STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105602	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hawthorne Center for Rehabilitation and Healing Of	4100 SW 33rd Ave Ocala, FL 34474

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview and record review the facility failed to administer oxygen at the correct flow rate according to physician orders for 2 residents (Resident #58 and #116) and failed to have physician orders documenting the prescribed flow rate for 1 resident (Resident #130) of 5 residents reviewed for oxygen therapy. Findings include: During an observation on 5/26/2026 at 10:49 AM Resident #58 was observed with oxygen at 3 liters via a nasal cannula. During and observation on 5/27/2026 at 7:26 AM Resident #58 was observed with oxygen at 3 liters via a nasal cannula. Review of Resident #58's admission record document diagnosis that include unspecified diastolic congestive heart failure, morbid severe obesity due to excess calories, protein calorie malnutrition, acute and chronic respiratory failure with hypoxia, asthma, cardiomegaly, atherosclerotic heart disease of native coronary artery without angina pectoris, age-related osteoporosis without current pathological fracture, anxiety disorder, hyperlipidemia, insomnia, essential primary hypertension and major depressive disorder recurrent moderate. Review of Resident #58's physician order dated 3/16/2026 read, Oxygen @ 2 L/Min continuous inhalation via nasal cannula. During an interview on 5/27/2026 at 2:28 PM, Staff M, Licensed Practical Nurse (LPN) stated, Her (Resident #58) oxygen should be at 2 liters, we check it every shift usually when we are finished with meds. We should follow the orders for the rate. During an interview on 5/28/2026 at 6:29 AM, the Director of Nursing (DON) stated, Oxygen should be running at the ordered rate and we should follow doctors orders. During an observation on 5/26/2026 at 10:07 AM Resident #116 was sitting at bedside, oxygen was being administered via nasal cannula at 4 liters per minute. During an interview on 5/26/2026 at 11:43 AM Resident #116 was sitting on a chair in her room Oxygen was being administered at 4 liters per minute via nasal cannula. During an interview on 5/26/2026 at 11:43 AM Resident #116 stated, The oxygen the nurses are the ones that will touch it, I never touch it. The machine is only assigned to me. During an observation on 5/27/2026 at 8:15 AM Resident #116 sitting up at bedside eating breakfast oxygen running at 4 liters per minute. (continued on next page)

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

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #116 physician order dated 5/14/2026 read, Oxygen @ [at] 2 L/Min [liters per minute] via NC [nasal cannula] inhalation as needed as needed. During an interview on 5/28/2026 at 8:29 AM with the Director of Nursing (DON) stated, Nurses are to check orders prior to administering oxygen if the order says two liters the oxygen concentrator should read 2 liters. The orders should be followed. During an observation on 5/28/2026 at 8:37 AM the DON confirmed Resident #116 oxygen was being administered at 4 liters per minute. During an observation on 5/26/2026 at 10:37 AM Resident #130 was lying in bed oxygen was being administered at 1.5 liters per minute via nasal cannula. There was no date on tubing. During an observation on 5/26/2026 at 12:10 PM Resident #130 was sitting up in a wheelchair. Oxygen was being administered at 1.5 liters per minute via nasal cannula. Oxygen tubing was dated 5/26. Review of Resident #130's physician orders did not document oxygen orders. During an interview on 5/27/2026 at 11:46 AM, Staff D, Licensed Practical Nurse stated, I do not see an order for oxygen. She [Resident #130] would need one for the nasal cannula and the liters of oxygen. I will have to contact the provider and get an order. During an interview on 5/27/2026 at 11:46 AM, Staff D, LPN, confirmed Resident #130 was resting in bed with eyes closed, oxygen at 2 liters per minute via nasal cannula. During an interview on 5/27/2026 at 8:28 AM, the Director of Nursing stated, Doctors orders need to be in place for oxygen. Review of the facility policy and procedure titled, Oxygen Administration, last approval date of 1/22/2026 read, Purpose: The purpose of this procedure is to provide guidelines for oxygen administration. Procedure: 7. Turn on the oxygen. Start the flow of oxygen at the prescribed rate. 9. Adjust the delivery device so that it is comfortable to the resident and the proper flow of oxygen is being administered.