STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105300	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Martin Coast Center for Rehabilitation and Healthc	9555 SE Federal Hwy Hobe Sound, FL 33455

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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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to act promptly upon grievances voiced at resident council meetings for 5 residents (Resident #116, #54, #52, #10, #48) of 11 sampled residents, who attended the Resident Council Meeting held during the survey, and for 1 resident (Resident #28) who complained during the initial screening process. The findings included:1 .Record review of monthly resident council meetings revealed complaints about long wait times for provision of services after residents used the call light. Delays in call light response times were mentioned in the monthly resident council meetings that were held on 02/24/26, 01/27/26, 12/30/25, and 11/25/25. The notes from the meeting held on 01/27/26 documented that the nursing staff had long delays in answering call lights most frequently during the night shifts. Record review of the monthly resident council meetings documented ongoing concerns regarding staff speaking foreign languages in resident rooms. This concern was noted in the resident council notes for the meetings held on 03/31/26, 02/24/26, and 12/30/25. 2. Record review revealed Resident #28 was admitted to the facility on [DATE]. His medical diagnoses included Muscle Wasting and Atrophy, Morbid, Severe Obesity due to Excess Calories, and Lymphedema. He had Congestive (Diastolic) Heart Failure, and he was administered a diuretic two times each day for Edema (diuretics increase urination). A quarterly assessment dated [DATE] revealed that Resident #28 had a Brief Interview for Mental Status (BIMS) of 15, which indicated that he was cognitively intact. The focus of his Activities of Daily Living (ADL) Care Plan described his dependence on staff for personal hygiene care that was related to his ADL deficit. He depended on staff for assistance with repositioning, toileting, and getting dressed. An interview was conducted with Resident #28 on 04/06/2026 at 10:00 AM during the initial screening process. Resident #28 said that he has waited for assistance from one to four hours after pressing the call light. He told about a time when he waited for three and a half hours to have his undergarment brief cleaned after a bowel movement. He said that his buttocks was stinging with pain from sitting in the dirty brief for so long. When asked how frequently he had long wait times, Resident #28 answered: Every day. 3. Record review revealed Resident #48 was admitted to the facility on [DATE]. Her diagnoses included Metabolic Encephalopathy, Type 2 Diabetes, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Major Depressive Disorder, Recurrent, Moderate. Review of Resident #48's quarterly assessment dated [DATE] revealed that she had a Brief Interview for Mental Status (BIMS) score of 14. This indicated that she was cognitively intact. Review of the quarterly assessment dated [DATE] revealed that Resident #48 required supervision or touching assistance for toileting. Her care plan documented that she had a self-care deficit and needed staff's assistance to perform and complete activities of daily living (ADLs). An intervention listed in the care plan dated 12/11/25 was to encourage the resident to use the bell to call for assistance. Resident #48 had a medication order for Tramadol HCL that was dated 04/06/26. It was prescribed as needed, for pain. An interview was conducted with Resident #48 in her room on 04/06/2026 at 2:53 PM. When asked if she used the call bell when she needed help with something, Resident #48 answered: Good luck with that! She explained that she could not walk. Resident #48 said when she presses the call light no one comes. It may be 3:00 AM or 4:00 AM, and if no one comes she climbs into the chair and (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 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheels herself into the bathroom. Resident #48 said she was afraid of falling. Resident #48 also pressed the call light at night when she needed pain medication for the pain in her leg or shoulder. She said one consequence of waiting too long for help was that she was in pain longer. At the Resident Council meeting on 4/08/2026 at approximately 2:20 PM Resident #48 said that she had pushed the button and pushed the button and pushed the button, and no one came. 4. Record review revealed Resident #10 was admitted to the facility on [DATE]. Her diagnoses included Invertebral Disc Degeneration, Lumbar Region, Immunodeficiency, and Sciatica. A quarterly assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score equal to 15. This indicated Resident #10 was cognitively intact. An interview during the Resident council meeting was conducted on 4/08/2026 at 2:20 PM. Resident #10 said she heard the call bell activated by another resident the other night and it rang continuously for 35 minutes. When asked how she knew it was 35 minutes, Resident #10 said that she timed it. She said she watched the clock just outside of her room. Resident #10 said the long waits for a response to the call bell was usually at night. 