STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105463	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Terrace at Courtenay Springs	1100 South Courtenay Parkway Merritt Island, FL 32952

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to establish routine, ongoing, and systematic collection, analysis, interpretation, and dissemination of surveillance data to identify infections, infection risks, communicable disease outbreaks, and to maintain or improve resident health status. The facility also failed to provide accurate influenza consent forms for 5 out of 5 residents reviewed for immunizations, of a total sample of 30, (#2, #7, #44, #50, and #68).Findings:1.On 3/16/26 at 2:15 PM, an interview with the Director of Nursing (DON) and the Infection Preventionist (IP), the IP said that she had been in the position for a year. The IP explained that part of her job was to follow residents on precautions, intravenous medications, educate staff on infection control, follow residents on antibiotics, communicate to the doctors about labs and reevaluate as needed. She continued to explain that she would contact the Department of Health if she believed there was an issue with outbreaks, and that the facility used a collective approach with an Infectious Disease Doctor when it comes to treating certain infections.On 3/16/26 at 3:07 PM, the IP and the DON acknowledged that there was no evidence of infection surveillance or data collection because everything was lost when they had a power outage in January. They both acknowledged they had no data to present and therefore the facility has no infection surveillance. The IP said she did not know that she needed a binder with hard copies. The DON stated that she oversees all nurses, but failed to say if she oversees the IP. She stated for the second time, I oversee the nurses.The facility's policy on Infection Surveillance implemented and revised 1/1/26 sated A system of infection surveillance serves as a core activity of the facility's infection prevention and control program. Its purpose is to identify infections and to monitor adherence to recommended infection prevention and control practices in order to reduce infections and prevent the spread of infections.2. Review of the facility's Influenza Vaccine Permission Form revealed the third option provided read, I have read and understand the information provided concerning the Pneumococcal Polysaccharide Vaccine (PPSV), but I do not wish to receive the vaccine. I understand if I wish to change my decision, I will notify the nurse in changes of my care.On 3/16/26 at 2:15 PM, the IP and DON were made aware that the five influenza consents were inaccurate and that it should read the Influenza Vaccine instead of PPSV and that the typo changes should be charge. The IP stated she could not tell how long they were using the form but that's the one I've used the entire time. They both acknowledged the residents did not have accurate consent signed and the IP said that she was responsible for reviewing the consents and did not realize the form was incorrect.The facility's policy implemented and revised on 1/1/26 stated It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering residents, staff members and volunteer workers annual immunization against influenza. Within the guidelines it stated that individuals receiving the vaccine or their legal representative will be required to sign a consent form prior to the administration of the vaccine. The completed signed, and dated record will be filed in the individual's medical record or the staff medical file.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 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 interview and record review, the facility failed to develop a comprehensive person-centered care plan to meet the resident's medical, nursing, and behavior needs for 4 of 4 residents reviewed for comprehensive care plans, of a total sample of 30 residents, (#8, #59, #44 and #95). Findings: 1. Resident #8 was admitted to the facility on [DATE]. Her diagnoses included schizophreniform disorder, schizoaffective disorder bipolar type, unspecified dementia, and generalized anxiety disorder. Review of resident #8's electronic medical record (EMR) revealed she resided on the facility's secured memory care unit. The EMR also contained an elopement evaluation dated 12/19/25 which indicated resident #8 was at high risk for elopement. Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 3/20/26 revealed resident #8 had a Brief Interview for Mental Status (BIMS) score of 9/15 which indicated she had moderate cognitive impairment. The assessment revealed she did not use a wander/elopement alarm. Review of the comprehensive care plan for resident #8 revealed no care plan for resident's high risk for elopement status. Review of the physician orders revealed no order for a wander/elopement alarm. On 4/14/26 at 11:41 AM, resident #8 was observed as she entered through the locked doors into the secured memory care unit and entered the common area to attend activities with other residents and staff. On 4/15/26 at 8:53 AM, resident #8 was observed in the front hallway of the facility. She was unaccompanied by any staff member. Resident #8 propelled her wheelchair independently as she entered the activity room. No wander/elopement alarm was observed on the wheelchair or on the resident's wrist or ankle. On 4/15/20 at 2:03 PM, the Director of Nursing (DON) verified resident #8 was an elopement risk. She acknowledged the resident was allowed to come out of the secured memory care unit but should have a wander/elopement alarm in place. The DON confirmed the comprehensive care plan did not contain an elopement risk care plan for resident #8. 2. Resident #59 was admitted to the facility on [DATE]. His diagnoses included metabolic encephalopathy, acute kidney failure and unspecified psychosis not due to a substance or known physiological condition. Review of the MDS admission assessment with ARD of 4/03/26 revealed resident #59 had a BIMS score of 15/15 which indicated was cognitively intact. The assessment revealed he did not exhibit any behaviors during the review period and did not use a wander/elopement alarm. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/13/26 at 12:51 PM, resident #59 was observed in his wheelchair next to his bed. Resident's shirt was turned inside out and was on backwards. He continued to roll his wheelchair back and forth while talking and changed position in chair frequently. He was noted to have a wander/elopement alert bracelet on his right ankle. Review of resident #59's EMR revealed a physician's order dated 4/08/26 use of a wander/elopement alarm. The record also contained an elopement evaluation dated 4/10/26 which indicated resident #59 was at high risk of elopement. An accompanying nurses progress note read that due to his elopement score of 25 a wander/elopement alarm was placed to resident #59's left ankle. Review of the resident's care plan revealed no care plan indicating resident was at risk for elopement. On 4/15/26 at 2:03 PM, the DON stated resident #59 had become increasingly confused since his admission and was considered an elopement risk. She explained he should be on the secured memory care unit but a bed was not currently available. The DON stated the Social Services department was responsible for behavior care plans. The Social Services Director, who was in the room, stated that social services did not complete care plans for elopement/wandering risk. 3. Resident #44 was initially admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis of the liver, dementia with other behavioral disturbances, senile degeneration of the brain, brief psychotic disorder, blindness of left and right eye, and chronic pain syndrome. Review of resident's clinical record revealed he was admitted to hospice services on 4/17/25 with an admitting diagnosis of senile degeneration of the brain. A hospice consult dated 1/29/26 revealed the resident was a high risk for falls due to generalized weakness and declining safety awareness. The resident was noted to make attempts to get up without assistance despite multiple falls. The resident showed increased memory deficit and increased forgetfulness. A review of resident #44's progress notes revealed on 8/12/25 the resident was found sitting on the floor next to his bed. He stated that he was unsure what happened and that he was in bed and 'the next thing he knew' he was on the floor. The resident has no injuries. A progress note on 8/13/25 revealed that a fall intervention to add bolsters to the bed to define mattress perimeter was initiated. Further review of the resident's progress notes revealed on 2/15/26 the resident was found on the floor next to his bed with a skin tear to his left elbow. Resident stated he was trying to get some water. A review of resident #44's care plan revealed that the resident is a high risk for falls related to being blind, impaired mobility, fall risk score greater than 10, narcotic medications and blood pressure medications. Interventions included adding bolsters to the bed to define mattress perimeter was initiated on 8/12/25 and to ask hospice to provide a volunteer to be his companion was initiated on 2/16/26. On 4/13/26 at 1:10 PM, the resident was observed sitting on the side of his bed with his lunch tray in front of him. Resident's mattress was noted not to have bolsters and there was no a companion at (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bedside. On 4/13/26 at 3:05 PM, the MDS Coordinator stated that they review care plans routinely and on an as needed basis. When it comes to falls, their process is to review the