STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105297	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brooksville Healthcare Center	1114 Chatman Blvd Brooksville, FL 34601

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure staff used appropriate Personal Protective Equipment (PPE) while providing care for residents on enhanced barrier precautions for 1 of 4 residents who were on enhanced barrier precautions (Resident #69) and for 3 residents who were on contact precautions (Resident #71, #154 and #148) and failed to ensure staff performed hand hygiene when required during medication administration to prevent the possible spread of infection and communicable diseases.Findings include: 1) During an observation on 5/19/2026 at 7:02 AM, there was an enhanced barrier precautions signage on Resident #69's doorway. No personal protective equipment was available on or near the door, inside Resident #69's room or bathroom. There were no gowns available in the hallway. Staff T, Certified Nursing Assistant (CNA), was at Resident #69's bedside, providing incontinence care and changing the resident's brief and clothing. Staff T was not wearing a gown. During an interview on 5/19/2026 at 7:10 AM, Staff T, CNA, stated, She [Resident #69] is on enhanced barrier precautions for wounds. I should have put on a gown to change her. During an observation on 5/19/2026 at 7:22 AM, Staff K, Licensed Practical Nurse (LPN), entered Resident #69's room and assisted the resident with repositioning in bed. Staff K did not wear gloves or a gown. Staff K left the resident room. During an observation on 5/19/2026 at 7:25 AM, Staff K, LPN, returned to Resident #69's room, donned gloves without performing hand hygiene and assisted the resident with repositioning. Two paramedics entered the room and asked why the resident was on isolation. Staff K did not request the paramedics wear a gown on. Staff K assisted the paramedics to move the resident from the bed to the stretcher. Staff K was touching the resident's arms, assisting resident to hold up arms while the paramedics were repositioning the resident on the stretcher. During an interview on 5/19/2026 at 7:32 AM, Staff K, LPN, stated, She [Resident #69] is on enhanced barrier precautions because she has open wounds on her legs. There are no gowns in the room or outside the room. There are some in the supply room on unit 2. I did not put on a gown when I helped her. I should have. Review of Resident #69's physician order dated 5/13/2026 read, Enhanced Barrier Precautions: (Wound). During an interview on 5/21/2026 at 9:50 AM, the Director of Nursing (DON) stated, We should be storing the gowns in the residents' closet when they are on enhanced barrier precautions. All staff should follow the orders for any type of isolation. (continued on next page)

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

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy and procedure titled Enhanced Barrier Precautions with the last approval date of 1/21/2026 read, Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Policy Explanation and Compliance Guidelines: 3. Implementation o Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. 4. High-contact resident care activities include: a. Dressing; c, Transferring; d. Providing Hygiene; f. Changing briefs or assisting with toileting. 10. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 2) Review of Resident #71's admission record showed the resident was diagnosed with chronic osteomyelitis left ankle and foot, type 2 diabetes mellitus, and MRSA (Methicillin-resistant Staphylococcus aureus) in toe wound. During an observation on 5/18/2026 at 11:38 AM, there was a contact isolation signage and personal protective equipment of gowns and gloves was on Resident #71's door. Staff E, Maintenance Staff, was in Resident #71's room. Staff E did not have personal protective equipment of gown and gloves. During an interview on 5/18/2026 at 11:40 AM, Staff A, LPN, stated, We are supposed to wear PPE when entering a contact isolation room. Review of the facility policy and procedure titled Transmission Based (Isolation) Precautions with the last review date of 1/21/2026 read, Policy: It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Policy Explanation and Compliance Guidelines: 1. Facility staff will apply Transmission-Based Precautions, in addition to standard precautions, to residents who are known or suspected to be infected or colonized with certain infectious agents requiring additional controls to prevent transmission. 2. The facility will use standard approaches, as defined by the CDC [Centers for Disease Control and Prevention], for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precautions will determine the type of personal protective equipment (PPE) to be used. (A table that depicts the types of PPE to use is attached to this policy.) 9. Contact Precautions: c. Healthcare personnel caring for residents on Contact Precaution's wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. VRE [Vancomycin-resistant Enterococci], C difficile, noroviruses and other intestinal tract pathogens, RSV [Respiratory Syncytial Virus]). 3) During an observation on 5/18/26 at 10:36 AM, there were enhanced barrier and contact isolation signages on the Resident #148's room door. Staff D, Housekeeper, was cleaning the room with gloves on. Staff D had no other PPE. During an interview on 5/18/26 at 10:36 AM, Staff D, Housekeeper, stated, I am a new employee. I wear gloves, but do not gown up. I do not understand the signs on the door. During an interview on 5/18/2026 at 10:46 AM, the Assistant Director of Nursing (DON) stated, The resident is on contact isolation for c-diff. The ADON took the enhanced barrier precautions signage off the door and left contact isolation signage on the outside of the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) During an observation on 5/19/2026 at 9:37 AM, there was an enhanced barrier precautions signage on Resident #155's room door. Staff C, LPN, was assisting the resident into the bathroom. Staff C had gloves on. Staff C did not have any other PPE. During an interview on 5/19/2026 at 9:38 AM, Staff C, LPN, stated that she should have put a gown on. 5) During an observation on 5/20/2026 at 1:35 PM, Staff F, CNA, obtained a blanket from the linen closet and walked into Resident #154's room. There was a contact precautions signage posted on the wall next to the door, and a rack containing gowns and gloves hanging on the door. Staff F did not don gloves or a gown and entered the room. During an interview on 5/20/2026 at 1:35 PM, Staff F, CNA, confirmed that she did not wear a gown or gloves when she went into Resident #154's room and she should have because the resident was on contact isolation. Review of Resident #154's physician order dated 5/19/2026 read, Contact Precautions d/t [due to] Conjunctivitis every shift until 05/25/2026 23:59 [11:59 PM]. 6) During an observation on 5/20/2026 at 8:24 AM, Staff H, LPN, was preparing medications for Resident #111. While pouring Clonazepam and Co Enzyme Q10, the medications fell unto the top of the medication cart. Staff H picked up the medication and poured them into the clear medication cup. Staff H did not perform hand hygiene or wear gloves. Staff H poured Furosemide, Albuterol, Eliquis and Clonidine from the medication blister packs into his ungloved hand and then poured them into the medication cup. Staff H proceeded to enter Resident #111's room and administer the medication. During an interview on 5/20/2026 at 8:34 AM, Staff H, LPN, stated, I know we are not supposed to touch medication with our hands. I prefer to wear gloves, but we are not allowed to in the hallway and when we are popping the medication from the blister pack, they go flying everywhere. I should have disposed of the medication that fell onto the medication cart. During an interview on 5/20/2026 at 10:49 AM, the DON stated, Staff should not be touching medication with their hands other than dropping it off into the medication cup directly. If medication falls outside of mediation cup, the staff should dispose of the medication. Review of the facility policy and procedure titled Hand Hygiene with the last review date of 1/21/2026 read, Policy: All staff will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors. This applies to all staff working in all locations within the facility. Policy Explanation and Compliance Guidelines: 1. Staff will perform hand hygiene when indicated, using proper hand hygiene technique consistent with accepted standards of practice. Hand Hygiene Table: Before preparing or handling medications. Review of the facility policy and procedure titled Medication Administration with the last review date of 1/21/2026 read, Policy: Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Policy Explanation and Compliance Guideline: 14. Remove medication from source, taking care not to touch medication with bare hand. 17. Wash hands using facility protocol and product. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7) During an observation on 5/19/2026 at 8:52 AM, Resident #152's door was closed. There was an enhance barrier precautions signage posted on the side of the room door. There was no PPE outside the room. Staff L, CNA, was in the room and came around the privacy curtain and stated, patient care. Staff L was wearing gloves, but no gown. At 8:56 AM, Staff L exited Resident #152's room with a clear bag in her hand, which contained gloves and a brief. During an interview on 5/19/2026 at 1:12 PM, Staff L, CNA, stated, I changed [Resident 152's name] brief. I just wear gloves. I did not know he [Resident #152] was under enhanced barrier precautions. I should have worn a gown. Review of Resident #152's physician orders showed an order dated 4/14/2026 for changing the dressing to dialysis access port/line. During an interview on 5/20/2026 at 10:51 AM, the Director of Nursing stated, If the resident is under enhanced barrier precautions, I expect staff to wear gloves and gown when providing direct care to the resident.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to notify the physician of a change in condition for hypoglycemia that required treatment for 1 of 4 residents reviewed for insulin administration (Resident #122) and for skin condition for 3 of 3 residents reviewed for skin conditions (Resident #35, #80 and #87). Findings include: 1) Review of Resident #122's admission record showed the diagnoses that include nondisplaced spiral fracture of shaft of left tibia subsequent encounter for closed fracture with routine healing, type 2 diabetes mellitus with diabetic neuropathy unspecified, hypertensive heart and chronic kidney disease without heart failure. Review of Resident #122's physician order dated 2/23/2026 read, Insulin Regular Human Injection Solution 100 unit/ml [milliliter] (Insulin Regular (Human)), Inject as per sliding scale: if 151-200= 4 units; 201-250= 6 units; 251-300= 8 units; 301-350= 10 units; 351-400= 12 units. If BS [Blood Sugar] greater than 350 give 10 units and notify provider, subcutaneously before meals and at bedtime for DM [diabetes mellitus]. Review of Resident #122's Medication Administration Record (MAR) for May 2026 showed a blood glucose of 47 documented on 5/2/2026 at 9:00 PM and a blood glucose of 47 documented on 5/15/2026 at 9:00 PM. Review of Resident #122's nursing progress notes showed no notification to Resident #122's physician or nurse practitioner on 5/2/2026 and 5/15/2026. Review of Resident #122's MAR for April 2026 showed a blood glucose of 51 documented on 4/3/2026 at 9:00 PM and a blood glucose of 58 on 4/16/2026 at 9:00 PM. Review of Resident #122's nursing progress notes showed no notification to Resident #122's physician or nurse practitioner on 4/3/2026 and 4/16/2026. During an interview on 5/19/2026 at 3:55 PM, Staff S, Licensed Practical Nurse (LPN), stated, I did not notify the doctor or nurse practitioner of the blood sugar. We should notify them. During an interview on 5/21/2026 at 10:10 AM, the Director of Nursing (DON) stated, All staff should notify the doctor or nurse practitioner when there is a change of condition. A low blood sugar that requires treatment is a change that should be called. 2) During an interview on 5/18/2026 at 12:10 PM, Resident #35 stated, This bandage on my right arm is from me hitting it in the bathroom when I go in there. During an observation on 5/18/2026 at 12:12 PM, Resident #35 had a bandage on his left forearm that is dated 5/8/2026. During an interview on 5/19/2026 at 2:35 PM, Staff B, Registered Nurse (RN), stated, I cannot find any documentation relating to the resident's skin tear on the resident's left wrist/forearm. During an interview on 5/19/2026 at 2:54 PM, the Assistant Director of Nursing (ADON) stated, It is (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	my expectation that when a resident gets a skin tear that the nurse assesses the skin care, documents the injury, contacts the physician and receives orders as needed and contacts the family. Review of the facility policy and procedure titled Skin Integrity- Skin Tears with the last review date of 1/21/2026 read, Policy: It is the policy of this facility to provide proper treatment and care to maintain skin integrity. This policy pertains to the prevention and management of skin tears. Policy Explanation and Compliance Guidelines: 2. Assessment a. Licensed nurses will conduct skin assessments in accordance with facility policy. c. When a skin tear is discovered, the nurse shall complete an incident report. The following information shall be recorded: i. The Resident's name ii. The name of the employee discovering the skin tear, iii. The site and description of the skin tear, iv. The date and time the skin tear was discovered, v. The date and time the injury occurred, if known, vi. The name(s) of the employee(s) who provided care for the resident for the previous 24 hrs, vii. Site care rendered and evaluation of the incident, viii. The name(s) of any witness(es) to the incident, ix. the date and time the physician and resident representative were notified. 5. Modification of Interventions a. The attending physician will be notified of the presence, progression toward healing, or lack of healing of any skin tears, or any changes in the resident's medical condition. 3) During an observation on 5/18/2026 at 10:15 AM, Resident #80's left forearm had a tan bandage with no date. During an observation on 5/19/2026 at 12:44 PM, Resident #80's left forearm had a tan bandage with no date. Review of Resident #80's physician orders showed no physician order for left hand bandage. During an interview on 5/19/26 at 1:10 PM, Staff C, LPN, regarding the bandage on Resident #80's forearm, stated, I do not know anything about it. I need to see if there is an order for it. During an interview on 5/19/2026 at 1:15 PM, Staff Q, Wound Care Nurse, stated, I think [Resident #80's name] has a skin tear to her forearm. 4) During an observation on 5/18/2026 at 9:52 AM, Resident #87 was sitting in her wheelchair. There was a dressing on her left lower leg that was dated 5/16. During an interview on 5/18/2026 at 9:52 AM, Resident #87 stated that she had not bumped her leg and did not know what had happened. Review of Resident #87's progress notes from 5/1/2026 through 5/18/2026 showed no progress notes documenting the presence of a wound, notification to a provider or the resident representative. During an interview on 5/19/2026 at 11:55 AM, Staff H, LPN, stated, I removed the bandage from [Resident #87's name] leg. There is no order or anything on her MAR or TAR [Medication Administration Record, Treatment Administration Record]. During an interview on 5/20/2026 at 4:20 PM, the DON stated that the expectation was that if a resident had a wound, the nurse should notify the provider and the family and document the notification and any treatment or treatment orders. Review of the facility policy and procedure titled Notification of Changes with the last approval date (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of 1/21/2026 read, Policy: The purpose of this policy is to ensure that the facility promptly informs the resident, consults the resident's physician; and notifies consistent with his or her authority, the resident's representative when there is a change requiring notification. Compliance guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: 3. Circumstances that require a need to alter treatment. This may include: a. New treatment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to coordinate Preadmission Screening and Resident Review (PASRR) for the residents with