STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105416	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Beneva	741 South Beneva Road Sarasota, FL 34232

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to implement processes to prevent avoidable accidents by failing to ensure the appropriate storage of ignition devices for 6 (Residents #71,#106, #9, #26, #43, and #67) of 23 residents who smoke tobacco products and/or use oxygen.The unsafe practice of allowing residents to store ignition sources such as lighters in their rooms where oxygen is in use created a significant fire safety risk to the entire facility. A fire originating in one resident's room can rapidly spread through bedding, furnishing, producing smoke and toxic fumes that travel quickly through hallways and ventilation systems, creating a likelihood of serious injury, impairment or death of all 101 residents from thermal burns and inhalation of toxic fumes and resulted in the determination of Immediate Jeopardy.The findings included:Cross reference F835, F865, F926On 1/6/26, the facility provided a list of current residents who smoke tobacco products dated December 18, 2025. The list contained 23 smokers, including Residents #71, #106, #9, #26, #43, and #67.Review of the facility policy titled, Smoking-Supervised with an effective date of 11/30/2014 and a revision date of 02/07/2020 revealed, . Residents that wish to smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if assistance or supervision is required for smoking. The Center will retain and store matches, lighters, etc. for all residents . Residents will be advised upon admission that violations of the smoking policy may result in revocation of smoking privileges, discharge, and/or being reported to law enforcement .Review of the Smoking Agreement/Notice of Policy utilized by the facility and signed by residents who smoke read, Smoking is allowed by the center to accommodate those who wish to smoke. However, for the safety of all residents and staff the center has promulgated a safe smoking policy. All residents who wish to smoke at the center will abide by the center's smoking policy. Resident electing to smoke will be provided a safe smoking assessment to determine and evaluate each resident's ability to safely smoke. Because violations of the smoking policy can lead to catastrophic consequences, the smoking policy will be vigorously applied without exception. Violations of the policy will result in remedial action based upon the nature of the infraction. Remedial action includes but is not limited to warning, revocation of smoking privileges, police intervention, and/or discharge. This agreement represents your acknowledgement that the center has provided you a copy of the center's smoking policy and your agreement to abide by the terms set forth in the policy.I, the undersigned, understand that these safety rules apply to me and the safety of the other residents and violations may result in subsequent education, warnings, and other remedial actions at the discretion of the Executive Director.Resident #9:On 1/6/26 at 9:56 a.m., in an interview Resident #9 said the residents get to smoke three times a day. She said she keeps her cigarettes and lighter in her purse and stores them in her room. Resident #9 said she knew she was supposed to turn the cigarettes and lighter into the nurses' station but they turned up missing. She said about a month ago, she voiced her concerns to the Administrator who said she would address them. Resident #9 said so far the Administrator had not addressed her concerns. She just keeps her cigarettes and lighter in her purse and brings them out with her.On (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	1/6/26 at 1:28 p.m., Resident #9 was observed exiting her room with her purse on her lap. She entered the vending machine room that leads to the smoking area. The Director of Patient Experience was observed approaching Resident #9 and speaking with her. Resident #9 opened her purse, took out a pack of cigarettes and a lighter and handed them to the Director of Patient Experience. Review of the clinical record for Resident #9 revealed an admission date of 5/17/23. The Annual MDS assessment dated [DATE] revealed Resident #9 used tobacco products. The MDS noted the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Diagnoses included cerebrovascular accident (CVA), Diabetes Mellitus, seizure disorder, and depression with anxiety.Review of the care plan revealed Resident #9 was a smoker and chooses to smoke in a laying down position. The goal was for the resident not to smoke without supervision. The interventions included: The resident was educated on proper positioning while smoking. Resident #9 stated that she is more comfortable laying down.Instruct resident about the facility policy on smoking, locations, times and safety concerns; The resident requires a smoking apron while smoking; The resident requires supervision while smoking.Review of the smoking evaluations revealed the last smoking evaluation was completed on 11/23/23 and contained conflictive information. The smoking evaluation noted the resident was determined to be a safe smoker and required constant supervision while smoking.On 8/31/25 Resident #9 signed the Smoking Agreement/Notice of Policy form.Resident #71:On 1/6/26 at 1:21 p.m., Resident #71 was observed in the smoking area. The Director of Patient Experience was also observed in the smoking area. She said that all smokers signed an agreement and are not supposed to have a lighter on them. She said Resident #71 had a lighter and he would not give it to the staff.On 1/6/26 at 1:24 p.m., Resident #71 was observed in the presence of the Director of Patient Experience using a red lighter he had with him to light his cigarette. On 1/6/26 at 3:35 p.m., observation of the resident's room revealed an oxygen concentrator at the resident's bedside.Review of the clinical record for Resident #71 revealed an admission date of 5/27/25. The admission Minimum Data Set (MDS) assessment dated [DATE] noted the resident used tobacco. The MDS noted Resident #71 scored 12 on the BIMS, indicating moderate cognitive impairment (May need help with daily tasks).On 9/2/25, Resident #71 signed the Smoking Agreement/Notice of Policy form.The last smoking evaluation was dated 9/11/25. The evaluation noted Resident #71 was a safe smoker and the supervision required while smoking was constant.The physician's orders dated 5/28/25 included Oxygen at 2 Liters (L) as needed.The care plan with a review start date of 12/10/25 noted Resident #71 was a smoker. The goal was for the resident not to smoke without supervision. The interventions included: Observe clothing and skin for signs of cigarette burns; Instruct resident about the facility policy on smoking: locations, times, safety concerns; The resident requires supervision while smoking. The care plan did not address Resident #71's known violation of the facility's smoking policy for storage of ignition devices.Resident #106:On 1/6/26 at 1:16 p.m., Resident #106 was observed entering the smoking area. She took cigarettes out of her purse. No lighter was observed with the resident. The smoking attendant approached the resident and lit the cigarette.On 1/6/26 at 3:39 p.m., observation of the resident's room revealed an oxygen concentrator at the resident's bedside.Review of the clinical record for Resident #106 revealed an admission date of 3/28/24.The admission MDS assessment dated [DATE] revealed Current Tobacco Use was listed under Other Health Conditions.On 1/20/25, Resident #106 signed the Smoking Agreement/Notice of Policy.The physician's orders dated 9/6/25 included Oxygen at 2 L as needed and Oxygen at 2 L continuously.Review of the care plan with a review start date of 10/17/25 revealed a focus for smoking. The goal was for the resident not to suffer injury from unsafe smoking practices.The clinical record lacked documentation of a smoking evaluation to identify unsafe smoking practices and determine if the resident required assistance or supervision for smoking.Resident #26:Review of the clinical record for Resident #26 revealed an admission date of 7/1/25.Review of the admission MDS assessment dated [DATE] revealed the resident's cognition was intact with a Brief Interview for Mental Status score of 15. The MDS listed Current Tobacco Use under Other Health