STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105305	A. Building B. Wing	02/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairway Oaks Center	13806 N 46th St Tampa, FL 33613

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations interviews and record review, the facility failed to ensure dependent residents received assistance with showers for three residents (#4, #3 and #2) out of four residents reviewed.Findings included: 1. During a facility tour on 2/21/2026 at 9:40 a.m., Resident #4 was observed in her room. The resident stated had not had a shower since she was admitted to this facility. She stated she had been assisted with one bed bath, upon admission, not sure exactly. Review of Resident #4's admission record revealed the resident was admitted on [DATE] with diagnoses to include hypertensive heart disease without heart failure, unsteadiness of the feet, other gait abnormalities, need for assistance with personal care and blindness of left eye. Review of a Minimum Data Set (MDS) for Resident #4 dated 2/8/2026 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14 meaning the resident was cognitively intact. Review of the Certified Nursing Assistant (CNA) task log for showers revealed there was no documentation to show the resident had received assistance with showers or baths for 13 days. 2. On 2/21/2026 at 10:02 a.m. an interview was conducted with Resident #3 observed in her room, noted scratching and itching her arms and upper body. Her skin was observed scaly with dry, rough, and large fishlike flakes. The resident stated she was supposed to see a dermatologist, but it had not been scheduled. She stated her family member had discussed this with the facility the previous Friday , on 2/13/2026. she stated she was applying regular store lotion, and it was not helping. The resident stated she had struggled with receiving assistance with showers. Resident #3 said, sometimes they just don't want to help you. The resident stated having filed a grievance that remained unresolved. She stated they, Just wash me up, late at night. The resident stated she wanted to shower. Review of Resident #3's admission record revealed the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses to include morbid (severe) obesity due to excess calories, Type 2 diabetes, unspecified kidney failure. Review of an MDS for Resident #3 dated 11/25/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, meaning the resident was cognitively intact. Review of a care plan for Resident #3 initiated 5/23/2024 revealed an ADLs self-care deficit r/t (related to)ADL needs. Participation varied due to chronic medical conditions, fatigue, impaired balance, and limited mobility. Interventions included to encourage and assist with ADL tasks including . bathing. Bathing – the resident is dependent on staff for bathing needs including transfer (continued on next page)

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	into and out of the shower. Review of the CNA task log for shower/bathing for the month of February 2026 revealed a shower/bathing schedule of Monday, Wednesday and Saturday evening on 3p.m. to 11p.m. shifts. The review showed the same time stamp was entered for all CNA task log. An interview with Staff A, CNA revealed that meant it was when the documentation was completed, not necessarily when the task was completed. Review of a grievance form for Resident #3 dated 2/11/2026 showed detail of complaint was, concerns regarding showers. The grievance official follow up documented CNA provided ADL care and gave resident a shower hair was washed, and nail care was performed. Resident satisfied with outcome no further concerns. The grievance was marked resolved on 2/13/2026. There were no other documents attached to include education or staff training. On 2/21/2026 at 12:35 p.m. an interview with Staff B, Licensed Practical Nurse/Unit Manager (LPN/UM). She stated Resident #3's family member was concerned about showers. She said, I followed up, I do not remember the day. I reviewed the book and saw she had not been showered. We gave her a shower. The LPN stated she thought the issue was resolved. She stated she had not heard the resident still had issues. On 2/21/2026 at 12:30 p.m. an interview was conducted with Staff A, CNA. Staff A stated Resident #4 was supposed to shower twice a week or as requested. She reviewed the showers binder and there were no shower sheets for this resident. She stated, It should be documented, I don't know why. On 2/21/2026 at 12:45 p.m. an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated if the resident refused the shower, the CNAs should let the nurse know and if it was on-going IDT (interdisciplinary team) should be notified. The care plan should reflect refusals. The ADON stated Resident #4 was scheduled to shower today. She stated the shower logs or task logs should be documented. The ADON reviewed the electronic medical record and shower sheets and did not see anything documented. The ADON said it should be documented unless, it is her preference not to shower at all. During an interview on 2/21/2026 at 2:41 p.m., the interim Director of Nursing (DON) stated there should be shower sheets for the residents' showers and there should be documentation in the CNAs task log. The DON stated there should be documentation if the resident refuses. It should be documented that the nurse followed up if the CNAs reported concerns. Review of a care plan initiated on 2/9/2026 revealed an ADL focus, [Resident #4] has an ADL deficit r/t (related to) ADL needs and participation vary, fatigue, and chronic medical conditions. Interventions included to encourage and Educate resident with increased Independence as tolerated and assist with all ADL (activities of daily living) tasks as indicated, including .bathing, . personal/oral hygiene. Observe resident for changes in ADL capabilities. Notify nurse, therapy, and/or MD [medical director] as indicated. Bathing : The resident needs assist limited to extensive of 1-2 based on fatigue, weightbearing, weakness. 