newly evident or possible serious mental disorder for 2 of 6 residents reviewed for behavioral health (Residents #6 and #152).Findings include:1) Review of Resident #6's admission record showed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses to include major depressive disorder (onset date of 3/4/2026), brief psychotic disorder (onset date of 1/22/2026), other specified persistent mood disorders (onset date of 1/22/2026), adjustment disorder with depressed mood (onset date of 1/22/2026), and bipolar disorder (onset date of 8/4/2025).Review of Resident #6's PASRR dated 8/1/2025 showed bipolar disorder documented as the only mental illness (MI) or suspected MI under Section I. PASRR Screen Decision-Making.Review of Resident # 6's psychiatry evaluation note dated 8/7/2025 read, Visit Type: Psychiatry: New Evaluation. Chief Complaint: Mood disorder and psychosis. History of Present Illness: This is a [AGE] year old patient with past psychiatric history of depression, anxiety, mood disorder and psychosis. Patient was evaluated for underlying psychiatric conditions and treatment. Facility requested consult. Diagnostic Assessment and Plan: Brief psychotic disorder. Other specified persistent mood disorders.2) Review of Resident #152's admission record showed the resident was initially admitted on [DATE] and readmitted on [DATE] with diagnoses to include major depressive disorder (onset date of 10/30/2025) and other specified persistent mood disorders (onset date of 10/30/2025).Review of Resident #152's PASRR dated 4/22/2025 showed depressive disorder documented as the only MI or suspected MI under Section I. PASRR Screen Decision-Making.Review of Resident #152's psychiatric subsequent note dated 5/8/2025 read, Chief Complaint: Depression, insomnia, and mood disorder. Rationale behind diagnosis: MDD [Major Depressive Disorder], Recurrent: The history suggests that this patient has suffered from episodes of depression lasting for more than 2 weeks. The symptoms have caused significant distress and functional impairment to the patient and they have occurred without any underlying substance use or organic brain pathology. Mood Disorder: The history suggest that the patient has experienced severe mood swings causing emotional distress. As the mood swings are severe requiring monitoring and as needed intervention, the patient qualifies for that diagnosis.During an interview on 5/20/2026 at 1:16 PM, the Social Services Director stated, I was not aware that [Resident #6's name] and [Resident #152's name] PASSR needed to be reviewed. For [Resident #6's name], I thought all the diagnosis fell under bipolar disorder. I did not think I needed to do another review. Psych comes in and have the ability to put new diagnosis. I do not see them. The communication portion would be between the Director of Nursing and the Assistant Director of Nursing. I am not part of their clinical meeting with psych. If they tell me about a significant new diagnosis or if the resident is having behaviors. Usually that is what they will notify me off, but if it's a diagnosis of like depression, it would not be something that they would necessarily tell me.During an interview on 5/21/2026 at 8:27 AM, the Director of Nursing stated, I would not be able to answer [when asked how new diagnosis found after resident is admitted would get updated in the PASSR]. You would have to speak to social services. There is psych in the building, and we have a list of patients that they see, and diagnoses are part of the list. I have only been here for 6 months and that has not been something I have been instructed to do. I have meetings with psych but social services does not sit with us in those meeting. You would need to ask social services if psych communicates with her regarding the new diagnosis.Review of the facility policy and procedure titled Resident Assessment- Coordination with PASARR program with the last review date of 1/21/2026 read, Policy: This facility coordinates assessments with the preadmission screening and resident review (PASARR) program under Medicaid to ensure that individuals with a mental disorder, intellectual disability, or a related condition receives care and services in the most (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	integrated setting appropriate to their needs. Policy Explanation and Compliance Guidelines. 9. Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a Level II resident review.

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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, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 3 residents reviewed for antibiotic use (Resident #24) and 2 of 4 residents reviewed for nutrition (Residents #55 and #67).Findings include: 1) Review of Resident #24's admission record showed the resident was most recently admitted on [DATE] with the diagnoses to include chronic respiratory failure with hypercapnia, unspecified dementia, chronic obstructive pulmonary disease, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, unspecified protein-calorie malnutrition, heart failure, hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease, pulmonary hypertension, obstructive sleep apnea (adult) (pediatric), major depressive disorder, generalized anxiety disorder, gastro-esophageal reflux disease without esophagitis, neuromuscular dysfunction of bladder, and atherosclerotic heart disease of native coronary artery without angina pectoris. Review of Resident #24's physician order dated 9/21/2025 read, Macrobid Oral Capsule 100 MG [milligram] (Nitrofurantoin Monohyd Macro), Give 1 capsule by mouth every 12 hours for UTI for 7 Days and Give 1 capsule by mouth one time a day for prophylactic UTI indefinably. Order Status: Active. Review of Resident #24's care plan showed no focus for antibiotic use. During an interview on 5/21/2026 at 10:00 AM, the Director of Nursing (DON) stated, She [Resident #24] did not have any care plan developed for her antibiotic use. It should have been done. She has been on the antibiotic since September of 2025. 2) Review of Resident #55's physician order dated 3/9/2026 read, Regular diet Easy to Chew MM5 [Level 5 Minced and Moist] Meat texture, Regular consistency, fortified foods. Review of Resident #55's weights and vitals summary showed the resident weighed 175.4 lbs (pounds) on 12/5/2025, and 160.6 lbs on 4/27/2026, which is a -8.44% weight loss. Review of Resident #55's dietary progress note dated 1/15/2026 read, Summary: LDN [Licensed Dietitian Nutritionist] reviewed rt [resident] chart and discussed w/IDT [with intradisciplinary team] during wt [weight] loss meeting. Rt is on a mm5 meat texture and lvl [level] 2 mildly thick consistency of liquids. Medpass started 1/1. No new wt has been taken since last intervention. Plan: Recommend weekly weights. Review of Resident #55's care plan did not show a nutritional focus. 3) Review of Resident #67's physician order dated 3/27/2026 read, Pureed IDDSI4 [level 4 purred food] texture, Level 3 Moderately Thick consistency, assist with all meats, aspiration precautions, fortified foods with all meals, Double Portions with all meals. Review of Resident #67's weights and vitals summary showed the resident weighed 198.2 lbs 10/28/2025, and 169.4 lbs on 4/27/2026, which is a -14.53% weight loss. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident #67's physician order dated 4/23/2026 read, Weekly weight x4 [4 times] every day shift every Sun [Sunday] Restorative will get weight. Review of Resident #67's dietary progress note dated 4/2/2026 read, Summary: LDN reviewed rt chart and discussed w/ DON during wt loss meeting. Rt is at risk for unintentional wt loss d/t [due to] dx [diagnosis] of COPD [Chronic Obstructive Pulmonary Disease], Dysphagia, hypertensive heart disease w/ heart failure, CHF [Congestive Heart Failure], and dementia. Rt has been supplemented with medpass TID [three times a day] and Ensure TID along with double portions and fortified foods to encourage weight stabilization. Weights have been increasing until recently until 10 d [days] ago before rt was sent to hospital for SOB [Shortness Of Breath]. Rt may benefit from weekly weights to monitor wt status and intakes. Plan: Recommend weekly weights x 4 wks. Review of Resident #66's care plan did not show a nutritional focus. During an interview on 5/20/2026 at 2:10 PM, the Minimum Data Set Coordinator stated, Certain departments will do the care plan for their areas. The Registered Dietitian and CDM [Certified Dietary Manager] do the nutrition focus. A nutritional focus will need to be added for [Resident #55's name and Resident #67's name]. They do not have one. Review of the facility policy and procedure titled Comprehensive Care Plans with the last approval date of 1/21/2026 read, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that are defined in the resident's comprehensive assessment and meet professional standards of quality. Policy Explanation and Compliance Guidelines: 2. The comprehensive care plan will be developed within 7 days after the completion of the comprehensive MDS [Minimum Data Set] assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. 