Conditions. On (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	9/3/25, Resident #26 signed the Smoking Agreement/Notice of Policy form.The last smoking evaluation was dated 12/20/25. The evaluation did not address the safe storage of ignition material. The summary of the evaluation noted Resident #26 was determined to be Safe smoker.On 1/7/26 at 3:23 p.m., in an interview Resident #26 said, I smoke every day. I go out at all smoking times. I never signed a contract for smoking and I was never told about the facility's smoking policy. The resident said, Right now, I don't have my lighter or cigarettes, they took them.Resident #43:Review of the clinical record for Resident #43 revealed an admission date of 5/12/22.Review of the Annual MDS assessment dated [DATE] revealed the resident's cognition was intact with a BIMS score of 15.The MDS listed Current Tobacco Use under Other Health Conditions. Resident #43 signed the Smoking Agreement/Notice of Policy on 11/8/23.The most recent smoking evaluation was dated 9/11/25 and did not include the safe storage of ignition devices. The evaluation noted Resident #43 was a safe smoker and none was entered for Supervision needed while smoking.On 1/7/26 at 3:41 p.m., in an interview Resident #43 said he smokes every day at all scheduled times. Resident #43 said the facility went over the smoking policy in a Resident Council Meeting but he didn't sign the smoking contract. He said, I am not going to. When asked about the facility policy for storing cigarettes and lighters, Resident #43 said, I buy my cigarettes and lighters, I'm allowed to keep them. I paid for it, not them. I'm not 7 years old, I do not smoke in my room. When they take your cigarettes, they never give them back. That's my money, I paid for them, not this place. I have never smoked in my room.Resident #67:Review of the clinical record for Resident #67 revealed an admission date of 7/11/25.The admission MDS assessment dated [DATE] revealed the resident's cognition was intact with a BIMS score of 13. The MDS noted Yes for current tobacco use.The most recent smoking evaluation dated 9/11/25 documented that Resident #67 was determined to be a safe smoker and no supervision was needed while smoking.There was no documentation Resident #67 was given the facility's smoking policy and signed the Smoking Agreement/Notice of Policy.On 1/6/26 at 1:51 p.m., in an interview Smoking Attendant Staff C said it was known that several of the residents kept cigarettes and lighters in their possession. She said the Administrator has had many meetings with residents regarding keeping cigarettes and lighters. Staff C said the residents go to the store, buy cigarettes and lighters and keep them. She said some of the residents don't bring them to staff for storage. Staff C said, The next thing you know, they come to the smoking area with their own cigarettes and lighters. She said the residents would say no when she asks them to give her their cigarettes and lighters. Staff C said she can ask for the lighter, but she can't take it from them. She said she reports it to the Unit Manager. She said a lot of their residents use electric wheelchairs and go to the corner store, or visitors brings them cigarettes and lighters, how do you fix that?. She said the residents signed papers that they would turn in their lighters. She may have the residents' cigarettes/lighters in the locked smoking box, but the residents come right past her. They do not get the smoking supplies from her and start smoking. The observation of Resident #71 using a lighter he had with him to light his cigarette was shared with Staff C. She said she knew Resident #71 kept his cigarettes but did not know he had a lighter. Staff C said there had been times when 17 residents were out there smoking and she was not able to keep a close eye on that many residents.Staff C reviewed the facility provided list of smokers and said Residents #9, #106, #26, #43 and #67 were known to keep cigarettes and lighters in their possession. She said the facility administration was aware of the issue and has had many discussions about smoking rules with the smokers. Staff C said unless something was enforced, they would keep getting away with it.On 1/6/26 at 2:00 p.m., the Administrator provided the facility's smoking policy. She said residents were not supposed to have smoking materials in their possession or room. She said if the resident leaves the building, they can sign out their smoking supplies.On 1/6/25 at 3:13 p.m., in an interview the Director of Nursing (DON) said the smoking concerns have been an ongoing issue since she began employment in September 2025. She said in December 2025 they met with the residents and talked to them about smoking and turning in their lighters. They also went over the risks involved with oxygen. She said if the smoking attendants see (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	residents with cigarettes and lighters, they should let them (Administrator and DON) know.On 1/6/26 at 3:20 p.m., in an interview the Administrator said she started employment at the facility in October 2025. They had noticed issues with residents keeping their smoking supplies. She said the residents were only allowed to have their smoking supplies if they were out of the facility on leave of absence. Otherwise, cigarettes and lighters should be turned in. The Administrator said they held special Resident Council meetings to discuss smoking.On 1/7/26 at 11:15 a.m., in an interview Unit Manager Staff T said it had been brought to his attention that residents were keeping cigarettes and lighters on them. He said they educated the residents on the smoking policy and thought that a month ago they met with the smokers and reviewed the smoking policy with them.

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, residents and staff interviews, the facility administration failed to provide effective oversight and enforcement of safe smoking practices. The facility Administration became aware of the concerns of unsafe storage of ignition devices and failed to intervene to protect the health and safety of all residents, as evidenced by interviews with the Director of Nursing and the Administrator who both stated that the issues were brought to their attention in September and October of 2025 when they started working in the facility. This failure created an environment that placed all 101 residents who reside in the single-story facility at a likelihood of serious injury, impairment or death from thermal burns and inhalation of toxic fumes and resulted in the determination of Immediate Jeopardy. The findings included:Refer to F689, F865, F926Review of the Executive Director (Administrator)'s job description revealed, The primary purpose of the Executive Director is to direct the day-to-day functions of the facility in accordance with current federal, state, and local standards, guidelines, and regulations that govern nursing facilities to ensure that the highest degree of quality care can be provided to our residents at all times . You will also provide leadership to all facility staff in meeting the goal of providing quality resident care . Duties and Responsibilities . Ensure a safe, clean and comfortable environment for residents, visitors and staff . Specific Requirements . Must possess the ability to develop, implement . policies, and procedures that are necessary to for providing quality care and maintaining a sound operation .On 8/19/25, the Administrator signed the job description, accepting the position and agreed to perform the functions contained in this job description in a safe manner and in accordance with the facility's established procedures. Review of the Director of Nursing (Director of Clinical Services)'s job description revealed, As the company Director of Clinical Services, you are entrusted with the responsibility of caring for our resident, families, co-workers, visitors, and all others. The primary purpose of your job position is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility . to ensure that the highest degree of quality care is maintained at all times . Duties and responsibilities . Maintain and guide the implementation of current policies and procedures . On 9/24/25, the Director of nursing signed the job description attesting that she had read the job description and agreed to, perform the tasks outlined