STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105448	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Titusville Rehabilitation & Nursing Center	1705 Jess Parrish CT Titusville, FL 32796

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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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, and record review, the facility failed to ensure the Quality Assessment & Assurance (QAA) / Quality Assurance and Performance Improvement (QAPI) committee conducted performance improvement activities to ensure prior improvement measures were sustained. Findings: Review of the policy and procedure, QAPI Facility Plan dated 10/19/25, revealed the QAPI committee monitored progress to ensure that interventions or actions were implemented and were effective in making and sustaining improvements.The facility had a deficiency cited at F842 for complete and accurate medical records during the previous recertification survey conducted 6/03/24 through 6/07/24. During this survey, the facility was found to again be in noncompliance with F842. As a result of this repeat deficiency, it was identified there was insufficient auditing and oversight to prevent the citation.On 3/06/26 at 5:10 PM, the Administrator stated the facility had a QAPI committee that met monthly. He explained that the committee reviewed several areas which included information obtained during rounds on the floor, clinical metrics, care issues, grievances and issues raised by residents during concierge' rounds. He stated when an issue was identified, the QAPI committee would create a performance improvement plan to address the concern to bring it back into compliance. Concerns from the current survey were reviewed with the Administrator. He acknowledged the repeat citation from the previous recertification survey. He explained that multiple providers still documented on paper and felt that contributed to medical records not being complete and accurate.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to maintain the highest practicable physical well-being by failing to prevent a facility acquired pressure ulcer, implement revisions to the pressure ulcer care plan after a change in wound status, and failing to implement physician orders for existing pressure ulcers for 2 out of 2 residents reviewed for pressure ulcers, of a total sample of 44, (#7, & #107).Findings: 1.Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, peg tube (feeding tube in stomach), type two diabetes, and brain damage from low oxygen. Review of the admission Minimum Data Set (MDS) dated [DATE] revealed resident #7 was severely impaired cognitively, he was dependent for all activities of daily living (ADL) and had no pressure injury. The MDS assessment revealed the resident was dependent on the helper for all functional abilities and the resident did none of the effort to complete. Additionally, the MDS showed that resident #7 was at risk for developing pressure injuries. The assessment indicated treatments to prevent pressure injuries included the use of a pressure reducing device for bed and applications of ointments and medications other than to the feet. A review of resident #7's care plan dated 1/28/26, revealed the resident had an ADL self-care performance deficit and was documented as total dependent upon staff for all ADLs. Additionally, the care plan initiated on 1/28/26 with no revision date, reflected the resident was at risk for developing a wound with interventions for Certified Nursing Assistants (CNA)s to encourage/remind/assist the resident in turning and repositioning as needed or requested, and for staff to float the resident's heels. The review of the Treatment Administration Record (TAR) for resident #7 revealed missing documentation for turning and repositioning and skin observations every shift. The February 2026 TAR revealed turning and repositioning was not documented as performed a majority of nights on the nightshift, for a total of 19 out of 28 shifts for the month. For the evening shift on the February 2026 TAR, 12 out of 28 shifts were not documented as performed, and for the dayshift was 6 out of 28 shifts did not include documentation the task was performed. For the task of skin observation, the February 2026 TAR was missing documentation of performance during nightshift for 18 out of 28 shifts. For the evening shift 12 out of 28 shifts were missing documentation as performed, and for dayshift 6 out of 28 shifts, performance of skin observation was not documented as completed. Review of the weekly skin check for resident #7, Section 2, revealed documentation for 2/23/26 showed No New Areas of Skin Impairment, Care Plan Reviewed and Current, See Skin/Wound Note and section 3 documentation Coccyx. On 3/2/26, section 2 documentation revealed No New Area of Skin Impairment, Care Plan Reviewed and Current, and on section 3, Right Buttock - pressure and Left Buttock – pressure. Review of resident #7's nursing progress notes dated 2/17/26 revealed new skin issues that were acquired in-house. The note indicated skin issues were a stage three pressure ulcer on the left side of buttock, stage three left upper buttock, stage two sacrum, and stage two right side buttock. Stage II pressure ulcers present as a shallow open ulcer with a red-pink wound bed without dead (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tissue (slough); stage III pressure ulcers are full thickness with possible subcutaneous fat visible, they may have dead tissue, undermining, and tunneling depending on the area of the wound. Stage IV pressure ulcers are full thickness tissue loss with exposed bone, tendon or muscles, and often include undermining and tunneling, (retrieved on 3/19/26 from