STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105588	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Santa Barbara	216 Santa Barbara Blvd Cape Coral, FL 33991

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. Based on observations, record review, review of facility's policies and procedures, residents and staff interviews the facility failed to have processes in place to prevent avoidable accidents for 6 (Residents #3, #103, #59, #74, #5, #95) of 6 residents by failure to accurately assess smoking risks, failure to identify unsafe storage and use of ignition devices where oxygen is in use and failure to adequately supervise residents who smoke tobacco products and electronic cigarettes. Residents #3 and #103 were roommates. Resident #3 was a smoker and Resident #103 received supplemental oxygen. On 8/27/25 Residents #3 and #103 were observed in their shared bedroom. Resident #3 was holding a cigarette and a lighter approximately 4 feet from Resident #103 who was receiving oxygen. On 8/27/25 a CNA was observed leaving cigarettes and lighters unlocked, unattended and easily accessible to 4 residents observed in the designated smoking area. Residents #59 and #74 were roommates and smokers. Resident #59 received supplemental oxygen via nasal cannula. On 8/27/25 Residents #74 and #59 were observed in their shared bedroom. Cigarette lighters were observed stored approximately 2 feet from Resident #59 while oxygen was in use. Both residents required constant supervision while smoking. Resident #5 used oxygen and vaped electronic cigarettes in her room. Staff did not intervene and allowed the resident to use and store the electronic cigarette in her room in close proximity of the oxygen source. The unsafe practice of allowing residents to use and/or store ignition sources such as lighters and electronic cigarettes in their rooms while oxygen is in use and the failure to ensure appropriate supervision of unsafe smokers created a likelihood of serious injury, impairment or death of residents from thermal burn and fire and resulted in the determination of Immediate Jeopardy.The findings included: Cross reference F726, F835, F926Review of the facility's policy titled, Smoking-Supervised (last revised 8/17/2017) revealed, The Center will provide a safe, designated smoking area for residents. Smoking is only allowed in designated area and oxygen is not permitted. The Center will have safety equipment available in designated smoking areas including: smoking blankets, smoking aprons, a fire extinguisher and non-combustible self-closing ashtrays. Residents who smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if additional adaptive or safety equipment is needed. Residents will be supervised during smoking including those residents utilizing electronic cigarettes. Staff will be assigned to supervise residents during designated smoking times. Smoking material will be retained and stored by the nursing staff for residents who have been granted smoking privileges. Residents who maintain smoking materials will be care planned as such. No ignition devices will be in the resident's possession at any time and is strictly prohibited. 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 the nursing staff.Resident #3:On 8/27/25 at 9:10 a.m., Residents #3 and #103 were observed in their shared bedroom. Resident #103 was in bed receiving supplemental oxygen via nasal cannula. Resident #3 was in bed, approximately 4 feet from Resident #103. He was holding a cigarette in his left hand and a lighter in his right hand. On 8/27/25 at approximately 9:15 a.m., the observation of Resident #3 holding a lighter in close proximity of an oxygen source was (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	shared with the Regional Nurse Consultant. She stated, Residents or family members can sneak stuff in. On 8/27/25 at 10:30 a.m., in an interview Resident #3 said he's been smoking and has kept a lighter in his room since his admission to the facility.On 8/27/25 at 10:32 a.m., in an interview Certified Nursing Assistant (CNA) Staff Z said Resident #3 has always been a smoking every day since his admission. CNA Staff Z said residents can keep cigarettes but not lighters in their room.On 8/27/25 at 10:33 a.m., in an interview CNA Staff Y said Resident #3 has been smoking every day since his admission. She said the resident was allowed to keep his cigarettes but no lighter.Review of the clinical record for Resident #3 revealed an admission date of 5/17/25. Diagnoses included unspecified dementia and acute respiratory failure with hypoxia (low oxygen level in the tissues).The admission evaluation dated 5/17/25 noted Resident #3 did not smoke, including electronic cigarettes.The care plan initiated on 5/19/25 did not include a focus for safe smoking.On 8/24/25 at 6:48 p.m., Registered Nurse (RN) Staff ZZ completed a smoking evaluation for Resident #3 which contained conflictive information. The evaluation noted the resident did not have the fine motor skills needed to securely hold a cigarette but the resident was determined to be a safe smoker. RN Staff ZZ entered none for Supervision needed while smoking.As of 8/24/25, the care plan was not updated to reflect Resident #3's smoking status, use and safe storage of lighters. Resident #103:Review of the clinical record for Resident #103 revealed a physician's order dated 12/1/23 for oxygen as needed 2 to 4 liters via nasal cannula. On 8/27/25 at 9:20 a.m., in an interview Resident #103 said he uses oxygen continuously.Resident #59:Review of the clinical record for Resident #59 revealed an admission date of 11/14/23. Diagnoses included Chronic Obstructive Pulmonary Disease, anxiety and bipolar disorder.The clinical record noted Resident #59 was a smoker.On 5/19/25, Licensed Practical Nurse (LPN) Staff S completed a smoking evaluation for Resident #59 which contained conflictive information. The evaluation noted Resident #59 was a safe smoker but needed constant supervision while smoking.The resident's ability to communicate why oxygen must always be shut off prior to lighting cigarette was not evaluated and left blank.Review of the physician's orders dated 8/25/25 revealed a new order for Oxygen as needed for shortness of breath or oxygen saturation below 90%.There was no documentation a new smoking evaluation was completed on 8/25/25 for Resident #59 when the physician issued an order for supplemental oxygen to determine if Resident #59 understood the importance of not smoking while receiving oxygen and the danger of storing lighters near an oxygen source.On 8/27/25 at 12:30 p.m., Resident #59 was observed in bed receiving oxygen via nasal cannula at 4 liters per minute.In an interview, Resident #59 verified he smoked cigarettes and stored his lighter and cigarettes in his nightstand. Observation of the resident's nightstand revealed a cigarette lighter stored in the top drawer, approximately 2 feet from the oxygen concentrator. photographic evidence obtained. Resident #74:Residents #74 and #59 were roommates.Review of the clinical record for Resident #74 revealed an admission date of 1/27/23. Diagnoses included Chronic Obstructive Pulmonary Disease, generalized muscle weakness and as of 6/19/24, nicotine dependence.Review of the smoking evaluations dated 4/23/25 and 7/24/25 revealed conflictive information. Both evaluations noted Resident #74 was a safe smoker and required constant supervision while smoking.On 8/27/25 at 12:45 p.m., in an interview Resident #74 verified he smoked cigarettes. He said he stored his cigarettes and lighter on windowsill of the bedroom he shared with Resident #59.Observation during the interview revealed a pack of cigarettes and a lighter on the windowsill of the bedroom. Resident #59 was not in the bedroom at the time of the observation. The oxygen concentrator was on and running.On 8/27/2025 at 10:27 a.m., an interview was held with LPN Staff N to discuss facility process to identify smokers and safe smoking practices. LPN Staff N said the facility identifies smokers on admission. A smoking assessment is completed to determine if the resident is a safe smoker. LPN Staff N said a safe smoker is someone who can take out cigarettes, light them and extinguish them on their own. When asked about storage of smoking material, LPN Staff N said, lighters and cigarettes are locked up even if the resident is a safe smoker. Residents should not have lighters or cigarettes in their room.On 8/27/25 at 10:54 a.m., in an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	interview CNA Staff X said residents should not have cigarettes or lighters in their rooms. Staff X said they lock cigarettes and lighters up. Resident #5:Review of the clinical record for Resident #5 revealed an admission date of 1/19/24. Diagnoses included Morbid Obesity, Bipolar Disorder and Major Depressive Disorder.The physician's orders dated 1/22/24 included oxygen at 3 liters per minute via nasal cannula at bedtime.The care plan related to smoking for Resident #5 was inconsistent:The care plan initiated on 10/12/23 with a target date of 10/28/25 noted Resident #5 was a former smoker and used oxygen at bedtime.The care plan initiated on 6/24/25 noted the resident was a smoker. The goal was for the resident not to smoke without supervision and the resident would not suffer injury from unsafe smoking practices.The care plan initiated on 6/24/25 noted the resident has behaviors and vapes (inhale and exhale vapors from an electronic cigarette) in her room. The goal was for the resident to have fewer episodes of vaping and the resident will have no evidence of behavioral concerns vaping. The interventions included to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behavior and potential causes.The care plan did not address the unsafe practice of vaping electronic cigarettes in the room while using oxygen.Review of the smoking evaluations revealed on 7/25/25 LPN Staff S documented Resident #5 was a safe smoker and the supervision required while smoking was constant.On 8/28/25 at 1:30 p.m., Resident #5 was observed in bed receiving oxygen via nasal cannula. In an interview Resident #5 said she doesn't get out of bed. She said she was a smoker but has been vaping electronic cigarettes in her room since she cannot get out of bed to go to the designated smoking area. She said she keeps her electronic cigarettes in her room.On 8/29/25 at 2:30 p.m., in an interview LPN Staff S verified she completed the smoking evaluations for Resident #5. She said she did not receive prior education on how to complete a smoking evaluation. She said, The smoking evaluation is self-explanatory. LPN Staff S said the residents are safe smokers