care plan and interventions after each fall to see if the care plan needs to be updated and if the interventions in place are appropriate. The MDS coordinator was unsure what hospice said when the facility asked them for a companion for the resident. She agreed there was no documentation as to say whether this intervention was initiated nor the outcome. The MDS Coordinator also agreed that if the intervention for bolsters to the bed was deemed inappropriate that it should have been removed from the care plan. 4. Resident # 95 was readmitted to the facility on [DATE] with diagnoses that included unspecified fracture of the right femur, acute respiratory failure with hypoxia, chronic obstructive pulmonary disease and congestive heart failure. Review of the Minimum Data Set (MDS) admission 5-day assessment with assessment reference date (ARD) of 1/07/26 revealed that the resident had a Brief Interview for Mental Status Score of 13 out of 15 which meant she was cognitively intact, and used oxygen as a special treatment. The physician orders dated 2/27/26 read continuous oxygen at 1.5 liters per minute (LPM) via nasal cannula. On 4/13/26 at 11:30 AM, resident #95 was observed in bed, alert with her husband at the bedside. The oxygen concentrator was on, but the nasal cannula was not connected to resident. She explained that she did not use oxygen often. The tubing was observed on the floor and concentrator read 2.5 LPM. On 4/13/26 at 12:25, the Director of Nursing (DON) was asked to verify the physician order in the computer, and she stated that it was for 1.5 LPM. She was then asked to verify the flow rate on the concentrator, and she said it was at 2.5 LPM. The DON said that her expectation was that nurses should verify the orders for oxygen before assuming care during shift report. Resident #95 told the DON that she did not want oxygen and that she does not usually use it. The DON turned off the oxygen concentrator and stated that she would call the physician. On 4/13/26 at 12:37 PM, the assigned licensed practical nurse (LPN) A was made aware and said that she would follow up with doctor about the oxygen orders. LPN A said that prior to this, the resident was not refusing oxygen. LPN A said that she checked it earlier during report, but her main concern was that the oxygen was on, and the resident was wearing it. She explained she did not check the flow rate and knew she should have but did not. A review of the comprehensive care plan for resident #95 did not address oxygen or any care area with respiratory status nor refusal of therapies. On 4/15/2026 at 4:55 PM, the MDS Coordinator acknowledged that resident #95's care plan did not address any respiratory diagnoses nor oxygen administration orders. She explained that she was the one who completed the care plan and could not explain why it was not done. She explained the process was to put in a basic care plan and review the diagnoses to ensure all were on the care plan. She would then check the orders and add the interventions or other areas if needed. She acknowledged the resident did not have a respiratory care plan and it was her responsibility to add it. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy implemented 1/1/26 and revised 1/1/26 on Comprehensive Care Plans stated that It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical nursing and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality.

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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 respond to recommendations for 1 of 1 residents reviewed for cardiac management out of 30 sampled residents, (#92). Findings:On 4/13/26 at 1:40 PM, resident #92 expressed his concerns related to blood pressure management while at the facility. The resident reported that he had cardiac surgery previously and his cardiac surgeon told him that he needed to maintain a systolic blood pressure below 130. Resident stated that, while at the facility, they would not give any antihypertensive medication unless his systolic blood pressure was above 160. Resident expressed frustration with the facility stating that his blood pressure being above 130 could be life threatening and he has relayed this information to the facility many times.Resident #92 was initially admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses including dissection of descending thoracic aorta, type 2 diabetes mellitus, severe morbid obesity, heart failure, chronic pain syndrome and hypertension.An aortic dissection is a tear in the inner layer of a weak area of the aorta. Blood surges through the tear, causing the inner and middle layers to separate (dissect) As diverted blood flows between the tissue layers, the normal blood flow to parts of the body may slow or stop, or the aorta may rupture completely. There are two main types of aortic dissection: Type A starts at the upper part of the aorta and typically requires open chest surgery to repair. Type B starts further down the aorta further away from the heart. (retrieved from https://my.clevelandclinic.org/health/diseases/16743-aortic-dissection on 4/29//26)Resident #92 facility progress note on 3/5/26 at 9:15 AM, revealed the resident was sent to the hospital for evaluation following an abnormal abdominal ultrasound.Review of hospital discharge paperwork on 3/13/26 revealed the resident had an abdominal aortic aneurysm (AAA) with open repair performed in 2016. He was transferred to the hospital from the facility on 3/5/26 following an abdominal ultrasound which showed a 5 centimeter (cm) abdominal aortic aneurysm. Subsequent radiology confirmed a type B aortic dissection with aneurysmal dilation up to 5.2 cm. At the hospital, vascular surgery was consulted and it was determined that dissection was likely a chronic or residual from the prior type A event and no urgent intervention was required. The plan was for systolic pressure to be kept under 130.Review of facility progress note on 3/19/26 at 12:15 AM revealed the resident called emergency services in order to be transported to the hospital related to an elevated blood pressure. Blood pressure noted to be 175/88. Further review of the progress note revealed that the on call physician services were contacted and a requested for a return call related to the resident having no as needed (PRN) orders for high blood pressure.Review of progress note on 3/19/26 at 1:30 AM revealed the physician gave a one time order of Clonidine 0.1mg and for the resident to be sent to the hospital for further evaluation.Review of hospital discharge paperwork from 3/19/26 revealed under the section titled ED course that at 6:18 AM the hospital provider was at the residents' bedside to evaluate the resident and that they would contact the facility to discuss blood pressure control with the facility physician. At 6:56 AM, hospital physician wrote that he spoke with the Nurse Practioner (NP) at the facility who stated that he was aware the resident needed close monitoring of blood pressure to maintain a systolic less than 130. Under the section titled Medical Decision Making, the hospital physician stated that prescription drug management not need at this time and the facility will review the resident's blood pressureReview of hospitals after visit summary paperwork from 3/19/26 revealed instructions for the resident to keep close monitoring of his blood pressure. The resident blood pressure per vascular surgery was to maintain systolic pressure less than 130.Facility cardiology consultation on 3/19/26 revealed the facility primary care physician referred the resident for cardiac management, The assessment and plan for managing the residents Type B [NAME] Aortic dissection was close monitoring of blood pressure and to maintain a systolic blood pressure of below 130. The resident had an order for PRN clonidine to assist with blood pressure management.Review of the resident's physician orders revealed an order for clonidine 0.1mg every 6 hours PRN for a systolic (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	blood pressure greater than 160 with a start date of 3/19/26.Review of progress note on 3/22/26 at 7:12 PM revealed the resident raised concerns related to his elevated blood pressure and requested medication. Residents blood pressure 144/75. Writer informed the resident he had an order for clonidine as needed for a systolic blood pressure greater than 160. Writer of the note notified the physician, and no new orders were given at that time.Review of progress note on 4/14/26 at 3:08 AM revealed the resident requested his blood pressure to be taken which showed a reading of 152/84. Resident was agitated and stated he was worried about his blood pressure. The resident refused antianxiety medication and requested the physician be notified about elevated blood pressure. A subsequent noted at 4:21 AM, revealed the Nurse Practioner (NP) followed up about elevated blood pressure but gave no new orders.On 4/16/26 at 3:00 PM, the Unit Manger stated that there was no order or consultation that required the resident to maintain a systolic blood pressure below 130. She stated she was not aware before 4/13 that the resident had concerns related to his blood pressure being too high. She was not aware that hospital paperwork and facility cardiologist recommended systolic blood pressure less than 130. She acknowledged that she is responsible for reviewing consultations and hospital paperwork to ensure orders and recommendations are followed up on.Facility policy titled Consulting physician/Practioner Orders revised 1/1/2026 revealed that consulting physicians orders are those orders provided to the facility by a physician other than the resident's attending physician who is acting on the behalf of the attending physician. A consulting physician may include a surgeon or specialist such as cardiologist. For a consulting physician who gives an order in writing, the nurse will call the attending physician to verify the order and document that order.