in this job description in a safe manner and in accordance with the facility's established procedures. Review of the facility policy titled, Smoking-Supervised with an effective date of 11/30/2014 and a revision date of 02/07/2020 revealed, . Residents that wish to smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if assistance or supervision is required for smoking. The Center will retain and store matches, lighters, etc. for all residents . All residents who wish to smoke will sign an agreement attesting to abide by the smoking policies and procedures . Residents will be advised upon admission that violations of the smoking policy may result in revocation of smoking privileges, discharge, and/or being reported to law enforcement.On 1/6/26, review of the facility provided list of current residents who smoke tobacco products dated December 18, 2025, revealed Residents #71, #106, #9, #26, #43, and #67 were smokers.On 1/6/26 at 9:56 a.m., in an interview Resident #9 said that her cigarettes and lighter turned up missing when she turned them into the nurses' station. She said about a month ago, the Administrator said she would address her concerns, but she has not. Resident #9 said she keeps her cigarettes and lighter in her purse and stores them in her room.On 1/6/26 at 1:28 p.m., Resident #9 was observed exiting her room. She retrieved a pack of cigarettes and a lighter and handed them to the Director of Patient experience.Clinical record review revealed Resident #9 had an admission date of 5/17/23. The last smoking evaluation was completed on 11/23/23. The evaluation noted the resident was determined to be a safe smoker and required constant supervision while smoking.On 1/6/26 at 1:21 p.m., Resident #71 was observed in the (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	designated smoking area. The Director of Patient Experience said Resident #71 had a lighter and he would not give it to the staff.On 1/6/26 at 1:24 p.m., Resident #71 was observed lighting a cigarette with a red lighter he had with him.Clinical record review revealed the Minimum Data Set (MDS) assessment dated [DATE] noted Resident #71 scored 12 on the Brief Interview for Mental Status, indicating moderate cognitive impairment.Review of the physician's orders dated 5/28/25 revealed an order for supplemental Oxygen at 2 Liters (L) as needed.The last smoking evaluation was dated 9/11/25. The evaluation noted Resident #71 was a safe smoker and the supervision required while smoking was constant.On 1/6/26 at 3:35 p.m., an oxygen concentrator was observed at the resident's bedside.On 1/6/26 at 1:16 p.m., Resident #106 was observed in the designated smoking area. The smoking attendant lit a cigarette that Resident #106 took out of her purse.Review of Resident #106's clinical record revealed an admission date of 3/28/24 and a physician's order dated 9/6/25 for Oxygen at 2 L as needed and Oxygen at 2 L continuously.On 1/6/26 at 3:39 p.m., an oxygen concentrator was observed at Resident #106's bedside.The clinical record lacked documentation of a smoking evaluation since the admission date of 3/28/24.On 1/6/26 at 1:51 p.m., in an interview Smoking Attendant Staff C said that several of the residents kept cigarettes and lighters in their possession. She said the residents refuse to give her the lighters and cigarettes when she asks and she cannot take the cigarettes and lighters from them. She reports it to the Unit Manager. The residents go to the corner store, or visitors bring them cigarettes and lighters. Staff C said there had been times when 17 residents were out there smoking and she was not able to keep a close eye on that many residents. Staff C said Residents #9, #106, #26, #43 and #67 were known to keep lighters and cigarettes in their possession. The facility Administration has had many discussions about the smoking rules with the smokers but unless something was enforced, they would keep getting away with it.On 1/6/26 at 3:13 p.m., an interview was held with the Director of Nursing (DON) to discuss her duties and responsibilities related to implementation of the facility's smoking policy to ensure the safety of all residents. The unsafe smoking observations, the incomplete clinical records related to smoking agreements and smoking evaluations were also discussed with the DON. The DON said since she started employment at the facility in September 2025, the smoking concerns have been an ongoing issue. She said the smoking attendants should report to them if they see residents with cigarettes and lighters. The DON said there has been no monitoring or auditing to ensure residents complied with the smoking policy.On 1/6/26 at 3:20 p.m., an interview was held with the Administrator to discuss the unsafe smoking practices and the administration failure to intervene to protect the health and safety of all residents, visitors and staff in the building.The Administrator said she started employment at the facility in October 2025. They had noticed issues with residents keeping their smoking supplies. She said cigarettes and lighters should be turned in. She said they held special Resident Council meetings to discuss smoking.Review of the facility provided special Resident Council Meeting minutes revealed:On August 29, 2025, the Administrator led the meeting, and the smoking policy was reviewed. The meeting minutes read, Safety concerns were highlighted, with emphasis on maintaining a healthy and secure environment for all residents. Specific instructions were stressed to turn lighters into the smoking attendant prior to leaving the designated outdoor smoking area. Residents are not allowed to keep lighters in their possession anywhere in the facility.The meeting attendees list included 10 of the current 23 smokers. Residents #106, #9, and #67 did not attend the meeting.On November 25, 2025, the Administrator and the DON attended the Resident Council meeting and reviewed the smoking policy with the residents. The meeting minutes included, Both cigarettes and lighters must be given to the smoking attendant. If leaving the facility, lighters and cigarettes may be taken on errands but given back to the smoking aid upon return . These rules need to be followed and will be enforced by the company. The list of 12 attendees did not include Residents #71, #106, and #67.On December 9, 2025, the Resident Council meeting minutes noted under old business that, Smoking policy was reviewed with residents expressly reviewing that lighters may not be kept in possession of resident and must be turned into the smoking attendant. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Safety risk.The list of 12 attendees included 10 of the current smokers. Residents #71, #106, #9, #26, #43, and #67 did not attend the meeting. On 1/7/26 at 3:23 p.m., in an interview Resident #26 said he was never told about the facility's smoking policy. He said right now he didn't have his cigarettes and lighter with him because they took the cigarettes and lighter from him.On 1/7/26 at 3:41 p.m., in an interview Resident #43 said the facility went over the smoking policy in a Resident Council Meeting but he refused to sign the smoking contract. The resident said, I am not going to. Resident #43 said he buys his cigarettes and lighters, and he was allowed to keep them. He said, When they take your cigarettes, they never give them back.Clinical record review for Resident #67 revealed an admission date of 7/11/25. The admission MDS dated [DATE] documented Yes for Current Tobacco Use.There was no documentation Resident #67 was given the facility's smoking policy and signed the Smoking Agreement/Notice of Policy.On 1/7/25 at 4:25 p.m., the facility Administrator provided a blank Mock Survey (Quality Assurance) checklist that included Are there signs/smells of smoke in the room? Are there any lighters or cigarettes visible? She stated the management staff use the form to conduct Angel rounds (Proactive walk-through rounds to ensure residents safety, comfort, and well-being).When asked to review the completed Mock Survey checklists, the Administrator stated that the completed forms were discussed in morning meeting and then shredded. The Administrator had no documentation that the rounds were completed and the management staff conducting the rounds identified the unsafe storage of ignition devices in residents' rooms where oxygen is stored and used.

