B there were several flies flying around the resident's bedside table. Observation of room [ROOM NUMBER] Bed C the resident had a washcloth hanging on his headboard and the washcloth had several flies on it. An interview with Resident #84 was conducted. Resident #84 stated the flies bother me. Resident #84 said they had been in his room for a long time and the flies are annoying and irritating. A record review of the exterminators invoice dated 1/16/2026 revealed, gnats big problem doesn't see to be getting better but worse throughout the facility, recommended a deep cleaning of the kitchen at this time. A record review of the exterminators invoice dated 1/28/2026 revealed logbooks had three entries for gnats in rooms [ROOM NUMBER]. Treatment of the drains in the rooms, left fly traps as the activity was the heaviest in that area; treated all drains in the 200 and 300 wings.there may be an underlying drain issue and that the need to be professionally cleaned.for the activity to be this consistent, over the span of several months with several various services, it appears that the treatments seem to be a Band-Aid that isn't treating an underlying source for the gnats. A record review of the exterminators invoice dated 1/30/2026 revealed call back services for flies in room [ROOM NUMBER] and 110 under the sinks and behind the nightstands. A record review of the exterminators invoice dated 2/6/2026 revealed following up on the gnat issues.after inspection of the kitchen cleaning was never performed. A record review of the exterminators invoice dated 2/16/2026 revealed checked the log books and found five entries for gnats, plus two more rooms requested by staff.spot treated the rooms.treated the restroom drains.treated the kitchen area under the sinks.most of the gnats were under the dishwasher area, soaked the walls and wooded baseboards as they were covered in bio material. A review of the pest control pest sighting logs revealed fruit flies / gnats had been reported in the facility dating back to 2021. An interview on 3/9/2026 at 3:45 P.M with the NHA was conducted. The NHA said the fruit flies are bad in the facility, stating, they are everywhere. An interview on 3/10/2026 at 10:30 A.M. with the Regional Housekeeping Director (RHD) was conducted. The RHD said the facility had always struggled with the flies, stating nothing is working. An interview on 3/12/2026 at 11:35 A.M. with the Maintenance Director (DM) was conducted. The DM said a pest control company comes to the facility and sprays, stating, I don't think it's working. A review of the policy effective August 2024 titled pest / insect control revealed the facility strives to protect the residents, staff and visitors from insects and other pest by controlling infestations through contracts with outside pest control agencies. 4: evaluate effectiveness of services.