www.in.gov/health). Physician orders dated 2/24/26 for treatment reflected, Treatment as follows: Sacrum – Cleanse wound with normal saline/wound cleanser, pat dry. Apply calcium alginate to wound bed and cover with dry dressing daily and as needed. Resident #7's TAR for wound care included, Sacrum – Cleanse wound with normal saline/wound cleanser, pat dry. Apply calcium alginate to wound bed and cover with dry dressing daily and as needed. There was no documentation of the treatment having been performed from 2/24/26 through 2/28/26 nor on 3/04/26. On 3/02/26 at 11:05 AM, resident #7 was observed in bed lying flat with the head of bed slightly elevated. His was mouth and lips were dry. The resident was dressed in a hospital gown; skid free socks and his heels were resting on the mattress. On 3/02/26 at 1:25 PM, resident #7 was observed in same position. His mouth and lips remained dry. On 3/03/26 at 9:20 AM, resident #7 was observed in bed lying flat, the head of bed slightly elevated, his eyes were closed. The resident was dressed in a hospital gown; skid free socks and his heels were resting on the mattress. On 3/03/26 at 11:10 AM, resident #7 remained in the same position. The bed sheet had fallen off to the side of the bed exposing the resident wearing only a disposable brief. On 3/03/26 at 11:20 AM, CNA N explained she tried to get residents who needed less assistance with ADLs finished first in the morning. She stated they were short staffed on many days, and it took longer to get care done. She stated she asked the nurse for help, but conveyed they were short staffed as well and often couldn't help. CNA N stated resident #7 needed to be repositioned every two hours but said she had not been in resident #7's room yet. She stated that she looked at the plan of care and documents when she had time and they had gone into the resident's room at shift change. On 3/03/26 at 2:40 PM, Resident #7 was observed in bed lying flat, head of bed slightly elevated, eyes closed. The resident was dressed in a hospital gown, skid free socks and heels resting on mattress. Two pillows on floor next to bed. On 3/04/26 at 9:00 AM, resident #7 was in bed lying flat, with the head of bed slightly elevated, and his eyes open. His wife was at bedside. Resident #7's wife stated she felt her husband did not receive good care and was on a waiting list for another facility. She stated her husband did not have a pressure wound when he came first came here and now, he does. She stated that one day her husband's bedsheets were full of brown stool all the way up to his shoulders and said she knew it had been there for a while because some of it was dried. Resident #7's wife stated she was a CNA for more than 30 years and felt the only care her husband received at the facility was from her. She stated, no one turns him but me and I can't be here all the time. On 3/04/26 at 9:11 AM, the 100 UM stated that resident #7 had stage two and three pressure wounds. She stated she completed wound care, described, staged and documents the wounds. The UM (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	explained she did not receive training at the facility for staging wounds and only had what she learned in nursing school. She stated when she first came to the facility, she was told if it was an existing wound and it opened; it was a stage two or three. The UM expressed skin observations were done each shift and verified resident #7 should be repositioned every two hours. She said it was the CNA's responsibility. On 3/04/26 at 9:20 AM, CNA C stated she assisted the nurses with wound care when they asked. She stated she tried to always check on the residents if they were not mobile. The aide stated she got busy and sometimes can't get in to check on everyone. The CNA said she let the nurses know if she couldn't do it but said they were busy as well. CNA C confirmed it was the CNA's responsibility to reposition residents. On 3/05/26 at 10:20 AM, resident #7 was again lying flat with head of bed slightly elevated. There were pillows on the floor next to his bed. His sheet was off exposing his briefs. The resident was dressed in a hospital gown; skid free socks and his heels were resting on the mattress. On 3/05/26 at 10:25 AM, the 200 UM stated she became aware of resident #7's pressure wound from a CNA. She explained she evaluated and took pictures of the wound. She said she did not have education on wound staging but had known how to do it from experience. The UM expressed, they met daily to discuss wounds, and the Director of Nursing (DON), MDS Coordinator, Social Worker, and UMs met twice a week. She stated that she looked at the care plan, treatment record, and documents in the computer. The 200 UM related she did not know the care plan for resident #7 did not have any revisions after the wound was discovered. She stated that care plan revisions were the MDS coordinators' responsibility. On 3/05/26 at 2:45 PM, resident #7 was in bed on his right side with pillows supporting his back. The head of bed was slightly elevated and his eyes were closed. Resident #7's wound was observed with Registered Nurse (RN) A. The resident's brief was removed by RN A to reveal no dressing was present covering the wound. RN A confirmed a dressing should have been present. RN A stated, the wound was looking much better and that it was a stage two. He stated the resident's pressure wounds should be considered one wound sacral wound. The nurse explained they took pictures of the wounds every Tuesday, but something was wrong with their system, so the pictures were not in there. On 3/05/26 at 3:00 PM, the MDS coordinator confirmed she was responsible for updating care plans including for wounds. She stated nurses could update the plans, but it was ultimately her responsibility. She stated the team met weekly and reviewed residents. She said he was familiar with resident #7 and confirmed his care plan needed to be revised with the most current information. She stated, I don't always have a laptop to update in meetings. 