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and provide ongoing monitoring of identified past trauma for 4 of 4 residents reviewed for Trauma Informed Care, of a total sample of 30 residents, (#40, #4, #16, #49). Findings: 1.Resident #40 was admitted to the facility on [DATE] with diagnoses which included alcohol abuse with alcohol-induced psychotic disorder, psychoactive substance abuse with withdrawal, major depressive disorder, and anxiety. A review of the psychiatry consult on 5/23/25 revealed an excerpt from Assessment and Plan for trauma: The history suggests that this patient has suffered from significant trauma resulting into nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month and have occurred without any substance use or organic brain pathology. Care Plan for PTSD diagnosis: Trauma: emotional abuse growing up with alcoholic parents. Triggers: slamming doors and yelling. Care plan: enter room calmly, introduce and self explain Further review revealed that the diagnosis of PTSD was confirmed and care plan added to the chart as the resident had active symptoms of PTSD. Review of the admission MDS assessment with assessment reference date (ARD) of 5/27/25 revealed resident #40 had Brief Interview for Mental Status (BIMS) Score of 15 out of 15 which indicated he had no impaired cognition. The assessment also showed that the Psychiatric /Mood disorders included depression, anxiety, psychotic disorder and PTSD. A review of resident #40's care plan revealed the resident had a risk for a mood problem related to a diagnosis of PTSD, ADHD and anxiety initiated on 5/22/25 and revised 2/18/26 with no specific interventions addressing PTSD or the triggers. On 4/15/26 at 10:01 AM, resident #40 stated that his Post Traumatic Stress Disorder (PTSD) stemmed from growing up in a military family. He stated some of his triggers included slamming door, yelling and fire drills. He also stated that he occasionally has nightmares and wakes up yelling with no memory of what had happened. Findings: 2. Resident # 4 was admitted to the facility on [DATE] with diagnoses that included unspecified dementia, major depressive disorder, other specified anxiety disorders and Post- Traumatic Stress Disorder (PTSD). Review of the Minimum Data Set (MDS) quarterly assessment with assessment reference date (ARD) of 8/15/24 revealed active diagnoses for Psychiatric /Mood disorders included anxiety, depression and PTSD. Review of the most recent MDS quarterly assessment with ARD of 2/11/26 showed the resident had a Brief Interview for Mental Status (BIMS) Score of 9 out of 15 which indicated he had moderate impaired cognition. Active diagnoses for Psychiatric /Mood disorders included anxiety, depression and PTSD. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a psychiatry note dated 6/21/24 revealed an excerpt from Assessment and Plan which addressed PTSD for resident #4 as The history suggests that this patient has suffered from significant trauma resulting into nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one months and have occurred without any substance use or organic brain pathology. On 8/23/24 a Care Plan Note (Non Face to Face) from the psychiatrist read Care Plan for PTSD diagnosis: Trauma: PTSD, Triggers: none noted and Care Plan: Refer to psychotherapy for PTSD. A review of resident #4's Care Plan revealed that he was at risk for mood distress /depression related to major depressive disorder, anxiety disorder and PTSD initiated on 11/25/25. The care plan also revealed that resident #4 required the use of psychotropic medications and antidepressants to assist with managing mood and had diagnoses of insomnia, depression, anxiety, PTSD and dementia initiated 5/23/24, however, there was no specific care plan addressing PTSD or triggers. On 4/14/26 at 4:43 PM, resident #4 was observed in his room and explained that he doesn't have any triggers or trauma and that was a long time ago. He said that doesn't bother him. On 4/15/26 at 2:34 PM, the resident stated that he recalled the psychologist had asked him about PTSD and he told her he had not served in the war he said there is a lot of things but did not think he had PTSD. 3. Resident #16 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, anxiety disorder, alcohol abuse with intoxication, persistent mood (affective) disorder and Post- Traumatic Stress Disorder (PTSD). Review of the Minimum Data Set (MDS) annual assessment with assessment reference date (ARD) of 6/13/25 revealed active diagnoses for Psychiatric /Mood disorders included anxiety