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation interview and record review the facility failed to ensure food was stored and served in a sanitary manner. Findings include: Observation of the walk in freezer on 5/26/2026 at 9:34 AM showed there was no stand alone thermometer in the walk-in freezer. During interview on 5/26/2026 at 9:35 AM, the Certified Dietary Manager confirmed there was no stand alone thermometer in the walk-in freezer. Service of the midday meal was observed on 5/29/2026 beginning at 11:20 AM. The cook was observed using a gloved hand to scoop and place meal items onto plates and touching the counter top. The cook was then observed lifting a cheese slice from a stack of cheese with her same gloved hand and placing the slice of cheese onto a hamburger bun for service to a resident. Throughout the meal service, while plating meal items to be served to residents, the cook was observed placing her hand on the food contact surface of 4 plates. The cook was also observed doffing used gloves and donning new gloves without washing her hands after doffing gloves. During interview on 5/29/2026 beginning 11:30 AM, the Certified Dietary Manager agreed dietary staff should not touch food items or the food contact surfaces of plates with their hands. She stated staff were expected to wash their hand after doffing gloves and before donning clean gloves. Review of the policy titled Food Handling, last reviewed 1/22/2026, read Food shall be handled in a proper method to ensure retention of flavor, appearance, quality, nutrients, and to safeguard against contamination. The policy specified 3. When it is necessary for staff to touch food during preparation, they must wash their hands immediately before beginning the process. Disposable gloves are used. Review of policy titled Storage of Perishable Goods, last reviewed 1/22/2026, 1. Freezer temperatures are maintained at a level to keep frozen food solid. Stored frozen foods shall be maintained frozen.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on interview and record review the facility failed to ensure assessments were updated following documentation of a new diagnosis for 4 Residents (Resident #2, 5, 70, and 119) out of 10 Residents sampled for preadmission screening and resident reviews (PASARR). Findings include: Review of Resident #119's admission record showed Resident #119 diagnoses included altered mental status (onset date 4/3/2025), depression (onset date 4/8/2025), anxiety disorder (onset date 4/8/2025), brief psychotic disorder (onset date 4/8/2025) and major depressive disorder (onset date 4/3/2025). Review of Resident #119's Level I Preadmission Screening and Resident Review (PASARR), dated 4/2/2026, showed no entry in section A. MI [mental illness] or suspected MI [mental illness]. During interview on 5/28/2026 at 11:43 AM, the Administrator confirmed Resident #119's Level I PASARR had not been updated to include mental health diagnoses. Review of Resident # 70's admission record showed a diagnosis of Dementia with other diseases classified elsewhere mild, without behavioral disturbances, psychotic disturbance, mood disturbance and anxiety onset date 2/13/2026. Review of Resident 70's PASARR dated 1/8/2026 was not revised to document a diagnosis of Dementia. Record review of Resident #2s admission record showed diagnoses including vascular dementia onset date 5/09/2025 and major depressive disorder onset date 2/4/2026. Review of Resident #2's Level I PASARR screening dated 5/08/2025 identified Resident #2 as diagnosed with Vascular dementia, the PASARR was not revised to reflect a diagnosis of major depressive disorder. Review of Resident #5's admission record showed a diagnosis of PTSD (Post Traumatic Stress Syndrome) onset date 6/24/2022. Review of Resident #5's Level I PASARR screening dated 2/16/2026 showed no documentation of PTSD. During an interview on 5/27/2026 at 11:32 am, the Social Services Director stated, I don't sign the PASARR's, but do review them when directed to do so. When a resident is first admitted , the Director of Nursing is the responsible one for the PASARR's. During interview on 5/28/2026 at 11:43 am, the Administrator stated, The PASARR process should be an IDT (Interdisciplinary Team) approach. Previously the Director of Nursing was responsible. During interview on 5/29/2026 at 11:05 am, the Director of Nursing stated, I saw the issues with the PASARRs.