because, they're having constant supervision. Resident #95:Record review for Resident #95 revealed a date of admission of 7/5/24. Diagnoses included hemiplegia (paralysis) /hemiparesis (weakness) of the right dominant side.Review of the smoking evaluation completed on 7/2/25 revealed Resident #95 was a safe smoker and did not need supervision while smoking.Review of Resident #95's care plan revealed on 8/26/25 a new intervention was added specifying the resident required a smoking apron while smoking.On 8/27/25 at 10:55 a.m., CNA Staff W was observed supervising residents #59 and #95 in the designated smoking area.Resident #95 was not wearing a protective smoking apron for safety as per his care plan initiated on 8/26/25. In an interview CNA Staff W said she gives the residents a cigarette and lights it for them. CNA Staff W said when the smoking time is over cigarettes and lighters are locked up in the designated box.On 8/27/25 at 10:58 a.m., Resident #59 interjected and said, I keep my lighter in my room. On 8/27/25 at 12:20 p.m., CNA Staff W was observed supervising residents in the courtyard.Resident #95 was in the designated smoking area holding an unlit cigarette.Resident #10 requested assistance to go to the bathroom. CNA Staff W left the smoking area with Resident #10. She left cigarettes and lighters unlocked, unsupervised, easily accessible to Resident #95 and 3 other residents observed in the designated smoking area.On 8/27/25 at 1:12 p.m., a tour of the designated smoking area was conducted with the Director of Nursing (DON). Resident #95 was observed smoking. Resident #95 was not wearing the protective smoking apron as specified in the care plan initiated on 8/26/25. The DON verified Resident #95 was not wearing the protective smoking apron and said the resident should be wearing the protective apron as care planned.On 8/27/25 at 2:49 p.m., an interview was conducted with the Administrator, DON, Regional [NAME] President, and the Maintenance Director to discuss identification of smokers, accurate smoking evaluations, adequate and appropriate supervision of smokers, development and revision of care plans to address smoking risks and individualized interventions to ensure the safety of smokers and other residents. The Administrator said he believes cigarettes and lighters should be locked up. He said they collect all the lighters.The Maintenance Director said smoking was a danger for residents who use oxygen. He said that oxygen was an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	accelerant which increased the risk of fire.The DON said smoking evaluations are done on admission and quarterly thereafter. The DON said as part of the evaluation, the licensed nurses completing the evaluation physically observe the resident smoking. She said a care plan is developed the next day at morning meeting. The DON said the CNA supervising the smokers has a list of residents who require protective aprons while smoking. He said Resident #95 was an example of a resident who needed a smoking apron due to left-sided weakness.When asked about supervision of residents during smoking sessions, the Administrator said the courtyard was always supervised and should never be left unattended even when residents are not smoking. He said he did not know who was responsible to educate the CNAs assigned to supervise the smokers.On 8/27/25 at 3:10 p.m., in an interview the Social Services Director said she purchases cigarettes but no lighters for residents when they give her the money. She said residents were not allowed to keep lighters in their rooms per facility policy. She tells the residents' family members the lighters are to be locked up. When asked how the facility monitors residents for compliance and enforces the smoking policy the Social Services Director said the managers have assigned residents' rooms and conduct angel rounds. She said during the rounds, managers look for lighters in residents' rooms. She said the Administrator kept the completed angel rounds forms.On 8/27/25 at 3:30 p.m., CNA Staff V was observed supervising the designated smoking area. In an interview, CNA Staff V said no one gave her training on smoking supervision.On 8/27/25 at 4:33 p.m., CNA Staff V was observed supervising the designated smoking area. In an interview CNA Staff V said she is supposed to light the residents' cigarettes but residents bring their lighters and light their own cigarettes. CNA Staff V said she tries to take the lighters from the residents but they don't listen. CNA Staff V said she has told the nursing staff and Social Services about the residents having their own lighters but they haven't done anything about it. She said she stopped reporting it to them because nothing was done.Review of the facility provided list of smokers (updated as of 8/25/25) revealed the facility currently had 14 current residents who smoke. Residents #5 and #3 were not on the list of smokers.On 8/28/25 at 11:55 a.m., an interview was held with the Administrator related to the prompt identification and evaluation of smokers. The Administrator said when residents are identified as smokers they should be put on the smoking list immediately. He verified the current list of smoker was incomplete. He said updating the smoking list is not happening. When asked about how the facility ensured complete and accurate smoking evaluations, the Administrator said a Registered Nurse determines if a resident is a safe smoker but did not know if the nurses received specific training on completing the smoking evaluations. He said safe smoker must be able to show they won't burn themselves or others. He said, We are not identifying safe smokers. We missed the boat.The Administrator said Resident #5 never leaves her room. She uses oxygen and vapes electronic cigarettes in her room. When asked about the process and expectation for angel rounds, he said angel rounds are expected to be done Monday through Friday. He said spot checks are done on weekends. The Administrator said the management staff conducting are supposed to look for lighters during angel rounds.The U.S. Food & Drug Administration noted in Tips to Help Avoid Vape Battery Fires or Explosions: . Although these incidents appear uncommon, vape fires and explosions are dangerous to the person using the vaping product and others around them. There may be added dangers, for example, if a vape battery catches fire or explodes near flammable gasses or liquids, such as oxygen.Tips to Help Avoid Vape Battery Fires or Explosions | FDA

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, record review, review of facility's policies and procedures, residents and staff interviews, the facility failed to ensure licensed nurses had the appropriate training and competencies to complete accurate smoking risk evaluations and identify unsafe smoking practices. The smoking risk evaluations for 7 (Residents #59, #105, #3, #74, #64, #5, #95) of 7 residents reviewed contained conflicting, inaccurate information and did not accurately reflect the residents' abilities to smoke independently. Each smoking evaluation noted the resident was a safe smoker and needs constant supervision.4 (Residents #3, #5, #59, and #74) of 4 residents observed with oxygen in use in their rooms were allowed to store ignition devices in their rooms while oxygen was in use.On 8/27/25 a Certified Nursing Assistant (CNA) was observed leaving cigarettes and lighters unlocked, unattended and easily accessible to 4 residents observed in the designated smoking area.Staff assigned to monitor residents who require constant supervision during smoking had not received appropriate training and competencies.The facility failure to ensure licensed nurses were trained and competent to complete smoking evaluations resulted in improper safety risks evaluation, unsafe smoking practices, including storage of lighters where oxygen is used.This failure created a likelihood of serious harm, injury, impairment or death of residents from thermal burn and fire from unidentified unsafe smoking practices and resulted in the determination of Immediate Jeopardy (IJ). The findings included:Refer to F689, F726, F835Review of the Facility's policy titled, Smoking-Supervised (last revised 8/17/2017) revealed, The Center will provide a safe, designated smoking area for residents. Smoking is only allowed in designated area and oxygen is not permitted. The Center will have safety equipment available in designated smoking areas including: smoking blankets, smoking aprons, a fire extinguisher and non-combustible self-closing ashtrays. The policy further states Residents smoke will be evaluated on admission/re-admission, quarterly, and with a change in condition to determine if additional adaptive or safety equipment is needed. Residents will be supervised during smoking including those resident utilizing electronic cigarettes. Staff will be assigned to supervise residents during designated smoking times. 1. On 8/27/25 at 9:10 a.m., during a tour of the facility, Residents #3 and #103 were observed in their shared bedroom.Resident #103 was in bed receiving oxygen via nasal cannula.Resident #3 was in bed approximately 4 feet from Resident #103's bed. Resident #3 was holding a lighter in his right hand and a cigarette in his left hand.On 8/27/25 at approximately 9:15 a.m., the observation of Resident #3 holding a lighter in close proximity of the oxygen source was shared with the Regional Nurse Consultant. She stated, Residents or family members can sneak stuff in.On 8/27/25 at 10:30 a.m., in an interview Resident #3 said he's been smoking and has had a lighter since his admission to the facility.On 8/27/25 at 10:33 a.m., in an interview Certified Nursing Assistant (CNA) Staff Y said Resident #3 has been smoking every day since his admission. She said the resident was allowed to keep his cigarettes but no lighter.Review of the clinical record for Resident #3 revealed an admission date of 5/17/25. Diagnoses included unspecified dementia, acute respiratory failure with hypoxia (low oxygen level in the tissues) and cerebral infarction.Review of the admission evaluation dated 5/17/25 revealed No was entered for Does the resident smoke (including electronic cigarettes).Review of the admission Minimum Data Set (MDS) assessment with a target date of 5/24/25 revealed Resident #3 scored 15 on the Brief Interview for Mental Status (BIMS), indicative of intact cognition. The MDS noted Resident #3 had functional limitation in range of motion of one upper extremity. No was entered in the MDS for current tobacco use.On 8/24/25 at 6:48 p.m., Registered Nurse (RN) Staff ZZ completed a smoking evaluation for Resident #3 which contained