disorder, psychotic disorder other than schizophrenia and PTSD. Review of the most recent MDS quarterly assessment with ARD of 3/13/26 showed the resident had a Brief Interview for Mental Status (BIMS) Score of 15 out of 15 which indicated his cognition was intact. Active diagnoses for Psychiatric /Mood disorders included anxiety disorder, depression, psychotic disorder and PTSD. A review of a psychiatry subsequent note on 6/3/25 revealed an excerpt from Assessment and Plan which addressed PTSD for resident #16 as The history suggests that this patient has suffered from significant trauma resulting into nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one months and have occurred without any substance use or organic brain pathology. Care Plan for PTSD diagnosis: Trauma: I've had a bunch of stuff. I wouldn't know where to label it as one thing. Triggers: Unable to identify any specific triggers. Care Plan: No changes. A review of resident #16's Care Plan revealed that he required the use of psychotropic medications, antidepressant medications and had diagnoses of persistent mood disorder, insomnia, anxiety, brief psychotic disorder and PTSD initiated 4/02/24, however, there was no specific care plan addressing PTSD or triggers. 4. Resident #49 was admitted to the facility on [DATE]. Her diagnoses included schizophrenia, alcohol abuse, epilepsy, unspecified dementia, other specified anxiety disorders and adjustment disorder with depressed mood. Review of the MDS quarterly assessment with ARD of 1/20/26 revealed resident #49 had long-term (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and short-term memory problems with severely impaired cognitive skills for daily decision making. The document revealed resident #49 had an active diagnosis of PTSD and received anti-anxiety medications. Review of resident #49's electronic medical record (EMR) revealed a psychiatry subsequent note dated 8/15/25 which listed a new diagnosis of PTSD (Post Traumatic Stress Disorder). The documentation read, The history suggests that this patient has suffered from significant trauma resulting in nightmares, flashbacks, and hypervigilance in the past. The symptoms have caused significant distress and functional impairment to the patient. The symptoms have lasted for more than one month and have occurred without any substance use or organic brain pathology. Review of resident #49's comprehensive care plan revealed a care was initiated 10/31/25 which indicated the resident demonstrated significant mood distress/depression related to her diagnoses of unspecified dementia, psychotic disturbance, mood disturbance, anxiety disorder, post-traumatic stress disorder and adjustment disorder. The interventions were to provide counseling/intervention sessions as desired and to help the resident work on one significant problem/factor related to depression at a time. The comprehensive care plan did not contain a care plan that specifically addressed resident #49's past trauma or triggers in order to eliminate or mitigate the triggers that may cause re-traumatization of the resident. In a group meeting with the Director of Nursing (DON), MDS Coordinator, facility Administrator and Social Services Director on 4/15/2026 at 2:48 PM, the MDS Coordinator stated she reviewed the psychiatric notes and added any new diagnosis to the resident's EMR. She explained she would initiate a care plan if the resident received medications related to the diagnosis. The MDS Coordinator clarified that social services was responsible for initiating care plans that were related to a behavior. The social services director confirmed she would be responsible for initiating a PTSD care plan if she was made aware of the diagnosis. The MDS Coordinator verified that there were no trauma informed care plans initiated for the four residents identified with a diagnosis of PTSD. She acknowledged the facility staff would be unaware of the specifics of the trauma or of any triggers each resident may have in order to make attempts to avoid re-traumatization of the resident. The facility's policy and procedure for Trauma Informed Care implemented 1/01/26 read, The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family, friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions. The document clarified that the facility would identify triggers which may re-traumatize residents with a history of trauma. The document indicated that trigger-specific interventions would identify ways to decrease the resident's exposure to triggers which could retraumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and would be added to the resident's care plan. The document included that the trauma-specific care plan interventions would recognize the interrelationship between trauma and symptoms of trauma such as substance abuse, eating disorders, depression, and anxiety.