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F 0865 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observation, record review and interviews, the facility failed to have an effective Quality Assurance and Performance Improvement (QAPI) program to address the known unsafe smoking practices since September 2025 for 6 (Residents #71, #106, #9, #26, #43, and #67) of 6 sampled residents who smoke tobacco products. The facility failure to develop corrective actions to ensure the safe storage of ignition devices and continuing to allow residents who use oxygen to retain/store lighters in their rooms created a significant, avoidable fire safety risk that could impact all 101 residents who reside in the single-story facility. A fire originating in one resident's room can rapidly spread, produce smoke and fumes that travel rapidly through hallways and ventilation systems, creating a likelihood of serious harm, injury or death. The failure of the QAPI program to address these concerns resulted in the determination of immediate jeopardy.The findings included:Cross reference F689, F835, F926Review of the facility's policy and procedure titled, Quality Assurance Performance Improvement Program (QAPI) with a revision date of 10/24/2022 revealed, The Center and organization has [sic] a comprehensive, data-driven Quality Assurance Performance Improvement Program that focuses on indicators of the outcomes of care and quality of life. The center's QAPI program is on-going comprehensive review of care and services provided to residents . Important functional areas may include but are not limited to Residents rights and responsibilities . Resident assessment . Potential Adverse Events . The Center Executive Director is accountable for the overall implementation and functioning of the QAPI program. The center will establish and utilize a systematic approach to identify underlying causes of the problems . The center will develop corrective actions based on the information gathered and review effectiveness of the actions .Review of the facility's policy and procedure titled, Smoking-Supervised with a revision date of 2/7/2020 revealed residents that wish to smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if assistance or supervision is required for smoking. The Center will retain and store matches, lighters, etc. for all residents. Residents will be advised upon admission that violations of the smoking policy may result in revocation of smoking privileges, discharge, and/or being reported to law enforcement.The facility provided list of current residents who smoke dated December 18, 2025, included Residents #71, #106, #9, #26, #43, and #67.On 1/6/26 at 9:56 a.m., in an interview Resident #9 said about a month ago, she voiced concerns to the Administrator that her cigarettes and lighter turned up missing when she turned them into the nursing station. She said so far, the Administrator had not addressed her concerns. She just keeps her cigarettes and lighter in her purse.On 1/6/26 at 1:21 p.m., in an interview, the Director of Patient Experience said Resident #71 had a lighter and he would not give it to the staff.On 1/6/26 at 1:24 p.m., Resident #71 was observed in the designated smoking area with a red lighter that he used to light a cigarette.On 1/6/26 at 1:28 p.m., Resident #9 was observed exiting her room. She retrieved a pack of cigarettes and lighters from her purse and handed them to the Director of Patient Experience who was observed speaking with the resident.On 1/6/26 at 1:51 p.m., in an interview Smoking Attendant Staff C said that Residents #9, #106, #26, #43 and #67 were known to keep lighters and cigarettes in their possession. The facility Administration has had many discussions about the smoking rules with the smokers but unless something was enforced, they would keep getting away with it.On 1/6/26 at 3:35 p.m., and 3:39 p.m., observation of Residents #71 and #106's rooms revealed an oxygen concentrator at each resident's bedside.On 1/6/26 at 3:13 p.m., an interview was held with the Director of Nursing (DON) to discuss corrective actions to address the unsafe smoking practices and review of the effectiveness of actions implemented. The DON said since she started employment at the facility in September 2025, the smoking concerns have been an ongoing issue. She said the smoking attendants should report to them if they see residents with cigarettes and lighters. The DON said there has been no monitoring or auditing to ensure residents complied with the smoking policy.On 1/6/26 at 3:20 p.m., an interview was held with the Administrator to discuss systematic approaches (continued on next page)

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F 0865 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	implemented by the facility to address the unsafe smoking practices. The Administrator stated that she started employment at the facility in October 2025. They had noticed issues related to residents keeping their smoking supplies. The Administrator said the unsafe smoking practices were discussed in a QAPI meeting on October 30, 2025, but no performance improvement plan was put in place. She said they also held special Resident Council Meetings on 8/29/25, 11/25/25, and 12/9/25, to discuss smoking.Review of the form dated October 27, 2025, provided by the Administrator showed a section for Smoking=Quarterly. The areas to be addressed included: No Evidence that residents have lighters or matches and Smokers are identified on admission and assessed quarterly for safety.No data was entered for these areas and 0 was entered in the 3 columns on the form for Smoking subtotal.On 1/8/25 at 2:00 p.m., an interview was held with the Administrator to discuss the Resident Council Meeting minutes for November 2025 which stated that both cigarettes and lighters must be given to the smoking attendant were reviewed with the Administrator.The Administrator said that it was a mistake. The facility's policy has always been that smokers were allowed to keep their cigarettes.When asked about enforcing the facility's smoking policy and procedure for the known unsafe smoking practices, such as revoking smoking privileges, the Administrator said that she had not taken that route with anyone at this time.

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Have policies on smoking. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to implement and enforce the facility's supervised smoking policy to ensure safe smoking practices for 6 (#71, #106, #9, #26, #43, and #67) of 6 sampled smokers and prohibit the storage of ignition devices around oxygen use for 2 (Residents #71 and #106) of 2 sampled residents reviewed for safe smoking.The facility failure to enforce the smoking policy that clearly addressed the safe storage of ignition devices by allowing residents who use oxygen, or share rooms with residents who use oxygen, to keep lighters/ignition devices unsecured in their rooms created an avoidable fire safety risk, placing all 101 residents who reside in the single story facility at a likelihood serious harm, injury or death from thermal burns and inhalation of toxic fumes. These concerns resulted in the determination of immediate jeopardy. A fire originating in one resident's room can rapidly spread, produce smoke and fumes that travel very quickly through hallways and ventilation systems.The findings included:Cross reference F689, F835, F865Review of the facility's policy and procedure titled, Smoking-Supervised, with a revision date of 02/07/2020 revealed, Residents that wish to smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if assistance or supervision is required for smoking. If a resident is identified during the smoking evaluation to require assistance or supervision with smoking, the Center will include the appropriate information in the care plan . The Center will retain and store matches, lighters, etc. for all residents . All residents who wish to smoke will sign an agreement attesting to abide by the smoking policies and procedures. Residents will be advised upon admission that violations of the smoking policy may result in revocation of smoking privileges, discharge, and/or being reported to law enforcement . Electronic cigarettes are permitted, but only in facility designated smoking areas. The same rules that apply to regular tobacco cigarettes also apply to electronic smoking materials. Electronic cigarettes and materials, including the liquids, will be retained and stored by nursing staff .Review of the Smoking Agreement/Notice of Policy revealed, Smoking is allowed by the center to accommodate those who wish to smoke. However, for the safety of all residents and staff the center has promulgated a safe smoking policy. All resident [sic] who wish to smoke at the center will abide by the center's smoking policy. Residents electing to smoke will be provided a safe smoking assessment to determine and evaluate each resident's ability to safely smoke. Because violations of the smoking policy can lead to catastrophic consequences, the smoking policy will be vigorously applied without exception. Violations of the policy will result in remedial action based upon the nature of the infraction. Remedial action includes but is not limited to warning, revocation of smoking privileges, police intervention, and/or