2. Review of resident #107's medical record revealed he was admitted to the facility on [DATE] with diagnoses including sepsis, necrotizing fasciitis, pressure ulcer of right buttocks stage 4, and paraplegia (partial paralysis) and polyneuropathy (nerve pain). Review of hospital paperwork prior to admission to the facility revealed resident #107 was admitted to the hospital with a worsening decubitus ulcer which resulted in sepsis. While at the hospital, the resident had a Computed Tomography (CT) scan that showed a right gluteal wound with fistula (abnormal passage between two parts of the body or organs) track which had a concern for necrotizing fasciitis. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the Center for Disease Control (CDC), necrotizing fasciitis is a serious bacterial infection which can develop quickly into a life-threatening emergency including sepsis, organ failure, limb loss, or even death. Recent data reveals that even with treatment, up to 1 in 5 people die from this infection (retrieved from www.cdc.gov on 3/06/26). Review of the admission Minimum Data Set assessment with Assessment Reference Date (ARD) of 2/22/26 revealed resident #107 had one Stage 4 pressure ulcer and one unstageable pressure ulcer due to a non-removable dressing or device. Review of hospital discharge paperwork revealed orders for negative pressure wound therapy which indicated the pump settings as 125 millimeters of mercury (mmHg) continuous to the stage 4 pressure ulcer to the right glute. The wound vacuum was to be changed three times weekly and to be monitored for wound healing and infection. Review of resident #107's physician orders revealed a treatment order to change the wound vacuum three times a week on Monday, Wednesdays and Fridays with a start date of 2/21/26. The Treatment Administration Record (TAR) was reviewed for February, and it contained no documentation of the wound vacuum being changed from the date of admission on [DATE] until 9 days later on 2/25/26. Resident #107's admission assessment dated [DATE] revealed under the skin integrity section, scabs to the resident's 2nd, 3rd and 4th toes on bilateral feet, scattered sores to his bilateral lower extremities, a surgical incision to his right buttocks and a pressure ulcer to his sacrum. Review of resident #107's weekly skin checks revealed: - On 2/17/26 at 6:15 AM, documentation of no new areas of skin impairment. In the section underneath titled 'location of new skin impairment,' listed pressure injuries to the left buttocks, coccyx, right and left rear thigh and right front thigh. These location did not have staging or measurements documented. - On 2/18/26 at 6:46 AM, documentation of no new areas of skin impairment. In the section underneath titled 'location of new skin impairment,' indicated pressure injuries to the right and left buttocks, sacrum, and right and left rear thigh. None of the locations had staging or measurements documented. - On 2/18/26 at 6:53 PM, documentation of no new areas of skin impairment. In the section underneath titled 'location of new skin impairment,' listed pressure injury of a stage 3 to left buttocks, stage 4 to coccyx, and stage 3 to right and left rear thigh. The evaluation also listed stage 3 bruising to the right front thigh. None of the locations had measurements documented. - On 2/19/26 at 12:54 AM, documentation of no new areas of skin impairment. In the section underneath titled 'location of new skin impairment,' listed pressure injury of a stage 2 to left buttocks, stage 4 to sacrum, a stage 2 to right rear thigh and stage 2 to right buttocks. None of the locations had measurements documented. - On 2/19/26 at 10:43 PM, documentation of no new areas of skin impairment. In the section underneath titled 'location of new skin impairment,' listed pressure injury of a stage 3 to left buttocks, stage 4 to coccyx, a stage 3 to right rear thigh and a stage 3 to the right buttocks. None of the locations had measurements documented. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 2/25/26 at 7:08 PM, documentation of no new areas of skin impairment. In the section underneath titled 'location of new skin impairment,' listed right gluteal fold with no documentation of the type of injury due to resident refusal of skin evaluation. On 3/05/26 the Director of Nursing (DON) acknowledged the weekly skin assessments were not consistent with the locations, descriptions and staging of the skin issues for resident #107. Review of the skin issue evaluation dated 2/18/26 revealed a new skin issue of a pressure ulcer/injury to the right gluteal fold which was present on admission. Review of the skin issue evaluation dated 2/25/26 revealed: - An evaluation of right gluteal fold pressure ulcer/injury which was present on admission. This skin issue was documented as receiving negative pressure wound therapy. - A new skin issue of the right lateral thigh abrasion documented as a new wound present on admission. - A new skin issue of the left lateral thigh abrasion documented as a new wound present on admission. - A new skin issue of a pressure ulcer/injury to the sacrum documented as a new wound present on admission. - A new skin issue of a pressure ulcer/ injury to the left heel documented as a new wound present on admission. - Review of the section titled 'current number of unhealed pressure ulcer/injuries at each stage' revealed documentation of 0 for stages 1 to 4 and 0 for number present on admission. Under the section 