conflictive information. The evaluation noted the resident did not have the fine motor skills needed to securely hold a cigarette but the resident was determined to be a safe smoker. RN Staff ZZ entered none for supervision needed while smoking.2. Residents #59 and #74 were roommates.On 8/27/25 at 12:30 p.m., Resident #59 was observed in bed in his room receiving oxygen via nasal cannula at 4 (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	liters per minute. In an interview Resident #59 said he was a smoker and kept his cigarettes and lighter in his nightstand.Observation of the resident's nightstand revealed a cigarette lighter stored in the top drawer, approximately 2 feet from the oxygen source. Photographic evidence obtained.Review of the clinical record for Resident #59 revealed an admission date of 11/14/23. Diagnoses included Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, anxiety disorder, and bipolar disorder.Review of the smoking evaluations revealed on 5/19/25, Licensed Practical Nurse (LPN) Staff S documented Resident #59 was a safe smoker and supervision needed while smoking was constant.No answer was entered on the smoking evaluation for Resident is able to communicate why oxygen must always be shut off prior to lighting cigarette .Review of the physician's orders revealed an order dated 8/25/25 for Oxygen as needed for shortness of breath or oxygen saturation below 90%.There was no documentation a new smoking evaluation was completed on 8/25/25 when the physician issued an order for supplemental oxygen for the resident to determine if Resident #59 understood the danger of smoking or storing lighters in his room while receiving oxygen.Review of the care plan for Resident #59 initiated on 11/20/24 and revised on 8/14/25 revealed the resident had impaired cognitive function/dementia or impaired thought processes related to impaired decision making. Resident #59 had current guardianship.3. On 8/27/25 at 12:45 p.m., a pack of cigarettes and a lighter were observed stored on the windowsill of Residents #74 and #59's shared bedroom. In an interview Resident #74 said he was a smoker and kept his cigarettes and lighter stored in the windowsill.4. On 8/28/25 at 1:30 p.m., Resident #5 was observed in bed receiving oxygen via nasal cannula. In an interview Resident #5 said she doesn't get out of bed. She said she was a smoker but has been vaping electronic cigarettes in her room since she cannot get out of bed to go to the designated smoking area. She said she keeps her electronic cigarette in her room.Review of the clinical record for Resident #5 revealed an admission date of 1/19/2024. Diagnoses included Morbid Obesity, Bipolar Disorder and Major Depressive Disorder.The physician's orders dated 1/22/24 included oxygen at 3 liters per minute via nasal cannula at bedtime.The care plan related to smoking for Resident #5 had conflictive information:The care plan initiated on 10/12/23 with a target date of 10/28/25 noted Resident #5 was a former smoker and used oxygen at bedtime.The care plan initiated on 6/24/25 noted the resident was a smoker. The goal was for the resident not to smoke without supervision and the resident would not suffer injury from unsafe smoking practices.The care plan initiated on 6/24/25 noted the resident has behaviors and vapes in her room. The goal was for the resident to have fewer episodes of vaping and the resident will have no evidence of behavioral concerns vaping. The interventions included to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behavior and potential causes.The care plan did not address the unsafe practice of vaping in the room while using oxygen.Review of the smoking evaluations revealed on 7/25/25 LPN Staff S documented Resident #5 was a safe smoker and the supervision required while smoking was constant.On 8/29/25 at 2:30 p.m., in an interview LPN Staff S verified she completed the smoking evaluations for Residents #5 and #59. She said she did not receive prior education on how to complete a smoking evaluation. She said, The smoking evaluation is self-explanatory. LPN Staff S said the residents are safe smokers because, they're having constant supervision.5. Record review for Resident #95 revealed a date of admission of 7/5/24. Diagnoses included hemiplegia (paralysis) /hemiparesis (weakness) of the right dominant side.Review of the smoking evaluations for Resident #95 revealed on 6/19/25 LPN Staff S answered No to Short term memory OK- Seems to recall after five (5) minutes. The summary of evaluation noted the resident was a safe smoker and needed constant supervision while smoking.The smoking evaluation dated 7/2/25 completed by LPN Staff T noted Resident #95 was alert and oriented and could consistently perform safe smoking techniques. LPN Staff T checked the box on the evaluation noting the resident was a safe smoker and did not require supervision while smoking.Review of the care plan initiated on 7/7/25 revealed Resident #95 had impaired cognitive function/dementia or impaired thought process related to impaired decision (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	making.The care plan for smoking initiated on 7/7/25 noted the goal was for the resident to not smoke without supervision. The interventions as of 7/7/25 specified Resident #95 required supervision while smoking. On 8/26/25 the care plan was updated with the intervention to observe clothing and skin for signs of cigarette burns and The resident requires a smoking apron while smoking.On 7/15/25 the care plan was updated and noted Resident #95 was incontinent of bowel and bladder related to confusion.Complete review of the clinical record failed to reveal documentation a new smoking evaluation was completed on 7/7/25 to address the resident's impaired cognition, and ability to smoke independently.On 8/27/2025 at 11:07 a.m., Resident #95 was observed smoking a cigarette in the designated smoking area. The resident was not wearing a smoking apron while smoking as specified in the care plan.On 8/28/2025 at 2:12 p.m., in an interview LPN Staff T said he had not received any training on how to complete smoking evaluations. LPN Staff T verified he completed the smoking evaluation for Resident #95 on 7/2/25. He verified the smoking evaluation noted that the resident was a safe smoker and did not need supervision while smoking. Upon reviewing the resident's care plan LPN Staff T said he was not aware Resident #95 required a smoking apron during smoking sessions. He said if he had known, he would have noted the resident was an unsafe smoker and needed constant supervision while smoking.On 8/29/2025 at 2:50 p.m., CNA Staff R was observed supervising smokers in the designated smoking area. In an interview Staff R said Resident #95 was the only resident who required an apron because he drools. He said they did not have enough smoking aprons for the smokers who needed it but today they brought more aprons. CNA Staff R said they struggle to get a break when assigned to supervise the smoking area,. No one comes and checks on the staff assigned to supervise the courtyard and smoking area.6. Review of the clinical record for Resident #105 revealed an admission date of 8/24/23. Diagnoses included Type 2 Diabetes and bilateral above the knee amputations.The smoking evaluation dated 6/30/25 and completed by RN Staff YY noted revealed Resident #105 was a safe smoker did not need supervision while smoking. In the comment section RN Staff YY documented, Smoking is supervised.7. Review of the clinical record for Resident #64 revealed an admission date of 8/8/23. Diagnoses included Chronic Obstructive Pulmonary Disease, Bipolar Disorder and Major Depressive Disorder. The smoking evaluation completed on 6/2/25 by LPN Staff S was incomplete and contained conflictive information. No answer was documented for Decision-making skills are reasonable and consistent. The evaluation noted the resident was a safe smoker and constant supervision was needed while smoking.Review of the Brief Interview for Mental Status for Resident #64 dated 6/30/25 noted the resident had Moderate impairment.8. On 8/27/25 at 12:20 p.m., CNA Staff W was observed leaving the designated smoking area. The CNA left cigarettes and lighters unlocked, unattended and easily accessible to 4 residents observed in the designated smoking area.9. On 8/27/2025 at 2:49 p.m., in an interview the Director of Nursing (DON) said smoking evaluations are completed upon admission and quarterly. The DON said the care plan is updated at morning meeting the day after the smoking evaluation is completed.10. On 8/27/25 at 2:50 p.m., an interview was held with the Administrator to discuss the incomplete, inaccurate smoking evaluations, and the training and competency of the licensed nurses who complete the smoking evaluations. The Administrator said he did not know who was responsible to ensure the licensed nurses were trained and competent to complete accurate smoking evaluations. The observation of the CNA leaving the designated smoking area with cigarettes and lighters unlocked, unattended and easily accessible to 4 residents observed in the smoking area was shared with the Administrator. He said the CNAs assigned to the smoking area did not have a direct supervisor and he did not know who was responsible to educate the CNAs not to leave residents unattended, and not to leave smoking material unlocked in the smoking area. The Administrator said the courtyard should be supervised at all times, regardless of smoking times and the smoking area should never be left unsupervised.On 8/27/25 at 3:20 p.m., CNA Staff V was observed supervising smokers during a smoking session in the designated smoking area. In an interview, CNA Staff V said she had not received any training related to supervision of smokers during (continued on next page)

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F 0726 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	smoking sessions. On 8/27/25 at 4:33 p.m., in an interview the Regional Director of Clinical services said there was no specific training for CNAs who supervise smokers.On 8/28/2025 at 11:55 a.m., in an interview the Administrator said he did not know if there was a specific training on how to do a smoking evaluation. He said a safe smoker must be able to show they won't burn themselves or others. The Administrator said, We are not identifying unsafe smokers, we missed the boat. The observation of Resident #95 not wearing the smoking apron as per the interventions listed on the care plan was shared with the administrator. He said, If a resident is identified as someone who requires an apron, they are expected to wear the apron while smoking.