3. Review of Resident #2's showering/bathing schedule showed the resident was to receive assistance with bathing on Tuesday and Fridays during the 3 p.m. -11:00 p.m. The review revealed the resident received one shower on 2/6/26 out of three opportunities. The task documentation did not reveal the resident had refused bathing from 1/30 – 2/6/26. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #2's admission Record revealed the resident was admitted on Friday 1/30/26. The Admission/readmission evaluation showed vital signs had been obtained on 1/30/26 at 4:38 p.m. The evaluation showed the resident required extensive assistance with bed mobility, was dependent upon staff assistance for toileting and transferring. Review of Resident #2's care plan showed the resident had a potential for Activities of Daily Living (ADL) self-care deficit related to ADL needs and participation vary, fatigue, (and) chronic medical conditions. The interventions showed the resident needs assist limited to extensive of 1-2 based on fatigue, weightbearing, and weakness for bathing. During an interview on 2/21/26 at 1:19 p.m. the Assistant Director of Nursing (ADON) state residents are scheduled for showering twice a week and per preference but at least twice a week. Review of a facility policy titled, ADL care and Services, revised 01/2024 revealed a standard- Residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living ADL's. Guideline: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene.4. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with, including but not limited to: (a.) hygiene bathing showers dressing grooming nail care oral care.

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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 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 record reviews and interviews the facility failed to ensure one (#2) of four residents received treatment and care in accordance with professional standards of nursing, physician orders, and person-centered care plan.Findings included: Review of Resident #2's February Medication Administration Record revealed an order dated 1/30/26 instructing staff to obtain vital signs every shift for 5 days. The order ended after vital signs had been obtained on the 3 p.m. - 11 p.m. shift on 2/4/26. The review revealed the following blood pressure (bp), temperature (temp), pulse, respiration (resp), and 02 saturation (sat):2/1/26 7:00 a.m. - 3:00 p.m.: bp 115/62, temp 97.8, pulse 85, resp 20, and O2 sat 97%.2/1/26 3:00 p.m. - 11:00 p.m.: bp 115/62, temp 97.8, pulse 85, resp 20, and O2 sat 97%.2/1/26 11:00 p.m. - 7:00 a.m.: bp 121/67, temp 98, pulse 78, resp 18, O2 sat 98%.2/2/26 3:00 p.m. - 11:00 p.m.: bp 121/67, temp 98, pulse 78, resp 18, O2 sat 98%.2/3/26 3:00 p.m. - 11:00 p.m.: bp 119/88, temp 98.3, pulse 60, resp 19, O2 sat 99%.2/3/26 11:00 p.m. - 7: 00 a.m.: bp 119/88, temp 98.3, pulse 60, resp 19, O2 sat 99%.The record showed staff had documented Resident #2's vital signs were identical on two consecutive shifts on 2/1, identical on the night shift on 2/1 and the afternoon shift on 2/2, and on two consecutive shifts on 2/3/26. Review of Resident #2's care plan revealed the resident had altered cardiovascular status related to hypertension (htn). The interventions included instructions for staff to Monitor VITAL SIGNS/weights as ordered/as needed (PRN). Notify Md of significant abnormalities/changes as ordered/indicated. Review of Resident #2's admission Record revealed the resident was admitted on [DATE] with diagnoses not limited to retroperitoneal fibrosis, unspecified chronic obstructive pulmonary disease, stage 4 (severe) chronic kidney disease, unspecified anemia, atrophy of kidney (terminal), and primary hyperparathyroidism. An interview was conducted on 2/21/26 at 1:58 p.m. the Assistant Director of Nursing (ADON) reviewed Resident #2's vital sign summary and confirmed blood pressures were missing, then reviewed the resident's vital signs documented on MAR. The ADON did not reveal how likely it was to have identical vital signs on multiple shifts but did say blood pressure could rise with pain. During an interview on 2/21/26 at 2:23 p.m. the Nursing Home Administrator viewed the vital summary and confirmed missing blood pressures for Resident #2. A review of the MAR was conducted and the NHA stated it was rare for a resident to have the same vital signs on different shifts. During an interview on 2/21/26 at 2:42 p.m. the Interim Director of Nursing (DON) stated she wouldn't say it was impossible but. (regarding identical vital signs over different shifts). Review of the policy - Documentation Medical Records, revised 01/2026, showed Services provided to the residents shall be documented in the resident's medical record. Their medical records should facilitate communication between the interdisciplinary team regarding the resident's condition in response to care.4. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to ensure outside resources were available for two residents (#4 and #3) out of two residents sampled, related to podiatry visit for Resident #4, and dermatology services for Resident #3.Findings included: 1. During a facility tour on 2/21/2026 at 9:40 a.m., Resident #4 was observed in her room. The resident stated she had notified the nurse she had long nails and she was not able to cut them herself. She stated they were uncomfortable but not painful. Resident #4 stated the nurse said she would see a podiatrist.Review of Resident #4's admission record revealed the resident was admitted on [DATE] with diagnoses to include hypertensive heart disease without heart failure, unsteadiness of the feet, other gait abnormalities, need for assistance with personal care and blindness of left eye. Review of a Minimum Data Set (MDS) for Resident #4 dated 2/8/2026 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, meaning the resident was cognitively intact.Review of a nursing progress note for Resident #4 dated 2/16/2026 revealed, Resident nails are very long. Resident needs a referral to a podiatrist.Further review of Resident #4's medical record did not show further follow up regarding the podiatrist referral.Review of a podiatry facility visit list dated 2/18/2026 revealed resident #4's name was not on the list.On 2/21/2026 at 3:47 p.m. an interview was conducted with the Social Services Director (SSD). She stated the nursing staff would let her know if a resident needed to be seen and then she puts them on the list. She stated the doctor was here last week. The SSD reviewed the progress note dated 2/16/2026 and stated the resident would have made the list. She said the nurse should have notified the Assistant Director of Nursing (ADON) or Director of Nursing (DON) to let her know to add the resident to the list.During an interview on 2/21/2026 at 3:52 p.m., the interim (DON) stated podiatry comes to the facility monthly. The DON stated they tell the SSD if anyone needed to be seen. She stated there was no reason why she would not have been seen. She said the nurse should have notified them to add her name to the list. The DON said, That is a learning opportunity. We will educate the nurses.2. On 2/21/2026 at 10:02 a.m. an observation and interview was conducted with Resident #3. The resident was observed in her room in bed, noted scratching and itching her arms and upper body. Her skin was observed scaly with dry, rough, and small fishlike flakes. The resident stated she was supposed to see a dermatologist, but it had not been scheduled. She stated her family member had discussed this with the facility the previous Friday on 2/13/2026. She stated she was applying regular store lotion, and it was not helping. Resident #3 stated her itching had increased and no one had said anything. The resident said, It's getting worse.Review of Resident #3's admission record revealed the resident was originally admitted on [DATE] and readmitted on [DATE] with diagnoses to include morbid (severe) obesity due to excess calories, Type 2 diabetes, unspecified kidney failure. Review of an MDS for Resident #3 dated 11/25/2025 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, meaning the resident was cognitively intact.Review of current physician orders for Resident #3, dated 2/21/2026 revealed the following orders:Dermatology consultation, itching body, dated 2/11/2026.Follow -up with Dermatology, dated 2/20/26.Ammonium Lactate External lotion 12% (Lactic Acid Ammonium Lactate) apply to lower/upper extremities topically two times a day for dry skin, ordered 2/6/2026.Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) dates 1/1/2026 to 2/7/2026 revealed Resident #4 was not receiving any treatment for the on-going itching condition.Review of a care plan for Resident #3 revealed a focus - the resident is at risk for skin impairment related to anemia, diabetes, incontinence, use of anticoagulant/antiplatelet medications, (continued on next page)

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and weakness/decreased mobility. Interventions included monitor/observe skin while providing routine care. Notify nurse of any area of concern as indicated. Preventative skin treatments as ordered/indicated, as tolerated by resident. Skin checks weekly and as indicated. Report any s/s (signs/symptoms) of skin breakdown to MD (Medical Doctor)/wound team as indicated.On 2/21/2026 at 2:29 p.m. an interview was conducted with the Social Services Director (SSD). The SSD stated dermatology appointments were scheduled by nursing. She said she had not heard of any concerns or that Resident #3 needed to be seen. The SSD stated if it would have been mentioned, she would have reached out and assisted if needed. The SSD stated she was not aware of any skin concerns for this resident. The SSD stated not having been notified of the family member's concerns the previous Friday. She stated a grievance would have been initiated.On 2/21/2026 at12:35 p.m. an interview with Staff B, Licensed Practical Nurse/Unit Manager (LPN/UM) revealed having visited the resident to investigate a grievance related to showers. She stated