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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 **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to ensure assessments were accurately and completely documented for 3 residents (Resident #7, #129, and #14) of 10 sampled for preadmission screening and resident review. Findings include: Review of Resident #7's admission record documented diagnoses that include non-ST elevation myocardial infarction, chronic obstructive pulmonary disease with acute exacerbation, pneumonia, protein calorie malnutrition, chronic respiratory failure with hypoxia, chronic pain syndrome, and idiopathic peripheral autonomic neuropathy. Review of Resident #7's physician order dated 4/24/2026 read, psych consult. Review of Resident #7's physician order dated 3/19/2026 read, Amitriptyline HCl Oral Tablet 25 MG (Amitriptyline HCl) Give 25 mg by mouth at bedtime for Mdd (major depressive disorder). Review of Resident #7's psychiatric note dated 5/8/2026 read, Note Type: Balanced Wellbeing Psychiatry Subsequent Note. Patient admit date : [DATE] Chief Complaint: Depression, anxiety and nicotine dependence disorder. Review of Resident #7's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASARR) dated 3/13/2026 showed there was no anxiety disorder or depressive disorder documented under Section 1A. Review of Resident #129's admission record documented diagnoses including Chronic obstructive pulmonary disease with acute exacerbation, bacteremia, pneumonia, Parkinson's disease with dyskinesia, chronic combined systolic congestive and diastolic congestive heart failure, atherosclerotic heart disease of native coronary artery, gastroesophageal reflux disease, depression, essential primary hypertension, hyperlipidemia, hypothyroidism, diaphragmatic hernia without obstruction or gangrene and anxiety disorder. Review of Resident #129's physician order dated 5/25/2026 read, RisperiDONE Oral Tablet 2 MG (Risperidone) Give 1 tablet by mouth two times a day for anxiety. Review of Resident #129's physician order dated 5/25/2026 read, HydrOXYzine HCl Oral Tablet 25 MG (Hydroxyzine HCl) Give 1 tablet by mouth two times a day for anxiety. Review of Resident #129's physician order dated 5/25/2026 read, Psych consult Review of Resident #129's physician order dated 5/25/2026 read, Xanax Oral Tablet 0.25 MG (Alprazolam) Give 1 tablet by mouth two times a day for anxiety. Review of Resident #129's PASSAR dated 5/20/2026 does not include anxiety disorder as a diagnosis. During an interview on 5/28/2026 at 6:35 AM the Director of Nursing (DON) stated, Their PASSAR's (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	do not include the appropriate diagnosis and they should. During an interview on 5/28/2026 at11:42 AM, the Nursing Home Administrator (NHA) stated, I have no additional PASSAR for them. They are not correct. Usually the DON completes them, but I see that they have either been incorrect on admission or if they were admitted and got a new diagnosis from psych the IDT (interdisciplinary) team is not updating them and they should. Review of Resident #14's State of Florida Agency for Health Care Administration Preadmission Screening and Resident Review (PASARR) dated 4/27/2026 documented bipolar disorder as a mental illness or suspected mental illness. Review of Resident #14's medical admission record resident was admitted on [DATE] with diagnosis including but not limited to major depressive disorder recurrent [onset date 4/28/2026], other specified anxiety disorders [onset date 4/28/2026], and other bipolar disorder [onset date 4/28/2026]. Review of Resident #14's physician order dated 4/28/2026 read, Clonazepam oral tablet 1 MG [milligram] (Clonazepam) give 1 tablet by mouth one time a day for severe anxiety. Review of Resident #14's physician order dated 4/28/2026 read, Bupropion HCl [hydrochloride] ER [extended release] (XL) Oral Tablet Extended Release 24 Hour 150 MG [milligram] (Bupropion HCl) Give 1 tablet by mouth one time a day for MMD [Major Depressive Disorder] Do not crush, chew, or split. During an interview on 5/29/2026 at 8:30 AM, the Director of Nursing stated, [Resident #14's Name]'s PASSAR should have been reviewed and corrected to reflect all the diagnoses. Review of the policy and procedure titled Pre-admission Screening and Resident Review (PASRR) last approval date of 1/22/2026 read, The Admissions Coordinator/Designee is responsible for ensuring that the Level I PASRR Screen and Level II PASRR Evaluation and Determination, if applicable, are completed prior to admission. Procedure: 2. A level I PASRR must be fully and accurately complete and distributed in accordance with Rule 59G-1.040,F.A.,C. Upon or prior to admission, if the facility finds the Level I to be incomplete or inaccurate, a corrected Level I PASRR must be completed by hospital staff or appropriate Nursing Facility staff (physician, RN, MSW, or LCSW) or KEPRO staff.