5. Record review revealed Resident #52 was admitted to the facility on [DATE]. Her diagnoses included Muscle Wasting and Atrophy, Right Lower Leg, and Muscle Weakness Generalized, Other Reduced Mobility. She had two prescriptions ordered to treat pain. The medication order for Biofreeze Cool Pain External Gel dated 09/30/25 was ordered for lower back pain. She requested Acetaminophen at times for headaches. An interview was conducted with Staff C on 04/09/2026 at 11:51 AM. When asked what type of pain Resident #52 described when she requested Acetaminophen, Staff C said that sometimes she complained of a headache. An interview was conducted with Resident #52 during the Resident Council meeting on 04/08/26 at approximately 2:30 PM. Resident #52 said that in one instance after she pressed the call light, someone on the floor came in and shut the light off. The CNA told Resident #52 that her assigned CNA will be in. Then, after 15-20 minutes, no one came, and I needed to press the call light again. When Resident #52 was asked if the delayed response to the call bells occurred more during one shift or another, Resident #52 said the delay happened most often during the 3:00 PM -11:00 PM and the 11:00 PM - 7:00PM shifts. She said the delay was a problem when she had a massive headache and had to wait for a long time in pain. 6. Record review revealed Resident #116 was admitted to the facility on [DATE]. His diagnoses included Type 2 Diabetes Mellitus, With Hyperglycemia, PVD (Peripheral Vascular Disease) and Diastolic Congestive Heart Failure. A quarterly assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15. This indicated that Resident #116 was cognitively intact. An interview was conducted with Resident #116 during the Resident Council meeting on 04/08/2026 at approximately 2:30 PM. Resident #116 said that the residents bring up problems at the Resident Council meetings, and nothing gets resolved. According to Resident #116, the problems with the call lights were not resolved. He said on one occasion he pressed the call bell when he needed water, and it was a challenge to get water or ice. He added that he had a problem when the CNAs spoke in a different language. When asked how often this occurred, Resident #116 said that it happens constantly, every day.7. Record review revealed Resident #54 was admitted to the facility on [DATE]. His diagnoses included Spinal Stenosis Cervical Region, Immunodeficiency, Morbid Severe Obesity due to Excess Calories, Adjustment Disorder with Mixed Anxiety and Depression, and Heart Failure. An assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15. This indicated he was cognitively intact. An interview was conducted with Resident #54 during the Resident Council meeting on 04/08/2026 at approximately 2:30 PM. After Resident #116 said he had a problem when CNAs spoke in a foreign language, Resident #54 said: You never know if they're talking about you or what they're saying. He said that the CNAs were warned many times to avoid speaking in another language in front of residents, but they continued to do it. An interview was conducted with Staff B, the Unit Manager (RN) on 04/09/26 at 7:05 AM. When asked if she had received complaints about it taking too long to answer the call bells, she answered yes. She told surveyor about audits that were performed, and she said that the results showed that the delays happened most frequently at meal times and shift (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	changes. Staff B said it had been about 2 weeks since they started doing audits.When asked how much time she thought was reasonable to answer a call light, she answered about 10 minutes. When asked how long was too long, she said 30 minutes, or 1 hour. She told of 1 random resident, who told her it took forever. When asked to view the audits, Staff B said that the Administrator had the documents. The RN provided the surveyor with copies of the audits and the PIP (performance Improvement Plan). She also provided a copy of the Survey Readiness In-service that included the words call lights that was given on 03/27/26. An interview was conducted with the Administrator 04/09/26 at approximately 12:50 PM. She said that the facility was aware of the issues regarding the delays with the call lights. The Administrator said they have been working on making improvements and they have seen improvements since the audits began.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, interview, and record review, the facility failed to ensure timely right to self-administer medications with the interdisciplinary team (IDT) assessment for 2 of 5 sampled residents reviewed for choices (Resident #104 and #7).The findings included:Review of the policy Self-Administration of Medications Program issued 06/2020, documented in part, Procedure: 1. The facility will allow the resident to self-administer drugs if the interdisciplinary team, has determined that this practice is safe. 7. The admitting nurse or designee will complete the Self-Administration of Medication Evaluation and report eh findings to the Unit Manager or designee. 8. The interdisciplinary team must also determine: a. Who will be responsible (the resident or the nursing staff) for storage; If medications are stored at the resident's bedside, a lockbox or locked drawer must be used to store the medication(s); b. Who will be responsible (the resident or the nursing staff) for documentation of the administration of drugs; If the resident is responsible for documentation, maintain a Medication Administration Record (MAR) in the resident's room for the resident to sign and maintain a duplicate MAR for nursing staff; as well as, c. The location of the drug administration (e.g., resident's room, nurses' station, or activities room). 9. Once the resident has been deemed safe by the IDT an order will be obtained from the resident's physician or physician extender listing the medications(s) that may be self-administered, where the medications will be stored, who will be responsible for documentation and the location of administration. 10. Appropriate document of the above determinations will be documented in the resident's care plan. 1) Review of the record revealed Resident #104 was admitted to the facility on [DATE]. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] documented Resident #104 had a Brief Interview for Mental Status (BIMS) score of 11 on a 0 to 15 scale, indicating the resident had moderate cognitive impairment. This MDS documented the resident's diagnoses to include Heart Failure and Respiratory Failure. Review of the initial admission Evaluation dated [DATE] documented the resident did not have the desire to self-administer medications. The progress notes and care plans lacked any documentation related to self-administration of medications. During an interview on [DATE] at 10:20 AM, when asked how he was doing that morning, Resident #104 stated angrily, I was fine until they took my meds away this morning. Resident #104 further explained he was diagnosed with asthma since age 7 and does not go anywhere without his inhalers as he never knows when he would need them. The resident explained he had three inhalers, tums, and Gas X at his bedside and they took them this morning, further stating they were sneaky about it as a nurse came in, stated she was going to look in the top drawer of his bedside stand, and she took the meds. Resident #104 stated he has had those medications at his bedside for the 6 weeks ever since he had been at the facility. The resident further volunteered some of the nurses just told him to put the medications in that top drawer and it would be OK. An order dated [DATE] documented unsupervised self-administration of the rescue inhaler Ventolin, 2 puffs every six hours as needed for shortness of breath or wheezing. During a supplemental interview on [DATE] at 10:25 AM, Resident #104 stated he now had his inhaler and a lock box with a key for storage. The resident explained they left him overnight Monday without his inhaler stating, What if I would have needed it in the middle of the night? (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:10 AM, when asked the process for a resident to self-administer a medication, Staff B, Unit Manager stated she would contact the physician to get an order, would do an education on safely administering the medication and safe storage, and would issue a key. When asked what documentation was completed besides the physician order, the Unit Manager stated she fills out a Resident/Family Education sheet and pulled up the one completed by her for Resident #104 on [DATE]. This documented the resident was accepting to learn and demonstrated correctly. This form lacked any documentation as to the storage of the medication or the inclusion of the IDT. When asked how she became aware of the medications at bedside, the Unit Manager explained she had gone into his room Monday ([DATE]) morning and saw the inhaler and Tums at bedside. She stated that the rescue inhaler was expired and there were two other non-rescue inhalers as well. The Unit Manager stated she ordered the rescue inhaler from the pharmacy for immediate replacement. When asked when the resident received the replacement, the Unit Manager stated it came into the facility Monday evening, and the nurse just put it in her medication cart. The Unit Manager provided the medication to the resident on Tuesday. When asked if the facility utilized any self-administration assessment form with input from the IDT, the Unit Manager stated that she was not aware of any. When told the resident had had the inhaler since admission, the Unit Manager stated she was not aware of that either. During a supplementary interview on [DATE] at 10:28 AM, Resident #104 confirmed he had the inhaler since he arrived to the facility and that he had used it a couple of times. The resident again stated, It is not right that they took it from me overnight. 2) Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Malignant Neoplasm of Larynx, Malignant Neoplasm of Anterior Surface of Epiglottis, Paralysis of Vocal Cords and Larynx, and Tracheostomy Status. Review of the Minimum Data Set, dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15 indicating a cognitive response. Review of the Physician's Orders for Resident #7 included in part the following: An order dated [DATE] for Budesonide Inhalation Suspension 0.5mg via trach three times a day for cold, upper congestion. The order was discontinued on [DATE]. An order dated [DATE] for Budesonide Suspension 0.5mg/2ml give 2ml inhale orally every 12 hours for shortness of breath unsupervised self-administration. An order dated [DATE] for resident to perform self-laryngectomy care and nebulizer self-administration medication; returned demonstration noted and resident education form uploaded. Report abnormalities to provider when applicable. (There was no order for self-administration of medication prior to [DATE]). There was no Self-Administration of Medications evaluation/assessment completed for Resident #7 until [DATE]. Review of the Care Plan for Resident #7 dated [DATE] with a focus on the resident has Laryngectomy tube he does his own Laryngectomy care and refuses to let staff do treatment of trach. The goal was for the resident to have no signs/symptoms of infection through the review date. The interventions included in part the following: Ensure that trach ties are secured at all times. May self-administer nebulizer treatments as ordered. Monitor/document respiratory rate, depth and (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quality. Check and document every shift as ordered. Suction as necessary. On [DATE] at 12:14 PM an observation was made of Resident #7 sitting on the edge of the bed with the tracheostomy in place. There were two vials of Budesonide Suspension 0.5mg/2ml sitting on his windowsill and an open bottle of Hydrogen Peroxide 3% sitting on top of his air conditioning unit. During an interview conducted on [DATE] at 12:14 PM with Resident #7, who was able to communicate by writing on a pad of paper with pen, when he was asked who provides the Budesonide breathing treatments, he said he does. He has done it for years. When asked if he was ever told the medications need to be locked at all times, he said he used to lock them in his nightstand but lost the key quite some time ago and so he just uses the windowsill and the top of the air conditioning unit. During an interview conducted on [DATE] at 10:00 AM with Staff K Licensed Practical Nurse who was asked who provides Resident #7 with the Budesonide, she said it is not due to be given on her shift it would be the nurses on the shift when it is due. When asked if residents can administer medications themselves, she said only if they have been assessed to do so. When asked if the medications need to be secured at all times, she said yes. During an interview conducted on [DATE] at 10:15 AM with H Registered Nurse Unit Manager who was asked about Resident #7 self-administering medications, she said he would need to be assessed, and the meds would need to be secured at all times. She acknowledged the Budesonide and the Hydrogen Peroxide were unsecured at the bedside. Review of the policy Resident rights – Self Administration of Meds – Clinically Appropriate issued 06/2020, documented in part, Procedure: . 2. When a resident requests to self-administer medication(s), it is the responsibility of the interdisciplinary team (IDT) to determine that it is safe before the resident exercises that right.