while there, I saw she has dry skin. I am not sure what the orders are, but she had some lotion on her bedside table which I applied. Staff B stated she did not review her orders to see if she was being seen by a dermatologist. Staff B said she could check. The staff member confirmed the resident had very dry, itchy, skin and was probably on the list to be seen by the in-house dermatologist. Staff B said, I have to look to see if she was seen by the in-house dermatologist. She stated it would be documented in the binder at the nurse's station.On 2/21/2026 at 12:41 p.m., review of the binder at the nurse's station with Staff B, LPN showed Resident #3 was scheduled to be seen on 2/19/2026, however there were no other entries to confirm if the appointment occurred. She stated she could not confirm if the resident was seen or not. She stated she would reach out to the dermatologist office.On 2/21/2026 at 1:33 p.m. an interview was conducted with the Assistant Director of Nursing (ADON). She stated not being aware of skin issues for Resident #3.During an interview on 2/21/2026 at 2:41 p.m., the interim Director of Nursing (DON) stated Resident #3 had on-going skin issues which had been long lasting. She stated she would have to check if the resident was frequently followed by the dermatologist. She stated if there were renewed issues, the physician would be notified, and it would be documented. She stated dermatology notes would be scanned in the resident's record.Review of the record showed there were no documented visits or physician notes. A follow - up was conducted with Staff B, LPN on 2/21/2026 at 2:50 p.m. Staff B stated she had reached out to the dermatologist and produced an encounter note dated 1/13/2026. Staff B stated there were no other notes.Review of a facility policy titled, Consults, Revised 01/2024 revealed - Social Services personnel shall coordinate most resident referrals with contracted providers or external agencies as indicated.Guideline:1. Social Services shall coordinate most resident referrals (i.e. podiatry, dental, vision, etc.). Exceptions might include emergency or specialized services that are arranged directly by a physician or the nursing staff.2. Referrals for medical services should be based on physician evaluation of resident need and a related physician order.3. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician.4. Social services will document the referral in the resident's medical record.5. Social services and administration will maintain a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs.6. Social services will help arrange transportation to outside agencies, clinic appointments, etc., as appropriate.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews the facility failed to maintain complete and accurately documented medical records for one (#2) of four sampled residents related to not completing the Admission/readmission evaluation in a timely manner, not completing a daily note for a resident receiving specialized services and skilled nursing. Findings included: Review of Resident #2s admission Record showed the resident was admitted on [DATE] with diagnoses not limited to other artificial openings of urinary tract status, retroperitoneal fibrosis, stage 4 (severe) chronic kidney disease, unsteadiness on feet (for therapy use), generalized muscle weakness (for therapy use), need for assistance with personal care (for therapy use), and oropharyngeal phase dysphagia (for therapy use). Review of Resident #2s assessments showed an Admission/readmission Nursing Evaluation, dated 1/30/26 at 5:41 p.m. was not completed and locked. The documentation showed sections a, l and n were unsigned by staff member. Section a (A) did not include information on how the resident was transferred to the facility (stretcher, wheelchair, (or) ambulatory), if the resident had weight bearing restrictions (yes or no), and did not document the presence of a nephrostomy tube. Section l (L) showed the staff had not evaluated the resident for a mechanical lift or if the resident could stand, pivot or transfer with no or limited assistance from staff. Section n (N) showed a medications were not reviewed and verified. Review of Resident #2s available assessments revealed the Daily Skilled Note assessment had not been accessed and/or completed for the resident. Review of Resident #2s progress notes did not reveal an admission note had been completed for the resident. The nursing progress notes included:-1/30/26 at 7:35 p.m. a general note showed Pt (patient) skin was checked pt has skin concern on coccyx. Pt emergency contact was notified that pt is at facility. (first note)- 1/31/26 at 8:49 a.m. electronic Medication Administration Record (eMAR) note showing the resident received pain medication. A follow up to the effectiveness was completed at 6:03 p.m.- 1/31/26 at 10:44 p.m. eMAR note revealed resident was administered pain medication for generalized pain with effectiveness documented on 2/1/26 at 5:39 a.m.- 2/1/26 at 8:32 p.m. eMar note revealed the administration of pain medication with effectiveness documented on 2/1/26 at 9:04 p.m.-2/2/26 at 1:04 a.m. an eMAR note showed the resident was administered pain medication and the effectiveness was documented on 2/2/26 at 6:14 a.m.- 2/2/26 at 9:34 a.m. an eMAR note showed the resident was administered pain medication and the effectiveness was documented on 2/2/26 at 3:46 p.m.