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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. Based on observation, record review, residents and staff interviews, the facility administration failed to utilize its resources effectively to provide effective oversight and enforcement of safe smoking practices. The smoking evaluations for 5 (Residents #59, #3, #74, #64 and #5) of 6 residents reviewed contained conflicting and inaccurate smoking risks. The evaluations noted the residents were safe smokers and required constant supervision for smoking. The licensed nurses who completed the smoking evaluations had no documentation of training or competencies to ensure the smoking evaluations were complete and accurately reflected each resident's smoking risks.Residents #3, and #59 were smokers and used supplemental oxygen in their rooms. Resident #5 used oxygen and vaped electronic cigarettes in her room. The residents retained and stored ignition devices (lighters or electronic cigarettes) in their rooms while oxygen was in use. The management staff responsible to enforce safe smoking practices had not received training and did not consistently complete the observation of assigned residents' rooms and failed to identify the unsafe storage of lighters and electronic cigarettes in residents' rooms where oxygen was in use. Staff assigned to monitor residents who require constant supervision during smoking had not received appropriate training and competencies.These failures created a constant hazardous environment and a likelihood of serious harm, injury or death of residents from fire and thermal burns from the unsafe smoking practices and resulted in the determination of Immediate Jeopardy. The findings included: Refer to F689, F726 and F926. Review of the Executive Director (Administrator)'s job description signed on 3/27/25 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 . Job functions . 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 .Review of the Director of Nursing's job description signed on 8/6/25 revealed, As the company Director of Nursing, you are entrusted with the responsibility of caring for our residents . 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 . Establish, implement, and continually update competency/skills checklists for nursing staff .Review of the provided facility assessment revealed smoking was not addressed as it relates to resident safety and facility risk. Review of the provided facility's New Hire Orientation revealed the facility was a drug-free workplace, no smoking, no tobacco use.On 8/25/25, the facility provided a residents' list titled, Resident smoking list subject to change based on admit/discharge updated on 8/25/25. The list included 14 smokers. On 8/27/27 at 9:10 a.m., Resident #3 was observed in his room in bed, holding a cigarette and a lighter, approximately 4 feet from his roommate (Resident #103) receiving supplemental oxygen via nasal cannula. Resident #3's smoking evaluation completed on 8/24/25 noted the resident did not have the fine motor skills needed to securely hold a cigarette. The summary of the evaluation noted that the resident was a safe smoker and did not need supervision while smoking. The resident's care plan did not address smoking risks and safety interventions necessary while smoking. Resident #3 was not included in the facility provided list of smokers. On 8/27/25 at 12:30 p.m., Resident #59 was observed in his room receiving supplemental oxygen via nasal cannula. Resident #59 was included in the facility provided list of smokers. During observation and interview, a cigarette lighter was observed stored in the resident's nightstand, approximately 2 feet from the oxygen concentrator. Review of the resident's clinical record revealed a physician's order for supplemental oxygen dated 8/25/25. The clinical record did not include a smoking evaluation or assessment of the resident's comprehension of safety precautions and the dangers of smoking or (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	storing ignition devices near oxygen. Resident #74 was included in the facility provided list of smokers and was Resident #59's roommate. The smoking evaluations completed on 4/23/25 and 7/24/25 contained conflictive information. The evaluations noted that the resident was a safe smoker and required constant supervision while smoking. The smoking evaluation completed on 7/24/25 did not include the resident's ability to communicate why oxygen must always be off prior to lighting cigarettes. On 8/27/25 at 12:45 p.m., cigarettes and a lighter were observed on the windowsill of Residents #74 and #59's shared bedroom. Resident #59's oxygen concentrator was on and running. In an interview Resident #74 said the lighter belonged to him and he kept it on the windowsill. On 8/28/25 at 1:30 p.m., Resident #5 was observed in her room in bed receiving supplemental oxygen. Resident #5 said she does not leave her room. She said she has been vaping and storing electronic cigarettes in her room. The resident's clinical record contained inconsistent and conflictive information related to smoking.The smoking evaluation completed on 7/25/25 noted Resident #5 was a safe smoker and also required constant supervision while smoking. Resident #5's current care plan noted she was a former smoker, a smoker, and had behaviors of vaping in her room. The care plan did not include interventions to stop the unsafe behavior of storing and vaping electronic cigarettes with oxygen in the room. Resident #64 was included in the facility provided list of smokers. The smoking evaluations completed on 3/4/25 and 6/2/25 noted that the resident was a safe smoker and needed constant supervision while smoking. On 8/27/25 at 12:20 p.m., Certified Nursing Assistant (CNA) Staff W was observed leaving cigarettes and lighters unlocked, unattended in the designated smoking area while she took a resident to the bathroom. The smoking materials were easily accessible to 4 Residents observed in the smoking area. On 8/27/25 at 2:50 p.m., an interview was held with the Administrator to discuss the incomplete, inaccurate smoking evaluations, and the training and competency of the licensed nurses who complete the smoking evaluations. The Administrator said he did not know who was responsible to ensure the licensed nurses were trained and competent to complete accurate smoking evaluations. The observation of the CNA leaving the designated smoking area with cigarettes and lighters unlocked, unattended and easily accessible to 4 residents observed in the smoking area was shared with the Administrator. He said the CNAs assigned to the smoking area did not have a direct supervisor and he did not know who was responsible to educate the CNAs not to leave residents unattended, and not to leave smoking material unlocked in the smoking area. The Administrator said the courtyard should be supervised at all times, regardless of smoking times and the smoking area should never be left unsupervised.On 8/27/25 at 4:33 p.m., in an interview the Regional Director of Clinical services said there was no specific training for CNAs who supervise smokers.On 8/28/25 at 11:55 a.m., an interview was held with the Administrator to discuss the unsafe smoking practices, and the facility oversight and leadership to maintain a safe environment for the residents. The Administrator said Managers conduct angel rounds Monday through Friday. Spot checks are done on the weekend. He said staff conducting the angel rounds were expected to intervene immediately if an issue is identified and notify him. The Administrator said managers had not received training specific on the angel rounds but they were expected to look for lighters in the residents' rooms.When asked for the completed angel rounds for the past two weeks, the Administrator said he had no documentation the management staff completed the angel rounds.When asked about operationalizing the smoking policy to ensure adequate supervision of residents who smoke tobacco or vape electronic cigarettes, the Administrator said a CNA is assigned to the smoking area each shift. They are told to never leave residents unsupervised.