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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 review the facility failed to ensure they provided a safe, clean, homelike environment for 7 of 13 rooms on the 300 unit (Rooms 306, 307, 311, 312, 313, 314, and 315)The findings included:1.On 04/06/26 at 9:45 AM, an observation was made in room [ROOM NUMBER] of the emergency cord in the bathroom that was approximately 3 feet from the floor. 2. On 04/06/26 at 9:42 AM, an observation was made in room [ROOM NUMBER] of the bathroom emergency cord threaded through the toilet tissue dispenser and tied in a knot. The toilet was missing a toilet seat cover. 3. On 04/06/26 at 9:52 AM, an observation was made in room [ROOM NUMBER] of the bathroom emergency cord threaded through the toilet tissue dispenser and wrapped around the grab bar. The bathroom bottom windowpane was of clear glass with no window covering for privacy. 4. On 04/06/26 at 9:53 AM, an observation was made in room [ROOM NUMBER] of the inside of the bathroom door with a crack in the door at the bottom. 5. On 04/06/26 at 9:54 AM, an observation was made in room [ROOM NUMBER] of the inside of the bathroom door with a crack in the door on the left side. 6. On 04/06/26 at 9:57 AM, an observation was made in room [ROOM NUMBER] of the bathroom emergency cord threaded through the toilet tissue dispenser and wrapped around the grab bar. 7. On 04/06/26 at 9:59 AM, an observation was made in room [ROOM NUMBER] of the bathroom emergency cord wrapped around the toilet tissue dispenser and tied in a knot, approximately five feet above the floor. There were holes inside of the bathroom door. During an interview conducted on 04/07/26 at 3:12 PM with the Director of Maintenance who was asked about emergency cords, he said they should be free hanging and function when pulled. During a side-by-side tour conducted on 04/07/26 at 3:18 PM with the Director of Maintenance, who acknowledged the above concerns and stated they are working on renovating some of the areas and the 300 unit has just been started. He acknowledged the emergency cords in the bathrooms should be freely hung and be no more than approximately six inches from the floor

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide nail care for 1 of 2 sampled residents (Resident #21), who was reviewed for nail care.The findings included: Record review revealed Resident #21 was admitted to the facility on [DATE]. His diagnoses included Chronic Obstructive Pulmonary Disease, Muscle Weakness, Other Lack of Coordination, and Arthritis. A Significant Change assessment dated [DATE], documented Resident #21's Brief Interview for Mental Status (BIMS) score was 14. This indicated that he was cognitively intact. Resident #21's care plan last revised on 12/06/25 documented that he had an ADL (Activities of Daily Living) self-care performance deficit related to Chronic Obstructive Pulmonary Disease, Arthritis, and Muscle Weakness. A documented intervention, since 07/19/24, was for staff to trim and clean his nails on bath day and as necessary. An observation on 04/06/2026 at 12:32 PM revealed that Resident #21's fingernails were long. They were approximately one half of an inch past his fingertips. An interview with Resident #21 was conducted on 04/06/26 at 12:35 PM. When asked if he liked his fingernails this long, Resident #21 said I don't have anybody to clean them. I don't like them so long. A second observation of Resident #21's fingernails on 04/07/2026 at 2:12 PM revealed his fingernails were long. Light brown to medium brown colored sediment was under his fingernails. Both hands had long fingernails that were approximately one half of an inch past fingertips. An interview was conducted with Staff M on 04/07/2026 at 4:35 PM. When asked to observe and describe the condition of Resident #21's fingernails, Staff M said that they were too long, and they needed to be cut. Staff M explained that Resident #21 liked his nails short.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to effectively communicate and document communication with medical professionals for 1 of 5 sampled residents observed during the medication administration observation. Resident #126 had low blood pressure readings on two consecutive days and Staff E, Registered Nurse (RN) made independent decisions as to which blood pressure medications to hold and then later provide. The facility also failed to ensure accurate skin assessments for 1 of 14 new admissions as evidenced by the failure to include a skin impairment to the right leg of Resident #126.The findings included:1) Review of the policy Medication Administration and Documentation - General not dated, documented in part, Policy: Medication Administration and Documentation shall occur in a timely and accurate manner. 2. Medications are to be administered within a two-hour time frame (i.e. one hour before or after the medication order time. Responsibility: The licensed nurse: . 18. Documents administration of medication on the MAR (Medication Administration Record) or eMAR (electronic) immediately following administration. Documents any medications not administered (i.e. refused, etc.) and documents reason. 