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive care plan for 1 (Resident #14) of 7 residents reviewed for medication management and for 1 (Resident #58) of 5 residents reviewed for respiratory services. Findings include: Review of Resident #14's care plan did not document a focus for anxiety or antianxiety medication. Review of Resident #14's medical record resident was admitted on [DATE] with diagnoses including but not limited to major depressive disorder [onset date 4/28/2026], anxiety disorders [onset date 4/28/2026], and bipolar disorder [onset date 4/28/2026]. Review of Resident #14's physician order dated 4/28/2026 read, Clonazepam Oral Tablet 1 MG [milligram] give 1 tablet by mouth one time a day for severe anxiety. Review of Resident #14's physician order dated 5/1/2026 read, Clonazepam Oral Tablet 0.5 MG give 0.5 mg by mouth in the morning for anxiety. Review of Resident #14's physician order dated 5/11/2026 read, Clonazepam Oral Tablet 0.5 MG give 1 tablet mouth in the morning for anxiety Hold for sedation. Review of Resident #14's physician order dated 5/19/2026 read, Hydroxyzine HCl [hydrochloride] Oral Tablet 25 MG (Hydroxyzine HCl) Give 1 tablet by mouth every 8 hours as needed for anxiety/agitation for 14 Days. During an interview on 5/28/2026 at 8:47 AM with Staff H, Minimum Data Set Lead stated, We will have a morning meeting where we go over new orders, and the care plan will be revised. In looking at her [Resident #14's Name] care plan, you are correct; anxiety is not a focus, and it should be since she is on medication for anxiety. Review of Resident #58's comprehensive care plan did not document a focus for oxygen use or respiratory care. Review of Resident #58 admission record document diagnoses that include unspecified diastolic congestive heart failure, morbid severe obesity due to excess calories, protein calorie malnutrition, acute and chronic respiratory failure with hypoxia, asthma, cardiomegaly, atherosclerotic heart disease of native coronary artery without angina pectoris, age-related osteoporosis, anxiety disorder, insomnia, essential primary hypertension and major depressive disorder recurrent moderate. Review of Resident #58 physician order dated 3/16/2026 read, Oxygen @ 2 L(liters)/Min(minute) continuous inhalation via nasal cannula. During an interview on 5/28/2026 at 6:44 AM the Director of Nursing stated, We go over residents and orders in our morning meetings. We should have implemented a care plan for her. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/28/2026 at 9:47 AM with Staff H, Minimum Data Set Lead stated, We will have a morning meeting where we go over new orders, and the care plan will be revised. I do not see any care plan related to oxygen use. Review of the facility policy and procedure titled Summit Care Resident Assessment Instrument Comprehensive Care Plan Policy with a last review date of 1/22/2026 read, Policy Statement. Purpose: To ensure that each resident in the facility receives individualized and appropriate care based on a thorough assessment using the Resident Assessment Instrument (RAI), and to comply with state and federal regulations. Policy Statement: The facility will utilize the RAI process to assess residents' needs, develop individualized care plans, and ensure the delivery of quality care. This process will involve interdisciplinary team members and be revised to reflect resident condition changes.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review the facility failed to provide dressing changes and have orders for flushing of intravenous catheters for 1 (Resident#32) of 3 residents reviewed for intravenous infusions, the facility failed to perform weekly skin observations for 1 (Resident #50) of 6 residents reviewed for skin conditions, the facility failed to provide daily weights for 1 Resident (Resident #45) out of 4 Residents reviewed for weights and failed to administer medication appropriately for 1 (Resident #103) of 7 residents reviewed for medication management. Findings include: During an observation on 5/26/2026 at 10:14 AM, Resident #32 was lying in bed PICC [peripherally inserted central catheter] line dressing dated 5/6/2026. The dressing was intact. The site was not red or swollen. During an interview on 5/26/2026 at 10:14 AM, Resident #32 stated she was getting antibiotics for wound infection of a wound in her back which she was admitted with. She was unable to recall when the last time was that they changed the dressing. During an interview on 5/26/2026 at 11:54 AM, Staff C, Licensed Practical Nurse (LPN) stated, IV (intravenous) dressing changes are done every 7 days. During an interview on 5/26/2026 at 12:22 PM, Staff C, LPN confirmed the dressing was dated 5/6/2026 and needed to be changed. Review of Resident #32's physician order dated 5/6/2026 read, IV: PICC Line: Change transparent dressing every 7 day (s) for preventative care and as needed for soiling or dislodgment. Review of Resident #32's physician orders did not document orders for flushing the PICC line for patency. During an interview on 5/28/2026 at 8:13 AM, the Director of Nursing stated, IV dressings should be changed every 7 days. There should be flush orders in the system if resident has a PICC line. During an interview on 5/29/2026 at 11:14 AM, the Advanced Practice Registered Nurse #1 stated, The dressing should have been changed. The facility has not called me with any concerns regarding the site. Review of the facility policy and procedure titled Ongoing Assessment, Site Care, and Dressing Change with a last review date of 1/22/2026 read, Policy: Transparent semipermeable membrane (TSM) dressing are changed