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Have policies on smoking. 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 accurate residents' smoking evaluations and prohibiting the use and storage of ignition devices around oxygen use in residents' rooms for 6 (Residents #3, #103, #59, #74, #5, and #95) of 6 residents reviewed for safe smoking.Residents #3 and #103 were roommates. Resident #3 was a smoker and Resident #103 received supplemental oxygen via nasal cannula.On 8/27/25 Residents #3 and #103 were observed in their shared bedroom. Resident #3 was holding a cigarette and lighter approximately 4 feet from Resident #103 who was in bed receiving supplemental oxygen.Residents #59 and #74 were roommates and smokers. Resident #59 received supplemental oxygen. Both residents required constant supervision while smoking. On 8/27/25 Resident #59 was receiving oxygen. A lighter was stored within 2 feet of the oxygen source and on the windowsill of the shared bedroom.Resident #5 received supplemental oxygen. The resident stored and vaped electronic cigarettes in her room without staff intervention or supervision. The facility failure to consistently implement and monitor for compliance with the smoking policy and allowing the presence and storage of ignition devices such as electronic cigarettes and lighters near oxygen sources in residents' rooms created a likelihood of serious harm, injury or death of residents from immediate fire which could result in serious thermal burn and resulted in the determination of Immediate Jeopardy.The findings included:Cross reference F689, F726 and F835Review of the facility's policy and procedure titled, Smoking-Supervised with a revision date of 8/17/2017 revealed, . Smoking is only allowed in designated areas and oxygen is not permitted . Residents smoke will be evaluated on admission/re-admission, quarterly and with a change of condition to determine if additional adaptive or safety equipment is needed. Residents will be supervised during smoking including those resident utilizing electronic cigarettes . Smoking materials will be retained and stored by the nursing staff for residents who have been granted smoking privileges . NO IGNITION DEVICES will be in the resident's possession at any time and is strictly prohibited. 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 .On 8/27/25 at 9:10 a.m., during a tour of the facility, Resident #103 was observed in his room in bed receiving supplemental oxygen via nasal cannula.Resident #3 was in bed within 4 feet of Resident #103. Resident #3 was holding a lighter and a cigarette. On 8/27/25 at approximately 9:15 a.m., the observation of Resident #3 holding a lighter in close proximity of an oxygen source was shared with the Regional Nurse Consultant. She stated, Residents or family members can sneak stuff in.Review of the clinical record for Resident #3 revealed the admission Minimum Data Set (MDS) assessment with a target date of 5/24/25 revealed Resident #3 scored 15 on the Brief Interview for Mental Status indicating intact cognition. The assessment noted Resident #3 had functional limitation in range of motion of one upper extremity. No was entered in the MDS for current tobacco use.On 8/24/25 Registered Nurse (RN) Staff ZZ completed a smoking evaluation for Resident #3. The evaluation noted the resident did not have the fine motor skills needed to securely hold a cigarette. RN Staff ZZ determined Resident #3 was a safe smoker and did not need supervision while smoking despite the inability to securely hold a cigarette. The clinical record did not include a care plan with individualized interventions for safe smoking.On 8/27/25 at 10:30 a.m., in an interview Resident #3 said he's been smoking and has kept a lighter in his room since his admission to the facility.On 8/27/25 at 10:32 a.m., in an interview Certified Nursing Assistant (CNA) Staff Z said Resident #3 has always been a smoking every day since his admission. CNA Staff Z said residents can keep cigarettes but not lighters in their room.On 8/27/25 at 10:33 a.m., in an interview CNA Staff Y said Resident #3 has been smoking every day since his admission. She said the resident was allowed to keep his cigarettes but no lighter.Resident #3 was not included in the facility provided (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Resident smoking list updated on 8/25/25. The Resident smoking list included Resident #59. On 8/27/25 at 12:30 p.m., Resident #59 was observed in bed in his room receiving oxygen at 4 liters via nasal cannula. In an interview Resident #59 verified he smoked cigarettes. Resident #59 said he stored his cigarettes and lighter in his nightstand. Resident #59 opened the first drawer of the nightstand where a cigarette lighter was observed, approximately 2 feet from the oxygen concentrator. Photographic evidence obtained.Review of the clinical record for Resident #59 revealed on 5/19/25 Licensed Practical Nurse (LPN) Staff S completed a smoking evaluation which contained conflictive information. The evaluation noted Resident #59 was a safe smoker but needed constant supervision while smoking. The resident's ability to communicate why oxygen must always be shut off prior to lighting cigarette was not evaluated and left blank. Review of the physician's orders revealed an order dated 8/25/25 for Oxygen as needed for shortness of breath or oxygen saturation below 90%. The clinical record lacked documentation a smoking evaluation was completed on 8/25/25 to address the use of oxygen and the resident's understanding and ability to verbalize why oxygen must always be shut off before lighting a cigarette. On 8/27/25 at 12:45 p.m., observation of Residents #59 and #74's shared bedroom revealed cigarettes and a lighter stored on the windowsill. Resident #59 was not in the room. The oxygen concentrator was on and running. In an interview during the observation, Resident #74 said he smoked cigarettes. He said the cigarettes and lighter on the windowsill belonged to him and that was where he stored them. On 8/28/25 at 1:30 p.m., Resident #5 was observed in bed receiving oxygen via nasal cannula. In an interview Resident #5 said she doesn't get out of bed. She said she was a smoker but has been vaping electronic cigarettes in her room since she cannot get out of bed to go to the designated smoking area. She said she has been using her electronic cigarette in her room for over a month but staff took it away from her last night. Resident #5 was not listed on the Resident smoking list. Review of the clinical record for Resident #5 revealed an admission date of 1/19/24. Diagnoses included Morbid Obesity, Bipolar Disorder and Major Depressive Disorder.The physician's orders dated 1/22/24 included oxygen at 3 liters per minute via nasal cannula at bedtime. The care plan related to smoking for Resident #5 was inconsistent:The care plan initiated on 10/12/23 with a target date of 10/28/25 noted Resident #5 was a former smoker and used oxygen at bedtime. The care plan initiated on 6/24/25 noted the resident was a smoker. The goal was for the resident not to smoke without supervision and the resident would not suffer injury from unsafe smoking practices. The care plan initiated on 6/24/25 noted the resident has behaviors and vapes in her room. The goal was for the resident to have fewer episodes of vaping and the resident will have no evidence of behavioral concerns vaping. The interventions included to monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved and situations. Document behavior and potential causes. The care plan did not include interventions to stop the unsafe practice of vaping electronic cigarettes in the room while using oxygen. Review of the smoking evaluations revealed on 7/25/25 LPN Staff S documented Resident #5 was a safe smoker and the supervision required while smoking was constant.Resident #95 was included in the facility's Resident smoking list. Resident #95's name was listed under Apron Assistance.Review of the clinical record for Resident #95 revealed a date of admission of 7/5/24. Diagnoses included hemiplegia (paralysis)/hemiparesis (weakness) of the right dominant side. Review of the smoking evaluation completed by LPN Staff T on 7/2/25 revealed Resident #95 was a safe smoker and did not need supervision while smoking. On 8/27/25, review of Resident #95's care plan revealed on 8/26/25 a new intervention was added to the smoking care plan specifying the resident required a smoking apron while smoking. On 8/27/25 there was no documentation a new smoking evaluation was completed to address the smoking apron and evaluate the resident's ability to smoke independently and unsupervised. On 8/27/25 at 10:55 a.m., CNA Staff W was observed supervising the designated smoking area. Resident #95 was smoking and was not wearing the smoking apron per the safety intervention listed on the smoking care plan on 8/26/25.On 8/27/25 at 12:20 p.m., CNA Staff W was observed monitoring the designated smoking area. CNA Staff (continued on next page)

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F 0926 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	W left the smoking area with a resident. She left cigarettes and lighters unlocked, unsupervised and easily accessible to Resident #95 and 3 other residents observed in the designated smoking area. On 8/27/2025 at 1:12 p.m., the designated smoking area was observed with the Director of Nursing (DON). Resident #95 was smoking and was not wearing the protective apron as care planned. In an interview, the DON verified Resident #95 was not wearing the protective smoking apron as care planned. On 8/27/2025 at 3:10 p.m., in an interview the Social Services Director said per the facility' s policy, residents were not allowed to have lighters in their possession. The Social Services Director said the managers are assigned residents' rooms and conduct angel rounds. She said during the rounds, the managers look for lighters in the residents' rooms. She said the Administrator kept the completed angel rounds forms. On 8/27/25 at 4:33 p.m., CNA Staff V was observed supervising the designated smoking area. She said residents bring their own lighters and light their cigarettes. She tries to take the lighters from the residents but they don't listen. CNA Staff V said she told both the nursing staff and social services about the residents having and keeping their own lighters. She said they have not done anything about it so she stopped reporting it to them. On 8/28/25 at 11:55 a.m., in an interview the Administrator verified Resident #5 received oxygen and vaped electronic cigarettes in her room. He said Resident #5 was not able to go outside and vaped in her room. When asked about the facility process to enforce the smoking policy, the Administrator said the managers conduct angel rounds Monday through Friday. Spot checks are done on the weekend. He said staff conducting the angel rounds were expected to intervene immediately if an issue is identified and notify him. The Administrator said managers had not received training specific on the angel rounds but they were expected to look for lighters in the residents' rooms. Review of a blank form titled, Morning Room Round identified by the facility as the Angel Round form noted, No Meds, treatment supplies, or unsafe items in room was part of the checklist. Review of the Angel Round Room Assignments form revealed:The Maintenance Director was assigned to Residents #59 and #105. The facility's concierge was assigned to Resident #64.The Social Worker was assigned to Resident #95.The Activity Director was assigned to Resident #5.The Assistant Business Office Manager was assigned to Resident #3. When asked for the completed angel rounds for the past two weeks, the Administrator said he had no documentation the management staff completed the angel rounds.When asked about operationalizing the smoking policy to ensure adequate supervision of residents who smoke tobacco or vape electronic cigarettes, the Administrator said a CNA is assigned to the smoking area each shift. They are told to never leave residents unsupervised. The Administrator said the facility had no other policy addressing smoking other than the provided Smoking Supervised policy and procedure.