discharge. This agreement represents your acknowledgement that the center has provided you a copy of the center's smoking policy and your agreement to abide by the terms set forth in the policy.Each smoker signed the agreement noting, I, the undersigned, understand that these safety rules apply to me and the safety of the other residents and violations may result in subsequent education, warnings, and other remedial actions at the discretion of the Executive Director.Review of the facility provided list of 23 current residents who smoke tobacco products dated December 18, 2025, revealed Residents #71, #106, #9, #26, #43, and #67 were smokers.Resident #9:Review of the clinical record for Resident #9 revealed an admission date of 5/17/23. The Annual MDS assessment dated [DATE] revealed Resident #9 used tobacco products. The MDS noted the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. Diagnoses included cerebrovascular accident (CVA), Diabetes Mellitus, seizure disorder, and depression with anxiety.The last smoking evaluation was completed on 11/23/23.The smoking evaluation noted the resident was determined to be a safe smoker and required constant supervision while smoking.On 8/31/25 Resident #9 signed the Smoking Agreement/Notice of Policy form.Review of the care plan revealed Resident #9 was a smoker and (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	chooses to smoke in a laying down position. The goal was for the resident not to smoke without supervision. The interventions included, The resident was educated on proper positioning while smoking. Resident #9 stated that she is more comfortable laying down. Instruct resident about the facility policy on smoking, locations, times and safety concerns, The resident requires a smoking apron while smoking. The resident requires supervision while smoking.On 1/6/26 at 9:56 a.m., in an interview Resident #9 said the residents get to smoke three times a day. She said she keeps her cigarettes and lighter in her purse and stores them in her room. Resident #9 said she knew she was supposed to turn the cigarettes and lighter into the nurses' station but they turned up missing. She said about a month ago, she voiced her concerns to the Administrator who said she would address them. Resident #9 said so far the Administrator had not addressed her concerns. She said she just keeps her cigarettes and lighter in her purse and brings them out with her.On 1/6/26 at 1:28 p.m., Resident #9 was observed exiting her room with her purse on her lap. She entered the vending machine room that leads to the smoking area. The Director of Patient Experience was observed approaching Resident #9 and speaking with her. Resident #9 opened her purse, took out a pack of cigarettes and a lighter and handed them to the Director of Patient Experience. Resident #71:On 1/6/26, review of the clinical record for Resident #71 revealed an admission date of 5/27/25. The admission Minimum Data Set (MDS) assessment dated [DATE] noted the resident used tobacco. The MDS noted Resident #71 scored 12 on the BIMS, indicating moderate cognitive impairment (May need help with daily tasks).On 9/2/25, Resident #71 signed the Smoking Agreement/Notice of Policy form.The last smoking evaluation was dated 9/11/25. The evaluation noted Resident #71 was a safe smoker and the supervision required while smoking was constant.The physician's orders dated 5/28/25 included Oxygen at 2 Liters (L) as needed.The care plan with a review start date of 12/10/25 noted Resident #71 was a smoker. The goal was for the resident not to smoke without supervision. The interventions included, The resident requires supervision while smoking.On 1/6/26 at 1:21 p.m., in an interview, the Director of Patient Experience said Resident #71 had a lighter and he would not give it to the staff.On 1/6/26 at 1:24 p.m., Resident #71 was observed lighting a cigarette with a red lighter he had with him. The Director of Patient Experience verified the observation of Resident #71 lighting a cigarette with a lighter he had with him.On 1/6/26 at 3:35 p.m., an oxygen concentrator at Resident #71's bedside.Resident #106:Review of the clinical record for Resident #106 revealed an admission date of 3/28/24. The admission MDS assessment dated [DATE] included Current Tobacco Use under Other Health Conditions.The physician's orders dated 9/6/25 included Oxygen at 2 L as needed and Oxygen at 2 L continuously.Review of the care plan with a review start date of 10/17/25 revealed a focus for smoking. The goal was for the resident not to suffer injury from unsafe smoking practices.The clinical record lacked documentation of a smoking evaluation to identify unsafe smoking practices and determine if Resident #106 required assistance or supervision for smoking.Resident #26:Review of the clinical record for Resident #26 revealed an admission date of 7/1/25.Review of the admission MDS assessment dated [DATE] revealed the resident's cognition was intact with a Brief Interview for Mental Status score of 15. The MDS listed current tobacco use under Other Health Conditions. On 9/3/25, Resident #26 signed the Smoking Agreement/Notice of Policy form.The last smoking evaluation was dated 12/20/25. The evaluation did not include the safe storage of ignition material. The summary of the evaluation noted Resident #26 was determined to be Safe smoker.On 1/7/26 at 3:23 p.m., in an interview Resident #26 said, I smoke every day. I go out at all smoking times. I never signed a contract for smoking and I was never told about the facility's smoking policy. The resident said, Right now, I don't have my lighter or cigarettes, they took them.Resident #43:Review of the clinical record for Resident #43 revealed an admission date of 5/12/22.Resident #43 signed the Smoking Agreement/Notice of Policy on 11/8/23.Review of the Annual MDS assessment dated [DATE] revealed the resident's cognition was intact with a BIMS score of 15.The MDS listed current tobacco use under Other Health Conditions. The most recent smoking evaluation was dated 9/11/25 and did not include the safe storage of ignition devices. The (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	evaluation noted Resident #43 was a safe smoker and none was entered for Supervision needed while smoking.On 1/7/26 at 3:41 p.m., in an interview Resident #43 said he smokes every day at all scheduled times. Resident #43 said the facility went over the smoking policy in a Resident Council Meeting but he didn't sign the smoking contract. He said, I am not going to. When asked about the facility policy for storing cigarettes and lighters, Resident #43 said, I buy my cigarettes and lighters, I'm allowed to keep them. I paid for it, not them. I'm not 7 years old, I do not smoke in my room. When they take your cigarettes, they never give them back. That's my money, I paid for them, not this place. I have never smoked in my room.Resident #67:Review of the clinical record for Resident #67 revealed an admission date of 7/11/25.The admission MDS assessment dated [DATE] revealed the resident's cognition was intact with a BIMS score of 13. The MDS noted Yes for current tobacco use.The most recent smoking evaluation dated 9/11/25 documented that Resident #67 was determined to be a safe smoker and no supervision was needed while smoking. The smoking evaluation did not include the safe storage of ignition material.On 1/6/26 at 1:51 p.m., in an interview, Smoking Attendant Staff C said it was known that several of the residents kept cigarettes and lighters in their possession. She said the Administrator has had many meetings with residents regarding keeping cigarettes and lighters. Staff C said the residents go to the store, buy cigarettes and lighters and keep them. She said some of the residents don't bring them to staff for storage. Staff C said, The next thing you know, they come to the smoking area with their own cigarettes and lighters. She said the residents would say no when she asks them to give her their cigarettes and lighters. Staff C said she can ask for it, but she can't take it from them. She said she reports it to the Unit Manager. She said a lot of their residents use electric wheelchairs and go to the corner store, or visitors brings them cigarettes and lighters, how do you fix that?. She said the residents signed papers that they would turn in their lighters. She said she may have the residents' cigarettes/lighters in the locked smoking box, but they come right past her and start smoking. They do not get the smoking supplies from her. The observation of Resident #71 using a lighter he had with him to light his cigarette was shared with Staff C. She said she knew Resident #71 kept his cigarettes but did not know he had a lighter. Staff C said there had been times when 17 residents were out there smoking and she was not able to keep a close eye on that many residents.Staff C reviewed the facility provided list of smokers and said Residents #9, #106, #26, #43 and #67 were known to keep cigarettes and lighters in their possession. She said the facility administration was aware of the issue and has had many discussions with the smokers about smoking rules. Staff C said unless something was enforced, they would keep getting away with it.On 1/6/26 at 3:20 p.m., an interview was held with the Administrator to discuss operationalizing the facility's