every 5-7 days. Review of the facility policy and procedure titled Flushing Midline and Central Line IV Catheters with a last review date 1/22/2026 read, Policy: Midline and Central Line IV catheters (CVADS) will be flushed to maintain patency; to prevent mixing of incompatible medications and solutions; and to ensure entire dose of solution or medication is administered into the venous system. Review of Resident #50's physician order dated 4/24/2026 read, Weekly Skin Observation every day (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	shift every Fri [Friday] for weekly skin check. Review of Resident #50's Skin Sweep Weekly dated 4/25/2026 read, 2. Is skin impaired? Yes. 3. Observations: 12. Chest. Description: Surgical incision. Review of Resident #50's evaluations did not document weekly skin observations. During an interview on 5/29/2026 at 10:11 AM, Staff G, Licensed Practical Nurse [LPN} stated, Nurses are the ones responsible for doing the weekly skin assessments. We will fill out a form under evaluations. During an interview on 5/29/2026 at 10:12 AM, the Director of Nursing stated, The nurses are the ones who do the skin assessments. If there is an order the nurses should follow the order and do the skin assessments weekly. Review of the facility policy and procedure titled Regular skin inspections and prompt interventions to address changes with a last review date of 1/22/2026 read, Policy: The facility will inspect the resident's skin on a regular and ongoing basis to provide documentation and prompt interventions of any changes noted. Procedure: Skin inspections will be conducted by the licensed nurse using the Skin Sweep form for documentation at the time of admission and weekly. Record review revealed that Resident #45 was admitted to the facility on [DATE] with diagnoses that included pleural effusion, chronic kidney disease, stage 3B and hypertensive heart disease with heart failure. During an observation on 05/28/2026 at 8:15 AM, Resident #45 was noted to have +1 pitting edema to bilateral ankles. Review of Resident #45's physician order dated 05/15/2026 read, Weight: Daily every shift. Start date 05/15/2026. Review of Resident #45's TAR [treatment administration record] for May 2026 showed weight was documented as 5 (hold/see progress notes) on 05/15/2026, NA on 05/16/2026, 9 (other, see progress notes) on 05/17/2026 on the 7a-7p shift, 9 on 05/18/2026 on the 7a-7p shift, NA on 05/19/2026 on the 7a-7p and 7p-7a shifts, NA on 05/20/2026 on 7a-7p shift, not documented on 05/20/2026 7p-7a shift, 9 on 05/22/2026 and 9 on 05/24/2026. Review of Resident #45's nursing note dated 05/17/2026 read, Weight: Daily every shift restorative to complete. Review of Resident #45 nursing note dated 05/18/2026 read, Weight: Daily every shift restorative to complete. Review of Resident #45's physician order dated 05/21/2026 read, Weight: Daily every day shift. Start date 05/21/2026. Review of Resident #45's nursing note dated 05/22/2026 read, Weight: Daily every day shift. restorative to complete. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/28/2026 at 8:33 AM, Staff J, LPN stated, The restorative aide is responsible for doing the daily weights. Restorative is here Monday through Friday, and if restorative is not here, the nurse is responsible. During an interview on 05/28/2026 at 8:26 AM, Staff F, LPN Unit Manager stated, Restorative is responsible for daily weights, and they should be documented in the chart every day. During an interview on 05/28/2026 at 8:30 AM, Staff L, Restorative CNA stated, I do the daily weights, write them down and put them in the computer, the ones I am aware of. The nurses tell me who is a daily weight, and I do the admission weights. I am not here on weekends. Sometimes I have an assignment, and the CNA responsible for that hall does the daily weight. I am not aware of whether [Resident #45's name] is a daily weight. During an interview on 05/28/2026 at 8:40 AM, Staff J, LPN stated, I am not sure whether [Resident #45's name] is a daily weight or not. I will have to check. I don't think she is. During an interview on 05/28/2026 at 8:45 AM, Resident #45 stated, They have not been checking my weight every day. During an interview on 05/28/2026 at 12:57 PM, the Director of Nursing stated, If daily weights are ordered, I expect the nurse and the CNA to check the weight every day and document it. During an interview on 05/29/2026 at 11:31 AM, the Administrator stated, We do not have a policy specifically about following physician orders. Review of Resident #103's admission record documented diagnoses that include generalized anxiety disorder, solitary pulmonary nodule, dementia severe with behavioral disturbance psychotic disturbance mood disturbance and anxiety, type 2 diabetes mellitus, systemic inflammation response syndrome or non-infectious origin, and hypertension. Review of Resident #103's physician order dated 1/27/2025 read, CloNIDine HCl Oral Tablet 0.1 MG (Clonidine HCl) Give 1 tablet by mouth every 8 hours as needed for HTN (hypertension) GIVE for SBP [systolic blood pressure] greater than 160 or DBP [diastolic blood pressure greater than 90. Review of Resident #103's physician order dated 1/16/2025 read, Blood Pressure every 8 hours see PRN (as needed) CLONIDINE for SBP greater than 160 