3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical. mental and psychosocial well-being. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure residents received services to prevent decrease in range of motion for 1 of 3 residents reviewed for rehabilitation services (Resident #64). Findings include: During an observation on 5/18/2026 at 9:17 AM, Resident #64 was lying in bed. The resident had contractures on both hands.During an interview on 5/18/2026 at 9:17 AM, Resident #64 stated, I am not receiving therapy and I have no splints.Review of Resident #64's physician order dated 11/30/2024 read, PT/OT/ST [Physical Therapy/Occupational Therapy/Speech Therapy] Eval and Treat as indicated.Review of Resident #64's Occupational Therapy Discharge Summary for the service period from 12/3/2024 through 3/7/2025 read, Discharge Recommendations. Range of Motion Program Established/Trained: Restorative Nursing trained and instructed to carry out ROM [Range of Motion] techniques appropriate w [with]/ prior progress in skilled therapy services.Review of Resident #64's medical record showed no occupational therapy evaluation since March 2025.Review of Resident #64's physical therapy encounter note dated 2/25/2025 read, Once in wc [wheelchair], pt [patient] did demonstrate ability to initiate some wc propulsion with BUE [bilateral upper extremities], R [right] > [less than] LUE [left upper extremity] due to hand function.Review of Resident #64's physical therapy encounter note dated 1/30/2026 read, Risk Factors: Due to the documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for: venous insufficiency, decreased circulatory function and contracture.Review of Resident #64's care plan initiated on 3/8/2025 read, Resident had a cerebral vascular accident. goal: the resident will be free form s/sx [signs/symptoms] of complications of CVA [Cerebrovascular Accident], DVT [deep vein thrombosis] , Contractures, aspiration, pneumonia, dehydration) monitor/document mobility status: if resident is presenting with problems or paralysis, obtain order for physical therapy and occupational therapy to evaluate and treat.During an interview on 5/20/2026 at 1:16 PM, Staff M, Physical Therapist, stated, I will try to fill in for OT as much as I can. He [Resident #64] does have active range of motion. He is able to pick up a napkin and clean his nose. He has lost range of motion in his left elbow. As PT, I would want to see what else could be done for him before turning to splints. If patients have a fall or come back from the hospital, we will assess the patients. I would not be able to tell you why he has not been evaluated for OT since last year. [Resident #64 ?s name] should have had at least an OT evaluation. I do not think screenings are sufficient. I think his progress is based on his medical history and OT not seeing him.During an interview on 5/20/2026 at 1:59 PM, the Director of Rehabilitation Services stated, At a minimal, we want patients to be assessed every 6 months. I would have loved for him to have had another OT evaluation in there, but his last one was done last year in January [2025].Review of the facility policy and procedure titled Prevention of Decline in Range of Motion with the last review date of 1/21/2026 read, Policy: Residents who enter the facility without limited range of motion will not experience a reduction in range of motion unless the resident's clinical condition demonstrated that a reduction in range of motion is unavoidable. Policy Explanation and Compliance Guidelines: 1. The facility in collaboration with the medical director, director of nurses and as appropriate, physical/occupational consultant shall establish and utilize a systemic approach for prevention of decline in range of motion, including the assessment, appropriate care planning, and preventive care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on record review and interview, the facility failed to monitor weights for residents who were at nutritional risk for 2 of 4 residents reviewed for weight loss (Residents #55 and #67).Findings include: 1) Review of Resident #55's weights and vitals summary showed the resident weighed 175.4 lbs (pounds) on 12/5/2025, and 160.6 lbs on 4/27/2026, which is a -8.44% weight loss.Review of Resident #55's dietary progress note dated 1/15/2026 read, Summary: LDN [Licensed Dietitian Nutritionist] reviewed rt [resident] chart and discussed w/IDT [with intradisciplinary team] during wt [weight] loss meeting. Rt is on a mm5 meat texture and lvl [level] 2 mildly thick consistency of liquids. Medpass started 1/1. No new wt has been taken since last intervention. Plan: Recommend weekly weights.Review of the nutritional recommendation form dated 1/15/2026 read, [Resident #55's name] 1. Weekly weights x [times] 4wks [weeks].Review of Resident #55's weight records showed the resident weighed 171 pounds on 1/10/2026 and 175.4 pounds on 2/2/2026. There was no weekly weight documented since January 2026.2) Review of Resident #67's weights and vitals summary showed the resident weighed 198.2 lbs 10/28/2025, and 169.4 lbs on 4/27/2026, which is a -14.53% weight loss.Review of Resident #67's dietary progress note dated 1/15/2026 read, Plan: Recommend Weekly weights.Review of Resident #67's dietary progress note dated 4/2/2026 read, Summary: LDN reviewed rt chart and discussed w/ DON during wt loss meeting. Rt is at risk for unintentional wt loss d/t [due to] dx [diagnosis] of COPD [Chronic Obstructive Pulmonary Disease], Dysphagia, hypertensive heart disease w/ heart failure, CHF [Congestive Heart Failure], and dementia. Rt has been supplemented with medpass TID [three times a day] and Ensure TID along with double portions and fortified foods to encourage weight stabilization. Weights have been increasing until recently until 10 d [days] ago before rt was sent to hospital for SOB [Shortness Of Breath]. Rt may benefit from weekly weights to monitor wt status and intakes. Plan: Recommend weekly weights x 4 wks.Review of Resident #67's physician order dated 4/23/2026 read, Weekly weight x4 [4 times] every day shift every Sun [Sunday] Restorative will get weight.During an interview on 5/20/2026 at 3:32 PM, the Registered Dietitian stated, [Resident #55's name] weight loss is unavoidable due to his medical condition. I don't put orders in. For weekly weights, the facility has a timeline of 4 weeks. I give my recommendations to the DON [Director of Nursing] and they put them into the system and go from there. After four weeks, I was expecting to have weekly weights. Every time we have a weight meeting if he had recommendations of weekly weights, it has been spoken about. In reviewing [Resident #67's name] notes, there was a note in April [2026] recommending weekly weights. He has had a lot of trouble swallowing, so he is on pureed diet and if he gets in the wrong mood, he will not want to eat. I don't see weekly weights for him [Resident #67]. It is helpful when we get weight in.During an interview on 5/21/2026 at 8:21 AM, the DON stated, I was unable to locate any additional weight for [Resident #55's name or Resident #67's name]. Usually, recommendations go to the CDM [Certified Dietary Manager], and she will communicate with the restorative aides. Weekly weight recommendations do not need to be approved by the provider. I don't know what happened that I was not able to locate the weights.During an interview on 5/21/2026 at 11:58 AM, the DON stated, The weights go to the CDM. I do not do weights. I have not asked the