Smoking-Supervised policy to ensure the safety of all residents, staff and visitors.The Administrator said she started employment at the facility in October 2025. They had noticed issues with residents keeping their smoking supplies. She said they held special resident council meetings with the smokers on 8/29/25, 11/25/25, and 12/9/25, to discuss smoking.Review of the facility provided Resident Council Meeting minutes revealed:On 8/29/25, the Administrator led the meeting and the smoking policy was reviewed.The meeting attendees list included 10 of the current 23 smokers. Residents #106, #9, and #67 did not attend the meeting.On 11/25/25, the Administrator and DON attended the Resident Council Meeting and reviewed the smoking policy with the smokers.The meeting attendees list of 12 residents did not included Residents #71, #106, and #67.On 12/9/25, the Resident Council Meeting minutes noted under old business that the smoking policy was reviewed with residents, expressly reviewing that lighters may not be kept in possession of residents and must be turned into the smoking attendant.The list of 12 attendees included 10 of the current smokers. #71, #106, #9, #26, #43, and #67 did not attend the meeting. Review of the Executive Director (Administrator)'s job description signed on 8/19/25 revealed, duties and responsibilities included to ensure a safe, clean and comfortable environment for residents, visitors and staff. Specific Requirements listed in the job description included, Must possess the ability to develop, implement . policies, and procedures that are necessary to for providing quality care and maintaining a (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	sound operation .On 1/7/26 at 11:07 a.m., in an interview Licensed Practical Nurse (LPN) Staff R said the nurses do not complete smoking assessments. She said the Unit Managers do the assessments to see if a resident needs to be supervised. LPN Staff R said she did not know how often the smoking assessments were done and had never supervised smoking. She said around November or December she found a lighter in a resident's room and gave it to the Smoking Aid.On 1/7/26 at 11:15 a.m., in an interview LPN Staff F said she had never completed a smoking assessment. She said she would have to ask the DON or Assistant Director of Nursing (ADON) when and how often smoking assessments were done. She said she was not sure who was responsible for completing smoking assessments but thought it was the DON, Administrator, or the Unit Manager. LPN Staff F said it was not brought to her attention that residents were keeping smoking materials.On 1/7/26 at 11:15 a.m., in an interview Unit Manager, LPN Staff T said smoking assessments are completed at admission and quarterly. LPN Staff T said, We check to see if they are safe and if not, then we put the apron on them or change them to an e-cigarette. Staff T said the smoking assessments are completed by the admission nurses and management staff. He said, If they are not completed, it is usually because we have some difficult residents here that are noncompliant. When asked how he supervised smoking, Staff T said, I just make sure the residents are safe, that there is a physician order for them to smoke. If not, I get one. LPN Staff T said it was brought to his attention that residents were keeping cigarettes and lighters with them and said, I think we just had a meeting a month ago and the smoking policy was reviewed with them.On 1/7/26 at 11:47 a.m., in an interview LPN Staff I said residents were not allowed to have cigarettes and/or lighters. She said the Smoking Aide monitored the residents who smoke at all times. If they have any concerns, they are required to inform the nurse to ensure the resident remains safe when smoking. She said the smoking evaluation is normally completed by the nurse on duty or the Unit Manager. The admitting nurse completes the initial smoking evaluation, then it is done quarterly or as needed.On 1/7/25 at 11:54 a.m., an interview was held with the DON to discuss her duties and responsibilities related to implementation of the facility's smoking policy to ensure the safety of all residents. She said she started employment at the facility in September 2025. She said nursing is supposed to complete the smoking assessments on the day they are due. She said she did not know how the smoking assessments were tracked in the past and said, We probably have not been tracking it. She said she has not done any training with the nurses on completing the smoking assessments. The DON said they were going to develop a better process for the completion of the smoking assessments.Review of the Director of Nursing job description signed on 9/24/25 revealed duties and responsibilities included to maintain and guide the implementation of current policies and procedures.On 1/7/25 at 4:25 p.m., the facility Administrator provided a blank Mock Survey (Quality Assurance) checklist that included Are there signs/smells of smoke in the room? Are there any lighters or cigarettes visible?. She stated the management staff use the form to conduct Angel rounds (Proactive walk-through rounds to ensure residents safety, comfort, and well-being). The Administrator had no documentation that the rounds were completed and the management staff conducting the rounds identified the unsafe storage of ignition devices in residents' rooms where oxygen is stored and used.The Administrator stated that the completed forms are discussed in morning meeting and then shredded.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review and interviews, the facility failed to follow physician orders for enteral feeding supplies for 1 of 3 residents sampled, (Resident #41).The findings included: On 1/5/26 at 10:26 a.m., during a tour of the facility observed a peg tube syringe and 2 water pitchers with dark liquid, a carton of Nutren (brand name liquid nutritional formula), 1 carton of whole milk and 1 carton of 1% low fat milk on Resident #41's overbed table. Observed on bedside table was a basin containing pudding, sardines, 2 large cartons of chicken broth and canned sausages. (photographic evidence obtained).On 1/5/26 at 1:47 p.m., during a tour of the facility observed a feeding tube syringe, 1 water with straw containing clear liquid; 1 water pitcher with dark liquid, and 3 plastic cups with light brown liquid on Resident #41's overbed table. Observed on bedside table was a basin containing pudding, sardines, 2 large cartons of chicken broth and canned sausages. (photographic evidence obtained)Review of the clinical record documented Resident #41 was originally admitted to the facility 2/13/25 with diagnosis malignant neoplasm of tongue, dysphagia, oropharyngeal phase, major depressive disorder, severe protein-calorie malnutrition, and chronic obstructive pulmonary disease.Review of Quarterly Minimum Data Set (MDS) with an assessment date of 10/8/25 documented Resident #41 was dependent on staff for oral hygiene; eating was not attempted due to medical condition. The MDS noted resident was independent with bed mobility and transfer. The MDS documented that Resident #41 had a BIMS (Brief Interview for Mental Status) with a score of 12 indicating his cognitive status was moderately impaired.Review of physician orders dated 10/5/25 documented Diet - Nothing by mouth (NPO). Enteral Feed (providing nutrition into abdominal wall access)Ordered 6 times daily for nutrition support; Nutren 2.0 250 milliliters at 6am, 10am, 1pm, 4pm, 8pm and 11pm via peg tube (Percutaneous endoscopic gastrostomy tube is a flexible feeding tube inserted through the abdominal wall directly into the stomach to provide long-term nutritional support, fluids and/or medications). Enteral Feed Order 6 times daily for nutrition support: enteral flush total 600 milliliters water via peg tube via peg; flush with 50 milliliters water before and after feedings via peg tube.Review of physician order dated 10/25/25 documented remove peg equipment from bedside every shift for dysphagia/peg tube feeding.Review of physician orders dated 10/29/25 documented for staff to date opened foods that patient has purchased and remove from room when out of date every shift for dysphagia/peg tube feed re: resident has a history of self-feeding.Review of Care Plan dated 2/14/25 documented the resident requires tube feeding related to dysphagia and cancer. Nothing by mouth. Interventions include remove peg tube feeding equipment from bedside as ordered; the resident is dependent with tube feeding and water flushes.Review of Care Plan dated 4/25/25 documented that the resident does not cooperate with care related to ordering food/liquid from outside and putting it in his peg tube. Staff removing feeding equipment from bedside, all food items dated when opened when observed in in room opened. Interventions included date open food in room that resident purchased and remove when out of date; educate resident/resident's representative/caregivers of the possible outcome(s) of not complying with treatment or care.Review of Care Plan dated 9/8/25 documented the resident has impaired cognitive function/or impaired thought processes related to diagnosis dementia, cancer of the tongue, mood disorder and depression. Interventions included communicate with the resident/resident's representative/caregivers