or DBP greater than 90. Review of Resident #103's May 2026 medication administration record (MAR) documented on 5/1/2026 at 2200 a blood pressure (B/P) of 188/93, on 5/2/2026 at 0600 a B/P of 116/99, on 5/10/2026 at 2200 a B/P of 175/76, on 5/11/2026 at 0600 a B/P of 162/76, on 5/13/26 at 1400 a B/P of188/90,on 5/14/26 at 1400 a B/P of 175/49, on 5/17 at 1400 a B/P of 178/63, on 5/21/26 at 1400 a B/P of 161/80 , on 5/23/26 at 0600 a B/P of 178/88 and on 5/24/2026 at 1400 a B/P of 164/83 and at 2200 a B/P of 168/79 and on 5/25/26 at 0600 a B/P of 168/79, no clonidine was administer every 8 hours as ordered on these dates. Review of Resident #103 April MAR documented on 4/1/26 a B/P of 168/82 at 1400 on 4/6/26 at 1400 a B/P of 168/76 , on 4/7/26 at 0600 a B/P of 168/78 and at 1400 a B/P of 165/82, on 4/10/26 at 1400 a B/P of 157/98, on 4/14/26 at 1400 a B/P of 179/97 on 4/24/26 at 1400 a B/P of 153/93, on 4/25/26 at 0600 a B/P of 180/91 on 4/28/26 at 2200 a B/P of 164/97 and on 4/29/26 at 0600 a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	B/P of 182/101 and at 1400 a blood pressure of 182/80, no clonidine was administered as ordered on these dates. Review of Resident #103 March MAR documented a B/P of 173/85 at 2200, on 3/3/2026 a B/P of 163/88 at 1400, on 3/6/26 at 1400 a B/P of 167/84, on 3/12/26 at 1400 a B/P of 164/91, on 3/13/26 at 1400 a B/P of 151/93, on 3/17/26 at 1400 a B/P of 171/93, on 3/20/26 at 2200 a B/P of 147/91, no clonidine was administered as ordered on these dates. During an interview on 5/27/2026 at 1:55 PM Staff M, Licensed Practical Nurse (LPN) stated, He does have that order for clonidine. No, I don't see that I did administer it. I should have. During an interview on 5/28/2026 at 6:45 AM the Director of Nursing (DON) stated, All orders should be followed. Review of the policy and procedure titled, Medication Administration General Guidelines approval date of 1/22/2026 read, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by people legally authorized to do so. Procedure: B. Administration: 2). Medications are administered in accordance with written orders of the prescriber.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure the resident's medication regimen remained free from unnecessary medications by administering midodrine outside of physician ordered parameters for 1 (Resident #108) of 7 residents reviewed for unnecessary medications. Findings include: Review of Resident #108's physician order dated 03/13/2026 read, Midodrine HCl [hydrochloride] Oral Tablet 5 MG [milligrams] (Midodrine HCl) [medication used to increase blood pressure] Give 1 tablet by mouth three times a day for hypotension [low blood pressure] Hold for SBP [systolic blood pressure] greater than 120. Review of Resident #108's physician order dated 05/20/2026 read, Midodrine HCl Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet by mouth three times a day for Hypotension Hold for SBP greater than 120. Review of Resident #108's MAR [medication administration record] for May 2026 read, Midodrine HCl Oral Tablet 5 MG (Midodrine HCl) Give 1 tablet by mouth three times a day for hypotension Hold for SBP greater than 120 D/C [discontinue] Date 05/20/2026 2135 [9:35 PM].Review of Resident #108's MAR for May 2026 revealed that on 05/01/2026, Resident #108's Blood Pressure (B/P) was documented as 132/84 and midodrine was administered at 1400 [2:00 PM], on 05/03/2026, B/P was 130/81 and midodrine was administered at 1400, on 05/06/2026, B/P was documented as 130/72 and midodrine was administered at 0600 [6:00 AM], on 05/10/2026, B/P was documented as 140/72 and midodrine was administered at 2200 [10:00 PM], on 05/11/2026, B/P was documented as 132/70 and midodrine was administered at 0600, on 05/11/2026, B/P was documented as 121/61 and midodrine was administered at 1400, on 05/11/2026, B/P was documented as 126/74 and midodrine was administered at 2200, on 05/12/2026, B/P was documented as 122/70 and midodrine was administered at 0600, on 05/12/2026, B/P was documented as 129/68 and midodrine was administered at 1400, on 05/13/2026, B/P was documented as 122/75 and midodrine was administered at 2200, on 05/14/2026, B/P was documented as 131/73 and midodrine was administered at 1400, on 05/15/2026, B/P was documented as 136/69 and midodrine was administered at 1400, on 05/17/2026, B/P was documented as 134/72 and midodrine was administered at 2200, on 05/18/2026, B/P was documented as 134/70 and midodrine was at 2200, on 05/21/2026, B/P was documented as 130/70 and midodrine was administered at 1400, 05/21/2026, B/P was documented as 145/78 and midodrine was administered at 2200, on 05/23/2026, B/P 145/65 and midodrine was administered at 1400, on 05/23/2026, B/P was 126/62 and midodrine was administered at 2200, on 05/24/2026, B/P was documented as 121/66 and midodrine was administered at 0600, on 05/24/2026, B/P was documented as 121/66 and midodrine was administered at 1400, on 05/27/2026, B/P was documented as 124/62 and midodrine was administered at 0600,During an interview on 05/28/2026 at 3:10 PM, Staff K, RN (Registered Nurse) stated, A check mark on the MAR means that a medication was administered. I don't know why there is a checkmark. I always check the parameters for medications. If I hold a medication, I document a number in the MAR and a nursing note. I am not sure what happened with [Resident #108's Name]'s midodrine. During an interview on 05/28/2026 at 12:55 PM, the Director of Nursing stated, The checkmark on the MAR means that a medication was given. When a nurse is holding midodrine per parameters they should document a number in the MAR, not a checkmark. The nurses should not have administered the medication if the blood pressure is outside of parameters. Review of policy and procedure titled, Nursing Policies-Medication Administration Guidelines reviewed on 01/22/2026 read, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. B. Administration 1) Medications are administered in accordance with written orders of the prescriber.