CDM about the weights. I just could not locate them.During an interview on 5/21/2026 at 12:00 PM, the CDM stated, For [Resident #67's name], I do not have any other weights for the month of April 2026 other than on 4/26/2026, which was 235.5 pounds. For [Resident #55's name], for January, I only have on 1/10/2026 of 171 pounds; no other weights for that month. The DON will give me the recommendations, and she will be the one to put the orders in.Review of the facility policy and procedure titled Nutritional Management with the last review date of 1/21/2026 read, Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to implement an effective staffing system to ensure sufficient nursing staff for meeting the resident needs. Findings include:During an interview on 5/19/2026 at 11:18 AM, Staff R, Licensed Practical Nurse (LPN), stated, I spoke to the staffing coordinator and told her I needed to leave. I have a situation with my daughter and she went to speak with the DON [Director of Nursing] and told me I needed to call my agency in order to find a replacement. I came back here and kept doing what I needed to do while I was waiting on them. I then went back to the staffing coordinator and told her I was behind on my medication administration. No one came to help me or ask me if I was okay. The DON has come to the nursing station and has been on her phone and talking to the other nurse on the other side. She never came to talk to me. I am behind. I have a total of 29 patients and 10 have not gotten their medication and now they are red in the system. Is this a medication error? I don't know what to do. This unit is crazy. There is 3 g-tube [gastric tube] patients. Now I have to do blood sugar checks and give coverage for meals. I have worked in this facility before and not had this happened to me.During an observation on 5/19/2026 at 11:18 AM, Staff R, LPN, had a total of 10 residents in red [medications are late] in the computer screen. Staff R was doing accu-checks for residents and providing insulin coverage for the residents. At 12:20 PM, Staff R, LPN, walked to the nursing station to call Resident #15's provider to notify Resident #15 had refused her medications that were supposed to be administered at 9 AM, and make a list of the residents she was running behind on and the providers' names they belong to in order to notify them that the residents' medications were running late and get further instructions. While sitting at the nursing station, the Assistant Director of Nursing (ADON) came to the nursing station and Staff R called her over to the computer station and informed the ADON she was running behind with medication administration of the ten residents, showing her the computer screen. The ADON had a surprised facial expression and stated, You are behind on all these residents. Staff R replied, Yes. The ADON proceeded to ask for the list of residents and stated she would take care of the situation.During an interview on 5/19/2026 at 12:49 PM, the DON stated, No one told me [Staff R, LPN's name] was behind on her medication administration. The Staff Coordinator came to me this morning and told me [Staff R's name] was having issues with her daughter or sister and needed to leave. I did not have anyone to relieve her and told the Staff Coordinator to tell her she needed to reach out to her agency and they would need to send a replacement. I did not speak to the staff, the Staffing Coordinator did.During an interview on 5/19/2026 at 12:53 PM, the Staffing Coordinator stated, She [Staff R, LPN] came to me in tears in her eyes that she needed to leave due to a situation with her daughter. I told her I did not have anyone to relieve her and I went to speak to the DON. The DON told me she needed to call her agency. I also called the agency and opened a shift, no one was picking up the shift. The nurse [Staff R] came to me again asking me if I had forgotten about her and asked if one of us could relieve her. She basically told me she was behind. I went back again and I let the ADON and DON know. I saw her MAR [Medication Administration Record] and. I did let the ADON know. I don't remember if I told the DON she was behind, but I did go and speak to the DON about replacement. I don't know if she [Staff R] asked another nurse for help. I always do my best to help and go to the person that can help her. The ADON said she was going to see what she could do to help her. I do not know what happened after that. I spoke to the DON. She was right there by the nurse [Staff R] and it is kind of frustrating because she didn't go speak to the staff. I am a CNA [Certified Nursing Assistant]. If I was a nurse, I would have helped. I tried to reach out staff that normally work here, but it did not work out because they had appointments. If we need coverage, the unit supervisor could help, the wound care nurse, the ADON or the DON would cover. I remember it was about 10 [o'clock] when she came to me and as soon as I saw the MAR red, I know I told the ADON.During an (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 5/19/2026 at 2:32 PM, the ADON stated, I was not aware that the staff member was running late. I only found out when you were sitting with the nurse at the nursing station. The staff coordinator did not tell me. I know they were trying to find a replacement for her. I try not to interfere in the DON decisions.Review of Resident #117's admission record showed the resident was admitted on [DATE] with diagnosis to include transient paralysis, dysphagia, conversion disorder with seizures or convulsion, spinal stenosis, major depressive disorder, and anxiety disorder.Review of Resident #117's administration note dated 5/19/2026 read, Per MD [medical doctor], okay to hold flush and continue with schedule as ordered.Review of Resident #117's administration note dated 5/19/2026 read, Per MD Okay to administer medication at 2 pm, continue with dosing as ordered.Review of Resident #117's administration note dated 5/19/2026 read, Per MD, okay to hold dose and resume normal dosing as scheduled.Review of Resident #117's administration note dated 5/19/2026 read, Per MD, okay to administer eye drops at 2pm x 1 dose.Review of Resident #117's administration note dated 5/19/2026 read, Per MD okay to administer eye drops at 2p, resume does time at HS [bedtime].Review of Resident #117's administration note dated 5/19/2026 at read, Per MD okay to reschedule medication at 2 pm, resume normal dosing at 9p.Review of Resident #117's administration note dated 5/19/2026 read, Ok for staff administer aspirin 81 mg [milligram] x 1 dose at 2p.Review of Resident #38's admission record showed the resident was admitted on [DATE] with diagnoses to include multiple sclerosis, ulcerative colitis, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease heart failure, major depressive disorder, atrial fibrillation, and hypokalemia.Review of Resident #38's administration note dated 5/19/2026 read, Copaxone Subcutaneous Solution Prefilled Syringe 20 MG/ML [milligram per milliliters] Inject 1 ml subcutaneously one time a day for MS [Multiple Sclerosis] ARNP [Advanced Registered Nurse Practitioner] aware of administration time, ok to move medication to 1700 [5:00 PM].Review of Resident #38's administration note dated 5/19/2026 read, Methadone HCl [Hydrochloride] Oral Tablet 10 MG give 1 tablet by mouth two times a day for non-acute pain. ARNP aware of administration time, ok to hold and give and next schedule dose.Review of Resident #38's administration note dated 5/19/2026 read, Miralax Oral Powder 17 GM/Scoop give 17 gram by mouth tow times a day for constipation Mix with 4-6 ounces of fluid of choice. ARNP aware of administration time, okay to give.Review of Resident #38's administration note dated 5/19/2026 read, Ferrous Sulfate oral tablet 325 (65 FE) MG give 1 tablet by mouth one time a day for age related vitamin deficiency ARNP aware of administration time, ok to give.Review of Resident #38's administration note dated 5/19/2026 read, Claritin Oral Tablet 10 MG give 1 tablet by mouth one time a day for seasonal allergies. ARNP aware of administration time, ok to give.Review of Resident #38's administration note dated 5/19/2026 read, Cholecalciferol Tablet 1000 Unit give 1 tablet by mouth one time a day for age related vitamin deficiency ARNP aware of administration time, ok