22. Documents all held or refused medications on MAR or eMAR. Uses prudent professional judgement by informing Physician in a timely manner when medications held, refused, or otherwise unavailable for administration.During a medication administration observation for Resident #126 on 04/08/26 beginning at 9:36 AM, Staff E, RN stated she had taken the resident's blood pressure earlier and it was 115/60 and that she was going to re-check it prior to the administration of her morning medications. Upon re-check the resident's blood pressure was 109/54. The RN told Resident #126, I will hold on to the BP (blood pressure) meds (medications) as your BP is in the good range Staff E stated she would hold the spironolactone (a blood pressure and diuretic, a pill to rid excess fluid through urination) and amlodipine (a blood pressure pill). Staff E returned to the medication cart and wasted the two blood pressure medications and stated, usually if it's below 110 (the upper reading of the blood pressure) we hold the medication.During medication reconciliation after the observation, the record revealed the same nurse had held only the amlodipine on 04/07/26 for a blood pressure reading of 98/63.During an interview on 04/08/26 at 11:13 AM, when asked if she was made aware the blood pressure medications were held on 04/07/26 for Resident #126, Staff F, Nurse Practitioner (NP) stated she was told yesterday that her blood pressure was under 110 and that she held her BP meds. When asked if she was told today, the NP stated, not yet, but we are rounding. When asked if she had been told which blood pressure medications were held yesterday, the NP stated she was not.During a supplemental interview on 04/08/26 at about 11:20 AM, when asked again the process for when a medication was held, Staff E, RN stated it would depend upon the parameters, but generally if the blood pressure was below 110 she would hold it to divert an emergency of extremely low blood pressures. The RN then stated she would wait two hours, re-take the blood pressure and give the medication if the blood pressure had increased above the 110 reading. When asked if she would document all of her interventions, the RN stated she should. When asked why she held both the amlodipine and spironolactone earlier that day, but only the amlodipine yesterday, the RN stated because the BP went up and she had given the amlodipine. When asked if she documented that follow-up administration of the amlodipine, the RN stated, Maybe not because if I'm in a hurry I may have forgotten. Review of the record lacked the documented administration of the amlodipine on 04/07/26. When asked if she was allowed to decide which medications to hold, the RN stated, No that is why I talk with the doctor. When told the NP was not aware which medication was held or that she only held one of the blood pressure pills, the RN stated, Oh.During a follow-up interview on 04/08/26 at approximately 11:39 AM, Staff F, NP stated she was unaware Staff E, RN, went back and gave the amlodipine on 04/07/26.During a follow-up interview on 04/08/26 at 1:08 PM, when asked again about her reason to hold both meds that same day, but only one medication the previous day, the RN (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated because Resident #126 was already on another diuretic, Lasix, and yesterday after holding just the amlodipine she voided excessively. 2) Review of the record revealed Resident #126 was admitted to the facility on [DATE]. Review of the skin assessment dated [DATE] in the admission Evaluation, the assessment lacked any documented issues. Review of a second skin assessment dated [DATE] documented bilateral upper extremity bruising, a right foot wound, bilateral lower extremity discoloration, and bruising to the resident's jaw. This entry lacked any documented dressing or open area to the resident's right leg. Review of the skin assessment dated [DATE] documented bruising but lacked any skin issue to the resident's right leg. A skin assessment dated [DATE] lacked any documented skin issues.Review of the physician orders and progress notes lacked any documentation related to a skin issue to the resident's right leg.During an interview and observation on 04/06/26 at 8:06 AM, Resident #126 was lying in bed on top of the covers. A boarder dressing dated 3/30 was noted to the resident's right leg just below her knee. Photographic evidence obtained. When asked about the dressing to her leg, the resident was unsure what had happened.On 04/08/26 at 9:36 AM when asked about the dressing on her right leg, Resident #126 stated it had been removed by staff but was unable to recall when or by whom.During an interview on 04/09/26 at 10:09 AM, when asked about completion of the skin assessment at admission, Staff B, Unit Manager, stated the nurse should utilize the skin/wound section in admission Evaluation. The Unit Manager reviewed the skin assessments and agreed with the findings, confirming the skin assessment dated [DATE] was completed by the wound care nurse and lacked any documentation related to the right leg.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to identify and treat hand contractures for 1 of 2 sampled residents, Resident #94, reviewed for range of motion. The findings included: Record review revealed Resident #94 was admitted to the facility on [DATE]. Her diagnoses included Gout, Glycoprotein Disorders, Rheumatoid Arthritis, Polyneuropathy, Arthritis and Dementia, Without Behavioral Disturbance. A quarterly assessment dated [DATE] revealed that Resident #94 had memory problems, and she required assistance with feeding. Her care plan for chronic pain related to Neuropathy and Arthritis, last revised on 06/18/24, included an intervention for physical activity to strengthen and improve mobility. It also included an intervention for staff to observe and report decreased functional abilities and decreased range of motion.An observation on 04/07/2026 at 11:00 AM revealed that both of Resident #94's hands were in her lap under a folded blanket. Staff N, her CNA (Certified Nursing Assistant), removed the blanket. Both of Resident #94's hands were contracted. Her fingers curled towards the palms of her hands. An interview was conducted with Staff N on 04/07/26 at approximately 11:00 AM. When asked if Resident #94 could open her hands to straighten the fingers, Staff N explained that Resident #94 did not open her hands. She said that Resident #94 kept her fingers curled in (like closed hands). Record review revealed no orders for a hand appliance to decrease the risk of further contracture. Medical physician's notes reviewed showed no mention of hand contractures. An interview with the Director of Rehabilitation on 04/09/2026 at approximately10:00 AM revealed that Resident #94 had no treatments for splinting or orthotic care for her hands. She said that the therapy department did not provide therapy for Resident #94's hand contractures. The Director of Rehabilitation confirmed that the benefits of treating hand contractures included possible prevention of pain and/or prevention of the contractures from worsening.