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review the facility to ensure complete and accurate records were provided for 2 (Residents #8 and #32) of 6 residents, reviewed for skin conditions. Findings include: During an observation on 5/26/2026 at 10:14 AM Resident #32 was lying in bed PICC [peripherally inserted central catheter] line dressing dated 5/6/2026. There was no redness or swelling at the site. During an interview on 5/26/2026 at 10:14 AM Resident #32 stated she was getting antibiotics for wound infection of a wound in her back which she was admitted with. She was unable to recall when was the last time they change dressing. Resident #32 denied any discomfort with her arm at this time. During an interview on 5/6/2026 at 11:54 AM, Staff C, Licensed Practical Nurse (LPN) stated, IVs [intravenous] dressing are to be changed every 7 days. During an interview on 5/26/2026 at 12:22 PM, Staff C, LPN, confirmed Resident #32's dressing was dated 5/6/2026 and needed to be changed. Review of Resident #32 physician order dated 5/6/2026 read, IV: PICC Line: Change transparent dressing every 7 day (s) for preventative care and as needed for soiling or dislodgment. Review of Resident #32 Treatment Administration Record for the Month of April 2026 documented change transparent dressing on 5/13/2026 and on 5/20/2026 {initial by Staff D, LPN] During an interview on 5/28/2026 at 8:13 AM with the Director of Nursing stated, IV Dressing should be changed every 7 days. There should be flush orders in the system if resident has a PICC line. During an interview on 5/27/2026 at 3:00PM Staff D, LPN, stated, I cannot recall why I checked off as completing the dressing changes. Normally they need to be done every week. During an interview on 5/28/2026 at 8:13 AM with the Director of Nursing stated, Staff should follow physician orders and make sure documentation is complete and accurate. Review of Resident #8's physician order dated 05/08/2026 read, Wound: Sacral wound cleanser, pat dry and apply zinc to peri wound, apply collagen/silver alginate then silicone bordered gauze every shift for pressure ulcer AND as needed for wound maintenance. Review of Resident #8's TAR [treatment administration record] for May 2026 showed wound care was not documented on 05/16/2026, 05/22/2026 and 05/26/2026 on 7AM-7 PM shift. During an interview on 05/29/2026 at 8:21 AM, Staff I, LPN stated, I have always done [Resident #8's name]'s wound care when it was on my shift. I must have forgotten to check it off after I did it. That is my mistake. During an interview on 05/29/2026 at 8:26 AM, the Administrator stated, When a nurse is doing wound care, I expect them to document that it was completed. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy and procedure titled Documentation with a last review date 1/22/2026 read, Purpose: The facility clinical staff will document the provision of care and services according to nursing standards and regulatory requirements. When completed, documentation will accurately reflect the clinical care and other services provided to the resident and ensure that the appropriate information is available to all the interdisciplinary team members. Review of the facility policy and procedure titled Ongoing Assessment, Site Care, and Dressing Change with a last review date 1/22/2026 read, Policy: Transparent semipermeable membrane (TSM) dressing are changed every 5-7 days.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to perform hand hygiene to prevent the possible spread of infection during medication administration in 6 of 9 observations of medication administration.Findings include: During an observation of medication administration on 5/27/2026 at 8:04 AM for Resident #111, Staff D. Licensed Practical Nurse (LPN) did not perform hand hygiene, retrieved keys from their uniform pocket, unlocked the medication cart, activated and typed on the computer. Staff D, LPN donned gloves without performing hand hygiene, locked the medication cart, placed keys in pocket, and closed the computer. Staff D. LPN picked up medication cards and a glass of water and the medication cup, placed their thumb in the inside of the medication cup touching the medications and entered the residents room, administered the medications without changing gloves or performing hand hygiene. During an observation of medication administration on 5/27/2026 at 8 :12 AM Staff D, LPN returned to the medication cart and began to prepare medications for Resident #133, Staff D. LPN retrieved keys from their uniform pocket, unlocked the medication