to give.Review Resident #38's administration note dated 5/19/2026 read, Potassium Chloride Crys Oral Tablet Extended Release 20 MEQ [milliequivalent] give 1 tablet by mouth one time a day for hypokalemia, APRN aware of administration time, ok to give.Review of Resident #38's administration note dated 5/19/2026 read, Nitrofurantoin Microcrystal oral capsule 50 mg give 1 capsule by mouth in the morning for UTI [Urinary Tract Infection] for 90 Days ARNP aware of administration time , ok to give.Review of Resident #38's administration note dated 5/19/2026 read, ARNP aware of administration time, ok to give.Review of Resident #38's administration note date 5/18/2026 read, Cardizem CD oral capsule extended release 24 hour 180 mg give 1 capsule by mouth one time a day related to hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease. ARNP aware of administration time, ok to give.Review of Resident #38's administration note dated 5/19/2026 read, Duloxetine HCl Capsule Delayed Release Particles 30 mg give 1 capsule by mouth tow times a day for depression related to Major Depressive Disorder Recurrent Moderate ARNP aware of administration time, ok to give.Review of Resident #38's administration note dated 5/19/2026 read, Clopidogrel Bisulfate Tablet (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	75 mg give 1 tablet by mouth one time a day for blood clot prevention APRN aware of administration time, ok to give.Review of Resident #38's administration note dated 5/19/2026 read, Midodrine HCl Oral Tablet 5 mg give 1 tablet by mouth three times a day for hypotension hold if SBP [Systolic Blood Pressure] greater than 130.Review of Resident #38's administration note dated 5/19/2026 read, Resident #38 stated she will take the next dose and wants to wait till after lunch.Review of Resident #97's admission record showed the resident was admitted on [DATE] with diagnoses to include epilepsy, dementia, chronic kidney disease, adjustment disorder, essential tremor, and chronic kidney disease.Review of Resident #97's administration note dated 5/19/2026 read, Sertraline HCl Oral Tablet 50 MG give 1 tablet by mouth one time a day for MDD [Major Depressive Disorder] ARNP notified that agency nurse did not administer residents scheduled 9 AM medications at the scheduled time. ARNP gave order to reschedule Sertraline to 9 PM. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #97's administration note dated 5/19/2026 read, ARNP notified that agency nurse did not administer resident's schedule 9 AM medication at the schedule time. ARNP gave order that it is acceptable to miss scheduled 9 AM ASA [Aspirin] and Keppra. Re-schedule Sertraline for 9 PM. Resident monitored with no noted distress.Review of Resident #97's administration note dated 5/19/2026 read, Keppra Oral Tablet 1000 mg give 1 tablet by mouth every 12 hours for seizures APRN notified that agency nurse did not administer resident scheduled 9 AM medications at the scheduled time. ARNP gave orders that it is acceptable for resident to miss scheduled 9 AM medication or today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #97's administration note dated 5/19/2026 read, Aspirin Oral Tablet Delayed Release 81 MG give 1 tablet by mouth one time a day for CAD [Coronary Artery Disease] ARNP notified that agency nurse did not administer resident's scheduled 9 AM medications at the scheduled time, ARNP gave orders that it is acceptable for resident to miss schedule 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #103's admission record showed the resident was admitted on [DATE] with diagnoses to include type 2 diabetes, heart failure, chronic kidney disease stage 5, major depressive disorder, and gastroesophageal reflux disease.Review of Resident #103's administration note dated 5/19/2026 read, gt [gastric tube] flush with 260 ml of water 5 times a day five times a day, md made aware, ok to administer now.Review of Resident #103's administration note dated 5/19/2026 read, in addendum, change time of administration to 0600 [6:00 AM].Review of Resident #103's administration note dated 5/19/2026 read, Keppra oral solution 100 mg/ml give 2.5 ml via peg tube in the morning related to narcolepsy without cataplexy, md modified new orders to change administration time to 1700 [5:00 PM].Review of Resident #103's administration note dated 5/19/2026 read, Iron oral liquid give 20 ml via peg tube one time a day for supplement house stock 220 mg/5 ml, md notified new order clarification to change time to 0600 [6:00 AM].Review of Resident #103's administration note dated 5/19/2026 read, Hydralazine HCl Tablet 25 MG give 1 tablet via G tube two time a day for HTN [hypertension] hold if BP [Blood Pressure] less than 105/60 or HR [Heart Rate] less than 55, md notified received orders to hold am [morning] dose and resume at next schedule dose.Review of Resident #116's admission record showed the resident was admitted on [DATE] with diagnoses to include hypertensive heart disease, heart failure, PVD [peripheral vascular disease], and hyperlipidemia.Review of Resident #116's administration note dated 5/19/2026 read, Lasix oral tablet 40 mg give 1 tablet by mouth two times a day for CHF, ARNP aware of administration time, ok to give.Review of Resident #116's administration note dated 5/19/2026 read, Metoprolol Tartrate Oral Tablet 100 mg give 1 tablet by mouth two times a day for heart failure hold for HR <60, ARNP aware of administration time, ok to hold until last scheduled dose current heart rate 64.Review of Resident #116's administration note dated 5/19/2026 read, Apixaban Oral Tablet 5mg give 1 tablet by mouth two times a day for Hx [history]: DVT/PE [Deep Vein Thrombosis/Pulmonary Embolism], ARNP aware of administration time, ok to hold until next scheduled dose.Review of Resident #116's administration note dated 5/19/2026 read, Omega 3 (continued on next page)

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Brooksville Healthcare Center	1114 Chatman Blvd Brooksville, FL 34601

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oral capsule 100 mg give 1 capsule by mouth one time a day for HLD [hyperlipidemia], ARNP aware of administration time, ok to give.Review of Resident #116's administration note dated 5/19/2026 read, Potassium Chloride ER [Extended Release] Oral Tablet Extended Release 20 MEQ give 1 tablet by mouth two times a day for diuretic use. ARNP aware of administration time, ok to hold until next scheduled dose.Review of Resident #116'a administration note dated 5/19/2026 read, Multivitamin Oral Tablet give 1 tablet by mouth one time a day for age related supplement, ARNP aware of administration time, ok to give.Review of Resident #116's administration note dated 5/19/2026 read, Coenzyme Q10 Oral Tablet 100 mg give 1 tablet by mouth one time a day for heart supplement, ARNP aware of administration time, ok to give.Review of Resident #116's administration note dated 5/19/2026 read, Cholecalciferol Oral Tablet 25 mcg (1000 UT [unit]) give 1 tablet by mouth one time a day for age related vitamin deficiency. ARNP aware of administration time, ok to give.Review of Resident #116's administration note dated 5/19/2026 read, Multivitamin Oral Tablet give 1 tablet by mouth time a day for age related supplement. ARNP notified that agency nurse did not administer resident's scheduled 9 AM medication at the scheduled time. ARNP gave order that is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #116's administration note dated 5/19/2026 read, ARNP notified that agency nurse did not administration resident's scheduled 9 AM medications at the schedule time. ARNP gave order that it is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #116's administration note dated 5/19/2026 read, Cholecalciferol Oral Tablet 25 MCG [microgram] (100UT) give 1 tablet by mouth one time a day for age related vitamin deficiency. ARNP notified that agency nurse did not administer resident scheduled 9 AM medications at the scheduled time. ARNP gave order that it is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #116's administration note dated 5/19/2026 read, Coenzyme Q10 Oral Tablet 100 mg give 1 tablet by mouth one time a dad for heart supplement, ARNP notified that agency nurse did not administer resident's scheduled 9 AM medications at the scheduled time. ARNP gave order that it