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on record review and interview, the facility failed to have a written transfer agreement in effect with one or more hospitals approved for participation in Medicare/Medicaid programs. The findings included:On 8/29/25 a request was made to the facility to review the facility's transfer agreement with one or more hospitals approved for participation in the Medicare/Medicaid programs. On 8/29/25 at 12:15 p.m., in an interview the Regional [NAME] President of Operations said the facility did not have a transfer agreement with any hospital.On 8/29/25 at 1:30 p.m., in an interview the Administrator verified the facility did not have a transfer agreement with one or more hospitals approved for participation in the Medicare/Medicaid program.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on record review, review of facility's policy and procedure, residents and staff interviews, the facility failed to act promptly upon the grievance expressed by the resident council group during their monthly meetings. The findings included:Review of the facility's Complaint/Grievance policy and procedure N-1042 dated 11/30/14 and revised 10/24/22 revealed that the center would support each resident's right to voice a complaint/grievance without fear of discrimination or reprisal. The center would make prompt efforts to resolve the complaint/grievance and inform the resident of progress towards resolution. An employee receiving a complaint/grievance from a resident, family and/or visitor would initiate a Complaint/Grievance Form. The original grievance form was then submitted to the Grievance Office/designee for further action. The Grievance Officer/designee would act on the grievance and begin follow-up of the concern or submit it to the appropriate department director for follow-up. The grievance follow-up should be completed in a reasonable time frame; this should not exceed 14 days. The findings of the grievance should be recorded on the Complaint/Grievance Form. The results would be forwarded to the Executive Director for review and filing. The Grievance Official would log complaints/grievances in the Monthly Grievance Log. The individual voicing the grievance would receive follow-up communication with the resolution, a copy of the grievance resolution would be provided to the resident upon request. On 8/26/25 at approximately 11:30 a.m., a meeting was held with 15 residents who participate in Resident Council Meetings. The Resident Council President said they held monthly resident council meetings. The Activity Director or designee runs the meetings and documents the minutes on the Resident Council Minutes form. The group said the facility did not always follow up on the concerns/grievances expressed in the meetings and no resolution is discussed in the next meeting. The Resident Council President said the group told the Activity Director over the past several months the resident's call lights had not been answered timely, mostly during the night shift and the newer employees need better training on how to answer resident's call lights and other concerns (maintenance concerns and menu changes) they voiced during the meetings. The group said no one from the facility had spoken to them on how their concerns would be addressed and/or resolved even though staff wrote it on the next month's resident council meeting minutes. Review of the Resident Council Meeting minutes dated 6/25/25, noted in the New Business section, the Activity Director wrote: call lights, maintenance on (brand name) full body mechanical lifts and lifts, maintenance on hand and foot bike and menu changes. The Resident Council Meeting minutes dated 7/23/25 under Old Business the Activity Director wrote call lights - new people not trained, resident orientation and menu changes. In the New Business section, the Activity Director wrote call lights to be answered timely, audits and staff education to be completed, check (brand name) mechanical lift and hand bike weekly by the maintenance department, and weekly food audits by the Kitchen Manager. On 8/28/25 at 12:00 p.m., in an interview the Social Service Director (SSD) said the Activity Director normally conducts the monthly resident council meetings and documents the meeting on the Resident Council Minutes form. She said after the resident council meeting, the Activity Director tells her the concerns/grievances brought up during the resident council meeting. They document the grievances on the monthly grievance log. She then delegates the grievance to the appropriate departments. The grievances had to be addressed/resolved within 14 days per the facility's complaint/grievance policy. The resolution is explained in the next monthly resident council meeting. The SSD reviewed the resident council meeting minutes for 6/25/25 and 7/23/25. She confirmed the resident council voiced concerns/grievance related resident call lights not being answered timely, staff training related to call lights, maintenance of (brand name) mechanical lift and hand bike equipment, and menu changes. The SSD said she could not find documentation the grievances voiced by the resident council group in June and July 2025 were addressed and that the resolution was communicated to the resident council group.On 8/28/25 at 12:30 p.m., in an interview the Administrator verified the lack of documentation the grievances voiced by the resident council (continued on next page)

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	105588	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Santa Barbara	216 Santa Barbara Blvd Cape Coral, FL 33991

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	group in June and July 2025 had been addressed. He said the facility did not follow their grievance policy and procedure.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews the facility failed to provide appropriate care and services to prevent complications of enteral feeding tubes for 3 (Residents #52, #15 and #94) of 4 residents reviewed.The findings included: Review of the clinical record revealed Resident #52 was admitted to the facility on [DATE]. Diagnosis included but not limited to aphasia following cerebral infarction, neuropathy, and gastrostomy.Care Plan initiated 8/12/25, revision date 8/20/25 revealed Resident #52 is at risk for complications, infections, fluid balance, aspiration (accidental inhalation of food, liquid into the airways or lungs) related to Resident #52 requires tube feeding to meet hydration/nutrition needs secondary to cerebrovascular accident (stroke). Interventions include observe for signs and symptoms of infection, report promptly; provide local care to g-tube site as ordered and monitor for signs and symptoms of infection.Review of physician orders reveals Resident #52 does not have an order to cleanse g-tube site or to change dressing.On 8/27/25 at 10:27 a.m. during medication pass with Resident #52 observed Staff O, LPN insert ungloved pointer finger into plastic medication sleeve for each medication pulled before crushing. During medication pass observed Staff O, LPN insert gloved pointer finger into water that was being used to flush the g-tube. Observed dressing to g-tube site with moderate amount of brown and yellow drainage, extending approximately one inch from the insertion site . Staff O, LPN said she did not do the treatment yet. Staff O, LPN said she was planning on doing the treatment in the afternoon.On 8/28/25 at 8:50 a.m. observed Resident #52 with soiled dressing to g-tube site. Date on the dressing was 8/25/25. (photographic evidence obtained). Present was Staff CC, LPN. Staff CC, LPN said the dressing should be changed daily and as needed. Staff CC, LPN said an infection could happen by not changing the dressing daily and keeping the area clean. Staff CC, LPN said every nurse should check to see if the site needs to be cleaned and the dressing changed.On 8/29/25 at 9:40 a.m., in an interview with Staff AA, LPN said g-tube sites need to be cleaned and a dressing applied at least daily. Staff AA, LPN said if there is redness you have to notify the physician. Staff AA, LPN said that it was not good Resident #52 did not have an order to clean and apply dressing. Staff AA, LPN said an infection could occur if the area is not cleansed and if the dressing is soiled.On 8/29/25 at 9:51 a.m., in an interview with Staff BB, LPN said residents with a feeding tube should have an order to cleanse and change the dressing daily and as needed if soiled. Staff BB, LPN said she did not know why Resident #52 did not have an order. Staff BB, LPN said if a dressing is not changed an infection could happen. Staff BB, LPN said there could be damage to the stoma and compromised skin integrity. Staff BB, LPN said it was not acceptable for a dressing dated 8/25/25 to be on 8/28/25.On 8/29/25 at 10:28 a.m., in an interview with the DON said after reviewing the orders, Resident #52 did not have an order to clean or change dressing to g-tube site. The DON said Resident #52 should have an order because there is a potential for infection without cleansing and applying a new dressing. The DON said the infection control breaks during medication pass were against infection control practices and could lead to an infection.Review of the clinical record revealed Resident #15 was admitted to the facility on [DATE]. Diagnosis included but are not limited to acute kidney failure, cerebral infarction, hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side, and dysphagia (swallowing disorder).Care plan 4/25/25 revealed Resident #15 requires a g-tube feeding related to dysphagia. Interventions