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure tracheostomy care was performed and documented; and failure to ensure of emergency equipment at bedside for residents with tracheostomy for 1 of 1 sampled resident reviewed for tracheostomy (Resident #7).The findings included:Review of the facility's policy titled, Tracheostomy Care with a revised date of August 2013 included in part the following: Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies. A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times. Site and Stoma Care: Document the procedure, condition of the site and the resident's response. Record review for Resident #7 revealed the resident was admitted to the facility on [DATE] with diagnoses that included in part the following: Malignant Neoplasm of Larynx, Malignant Neoplasm of Anterior Surface of Epiglottis, Paralysis of Vocal Cords and Larynx, and Tracheostomy Status. Review of the Minimum Data Set assessment dated [DATE] documented in Section C a Brief Interview of Mental Status score of 15, indicating a cognitive response. Review of the Physician's Orders for Resident #7 included in part, the following:An order dated 04/06/26 for resident to perform self-laryngectomy care and nebulizer self-administration medication; returned demonstration noted and resident education form uploaded. Report abnormalities to provider when applicable.An order dated 04/08/26 for resident to perform trach care every day shift and as needed.An order dated 04/09/26 for Suction as needed: Oral/Nasopharyngeal/Tracheal as needed for Respiratory Secretions.Review of the Medication Administration Record and Treatment Administration Record for Resident #7 revealed no documentation of trach care having been performed (by staff or resident) from 03/23/26 to 04/06/26.Review of the Nursing Progress Notes from 03/23/26 to 04/06/26 revealed no documentation of trach care having been performed (by staff or resident)Review of the Care Plan for Resident #7 dated 10/24/23 with a focus on the resident has Laryngectomy tube; he does his own Laryngectomy care and refuses to let staff do treatment of trach. The goal was for the resident to have no signs/symptoms of infection through the review date. The interventions included in part the following: Ensure that trach ties are secured at all times. May self-administer nebulizer treatments as ordered. Monitor/document respiratory rate, depth and quality. Check and document every shift as ordered. Suction as necessary. On 04/06/26 at 12:14 PM an observation was made of Resident #7 sitting on the edge of the bed with a tracheostomy in place. There was no suction machine observed in the room. During an interview conducted on 04/06/26 at 12:14 PM with Resident #7, who was able to communicate by writing on a pad of paper with pen, when he was asked who provides the care for his tracheostomy, he communicated he does all of the care himself. During an interview conducted on 04/08/26 at 8:37 AM with the resident's Primary Physician, who was asked about Resident #7, he said he did not recall this resident but has so many patients that he sees. When reminded that this resident has a stoma in his throat, he said he still did not recall the patient. When asked in general whether he would have orders for cleaning or monitoring the stoma, he said there should be standing orders for stoma site care. He said no staff has reached out to him regarding any stoma care. Again, he stated it should be in the standing orders and directed the surveyor to speak with nursing staff. During an interview conducted on 04/08/26 at 9:30 AM with Staff F, Nurse Practitioner, who was asked in general about tracheostomy care, she said the facility would need to follow their protocol. She stated she would expect the tracheostomy care to be provided daily minimally and documented as such. When asked about emergency supplies at the bedside, she stated she would expect to see a suction machine, an Ambu bag and replacement tracheostomy tube at the bedside. When asked about Resident #7 she said the resident has a well healed tracheostomy stoma and feels he is quite capable of performing self-care of the tracheostomy stoma. During an interview conducted on 04/08/26 at 10:15 AM with Staff H, Registered Nurse Unit Manager, who was asked about Resident # 7 if he would (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	need any emergency equipment at the bedside due to having a tracheostomy, she said he should have a suction machine, and an inner cannula at the bedside. She acknowledged Resident #7 did not have a suction machine at the bedside.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interview, the facility failed to remove bed rails for residents that were assessed not to have them (Resident #69 and Resident #78); and failed to get obtain appropriate assessments for a resident was able to have bedrails (Resident #11) for 3 of 3 residents renewed for bedrails. 