is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident monitored with not noted distress.Review of Resident #116's administration note dated 5/19/2026 read, Apixaban Oral Tablet 5 MG give 1 tablets by mouth two times a day for Hx: DVT/PE, ARNP notified that agency nurse did not administer resident's scheduled 9 AM medication at the scheduled time. ARNP gave order that it is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #63's admission record showed the resident was admitted on [DATE] with diagnoses to include traumatic ischemia of muscle, dementia, essential hypotension, and brief psychotic disorder.Review of Resident #63's administration note dated 5/19/2026 read, Metoprolol Succinate ER Oral Tablet Extended Release 24 hour 50 MG give 1 tablet by mouth one time a day for HTN Hold for HR <60 or BP <105/55, ARNP notified that agency nurse did not administer resident's scheduled 9 AM medications at the scheduled time. ARNP gave order that it is acceptable for resident to miss schedule 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #63's administration note dated 5/19/2026 read, Medpass two times a day for weight maintenance 90 ML, ARNP notified that agency nurse did not administer resident's scheduled 9 AM medications at the scheduled time. ARNP gave order that it is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident monitored with no noted distress.Review of Resident #63's administration note dated 5/19/2026 read, Docusate Sodium Capsule 100 mg give 1 capsule by mouth two time a day for constipation, ARNP notified that agency nurse did not administer resident's scheduled 9 AM medications at the scheduled time. ARNP gave order that it is acceptable for resident to miss scheduled 9 AM medications for today. No new orders received at this time. Resident (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	monitored with no noted distress.Review of Resident #118's admission record showed the resident was admitted on [DATE] with diagnoses to include type 2 diabetes, essential hypertension, benign prostatic hyperplasia, major depressive disorder, and gastroesophageal reflux disease.Review of Resident #118's administration note dated 5/19/2026 read, Flomax Capsule 0.4 mg give 1 capsule by mouth one time a day for beginning prostatic hyperplasia order clarification for time change. MD given new orders to change time of medication.Review of Resident #118's administration note dated 5/19/2026 read, Gabapentin Capsule 400 mg give 1 capsule by mouth three times a day for pain, ok to hold am dose per MD.Review of Resident #118's administration note dated 5/19/2026 read, Cyanocobalamin Tablet 1000 MCG give 1 tablet by mouth two time a day for age related vitamin deficiency. OK to hold am dose per MD.Review of Resident #118's administration note dated 5/19/2026 read, Nu-Iron Oral Capsule 150 mg give 1 capsule by mouth one time a day for anemia. Order Clarification for time change. MD given new order to change time of medications.Review of Resident #118's administration note dated 5/19/2026 read, Cardizem Oral Tablet 30 mg give 1 tablet by moth two time a day for HTN. Ok to hold am dose per MD.Review of Resident #118's administration note dated 5/19/2026 read, Metoprolol Succinate ER Oral Tablet Extended Release 24 hour 25 MG give 1 tablet by mouth one a day for HTN Hold or HR < 60 & notify MD, Order clarification for time change. MD given new order to change time of medication.Review of Resident #118's administration note dated 5/19/2026 read, Metformin HCl ER tablet extended release 24 hour 500 mg give 2 tablet by mouth two times a day for DM [Diabetes Mellitus] give 2 tabs=1000 mg, ok to hold am dose per MD.Review of Resident #118's administration note dated 5/19/2026 read, Acetaminophen Tablet 325 mg give 2 tablet by mouth two times a day for non-acute pain ok to hold AM dose per MD.Review of Resident #118's administration note dated 5/19/2026 read, Glipizide Oral Tablet give 5 mg by mouth one time a day for DM, order clarification for time change. MD given new order to change time of medication.Review of Resident #118's administration note dated 5/19/2026 read, Insulin Glargine Solution 100 UNIT/ML inject 65 unit subcutaneously two times a day for diabetes order clarification for time change. MD given new order to change time of medication.Review of Resident #126's admission record showed the resident was admitted on [DATE] with diagnoses to include heart failure, chronic kidney, chronic atrial fibrillation, major depressive disorder, anxiety disorder, PVD, rheumatic heart disease, cardiomyopathy, and brief psychotic disorder.Review of Resident #126's administration note dated 5/19/2026 read, Tramadol HCl tablet 50 mg give 1 tablet by mouth two times a day for none acute pain. Ok to hold morning dose per MD.Review of Resident #126's administration note dated 5/19/2026 read, Sodium Chloride Oral Tablet 1 GM give 2 tablets by mouth one time a day for hyponatremia. Order clarification for time change. MD given new order to change time of medication.Review of Resident #126's administration note dated 5/19/2026 read, Senna S Tablet 8.6 -50 MG give 1 tablet by mouth two times a day for constipation. OK to hold morning dose per MD.Review of Resident #126's administration note dated 5/19/2026 read, Potassium Chloride ER Oral Capsule Extended Releasee 10 MEQ give 1 capsule by mouth one time a day for supplement. Order clarification for time change. MD given new order to change time of medication.Review of Resident #126's administration note dated 5/19/2026 read, Eliquis Tablet 2.5 MG give 1 tablet by mouth two times a day for a-fib. OK to hold morning dose per MD.Review of Resident #15's admission record showed the resident was admitted on [DATE] with diagnoses to include hypertensive chronic kidney disease, dementia, dysphagia, major depressive disorder, and type 2 diabetes.Review of Resident #15's administration note dated 5/19/2026 read, Medication declined, unable to redirect, will f/u with MD.Review of Resident #6's admission record showed the resident was admitted on [DATE] with diagnoses to include hypertensive heart and chronic kidney disease, dementia, pneumonia, chronic systolic heart failure, type 2 diabetes, and acute kidney failure.Review of Resident #6's administration note dated 5/19/2026 read, Amlodipine Besylate Oral Tablet 5 MG give 1 tablet via Peg [Percutaneous Endoscopic Gastrostomy]-Tube one time a day for HTN Hold for B/P <105/60 or hr <55 & notify MD/ARNP. Order clarification for time change. MD given new order to change time of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication.Review of Resident #6's administration note dated 5/19/2026 read, Benztropine Mesylate Oral Tablet 0.5 MG give 1 tablet via Peg-Tube one time a day related to Bipolar Disorder, Unspecified. Order clarification for time change. MD given new order to change time of medication.Review of Resident #6's administration note dated 5/19/2026 read, Multivitamin Oral Tablet give 1 tablet via PEG-Tube one time a day for nutritional support or wound healing. MD notified of medication being held. OK to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Zinc Oral Tablet 50 MG give 1 tablet via PEG-Tube one time a day for nutritional support for wound healing. MD notified of medication being held. OK to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Ivabradine HCl Oral Tablet 5 MG give 1 tablet via PEG-Tube one time a day for heart failure. Order clarification for time change. MD given new order to change time of medication.Review of Resident #6's administration note dated 5/19/2026 read, Cefuroxime Axetil Oral Tablet 500 MG give 1 tablet via PEG-Tube two times a day for Pneumonia for 14 Days. MD notified of medication being held. OK to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Magnesium Oxide Oral Tablet 400 MG give 1 tablet via PEG-Tube one time a day for supplement. MD notified of medication held. OK to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Eliquis Oral Tablet 5 MG give 1 tablet via PEG tube two times a day for DVT. MD notified of medication being held. Ok to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Ascorbic Acid Tablet 500 mg give 1 tablet via PEG-Tube one time a day for nutritional support for wound healing MD notified medication held. OK to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Iron Supplement Oral