include provide local care to g-tube site as ordered and monitor for signs and symptoms of infection.Review of physician order 7/31/25 revealed enteral: stoma care every shift (2 times per day) left lower quadrant.Review of Treatment Administration Record revealed no documentation for 8/19/25 day shift.On 8/28/25 at 9:00 a.m., observed Resident #15 had no dressing to g-tube site. Staff CC, LPN said she did not know why Resident #15 did not have a dressing on. Staff CC, LPN said that no one had come to her to say the (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing was off.Review of the clinical record revealed Resident #94 was admitted to the facility on [DATE]. Diagnosis included but not limited to hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, dysphagia, and gastrostomy.Review of physician order 9/19/24 enteral: stoma care every shift (2 times per day).On 8/28/25 at 8:53 a.m. observed dressing to g-tube site dated 8/25/25. (photographic evidence obtained). Present was Staff CC, LPN. Staff CC, LPN said the dressing should be changed daily and as needed. Staff CC, LPN said an infection could happen by not changing the dressing daily and keeping the area clean. Staff CC, LPN said every nurse should check to see if the site needs to be cleaned and the dressing changed.Review of the Treatment Administration Record revealed no documentation for 8/19/25 day shift.Review of the Treatment Administration Record revealed enteral: stoma care every shift was signed for on 8/26/25 and 8/27/25 on both day and night shifts.On 8/29/25 at 10:12 a.m., in an interview with Staff S, LPN said it is not acceptable for a nurse to sign for something that was not done. Staff S, LPN said nurses have to follow physician orders and if you are signing, it must be done. Staff S, LPN said nurses are trained in feeding tubes and stoma care.On 8/29/25 at 10:28 a.m., in an interview with the DON said nurses should not sign for something they did not do. The DON said an infection could occur if the dressing is not changed and the area cleansed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure timely acquiring and administering of medications to meet the needs of 3 (Residents #48, #51, and #18) of 3 residents selected for medication administration observation.The findings included:1. On [DATE] at 8:16 a.m., during a medication administration observation for Resident #48, Licensed Practical Nurse (LPN) Staff M said Resident #48's Tenofovir Discoproxil Fumarate (hepatitis medication) was not available. She said the medication was ordered on [DATE] and had not arrived from the pharmacy yet. Review of Resident #48's Medication Administration Record for [DATE] revealed several days medications had not been documented as given including: [DATE]th and 25th which had blank boxes for Levothyroxine (thyroid medication), Naloxogol Oxalate (medication for constipation), Torsemide (diuretic medication). [DATE]th also had a blank box for Insulin Glargine (diabetic medication). No documentation was found explaining what the blank boxes meant or that the doctor had been notified anything regarding these medications on these days. 2. On [DATE] at 8:21 a.m., during observation of medication administration for Resident #18, LPN Staff N said Resident #18's Irbesartan (blood pressure medication) was not available. She said it was reordered today.Review of Resident #18's Medication Administration Record (MAR) for [DATE] revealed: On [DATE], [DATE], [DATE], and [DATE], 9 (other/see nurse's notes) was entered for OcuSoft eyelid cleansing external Pad (medication for eyelid inflammation).On [DATE] there was no documentation the ordered Miralax powder (laxative), Lorazepam (anxiety medication), Tramadol (opioid pain medication) were administered. Review of Resident #18's progress notes for [DATE] revealed a progress note on [DATE] that the Ibersartan had been ordered from pharmacy, but no documentation the doctor was notified about the missed dose. Progress notes were found for the Ocusoft indicting the medication was not available, however no documentation that the doctor was notified of the missed applications. No progress notes were found to explain the blank boxes on [DATE] for the Miralax, Lorazepam or Tramadol. 3. On [DATE] at 8:25 a.m., during a medication administration observation for Resident #51, LPN Staff N said Resident #15's Oxycontin Extended Release 15 mg every 12 hours (opioid pain medication) was not available. She said she would have to contact the pharmacy. Review of Resident #51's Medication Administration Record for [DATE] failed to reveal documentation the morning dose of Oxicontin was administered on [DATE], [DATE] and [DATE] or the evening dose was administered on [DATE]. Review of the progress notes revealed the medication was not available on those days and the doctor had been notified.On [DATE] at 4:49 p.m., in an interview the Director of Nursing (DON) said when a medication is unavailable the process should be to check the bottom drawer of the med cart for overflow and check the electronic medication dispensing system. The DON said if the medication is not found, staff should notify the doctor of the missed dose, write a progress note the doctor was notified and their response and write an order if the doctor gives one. He said nurses should be documenting on the MAR (Medication Administration Record) and not leaving blank spots. The DON said when it comes to re-ordering medications, if the prescription is still good, nursing staff should re-order before the medication runs out, usually when there is a 7-day supply left. He said if the prescription has expired, the doctor should be notified in the same time frame. The DON agreed when the boxes on the MAR are left blank there is no way to know whether the resident received the medication or not.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on record review, review of the facility's policy and procedure, and staff interview, the facility failed to ensure 2 (Residents #65, and #51) of 5 residents reviewed for immunization received education regarding the benefits and potential side effects and were offered pneumococcal immunization.The facility failed to ensure 1 (Resident #65) of 5 residents residing at the facility between October 1, 2024, and March 31, 2025, received education and was offered the influenza immunization.The findings included:Review of the Pneumococcal Vaccine Policy dated 2001, revised October 2019 revealed that all residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. (1) Prior to or upon admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, will be offered the vaccine series within thirty days of admission to the facility unless medically contraindicated prior to admission. (2) Assessments of pneumococcal vaccination status will be conducted within five working days of the resident's admission if not conducted prior to admission. (3) Before receiving a pneumococcal vaccine, the resident or legal representative shall receive information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education shall be documented in the resident's medical record. (5) Residents/representatives have the right to refuse vaccination. If refused, appropriate entries will be documented in each resident's medical record indicating the date of the refusal of the pneumococcal vaccination. (6) For residents who receive the vaccines, the date of the vaccination, lot number, expiration date, person administering, and the site of the vaccination will be documented in the resident's medical record.Review of the clinical record for Resident #65 revealed an admission date of 12/17/24.The clinical record for Resident #65 lacked documentation upon admission of screening, education, offering and current vaccination status for Pneumococcal Vaccine.Review of the clinical record for Resident #51 revealed an admission date of 8/27/24.The clinical record for Resident #51 lacked documentation upon admission of screening, education, offering and current vaccination status for Pneumococcal Vaccine.Review of the Influenza Vaccine Policy and Procedure for Residents with an effective date of 11/30/2014 and a revision date of 8/17/2020 revealed that residents will be offered the influenza vaccine annually (between October 1st and March 31st) unless otherwise directed by the Centers for Disease Control (CDC), to encourage and promote the benefits associated with vaccinations against influenza, in accordance with the local health department and CDC Guidelines. (1) Provide resident/resident representative education on potential side effects and risk benefits of the vaccine. Review the potential risk/side effects and benefits from the vaccine. (2) Obtain an informed consent form the patient/resident or legal representative if indicated indicating acceptance or declination. (5) File the informed consent in the medical record. (6) Document in the medical record including but not limited to: the resident or legal representative was provided education including potential side effects of the vaccine; the resident received the vaccine date, lot number, expiration date, manufacturer or, the resident did not receive the vaccine due to medical contraindication, has received the vaccine outside of the center, or refused.Record review showed Resident #65 was at the facility between October 1, 2024, and March 31, 2025.The clinical record for Resident #65 lacked documentation of screening, education, offering and current vaccination status for Influenza Vaccine.On 8/27/25 at 9:30 a.m., in an interview the Regional Director of Clinical Services said she reviewed the clinical record for Residents #65. She verified Residents #65 was at the facility between October 1, 2024, and March 31, 2025, had no contraindication to the vaccine and was not offered the influenza vaccine. The Regional Director of Clinical Services also verified that Residents #59, #64, #65 and #51's clinical record lacked documentation of pneumococcal vaccine status. She said there was no documentation Residents #59, #64, #65, and #51 received information about pneumococcal vaccination and were offered, requested or declined pneumococcal vaccination.