'does this resident have one or more unhealed pressure ulcers/injuries' the box 'yes' was selected. On 3/05/26 at 2:45 PM, the DON acknowledged there was no documentation of a left heel wound nor left and right lateral abrasions before 2/25/26 even though they were listed in the evaluation as present on admission. She stated her expectation was for a brief documentation of all skin issues to be completed in the admission assessment so all issues could be monitored and treatments ordered as needed. Review of TAR revealed treatment orders with a start date of 2/25/26 for: - A treatment to the left inner thigh which had no documentation as being performed on 2/26/26 - A treatment to the right inner thigh which had no documentation as being performed on 2/26/26 and 2/27/26. - A treatment order to the sacrum which had no documentation as being performed on 2/26/26 and 2/27/26. On 3/05/26 at 2:45 PM, the DON acknowledged the lack of documentation for the treatments having (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been performed. She stated her expectation was for nurses to follow the physician orders for treatments and to document directly after performing the treatments. She explained if the resident was unavailable or refused, then that should be reflected in the resident's medical record. The DON confirmed there were no treatment orders for the sacrum and the left and right inner thigh before 2/25/26. The DON expressed if the resident was admitted without a treatment order or a new skin issue appeared, the nurse was responsible to notify the physician and receive a treatment order. Review of the facility's policy titled, Physician Orders effective February 2026, revealed at the time of admission, the facility would have physician order for the immediate care of the resident. The facility policy titled, Wound Prevention and Treatment Overview effective October 2021, indicated residents with ulcers would receive continued preventative interventions and necessary treatment and services to promote healing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure frying pans, refrigerated foods, and spices were stored under clean and sanitary conditions, dry food was stored at the appropriate temperature; prepare, distribute and serve food in a manner to prevent food borne illness, by failing to maintain potentially hazardous pureed and regular foods at the correct hot holding temperature for four residents on a puree diet, and 57 residents on regular house diet, of a total population of 93 residents.Findings:On 3/02/26 at 10:25 AM, the initial kitchen tour was conducted with the Certified Dietary Manager (CDM). In the walk-in refrigerator there was visible food debris and residue along the baseboards and corners. The CDM stated there was a weekly deep clean schedule but could not say when the last time a deep clean was done. In the food preparation area, two spice bins had a visibly sticky residue and debris in the bottom of the container. (photo evidence obtained) The CDM acknowledged the spice bins and stated the containers were expected to be cleaned three days per week. The CDM could not say when was the last time they were cleaned.In the dry storage room, the air conditioning unit had the cover off and the top of the unit had debris and rust visible. The temperature in the room was 76 degrees Fahrenheit (F). (photo evidence obtained) The CDM stated she wasn't sure how long the air conditioning unit had been broken. She stated she notified maintenance but could not recall when and was not able to produce a work order for the repair request. Additionally, there was a bin with granola bars past their expiration date. (photo evidence obtained) In the food preparation area, there was a dietary aide working with a beard covering under their chin, not covering the full beard. The CDM acknowledged the aide's beard needed to be fully covered. On 3/04/26 at 11:35 AM, the facility menu revealed Sloppy [NAME] on a Bun as the lunch main entree on 3/04/26. The lunch tray line was observed. The cook took the hot holding temperatures of the food on the steam table with a digital stem bayonet style instant read thermometer. The cook stated she did not know the hot holding temperature range of potentially hazardous foods but was able to state the hot holding temperature needed to be at least 135 degrees F or greater. During cleaning of the thermometer, the cook dropped a corner of the alcohol wipe into the mashed potatoes. She reached into the mashed potatoes with ungloved fingers to remove the piece of the wipe. The CDM stated gloves were not a requirement for checking temperatures and her hands were not close to the food. The CDM confirmed the cook should have used gloves to remove the corner of the alcohol wipe.Potentially hazardous foods on the steam table were held below the required holding temperature of 135 degrees F or greater. Observed temperatures included: sloppy joe was 120 degrees F, pureed cabbage was 85 degrees F, mashed potatoes were 132 degrees F. Other observations made on 3/02/26 and 3/04/26 included rust on wheels of equipment in the food preparation area, a shelf with three frying pans (one-12 inch, two- 8 inch) lying with handles down had debris and food particles next to the three pans. The Registered Dietitian was in the food prep area with hair net not covering the front of hair, and a male dietary aide was handling plates with food without gloves.