regarding resident capabilities and needs.Review of facility notes for care conference conducted on 10/30/25 which included Resident #41 spouse documented Resident is NPO (nothing by mouth), has G-tube (gastric tube for providing liquid nutrition) for all nutrition / hydration. Observed by staff pouring liqs down feeding tube. Explained to wife that this process is unsafe and is at risk for infection / aspiration as he is also taking po (by mouth) items. On 1/5/26 at 1:52 p.m., in an interview Registered Nurse (RN) Staff Q, said when she went past Resident #41's room she saw him administering something into his feeding tube. RN, Staff Q, said Resident #41 said it was a mixture of feeding (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	formula and coffee. She said she signed for administering the feeding at 1:00 p.m. even though she did not administer it. Staff Q, RN said she saw the cups on the overbed table and documented he consumed 100%. Staff Q, RN said it is really hard to tell what Resident #41 is consuming. She confirmed he should not have any tube feeding supplies in his room. She said he came up to the nurse's station and asked for a new syringe. Staff Q, RN said staff should not be providing the resident with feeding tube supplies and should be removing them from his room.On 1/7/26 at 12:41 p.m., a feeding tube syringe was observed on Resident #41's bed. Observed on bedside table was a basin containing pudding, sardines, 2 large cartons of chicken broth and canned sausages. (photographic evidence obtained)On 1/7/26 at 12:55 p.m., in an interview Licensed Practical Nurse (LPN), Staff F said resident #41's diet is Nothing by Mouth (NPO) but he put liquids in his feeding tube himself. She said he is not supposed to have a syringe in his room. She said she is not sure where he got it from. LPN, Staff F said Resident #41 does not have an order to give himself formula. She said he does give himself formula. LPN, Staff F said none of the food in his room should be there because he is NPO. She said he could aspirate if he had any of that food.On 1/7/26 at 1:14 p.m., in an interview LPN Unit Manager, Staff T and the Director of Nursing (DON) said Resident #41 orders food and supplies from outside. LPN, Staff T Unit Manager, said staff does remove the feeding tube supplies and food but obviously something was missed. The DON said staff were in-serviced but there is no documentation to show the education. The DON said there are room rounds and she will check to see if staff documented. The DON said the staff should be removing food from the resident's room. The DON said it does not look like there is anything documented to show the resident was educated about the risks of consuming food or fluids. The DON said the resident did not have a Self-Administer Assessment for tube feedings. The DON said staff never watched the resident to make sure the resident was properly administering his own feedings. The DON confirmed the resident does not have a physician order to administer his own feedings.On 1/9/26 at 10:29 a.m., a feeding tube syringe and 2 water pitchers with dark liquid were observed on Resident #41s overbed table. (photographic evidence obtained)On 1/9/26 at 10:50 a.m. in an interview the Licensed Speech Therapist said Resident #41 is at risk for aspiration that could lead to pneumonia or respiratory issues. She said the staff should be removing any food and tube feeding supplies and document every time he is non-compliant.Enteral Feeding N-405 Policies and Procedures effective date 11/30/2014, revision dated 11/12/2018 documented nurses administer enteral feeding when volume control is indicated and as ordered by physician.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, review of facility policy and staff interviews, the facility failed to provide a clean and sanitary environment for 3 residents, (Resident #82, #41 and #59) of 7 residents sampled.The findings included: Review of Facility Policy 5-Step Room Cleaning revised date 10/25/16 documented Purpose: To teach Environmental Services employees the proper cleaning method to sanitize a patient room or any area in a healthcare facility. 4) Dust Mop: the entire floor must be dust mopped - especially behind dressers and beds. 5) The most important area of a patient's room to disinfect is the floor. This is where most air-borne bacteria will settle and so it needs to be sanitized daily.On 1/5/26 at 10:05 a.m., during a tour of the facility, 2 floor mats observed for Resident #82 covered with an unclean black substance. (photographic evidence obtained).On 1/5/26 at 10:26 a.m., during a tour of the facility, 2 floor mats for Resident #41were observed covered with an unclean black substance and a soiled water pitcher on overbed table. (photographic evidence obtained).On 1/5/26 at 10:54 a.m., during a tour of the facility, observed 1 floor mat and floor for Resident #59 covered with brown, sticky substance. (photographic evidence obtained).On 1/8/26 at 12:28 p.m., in an interview Staff S, Licensed Practical Nurse (LPN), Unit Manager and Staff T, LPN Unit Manager said they do not know when floor mats are cleaned or replaced. Staff T, LPN Unit Manager said cleaning is the responsibility of housekeeping. Staff T, LPN, Unit Manager said if nursing sees any soiled mats, they stand them up and use sanitizer wipes to clean them. Accompanied Staff T, LPN, Unit Manager, to Resident #82's room and he said the floor mats need to be replaced. Staff T, LPN, Unit Manager, said he was not sure about the last time this room was cleaned.On 1/8/26 at 12:30 p.m., in an interview the Floor Technician said housekeeping is supposed to move the floor mats and clean the floor mats and floor every day. Accompanied Floor Technician to Resident #82's room and he said the floor mats are not acceptable.On 1/8/26 at 1:00 p.m., in an interview the Housekeeping Manager said the floor mats should be cleaned every day when housekeeping goes in the room. She said housekeeping should move the floor mats, stand them up to be able to sweep and clean the floor. The Housekeeping Manager said the floor mats for Resident #82 should have been cleaned all week and it appears they were not.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, record review and resident and staff interview, the facility failed to ensure 1, (Resident #89), of 1 resident with a pressure ulcer received treatments, including turning and repositioning using a wedge pillow, as part of pressure ulcer prevention and management.The findings included:Review of the facility policy and procedures Clinical Guideline Skin and Wound effective 4/1/2017 documented To provide a system for identifying skin at risk, implementing individual interventions including evaluation and monitoring as indicated to promote skin health, healing and decrease worsening of/prevention of pressure injury. Develop individualized goals and interventions and document on the care plan and the CNA Kardex.(Certified Nursing Assistant (CNA) Kardex is clinical documentation to show CNAs resident specific treatment plan.)Review of the clinical record revealed Resident #89 originally admitted on [DATE] with diagnoses including type 2 diabetes mellitus, ASHD (atherosclerotic heart disease), dysphagia, need for assistance with ADL's (Activities of Daily Living) and cardiac pacemaker. admission MDS (Minimum Data Set) dated 2/14/25 section M documented the resident was not at risk for pressure ulcers and did not have any pressure ulcers upon admission. BIMS (Brief Interview for Mental Status) score of 15 indicating intact cognition. Quarterly MDS dated [DATE] section M identified a pressure ulcer, present on admission stage 4. (severe full thickness wound with high infection risk) BIMS score of 15. The MDS noted the resident was dependent on staff for toileting, personal hygiene and bed mobility. Resident #89 was discharged on 12/17/25 and readmitted on [DATE]. readmission diagnosis included stage 4 pressure ulcer of the left buttocks, osteomyelitis, need for assistance with personal care.Review of the care plan initiated 10/7/25, identified the resident had a stage 4 pressure wound on the left ischium. The interventions instructed staff to reposition/off load torso as ordered/tolerated. Review of the Certified Nursing Assistant (CNA) Kardex documented reposition/off load torso as ordered/tolerated, must use foam wedge, turn every 2 hours and no lying on the left side.Clinical record review for Resident #89's spouse (Resident #90) documented on the Quarterly MDS dated [DATE] a BIMS score of 15 cognitively intact.On 1/5/2026 at 10:39 a.m., during an observation and interview Resident #89 said he had a wound on the left buttocks. Resident #89 said the staff do not come and turn him every 2 hours like they are supposed to. He was observed positioned on his back with a wedge positioning cushion under the left side of his upper back. A sign was noted above the resident's bed instructing staff to turn the resident every 2 hours.On 1/5/2026 at 1:18 p.m., during an observation Resident #89 was observed in bed positioned on his back. He said the staff had not come in to turn him. His wife (Resident #90), who is also his roommate, confirmed staff had not been in to turn her husband every 2 hours as required. There was a wedge positioning device under the resident's left