cart, opened up, activated and typed on the computer without performing hand hygiene, Staff D,LPN prepared medications, locked the medication cart and entered the resident room without performing hand hygiene, administered the medications after touching the bed controls and the resident while assisting the resident reposition in the bed without performing hand hygiene. During an observation of medication administration on 5/27/2026 at 8:18 AM Staff D, LPN returned to the medication cart and began to prepare medications for Resident #32. Staff D , LPN staff retrieved keys from their uniform pocket, unlocked the medication cart, opened, activated and typed on computer without performing hand hygiene. Staff D. LPN entered the residents room without performing hand hygiene and administered the medications.During an interview on 5/27/2026 at 8:25 AM Staff D, LPN stated, I should have used more hand sanitizer before I poured the meds(medications) and when I entered the room or touched the resident. During an observation of medication administration on 5/27/2026 at 8:29 AM Staff M, LPN began to prepare medications for Resident #40 without performing hand hygiene. Staff retrieved keys from their uniform pocket, unlocked the medication cart opened the computer activated the computer and typed on the keyboard. Staff M, LPN poured 3 medications into the medication bottle cap, Staff M,LPN placed their thumb over 2 medications and let the extra 1 medication fall into the medication cup and then placed the 2 tablets back into the bottle of medications. Staff M, LPN placed on gloves without performing hand hygiene, touched the stethoscope hanging round their neck and their hair with their gloved hand, entered the residents room, administered medications and removed gloves without performing hand hygiene. Staff M. LPN then returned to medication cart without performing hand hygiene, retrieved the keys from their uniform pocket unlocked the medication cart, opened, activated and typed on the computer keyboard. Staff M, LPN returned to the residents room, without performing hand hygiene inquired about pain level and asked if she wanted medication for pain without performing hand hygiene, Staff M, LPN was observed touching the bed side table. Staff M, LPN exited the room without performing hand hygiene, retrieved the keys from their uniform pocket, unlocked the medication cart, activated and typed on the computer keyboard without performing hand hygiene, poured medication, locked the medication cart closed computer and entered resident room without performing hand hygiene and administered the medication. During an observation of medication administration on 5/27/2026 at 8:42 AM Staff M, LPN returned to the medication and began preparing medications for Resident #12. Staff M, LPN retrieved the keys from their uniform pocket, unlocked the medication cart, activated and typed on the computer keyboard, staff poured medications into the medication cap, placed their ungloved hand over 2 medications covering them with their by thumb and placed 1 medication into the medication cup. Staff M, LPN then placed the 2 remaining medications back in the medication bottle and placed the cap back on, Staff M, LPN entered the resident room without performing hand hygiene and administered the medication. During an interview on 5/27/2026 at 9:02 AM Staff M, LPN stated, I (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have used hand sanitizer before and after I put on gloves. I should not have put my hands on the medications and then let them go back in the medication bottle. During an interview on 5/28/2026 at 06:42 AM the Director of Nursing (DON) stated, All nurses should follow all infection control policies during medication pass.Review of the policy and procedure titled, Medication Administration General Guidelines last approval; date of 1/22/2026 read, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by people legally authorized to do so. Procedure: A). Preparation: 2. Handwashing and hand sanitization: The person administering medications adheres to good hand hygiene, which includes sanitizing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming into direct contact with a resident. B. Administration: 2). Medications are administered in accordance with written orders of the prescriber. 9). Hands are sanitized before putting on examination gloves and upon removal for administration of topical, ophthalmic, injectable, enteral, rectal, and vaginal medications. Review of the policy and procedure titled, Handwashing/Hand Hygiene last approval date of 1/22/2026 read, Policy Statement: This facility considers hand hygiene the primary means to prevent the spread of infection. Policy Interpretation and Implementation: 2. All personnel shall follow the handwashing/ hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 5. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non anti-microbial) and water for the following situations: b. Before and after direct contact with residents; c. Before preparing or handling medications; i. After contact with residents intact skin; m. After removing gloves. 6. Hand hygiene is the final step after removing and disposing of personal protective equipment. 7. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare- associated infections.