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor resident rights in regard to self-determination for 1 of 7 residents reviewed for reviewed for choices, of total sample of 44 residents, (#63). Findings: On 3/02/26 at 10:14 AM, resident #63 said she was unhappy at the facility, didn't feel like she belonged, and had requested a transfer. She expressed she preferred to be outside as much as possible, and this facility only allowed residents to exit the building if they smoked. Review of the Quarterly Minimum Data Set assessment dated [DATE] revealed resident #63 had a Brief Interview for Mental Status of 13/15, indicating she was mostly cognitively intact, was dependent on staff for all activities of daily living and was unable to move from the waist down. The assessment indicated she had a history of traumatic brain injury, was able to use the internet, hold a conversation, and recall events. Review of resident #63's medical record indicated she sought assistance on 12/05/25 from the Social Services Director, stated a desire to move to a skilled nursing facility in a nearby city, to be closer to family. Resident #63 had a care plan dated 11/19/25 with a goal that the resident wished to adjust to long term care placement. The care plan had an intervention of referral to a local contact agency as needed. On 3/03/26 at 3:42 PM, the Social Services Director (SSD) expressed she sent several referrals for the resident. She stated that resident #63 didn't get accepted to a facility in either of the nearby cities she desired. The SSD said the resident had been to the hospital and wasn't approved to move back to her previous home. On 3/04/26 at 1:38 PM, the Administrator was unable to provide any copies of referrals for resident #63. There were no notes in the resident's medical record that indicated attempts had been made to find alternate placement for resident #63 per her request. On 3/04/26 the Social Services Director (SSD) stated there were no long-term beds available at one facility nearby and had faxed referrals to other facilities nearby. She did not explain why there were no documented referrals for alternative placement for resident #63 until that day. On 3/05/26 at 10:42 AM, in a joint interview with the Director of Nursing (DON) and the Administrator, the DON stated she and the Social Worker were supposed to meet with residents who preferred to move from the facility to assess their needs in a care meeting. The Administrator had no comment. The facility was asked for a policy for helping residents to transfer, but a Discharge Documentation Policy was provided instead.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 out of 2 residents reviewed for care plans, of a total sample of 44 residents, (#99). Findings: Resident #99 was admitted to the facility on [DATE] with diagnoses of bipolar disorder, morbid obesity, and muscle wasting. The hospital transfer form indicated the resident was blind. On 3/02/26 at 1:11 PM, resident #99 remarked she was mostly blind, and needed cataract surgery. She explained the facility had her sign financial paperwork without explaining it to her. The Minimum Data Set (MDS) assessment dated [DATE] revealed resident #99 had severely impaired vision but was cognitively intact and required moderate assistance from staff. Review of resident #99's care plan revealed no interventions related to her blindness or impaired vision. Review of the Electronic Medical Record (EMR) revealed a nurse progress note dated 2/08/26 which indicated resident #99 was legally blind. The medical record revealed several notes from the Social Services Director (SSD) that indicated she was aware resident #99 was unable to see. In a note dated 1/19/26 the SSD documented the resident's cataract surgery needed to be rescheduled. Another SSD note from 2/27/26 documented the resident requested help in getting access to her funds. On 3/03/26 at 3:42 PM, the SSD stated if a resident had trouble seeing, it should be noted in their care plan. She stated the resident should be seen by an eye doctor. The SSD explained if a resident who had vision problems needed to sign paperwork, she would call the family to explain the paperwork. The SSD did not know if or when the cataract appointment had been rescheduled, and with the assistance of the Director of Nursing (DON), they could not find any information on the surgery. On 3/04/26 at 10:05 AM, the Business Office Manager explained they transferred resident #99's money from her previous facility to this one, and she signed her own paperwork. The manager said the SSD obtained her signature; and confirmed they did not call the resident's family to explain the paperwork she was signing. On 3/04/26 at 3:00 PM, the MDS Coordinator explained care plans were the responsibility of the SSD, MDS, and other nursing staff combined. She confirmed resident #99 did not have a care plan for her visual impairment, and said if a resident was blind, it should be in their care plan. On 3/05/26 at 10:42 AM, the DON stated residents who were blind or visually impaired should have that reflected in their care plan. The facility's Care Plan Policy and Procedure - Interdisciplinary Plan of Care from Interim to Meeting dated February 2024 specified, The facility shall assess and address care issues that are relevant to individual residents, to include. monitoring resident condition, and responding with appropriate interventions. The document included care plan development should involve the resident and the resident's representative as appropriate.