upper back. On 1/5/2026 at 4:01 p.m., Resident #89 was observed in his bed lying on his back. He had a wedge positioning device that was placed on the left side of the resident's upper back. On 1/6/2026 at 8:49 a.m., Resident #89 was observed in bed lying on his back. The wedge positioning device was on the resident's right side of the upper back. On 1/6/26 at 3:23 p.m., in an interview the Director of Rehabilitation said if a wedge positioning device is used to decrease pressure on the buttocks area it's placement would vary on where the wound was located. She explained that the wedge should not be under the wound because it would cause pressure. The Director of Rehabilitation said the device should be placed at the lower back/hip area. She said the ideal position would be for the resident to be on their side. If on the left side, then the right leg would cross over the left to keep the resident positioned properly.On 1/6/26 at 4:32 p.m., Resident #89 was observed in bed on his back. The wedge positioning device was observed on the wheelchair next to the bed. His wife (Resident #90) said they will position him one more time then and put on his back to sleep for the night. She said he spends the entire night on his back; no one comes in to turn him. On 1/7/26 at 9:45 a.m., in an interview CNA Staff N said residents are turned every 2 hours. She said she was not assigned to Resident #89 today (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	but cared for him in the past. She said the resident was dependent for care, except feeding himself. On 1/7/26 at 10:00 a.m., in an interview CNA Staff H said he was assigned to Resident #89 today. He said he did not know about repositioning /turning and was not able to answer any questions regarding the resident's care needs. On 1/7/26 at 4:00 p.m., Resident #89's spouse (Resident #90) was very upset. She said no one has turned her husband since 11:00 a.m. She said she had put the call light on and asked CNA Staff H three times to change her husband due to incontinence and pull him up in the bed, but the CNA did not understand her request. She said she had approached Unit Manager Staff T and the Administrator for assistance but received none. Resident #89 was observed scooted down in bed on his back and his head was resting on the side rail. He was upset and said, CNA Staff H did not come back in here to do anything. I'm tired of this, he doesn't speak the language, and he can't do anything you ask for. Resident #89's wife said, I have been at the desk complaining and no one has done anything.On 1/7/26 at 4:05 p.m., observed Resident #89's call bell activated from the hall. Several staff members were observed walking past the room, not answering the call light. Transportation CNA Staff M entered the room to assist the resident and asked the resident who his CNA was for the evening shift. Resident #89 told her CNA Staff L was in here and that he had told him he needed to be turned and changed but he does not understand. Another CNA was in the hall and called Staff L to come and assist the resident as he was assigned to Resident #89 on the evening shift. CNA Staff L entered the room and said, I do not understand. CNA Staff M told CNA Staff L the resident needed to be turned and pulled up in bed. He replied, I don't know. CNA Staff M showed him how to assist her to pull the resident up in the bed and turn him using the wedge positioning device. CNA Staff M explained to CNA Staff L he needed to turn Resident #89 every 2 hours, but CNA Staff L exited the room without speaking to the resident.On 1/7/26 at 4:30 p.m., in an interview the Administrator said, I looked and I can't find any education on the use of the position wedge. I had the Director of Rehabilitation look as well and we have nothing.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff and resident interview, the facility failed to administer intravenous (IV) medication as ordered for 1, (Resident #90), of 1 resident sampled with a urinary tract infection (UTI). The failure to administer antibiotics as ordered can lead to treatment failure, prolonged illness and the development of dangerous antibiotic-resistant bacteria.The findings included: Review of the clinical record revealed Resident #90 was [AGE] years old and had an admission date of 5/2/25. Diagnoses included recurrent UTI, urinary incontinence, incomplete bladder emptying, chronic renal impairment and chronic kidney disease. admission MDS (Minimum Data Set) dated 5/8/25 documented a BIMS (Brief Interview for Mental Status) score of 15 indicating resident is cognitively intact. The Quarterly MDS dated [DATE] BIMS 15,Review of the physician orders revealed an order dated 12/27/25 for Daptomycin Intravenous Solution Reconstituted 500 milligrams. (Antibiotic to treat urinary tract infections). Use 300 milliliters intravenously one time a day for UTI for 15 days.Review of the physician progress noted dated 12/27/25 documented: Review for management of a urinary tract infection requiring intravenous antibiotic therapy. The resident was seen for follow-up on a urinary tract infection for which she was recently started on intravenous Daptomycin (300 milliliters daily for 15 days). The IV was placed in the left arm on 12/26/25. Today, she is complaining of pain and bleeding at the IV insertion site, prompting notification of the IV team for troubleshooting. She is an [AGE] year-old female with multiple comorbidities including chronic kidney disease stage 3B. She has required as needed acetaminophen for pain and ondansetron for nausea over the past several days, likely related to the infection or antibiotic side effects. She has a follow-up appointment with Infectious Disease scheduled for 1/2/2026. The primary focus of today's visit is to manage the complications of her IV antibiotic therapy, monitor the underlying UTI, and coordinate care for her multiple chronic conditions in this acute setting.On 1/5/2026 at 2:55 p.m., during an observation, Resident #90 was noted with a Peripherally Inserted Central Catheter (PICC) line in her left upper arm, she said she was receiving IV antibiotics for a kidney infection. Resident #90 said she got the infection while at the facility.On 1/7/2026 at 4:00 p.m., Resident #90 who was very upset said she did not receive her 2:00 p.m., dose of the IV antibiotic. She said, I told the nurse I need my medication; I went to the nurse's desk and told them. Resident #90 was tearful and said, I just want my medication, so I can be done with this.On 1/7/26 at 4:05 p.m., Licensed Practical Nurse (LPN) Staff F arrived in Resident #90's room. The resident said, I did not get my antibiotic today, you said you would do it at 2:00 p.m. LPN Staff F said, I can't give it to you because I only have one of the medications. I don't have the one that goes with it. Resident #90 began to cry and said, Why did you not come and tell me then so I would not get upset? LPN Staff F told Resident #90 she was busy and going all day and had not had a break. The resident said If you had just come and told me I would not be so upset. Resident #90 asked why she did not have the medication and LPN Staff F responded I don't know. I don't know why it's not here.Review of the progress notes revealed LPN Staff F documented on 1/7/25, medication not at facility. Medication ordered by writer.Review of the clinical records failed to show any documentation of physician notification regarding the missed antibiotic dose on 1/7/25.On 1/8/2026 at 3:23 p.m., in an interview the Assistant Director of Nursing (ADON) said she was not aware Resident #90 did not receive her schedule antibiotic on 1/7/26. The ADON said, I would imagine the pharmacy did not send it. I will check with the DON.On 1/8/2026 at 3:28 p.m., in an interview the Director of Nursing (DON) said Resident #90 did not receive her IV medication because it was not delivered from pharmacy. The DON confirmed there was no documentation that the Physician was notified of the missed antibiotic dose.

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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. Based on record review and interview, the facility failed to ensure residents who were offered an opportunity to consent or decline vaccines, received the vaccines consented for, unless medically contraindicated for 1 (Resident # 5) of 5 residents reviewed for vaccines. The findings included: On 1/7/25, a record review of Resident #5's chart revealed an informed consent for pneumococcal vaccine dated 11/30/25 on which Resident #5 indicated he consented to receiving the pneumococcal vaccine. Further review of Resident #5's chart failed to reveal documentation that he had received the vaccine.On 1/8/26 at 10:22 a.m., in a meeting with the Director of Nursing (DON) and the Infection Control Preventionist (ICP), Resident #5's pneumococcal vaccine was discussed. The DON reviewed the electronic chart and said she was unable to find documentation in computerized file that it had been given. The ICP checked Resident #5's hard paper chart and was unable to find documentation the vaccine had been given. Neither the DON nor ICP could offer an explanation why the consented for vaccine hadn't been given. The DON said, it had been missed. The DON said they did not have a facility policy for administering the pneumococcal vaccine.