Solution 220 give 10 ml via PEG Tub one time a day for supplement. MD notified of medication being held. OK to skip am dose.Review of Resident #6's administration note dated 5/19/2026 read, Amiodarone HCl Oral Tablet 200 MG give 1 tablet via PEG-Tube tow times a day for arrhythmia. MD notified of medication being held. OK to skip am dose.During an interview on 5/20/2026 at 11:20 AM, Medical Doctor #1 stated, The facility notified me. There are no concerns of harm. We reschedule some medications. There is no concerns regarding patient health or safety.During an interview on 5/20/2026 at 5:08 PM, the Medical Director stated, The facility reached out to me and we are looking at the root cause analysis. This has never happened here before. Nobody knew she was behind in her medications she did not tell anybody.During an interview on 5/21/2026 at 9:27 AM, the Advanced Registered Nurse Practitioner #1 stated, I was in the building when this happened and I saw the residents. There were no concerns or potential harm. The following day there was no health concerns. This is not something that happens normally here in the facility. We have a charge nurse and also an Assistant Director of Nursing. You will help if anything like this is happening. She needed to tell them. I spoke to the ADON and she never asked for help. The ADON would have jumped in and helped take care of the patients. She is always around. There was no health concerns regarding the residents involved.Review of the facility policy and procedure tiled Nursing Services and Sufficient Staff with the last review date of 1/21/2026 read, Policy: It is the policy of this facility to provide sufficient staff with appropriate competencies and skills set to assure resident safety and attain or maintain the highest practical physical, mental and psychosocial well being of each resident, as determined by resident assessments and individual plans of care. The facility's census, acuity and diagnoses of the resident population will be considered based on the facility assessment. Policy Explanation and Compliance Guidelines: 5. Providing care includes, but is not limited to, assessing, evaluating, planning and implementing resident care plans and respond to resident's needs.Review of the Facility Assessment Tool revised on 1/21/2026 read, Part 2: Services and Care we offer based on our Resident's Needs: Medications: Awareness of any limitations of administering medications. Administering of medications that residents need.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to accurately document urinary catheter care for 1 of 3 residents reviewed for catheter care (Resident #6), failed to ensure change in condition was documented for 3 of 3 residents reviewed for skin conditions (Residents #35, #80 and #87), and failed to ensure treatment documentation was accurate for 1 of 3 residents reviewed for rehabilitation services (Resident #1). Findings include: 1) During an observation on 5/18/2026 at 10:28 AM, Resident #6 was lying in bed. There was a urinary catheter bag, covered with a privacy bag, hanging from the side of the bed. The urinary tubing was clear and free of any kinks. Review of Resident #6's physician order dated 4/25/2026 read, Urinary Catheter: Change Indwelling Catheter and Drainage Bag every 30 days and PRN [as needed] due to clinical indications of infection (sediment, foul odor, dark in color), obstruction (slow drainage), or when the closed system is compromised. Every night shift every 30 day(s) for Preventative and as needed for s/s of infection (sediment, foul odor, dark in color). Review of Resident #6's physician order dated 4/25/2026 read, Urinary Catheter: Indwelling Catheter in place. Size: 16 FR [French scale], Bulb:10 mL [milliliter], Diagnosis: neuromuscular dysfunction of bladder, unspecified. Review of Resident #6's physician order dated 4/25/2026 read, Enhanced Barrier Precautions due to catheter/wound. Review of Resident #6's physician orders did not show order for providing catheter care. During an interview on 5/20/2026 at 10:47 AM, the Director of Nursing (DON) stated, There should be orders in the system for residents who have catheters for catheter care. During an interview on 5/20/2026 at 12:02 PM, Staff N, Licensed Practical Nurse (LPN), stated, Every shift foley care is done and as needed. There should be an order in the system, but we do it anyways. We have a standing order for anyone who has a catheter to do catheter care. During an interview on 5/20/2026 at 12:30 PM, Staff O, Certified Nursing Assistant (CNA) stated, We will always do catheter care on [Resident 36's name] every shift and as needed. During an interview on 5/21/2026 at 11:00 AM, the Assistant Director of Nursing stated, When [Resident #6's name] came back from the hospital, the orders for catheter care fell off. The treatment record would be the only way to document that the care was provided. It is a batch order set. I would expect for orders to be in place in order for staff to have a place to accurately document the care that is being provided. Review of the facility policy and procedure titled Catheter Care with the last review date of 1/21/2026 read, Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use. Policy Explanation: 24. Document care and report any concerns to the nurse on duty. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2) During an interview on 5/18/2026 at 12:10 PM, Resident #35 stated, This bandage on my right arm is from me hitting it in the bathroom when I go in there. During an observation on 5/18/2026 at 12:12 PM, Resident #35 had a bandage on his left forearm that is dated 5/8/2026. Review of Resident #35's nursing notes from 5/8/2026 through 5/18/2026 did not show any skin tear to left forearm/wrist or an application of a bandage to the left forearm/wrist. Review of Resident #35's physician orders from 5/8/2026 through 5/18/2026 showed no physician orders for the left forearm/wrist wound. During an interview on 5/19/2026 at 2:35 PM, Staff B, Registered Nurse (RN), stated, I cannot find any documentation related to the resident's skin tear on his left forearm. During an interview on 5/19/2026 at 2:54 PM, the Assistant Director of Nursing (ADON) stated, It is my expectation that when a resident gets a skin tear that the nurse assesses the skin care, documents the injury. Review of the facility policy and procedure titled Skin Integrity- Skin Tears with the last review date of 1/21/2026 read, Policy Explanation and Compliance Guidelines: 2. Assessment a. Licensed nurses will conduct skin assessments in accordance with facility policy. b. The comprehensive assessment process will be utilized for identifying additional risk factors or conditions that increase risk for skin tears. Examples, include, but ae not limited to: Advanced age, poor locomotion, and presence of ecchymosis. c. When a skin tear is discovered, the nurse shall complete an incident report. The following information shall be recorded: i. The Resident's name ii. The name of the employee discovering the skin tear, iii. The site and description of the skin tear, iv. The date and time the skin tear was discovered, v. The date and time the injury occurred, if known, vi. The name(s) of the employee(s) who provided care for the resident for the previous 24 hrs, vii. Site care rendered and evaluation of the incident, viii. The name(s) of any witness(es) to the incident, ix. the date and time the physician and resident representative were notified, and x. Any other information relevant to the incident. 3) During an observation on 5/18/2026 at 10:15 AM, Resident #80's left forearm had a tan bandage with no date. During an observation on 5/19/2026 at 12:44 PM, Resident #80's left forearm had a tan bandage with no date. Review of Resident #80's physician orders showed no physician order for left hand bandage. Review of Resident #80's progress notes showed no documentation of left forearm bandage. During an interview on 5/19/26 at 1:10 PM, Staff C, LPN, regarding the bandage on Resident #80's forearm, stated, I do not know anything about it. I need to see if there is an order for it. During an interview on 5/19/2026 at 1:15 PM, Staff Q, Wound Care Nurse, stated, I think [Resident #80's name] has a skin tear to her forearm. (continued on next page)

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