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to revise the comprehensive care plan to include wound management for 1 of 2 residents reviewed for non-pressure related skin conditions, of a total sample of 44 residents, (#36).Findings:Review of the medical record revealed resident #36, an [AGE] year-old female was admitted to the facility on [DATE] and re-admitted from an acute care hospital on 9/19/25. The resident's diagnoses included type 2 diabetes mellitus, adult failure to thrive, malnutrition, heart disease, muscle wasting and atrophy of multiple sites, and left lateral forehead squamous cell carcinoma (skin cancer).The most recent Minimum Data Set (MDS) Quarterly Assessment with an Assessment Reference Date of 12/03/25 noted resident #1 scored 13 out of 15 on the Brief Interview for Mental Status that indicated intact cognition. The skin and wound assessment documented there were no surgical wounds or care during the look-back period.On 3/03/26 at 9:05 AM, resident #36 was observed in her room eating breakfast while lying in bed. There was one small and one large undated bordered adhesive gauze dressing with peeling edges on her forehead and scalp. The resident said she had skin cancer lesions removed at the Dermatologist's office approximately one week earlier where the dressings were applied and facility nurses had not looked at them since then.Review of the active physician's orders and Medication/Treatment Administration Records (MARs/TARs) did not include monitoring of resident #36's head wounds.The Care Plan Report did not include any wound monitoring/care.A nurse progress note dated 2/25/26 documented resident #1 had a head wound dressing after an outpatient medical appointment on 2/24/26.On 3/05/26 at 2:54 PM in an interview with the MDS Coordinator, the nurse explained she was primarily responsible for updating and revising comprehensive care plans. She said the Interdisciplinary Team (IDT) met weekly and the clinical team met every morning to discuss residents' treatment plan revisions where updates were entered. She checked resident #36's medical record and confirmed the care plan was not revised to include the head wounds. The nurse relayed the plan of care should have been updated to include the wound care and monitoring and she didn't see any orders in the record, so she wouldn't have been alerted to update it.On 3/05/26 at 1:46 PM, the Director of Nursing (DON) explained the MDS Coordinator was primarily responsible for updating wound care plans. She said updates were discussed during morning and weekly meetings with the IDT and resident #36's wounds should have been added to the comprehensive care plan after her physician's visit at the next clinical meeting.Review of the facility's standards and guidelines dated February 2024 and titled Care Plan - Interdisciplinary Plan of Care from Interim to Meeting outlined that care plans were regularly updated by the IDT which was necessary to plan care and meet the resident's medical and nursing needs.

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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 observation, interview, and record review, the facility failed to provide appropriate care consistent with professional standards of practice, and treatment to promote healing of other skin conditions for 1 of 4 residents reviewed for skin conditions, of a total sample of 44 residents, (#107).Findings:Resident #27 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction, flaccid hemiplegia (one-sided paralysis, where muscles are weak), affecting the dominant right side and bladder dysfunction. Review of the Annual Minimum Data Set (MDS) assessment with reference date of 11/22/25 revealed the resident was cognitively intact. The assessment revealed resident #27 was at risk for developing pressure ulcers with treatments that included the application of ointments or medications other than to the feet. Review of physician orders dated 7/30/25 instructed nurses to apply Bacitracin 500 UNIT/GRAM (GM) (Bacitracin (Topical) to buttock excoriation topically every shift for excoriation. The order specified that over the counter medication provided by facility, and instructed pharmacy to not send. A review of resident #27's care plan revealed that the resident had activities of daily living (ADL) self-care performance deficit and required the assistance of one person for bathing. Resident #27 had a care plan for risk for developing wounds related to impaired mobility, bowel and bladder incontinence, fragile skin and right sided hemiplegia. Interventions instructed Certified Nursing Assistants (CNAs) to observe for any new areas of skin breakdown including redness, blisters, discoloration, and report to the nurse. On 3/02/26 at 10:50 AM, resident # 27 stated she believed there was a wound on her right thigh that no one had looked at. She expressed she was afraid the wound might be getting worse. On 3/03/26 and 3/04/26 resident #27 said no nurse had followed up or assessed her skin on the right thigh. She said, not as yet. A review of the weekly skin assessments for February 2026 revealed on 2/06/26 and 2/12/26 for Section 2, No New Skin Impairment was checked. On 2/26/26 there was No New Skin Impairment checked however in section 3, Location of new Skin Impairment, it listed redness to buttock. A review of the Treatment Administration Record (TAR) revealed the Wing 3 Unit Manager (UM) applied the prescribed treatment of Bacitracin ointment on the day and night shift on 3/02/26 and on 3/04/26 on the day shift. The TAR also revealed that Registered Nurse (RN) A applied the prescribed treatment of Bacitracin ointment on the evening shift on 3/02/26 and 3/03/26. The TAR had missing signatures for the day shift application of the prescribed treatment of Bacitracin ointment on 3/01/26 and 3/03/26 and for the evening shift on 3/04/26. On 3/05/25 at 11:07 AM, the assigned CNA E said she often told the nurses of any new skin issue and was aware of the resident # 27's skin breakdown. She could not remember which nurse she informed that resident #27's skin looked worse. With the resident's permission to observe, CNA E propped the resident on her side so her buttocks and upper right thigh could be viewed. The sacral area was covered in a thick pink cream