- 2/2/26 at 2:24 p.m. a Skin/Wound note, Second skin check; scar tissue to sacrum, surgical site to right flank; minimal serous drainage - tx (treatment) in place. Scar tissue to abdomen.- 2/3/26 at 5:57 a.m. an eMAR revealed the resident was administered pain medication.- 2/3/26 at 6:02 a.m. an eMAR note related to a dressing change revealed pt was in pain and needed her pain med before.- 2/3/26 at 4:53 p.m. an eMAR note showed the pain medication was effective.- 2/3/26 at 8:43 p.m. an eMAR note showed topical pain ointment had been applied.- 2/3/26 at 9:21 p.m. an eMar note revealed the resident had received oral pain medication and the effectiveness was documented on 2/3/26 at 10:13 p.m.- 2/4/26 revealed no eMAR notes or other progress notes had been written by nursing regarding the wellbeing of Resident #2.- 2/5/26 at 4:18 a.m. an eMAR note revealed the resident was administered oral pain medication and the effectiveness was documented on 2/5/26 at 5:38 p.m.- 2/5/26 5:59 a.m. an eMAR note showed a dressing change treatment was completed for the resident.- 2/5/26 at 7:59 p.m. an eMAR note revealed the resident was administered oral pain medication and the effectiveness was documented on 2/5/26 at 8:45 p.m.- 2/6/26 at 5:39 a.m. an eMAR note revealed the resident was administered oral pain medication and the effectiveness was documented on 2/6/26 at 7:11 p.m.- a late entry note was documented on 2/7/26 for (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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2/6/26 at 9:30 a.m. revealing the nurse had been notified by administrative staff to report to the resident's room. The resident did not appear to be in respiratory distress with a family friend at bedside and family member on the phone. The family friend had informed the daughter the resident did not look well and the daughter wanted the resident go to the hospital with other concerns. Emergency Medical Services (EMS) arrived prior to staff being able to obtain vital signs. The review showed nursing staff had documented one general note regarding the resident had an issue on sacral area and the emergency contact had been notified of the resident's arrival at the facility on 1/30, one skin/wound note on 2/2/26 showed the presence of a surgical site, and one late entry note for 2/6/26 regarding the family member requesting the resident be transferred to the hospital, all other notes were regarding the administration of oral and topical pain medications. An interview was conducted on 2/21/26 at 11:31 a.m. with the Director of Rehab (DoR). The DoR stated Resident #2 had come to the facility for fatigue and hematuria and had received both physical and occupational therapy. The DoR stated the resident was treated in the resident's room as the resident had refused to go to the gym. The DoR stated physical therapy had done exercises with the resident on 2/5/26 till the pain level had increased and the resident had refused to sit on the side of the bed. The DoR stated Resident #2s evaluation showed the resident was status post nephrostomy placement. An interview was conducted on 2/21/26 at 1:19 p.m. with the Assistant Director of Nursing (ADON). The ADON stated Resident #2 was skilled so there should have been daily skilled charting notes. An interview was conducted on 2/21/26 at 12:07 p.m. with Staff C, Licensed Practical Nurse (LPN). The staff member stated Resident #2s name sounded familiar but couldn't picture the face. Staff C reviewed the resident's chart and reported not being able to tell anything specific regarding the resident. On 2/21/26 at 1:56 p.m. Staff C reported doing daily skilled assessments for all skilled residents. During an interview on 2/21/26 at 2:23 p.m. the Nursing Home Administrator (NHA) reviewed Resident #2s Admission/readmission Evaluation and stated no it was not completed. A review was conducted of the resident's other assessments and progress notes. The NHA stated there were not any daily skilled notes and the only nursing note was on 2/6/26 showing the resident had left and it was a late entry. An interview was conducted on 2/21/26 at 2:42 p.m. with the Interim Director of Nursing (DON). She stated staff should be doing daily skilled notes. Review of policy - Documentation Medical Records, revised 01/2026, revealed Services provided to the residents shall be documented in the resident's medical record. The medical records should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.2. The following information is to be documented in the resident medical record: a) objective observations. b) Medications administered. c) Treatments or services performed. d) changes in the resident's condition. e) care provided.3. Documentation in the medical record is required as updates/ changes in the residence plan of care is made.4. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.8. Documentation of procedures and treatments will include care-specific details, including: a) the date and time the procedure/ treatment was provided; b) the name and title of the individual(s) who provided the care;c) the assessment data and/ or any unusual findings obtained during the procedure/ treatment. d) Whether the resident refused the procedure/ treatment; The facility did not provide a policy specific to completing an admission assessment and/or completing daily skilled notes.