1. Review of Resident #11 medical records revealed the resident was admitted to the facility 12/19/22 with a diagnosis to include Dementia with Psychotic Disturbances, Anxiety Disorder, Parkinson's Disease, and Wandering. Her quarterly Minimum Data Set (MDS) assessment documents her Brief Interview for Mental Status (BIMS) was 00, indicating severe cognitive impairment. During multiple observations from 04/09/26-04/09/26, the resident was seen with side rails / enablers up on her bed. Review of the physician orders, dated 03/19/26, documented for side rails. Review of the care plan documents for adaptive equipment: Bilateral adaptive side rails for bed mobility dated 03/31/23. Resident #11 had a consent in her records, but it was not filled out or signed. The record had 4 ?Side Rail Assessments' that were dated 12/20/23, 03/18/24, 12/13/24 and 03/13/25. All of the documents show that there is a quarterly assessment and only two questions had been answered: A. Reason for evaluation? Quarterly and is resident immobile? Yes (If yes, evaluation is complete. Do not proceed further), and B. Side rail Determination: Not completed since Yes was answered above. 2. Review of Resident #69's records revealed the resident was admitted to the facility 10/02/23. Her diagnosis included Dementia and Depression. Her quarterly MDS assessment dated [DATE] documents her BIMS score of 00 indicating severe cognitive impairment. Review of the physician order dated 03/26/26 documented for Adaptive Equipment: Bilateral adaptive side rails for bed mobility. Monitor for proper functioning every shift. Review of the last quarterly side rail assessment, dated 10/03/25, documents the reason for evaluation as: Quarterly and then asks is resident immobile. Yes (if yes, evaluation is complete. Do not proceed further). Section B documents the side rail determination. This section cannot be opened if staff answered yes to section A. Review of the care plan,, dated 01/15/26, documents that Resident #69 has an ADL (Activities of Daily Living) Self Care Performance Deficit related to muscle weakness and has Adaptive Equipment: Bilateral adaptive side rails for bed mobility. During multiple observations from 04/09/26 to 04/09/26, the resident was seen with side rails / enablers up on her bed. 3. Review of Resident #78's medical records revealed Resident #78 was admitted to the facility on [DATE] with a diagnosis to include a Fracture Left Hip, Diabetes Mellitus, Major Depressive Disorder. Review of the Medicare 5 Day MDS dated [DATE] documents a BIMS score of a 5 indicating severe cognitive impairment. A side rail evaluation and consent were not located in her electronic record but Staff H, Unit Manager, who is also the relative of this resident showed the surveyor on her computer the evaluation and consent dated 03/10/26. Further review revealed a physician's order for the adaptive side rails was put in place on 04/08/26 while the surveyors were onsite as well as the Care Plan for side rails that was dated 04/08/26. During multiple observations from 04/09/26 to 04/09/26, the resident was seen with side rails / enablers up on her bed. During an interview on 04/08/26 at 12:05 PM with the Director of Nursing (DON), the DON reviewed Resident #11, Resident #69 and Resident #78's medical records for the bed rail assessments, physician orders, care plans, and consents. The DON acknowledged the surveyor findings. She acknowledged that when doing the evaluation when you answer yes if the resident is immobile then you do not go any further, and that the resident is not appropriate for the side rails.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations interview and record review the facility failed to follow their policy to assure the drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled for 2 of 8 sampled residents reviewed for medication reconciliation (Resident #20 and #50). The findings included:Review of the facility's policy titled, Discarding and Destroying Medications with no date documented in part the following: Medications will be disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances. Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident. 1. Record review for Resident #20 revealed a physician's order dated 05/27/25 for Lorazepam 0.5mg give half tab by mouth once daily as needed for 30 days. The medication was discontinued on 06/26/25.On 04/09/26 at 10:40 AM a review of the 300 unit med (medication) cart was completed with Staff K, Licensed Practical Nurse (LPN), including controlled medications. The monitoring/control records included Lorazepam 0.5mg for Resident #20 and the medication continued to be on the med cart in spite of having been discontinued on 06/26/25.During an interview conducted on 04/09/26 at 10:40 AM with Staff K LPN who was asked about controlled medications, she said they are removed from the cart upon discontinuation of the medication.2. Record review for Resident #50 revealed an order dated 02/05/26 for Lorazepam 0.5mg give 2 tablets by mouth every 6 hours as needed. The medication was discontinued on 02/06/26.On 04/09/26 at 11:45 AM a review of the 400 unit med cart was conducted with Staff L Licensed Practical Nurse (LPN) including controlled medications. The monitoring/control records included Lorazepam 0.5mg for Resident #50 and the medication continued to be on the med cart in spite of having been discontinued on 02/06/26.During an interview conducted on 04/09/26 11:45 AM with Staff L LPN who was asked when controlled medications are removed from the cart, she said when they are discontinued, she will bring them to the Director of Nursing.During an interview conducted on 04/09/2026 11:50 AM with Staff H, Registered Nurse Unit Manager, who was asked when controlled medications are discontinued when they are removed from the medication cart, she said it should be immediately. When asked about the Lorazepam for Resident #20 she acknowledged there was no active order and the medication should have been removed from the medication cart upon it being discontinued. When asked about the Lorazepam for Resident #50 she acknowledged there was no current order for the medication and it also should have been removed from the medication cart upon it being discontinued.