paste, however, the right buttock had bright red drainage, and the right upper thigh had a large, bright, reddened area. CNA E said she often applied the Desitin cream to the buttocks but did not put anything on the right thigh area because it was new and seemed to be getting bigger. Resident #27 said the area was not painful but was very itchy. On 3/05/26 at 11:12 AM, assigned Licensed Practical Nurse (LPN) F explained the treatment orders as she accessed them in the computer. LPN f said it showed an order for Bacitracin to be applied every shift. She explained she had not provided the treatment as yet but said it would be in the treatment cart. Together with the Wing 3 UM, LPN F opened the treatment cart but could not find the Bacitracin she said would be in a tube with the resident's name labelled on it. LPN F went into the stockroom but could not find any Bacitracin. She said she did not know if the medication came from the pharmacy. On 3/05/26 at 11:25 AM, the Wing 3 UM said resident #27 was not on the wound list and did not have any wounds. She explained she did not observe the resident's skin this week on Monday, Tuesday, nor Wednesday because resident #27 had no issues. The UM said she had to check if she signed the TAR in error in regard to her (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation of a treatment applied to resident #27, because the resident did not have skin issues that she was aware of. The Wing 3 UM then excused herself and left. On 3/05/26 at 1:47 PM, the UM explained she had not been paying attention and just signed off the TAR but did not provide any treatment. On 3/05/26 at 1:58 PM, the (DON) acknowledged the skin impairments on resident # 27's sacral area and right thigh after it was brought to her attention. She said that none of the CNAs nor nurses had mentioned any new or worsening areas and she had not been aware previously. She said she could not understand why there was no Bacitracin in the carts nor stock room because they came in small packets. On 3/05/26 at 4:14 PM, RN A said he was not aware of any new or worsening skin issue for resident #27 and he applied Bacitracin to her sacral area but there was not anything on her right thigh. On 3/05/26 at 3:45 PM, the DON said she spoke to the Wing 3 UM and said it was not best practice for the nurse to check off the creams for treatment before completing the task, but she missed the opportunity to address the issue. The DON acknowledged it was not best practice for nurses to sign off something they did not do. The DON said she could not answer why the TAR was left blank with no signature of application of the treatment. The facility's policy on wound prevention and treatment overview effective October 2021, indicated in the facility recognized the most vigilant nursing care may not prevent the development &/or worsening of ulcers in high-risk categories. In those cases, efforts would be directed at managing risk factors and providing therapeutic intervention and providing treatment. In their Procedure section it described the facility reviewed skin integrity on a weekly basis as a proactive approach enabling the facility staff to identify possible changes in skin integrity/condition.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor supplemental oxygen therapy for 1 of 2 residents reviewed for respiratory care, of a total sample of 44 residents, (#1).Findings:Review of the medical record revealed resident #1, a [AGE] year-old male was admitted to the facility on [DATE] and re-admitted from an acute care hospital on 1/19/26. The resident's active diagnoses included respiratory failure, pneumonia, Chronic Obstructive Pulmonary Disease (COPD), sepsis, presence of gastrostomy (feeding tube), atrial fibrillation (abnormal heart rhythm), and type 2 diabetes mellitus.The most recent Minimum Data Set Quarterly Assessment with an Assessment Reference Date of 1/26/26 revealed resident #1 scored 10 out of 15 on the Brief Interview for Mental Status that indicated moderate cognitive impairment. Active diagnoses included pneumonia, Multidrug-Resistant Organism (MDRO), dementia, traumatic brain injury, asthma, respiratory failure with hypoxia (tissue oxygen deficiency), and sepsis (major infection causing organ damage). The assessment noted oxygen therapy was administered while a resident during the look-back period.On 3/03/26 at 9:27 AM and 3/03/26 at 3:21 PM, resident #1 was observed lying in bed in his room with a nasal cannula (two-pronged oxygen delivery device) delivering supplemental oxygen at a flow rate of two liters per minute (LPM). On 3/03/26 at 3:33 PM, in a joint observation with Registered Nurse (RN) A, the nurse verified resident #1 was receiving continuous supplemental oxygen at two LPM.Review of the Medication Administration Record's (MARs) active physician's medication nebulization inhalation orders included Aformoterol Tartrate 15 Micrograms (Mcg) twice daily, Budesonide 0.5 Milligrams (MG) twice daily, and Ipratropium-Albuterol 0.5-2.5 MG every four hours as needed for COPD with acute exacerbation. There were no physician's orders for supplemental oxygen, and no directions to monitor the resident's blood oxygen saturations. Review of the Care Plan Report noted a care plan was initiated on 1/28/19 and revised on 12/05/23 for oxygen therapy related to ineffective gas exchange, shortness of breath, and COPD. The interventions included continuous supplemental oxygen at a flow rate of 3 LPM, nurse monitoring/physician reporting of changes in or development of breathing difficulty and respiratory status.On 3/03/26 at 3:33 PM, RN A said nurses were expected to monitor supplemental oxygen per physician's orders which was documented in the MAR. He said he did not recall checking resident #1's oxygen