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and staff interview, the facility failed to ensure the Advanced Beneficiary Notice of Non-Coverage issued to 2 (Residents #15 and #57) of 3 residents was complete and accurately reflect the residents' decision to stop or continue skilled services and the financial liability. The findings included:Review of the Facility policy titled Advanced Beneficiary Notice - ABN with a revision date of 11/10/2015 revealed, An ABN will be utilized to notify resident of the possibility that Medicare will not pay for the item(s) or service(s) that are described on the form . The form will be reviewed with the resident or authorized representative .Procedure 1. d. The resident or authorized representative is to choose one of the three options, date and sign the form. The resident must comprehend the contents. If the resident is unable to comprehend the contents of the notice, it must be delivered to and signed by an authorized representative . On 8/27/25 the Social Services Director (SSD) provided the Advance Beneficiary Notices of non-coverage that had been issued to current Residents #15 and #57.Review of the Skilled Nursing Facility Advance Beneficiary Notice of non-Coverage (SNF ABN) forms revealed:On 7/23/25, Resident #15 signed the form that beginning on 7/28/25 the resident may have to pay out of pocket for Physical Therapy. The form did not include the estimate cost the resident would have to pay per day/item or service. The form contained instructions to check the box for one of the 3 options listed to choose whether the resident wanted to continue the care listed and assume financial responsibility or that they did not want to continue the care. The resident signed the form but no option was checked. On 8/14/25 Resident #57 signed the ABN notice that beginning on 8/22/25 Resident #57 may have to pay out of pocket for physical therapy care at a rate of $400.00 per day. Under the section titled Options: check only one box, which allows resident the option to choose whether they want to continue the care listed and assume financial responsibility or choose they do not want the care, all 3 options had been chosen indicating they wanted the care and they did not want the care. On 8/28/25 at 10:38 a.m., in an interview the SSD verified both forms had not been completed correctly. She said with the forms filled out in this manner, they could not say whether the resident wanted to continue care and potentially assume financial responsibility or that they did not want the care.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on record review, review of facility's policy and procedure and staff interview the facility failed to refer 1 (Resident #11) of 2 residents with signs of serious mental illness, intellectual disability or a related condition for a Level II Pre admission Screening and Resident Review as required. The findings included: Review of the facility's policy for Preadmission Screening and Resident Review (PASSR) with a revision date of 11/8/2021 indicated: 1. It is the responsibility of the center to assess and assure that the appropriate preadmission screenings, either Level I or Level II are conducted and results obtained prior to admission and placed in the appropriate section of the resident's medial record. 7. Social Services will be responsible for coordinating significant change updates of these screenings, conducted by the appropriate agency. These results, along with the results from the previous years will be kept in the appropriate sections of the resident's records. Review of the clinical record for Resident #11 revealed an admission date of 7/20/15. Diagnoses included anxiety and unspecified head injury of head. Review of the Level I PASSR dated 7/20/15 revealed instructions that a Level II evaluation must be completed if any box in Section II.A is checked and there is a YES checked in Section III.1, III.2, or III.3.The form noted that Resident #11 had a diagnosis of anxiety (Section IIA). Yes was entered for Section III.2 (A). Fear of strangers was Underlined. Yes was entered for Section III.2 (B). Pacing was underlined. Yes was entered for Section III.2 (C). Adaptation to changes. There was no documentation a level II PASSR was completed for Resident #11. Resident #11's clinical record contained a Level I PASSAR dated 2/18/24. The instructions specified that a level II PASSAR examination must be completed prior to admission if any box in section 1.A. or 1.B. is checked and there is a yes checked in section II.1 II.2 or II.3, unless the individual meets the definition of a provisional admission or a hospital discharge exemption. The form indicated Resident #11 was not a provisional admission. Section 1.A. was marked for anxiety disorder and depression disorder. Section 1.B. was marked for traumatic brain injury. Section II.1 was marked yes, Section II.2 A, B and C were marked yes and Section II.3 was marked yes for question B.The clinical record contained a letter dated 2/18/24 from a pre-admission screening company indicated Resident #11's Level I screening results indicated signs of serious mental illness and intellectual disability or a related condition were found. A Level II screening is needed.The clinical record lacked documentation of a Level II screening. On 8/27/25 at 1:20 p.m., in an interview the Regional Social Services Director (SSD) said Resident #11 did require a Level II screening. She said she could not find documentation that a Level II had been done. She said she could not explain why a Level II PASSAR screening was never done for Resident #11.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide an ongoing program of activities to meet the needs of 1 (Resident #113) of 3 reviewed for activities program.The findings included:Review of Individual Activities Policy and Procedure dated 11/1/21 revealed residents who are unwilling and/or unable to attend scheduled group activities are provided one-to-one individualized recreational and Community Life based on their needs, interests, and functional ability. (1) Review the preferred activities and activity times of the resident found on the following form: Activity Plan of Care, MDS (3) Include resident and family in development of recreational and Community Life interventions that meet their needs, interests, and functional ability. (4) Determine and schedule activities and times that support preferences. (5) Obtain the appropriate supplies for the 1:1 visits.Review of clinical record revealed Resident #113 was admitted to the facility on [DATE]. Diagnosis included but were not limited to mycosis (a disease caused by fungus), muscle weakness, cleft palate, dysphagia (difficulty swallowing).Minimum Data Set (MDS) admission Assessment 8/23/25 revealed Resident #113 scored a 00 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.MDS admission Assessment 8/23/25 asked How important is it to you to do your favorite activities. Resident #113 response was very important.On 8/25/25 at 10:12 a.m., in an interview Resident #113's family member said the resident was special needs, developmentally delayed. She said Resident #113 was non-verbal and used gestures to communicate. She said Resident #113 likes to color and watch children's shows on television. Resident #113 family member said as long she is coloring or watching her shows on TV she is happy. Review of care plans revealed no Activity Care Plan.Care Plan revealed Resident #113 has impaired cognitive function/dementia or impaired thought process related to developmentally delayed initiated on 8/22/25. Interventions include asking yes/no questions in order to determine the resident's needs; cue, reorient and supervise as needed.Care Plan revealed Resident #113 has a communication problem related to no speech, responds to name, diagnosis of cleft palate initiated 8/25/25. Interventions include anticipate and meet needs; allow adequate time to respond; avoid isolation.On 8/26/25 at 9:15 a.m., 9:38 a.m.,10:15 a.m.,11:33 a.m.,11:45 a.m.,12:45 p.m. and 1:28 p.m. the resident was observed in window bed, curtain drawn, dressed in a hospital gown, the television was off, container of crayons on overbed table, no paper or coloring pages. On 8/28/25 at 11:19 a.m., in an interview with Staff Q, Activities Assistant, when asked about the program of activities for Resident #113 and the goals, she said she was not familiar with the resident. On 8/28/25 at 4:46 p.m. in an interview with Staff Q, Activities Assistant said she does not have access to a computer so she would not be able to see if an Activities Assessment was done for Resident #133. She said only the Activities Director has access to a computer, and she was not in. When asked about resident care plans, Staff Q said she does not have access to care plans.On 8/28/25 at 4:54 p.m. in an interview with Staff P, MDS said it doesn't look like the activities assessment was completed. He said it should have been done.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105588	A. Building B. Wing	08/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aviata at Santa Barbara	216 Santa Barbara Blvd Cape Coral, FL 33991

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on record review, review of the facility's policies and procedures and staff interviews, the facility failed to have documentation of COVID-19 vaccination status, screening, education, and offering of the vaccine for 1 (Resident #65) of 5 residents reviewed for immunization status. The findings included:Review of Covid-19 Vaccine for Residents Policy and Procedure with an effective date of 8/03/21, and a revision date 11/17/2021 revealed documentation that residents or their representatives will be educated about and offered the Covid-19 vaccine.(1) Covid-19 vaccinations will be offered to residents (or their representative if they cannot make health care decision) per Centers for Disease Control (CDC) and/or Federal Drug Administration (FDA) guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period or the individual refuses to receive the vaccine.(2) Residents/representatives will be educated on the Covid-19 vaccine they are offered, in a manner they understand, including information on the benefits and risks consistent with CDC and/or FDA information. (2c) Residents/representatives will be provided the opportunity to refuse the vaccine and/or change their decision about vaccination at any time. Documenting Covid-19 vaccine: (5) Review the consent with the resident/resident representative. (5b) File the consent form in the resident electronic health record. (6) Documentation includes but is not limited to (6a) Whether the resident consented or declined the vaccine. If declined, reason for declination.Review of the clinical record for Resident #65 revealed an admission date of 12/17/24. Diagnoses included coronary artery disease, malnutrition, arthritis and renal insufficiency.Review of the Comprehensive Minimum Data Set (MDS) Assessment with a target date of 7/10/25 revealed Resident #65 scored a 06 on the Brief Interview or Mental Status (BIMS), indicating severe cognitive impairment.Review of Immunization Record for Resident #65 revealed no documentation for the Covid-19 vaccine.On 8/27/25 at 9:30 a.m., in an interview the Regional Director of Clinical Services said she reviewed Resident #65's clinical record and verified the lack of documentation of immunization status or contraindication for COVID-19 for Resident #65 and lacked documentation the resident/responsible party received education regarding the benefits and potential risks associated with COVID-19 vaccine and was offered COVID-19 vaccination. The Regional Director of Clinical Services said, It should have been documented.