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to provide the minced and moist diet to 3 of 3 sampled residents (Resident #77, Resident #132, and Resident #3). This had the potential to affect 9 residents who were on the minced and moist diet.The findings included: A record review of the facility's Policy on the International Dysphagia Diet Standardization Initiative (IDDSI) Implementation revealed that following the specific prescribed food textures was necessary to ensure the safety and well-being of residents with swallowing difficulties. The Level 5 - Minced and Moist Diet specified that foods are finely minced or chopped into small (approximately 4 mm) in size and then moistened with gravy. The IDDSI Handout for people on the Minced and Moist Diet specifies that foods that are dry, hard, crispy, and crusty should be avoided. Photographic Evidence of Facility's Policy was obtained. Reference to the Minced and Moist Handout can be obtained from 5_minced_moist_adults_consumer_handout_30jan2019.pdf. 1 Record review showed that Resident #77 was admitted to the facility on [DATE]. Her diagnoses included Immunodeficiency, Dementia, Moderate, with Anxiety, and Oropharyngeal Dysphagia (swallowing difficulty). A Brief Interview for Mental Status (BIMS) performed on 03/25/26 revealed a score of 4. This meant that Resident #77 had severe cognitive impairment. The electronic medical record revealed a doctor's order for a Regular diet, Minced and Moist texture (MM5), with Thin Fluids consistency since 04/16/25. An observation of the lunch meal on 04/08/26 at 12:20 PM in the main dining room revealed that Resident #77 was served clusters of crispy fried chicken with thick light brown gravy. The gravy was on top of the chicken and it covered approximately 70% of the surface area on top of the chicken. The gravy was not mixed into the chicken. The meal specified that she was to receive the Regular diet, with Minced and Moist texture foods, and Thin Liquids. The chicken should have been minced into pieces that were small, approximately 4 mm in size, and then moistened with gravy. Photographic Evidence Obtained. 2. Record review showed that Resident #132 was admitted to the facility on [DATE]. Her diagnoses included Immunodeficiency, Unspecified, Muscle wasting and atrophy, and Gastroesophageal Reflux Disease. A Brief Interview for Mental Status (BIMS) performed on 04/01/26 revealed a score of 13. This meant that Resident #132 was cognitively intact. The electronic medical record revealed a doctor's order for a Regular diet, Minced and Moist texture (MM5), with Thin Fluids consistency since 04/01/26. According to the Nutrition Risk Evaluation dated 04/03/26, Resident #132 had a history that included a procedure that removed retained food from the esophagus. An observation of the lunch meal in the Memory Support Dining Room on 04/08/26 at 12:33 PM revealed that Resident #132 was served an entree that had mostly minced chicken and 1 piece of chicken that was approximately one inch in length. That piece of chicken had dark crusty edges and it was not minced. Photographic Evidence Obtained. 3. Record review revealed Resident #3 was admitted to the facility on [DATE]. Her diagnoses included Immunodeficiency, Muscle Weakness, Generalized, Chronic Obstructive Pulmonary Disease and Dementia, Unspecified Severity, with Other Behavioral Disturbance. An assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03. This indicated she had severe cognitive impairment. The physician's order for a Regular diet, with Minced and Moist (MM5) texture, and thin fluids consistency was dated 01/15/26. An observation of the lunch meal in the Memory Support dining room on 04/08/26 at 12:42 PM revealed that Resident #3 was served minced chicken with thick light brown gravy on top of approximately 35-40% of the minced chicken. There were areas of minced chicken that had no gravy. The Registered Dietitian was present in the Memory Support dining room. An interview was conducted with the Registered Dietitian in the dining room on 04/08/26 at 12:42 PM. When she was asked if she saw any parts of the chicken entree that were dry, she said that there was no gravy on the chicken that was on the edges of the plate. She added, If it were mixed in, it would be adequate. An interview was (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure offering and provision of the pneumococcal vaccine for 1 of 5 sampled residents, Resident #48.The findings included:Review of the record revealed Resident #48 was admitted to the facility 04/20/23. Review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 14, on a 0 to 15 scale, indicating the resident was cognitively intact.Review of the electronic medical record under the immunization tab revealed documentation Resident #48 had refused the pneumococcal vaccine on 06/28/23. The record lacked any further documentation related to that vaccine.During a side-by-side record review and interview on 04/08/26 at 3:17 PM, when asked how often the pneumococcal vaccine was offered to residents, the Infection Preventionist (IP) stated upon admission and annually when they are obtaining consents for the flu vaccine. The IP was unable to find any evidence of a current consent for or declination of the pneumococcal vaccine for Resident #48.During an interview on 04/09/26 at 11:56 AM, when asked if she were offered the pneumonia vaccine would she want it, the resident stated, I think so. When asked if she knew what the vaccine was for, she stated she wasn't sure. When told the vaccine was to help prevent pneumonia the resident stated, I've had that before. When asked again if she would want the vaccine if it were offered to her, Resident #48 stated she would. When asked if she had been offered the pneumonia vaccine the resident stated she had not.During an interview on 04/09/26 at 11:59 AM, when asked about the cognition of Resident #48, Staff D, Registered Nurse (RN) stated she can be a little confused at times, but she is alert and oriented and can make her needs known.During an interview on 04/09/26 at 9:30 AM, when asked why the pneumococcal vaccine was missed for Resident #48 this past season, the Assistant Director of Nursing (ADON) stated they have no idea how she was missed.