status during that day's 7:00 AM to 3:00 PM shift. The RN explained it was important to monitor and check blood oxygen saturation levels when receiving supplemental oxygen therapy to ensure effective treatment and evaluate whether the physician needed to be notified. The nurse checked the resident's medical record and stated there were no physician's orders for oxygen and without an order, nurses wouldn't accurately know what flow rate of oxygen to administer.Review of the previous 90 days oxygen saturation record noted that resident #1's blood oxygen saturations were not checked by nurses for more than six weeks, with the last recorded measurement on 1/27/26.Oxygen saturation is a key metric in understanding how well oxygen is carried in the blood. Oxygen-saturated hemoglobin (red blood cell protein) is crucial for assessing how well the body is oxygenated, (retrieved from namdrc.org on 3/06/26).On 3/03/26 at 3:40 PM, the Director of Nursing (DON) explained nurses were expected to enter orders upon re-admission and when revised thereafter. She said physician's orders were reviewed every morning and checked for accuracy by the clinical team. She checked resident #1's medical record and was unable to locate supplemental oxygen orders or monitoring. She stated it was very important to have accurate orders and nurse monitoring, otherwise it wasn't known what the resident should be receiving. She conveyed the orders must have been missed on re-admission and stated the resident's oxygen orders were revised several times while in the facility. Review of the facility's standards and guidelines dated August 2025, and titled Oxygen Therapy outlined that oxygen is provided to residents based on physician's orders to supplement oxygen as needed per disease process. The procedures included verification of physician's orders and documentation in the resident's medical record.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records for 1 of 2 residents reviewed for non-pressure related skin conditions, of a total sample of 44 residents, (#36).Findings:Review of the medical record revealed resident #36, an [AGE] year-old female was admitted to the facility on [DATE] and re-admitted from an acute care hospital on 9/19/25. The resident's diagnoses included type 2 diabetes mellitus, adult failure to thrive, malnutrition, heart disease, muscle wasting and atrophy of multiple sites, and left lateral forehead squamous cell carcinoma (skin cancer).The most recent Minimum Data Set Quarterly Assessment with an Assessment Reference Date of 12/03/25 noted resident #1 scored 13 out of 15 on the Brief Interview for Mental Status that indicated intact cognition. The skin and wound assessment documented there were no surgical wounds or care during the look-back period.On 3/03/26 at 9:05 AM, resident #36 was observed in her room eating breakfast while lying in bed. There was one small and one large undated bordered gauze dressing with peeling edges on her forehead and scalp. The resident said she had skin cancer lesions removed at her Dermatologist's office approximately one week earlier where the dressings were applied and facility nurses had not looked at them since then.Review of the active physician's orders and Medication/Treatment Administration Records (MARs/TARs) did not include monitoring of resident #36's head wounds.The Care Plan Report did not include any wound monitoring/care.A nurse progress note dated 2/25/26 documented resident #1 had a head wound dressing after an outpatient medical appointment on 2/24/26.Resident #36's electronic and paper medical records did not include physician's notes or instructions/wound care for an outpatient appointment/surgical procedure done on 1/24/26.On 3/04/26 at 2:20 PM, the Regional Nurse Consultant said she was unable to locate the most recent Dermatology physician's progress notes in resident #36's medical records, so she requested them from the doctor's office.On 3/05/26 at 2:25 PM, Licensed Practical Nurse F said she received information that morning in nurse-nurse report that resident #36 had head wounds and stated the dressings were, to stay put. The nurse explained wound monitoring was documented on the MAR/TAR. She checked the medical record and said there was no directions about the wound and stated, it should be in the MAR to sign off.On 3/05/26/26 at approximately 2:15 PM, resident #36 was observed awake lying in bed in her room. She pointed to her head wounds and said after her Dermatologist appointment the previous week, nurses had changed the smaller dressing the previous day, but not the larger one. There was one small and one large undated bordered gauze dressing with peeling edges on her forehead and scalp.On 3/05/26 at 12:55 PM, the Regional Nurse Consultant explained she was still trying to get resident ##36's recent dermatology appointment records and confirmed the facility should have the post appointment documents in order for a complete medical record. She stated, we should have them.On 3/05/26 at 1:46 PM, the Director of Nursing explained she expected nurses to update orders and all outpatient physician records in the TAR with orders from the primary provider. She said, even if we weren't supposed to touch it, nurses should verify that, note it in the TAR to monitor for signs of complications. She stated outpatient records were expected to be up to date and accessible in electronic and hard charts to ensure up to date access of clinical information. The DON stated, I'm not sure what happened to the records.Review of the facility's standards and guidelines titled Care Plan - Interdisciplinary Plan of Care from Interim to Meeting dated February 2024 outlined that resident care records included dated new, revised, or discontinued problems.