

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105688	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/24/2026
NAME OF PROVIDER OR SUPPLIER Aventura at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 4th St N Saint Petersburg, FL 33716	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide a safe, clean, comfortable, and homelike environment on one (200 hall - secured unit) of four units. Findings included: On 06/22/2026 at 9:54 a.m. and 4:26 p.m., and on 06/23/2026 at 9:45 a.m., observations were made of a sitting chair located in the small common area at the end of the high end 200 hall - secured unit. The chairs had visible stains and uneven discoloration. Both the chairs and the floor were unclean, with brown streaks and an odor of feces present. In the corner of the common area, a clear trash bag containing soiled incontinent products, an open milk carton, and other trash was observed. In the middle of the high end 200 hall - secured unit, a recessed area contained two sitting chairs with brown stains and varying discoloration to the fabric. The floor beneath this area had a dark brown smear and appeared soiled. On 6/22/2026 at 10:03 a.m., an interview was conducted with Resident #19 who stated seeing bugs all the time in his room. On 06/22/2026 at 4:30 p.m. and again on 06/23/2026 at 10:15 a.m., an observation of room [ROOM NUMBER] was conducted. An open closet was observed. On the floor of the closet were dried clumps of feces and smeared fecal matter surrounding them. A noticeable feces odor was present. Additionally, on the floor next to the window-side bed, a semi-dried liquid substance was observed that appeared sticky. On 06/22/2026 at 4:30 p.m., an observation of room [ROOM NUMBER] was conducted. A soiled brief was observed on the floor at the bedside. The door-side bed did not have linens present and had dried brown matter smeared across the top and sides of the mattress, accompanied by a noticeable bowel movement odor. A padded cloth sitting chair positioned in front of the closet was observed with smears and discoloration. An observation of the bathroom in room [ROOM NUMBER] revealed a toilet containing an adult washcloth package, a used washcloth, and an unflushed bowel movement. The shower floor contained fragments of a large bug carcass. On 06/22/2026 at 10:15 a.m., an observation was made of rooms [ROOM NUMBERS]. In room [ROOM NUMBER], a dead roach was observed by the window-side bed. The floors were dirty and had sticky appearing stains on the right side of the bed. The nightstand at the window-side bed had an old meal ticket with another resident's name on it. In front of room [ROOM NUMBER], a dark brown stain was observed on the door. On 06/22/2026 at 10:19 a.m., an observation was made of room [ROOM NUMBER]. The nightstand contained resident belongings in the top drawers and the bottom drawers had insect droppings. The light switch near the room entrance had a brown substance smeared on it. The trash can by the sliding glass door contained trash. On 6/23/2026 at 9:45 a.m., a follow up observation was made of the trash can in room [ROOM NUMBER] still containing trash. On 06/22/2026 at 10:40 a.m. and again on 06/23/2026 at 9:45 a.m., an observation was made of room [ROOM NUMBER]. Stains were observed on the floor, and a collection of debris was present under the door-side bed. On 6/24/2026 at 11:44 a.m. an observation was made of the bed in room [ROOM NUMBER]. The stains on the floor were gone, however the debris was still present underneath the bed. On 06/23/2026 at 9:45 a.m., a follow up tour of the 200 hall - secured unit was conducted and the following observations. room [ROOM NUMBER] revealed two pills on the floor behind the residents' beds. room [ROOM NUMBER] revealed roach (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and record review, the facility failed to ensure the grievance process was followed for one (#5) out of 11 residents reviewed. Findings included: On 6/22/26 at 11:06 a.m., a telephone interview was conducted with Resident #5. Resident #5 said he communicated grievances several times to the facility staff. He said he felt the facility was short staffed. Resident #5 provided an example that he was turned and laying on his side for four hours. He said when the certified nursing assistant (CNA) came to assist him, he was told she was busy with other residents. He said he talked to the nursing supervisor about his concerns but was not sure if the concerns were written down. Resident #5 stated, There should be documentation and some kind of follow up. A review of Resident #5's admission record revealed an admission date of 3/27/26 and discharge date of 6/6/26. Further review of the admission record revealed diagnoses to include pressure ulcer of sacral region, stage 3, quadriplegia, disorder of kidney and ureter, and neuromuscular dysfunction of bladder. A review of Resident #5's physician orders revealed the following:- Supra-pubic catheter due to neurogenic bladder, with an order date of 3/29/26.- Suprapubic Catheter Care every shift for Urinary Elimination, with an order date of 3/29/26.- Please flush suprapubic catheter with 30 ml [milliliters] NS [normal saline] daily. every night shift for maintenance, with an order date on 3/31/26- Supra-Pubic catheter site: Cleanse with normal saline, pat dry and apply split Gauze every night shift. every night shift, with an order date on 3/31/26.- Change 18 Fr [French] Suprapubic catheter with 10 cc [milliliters] balloon every 4 weeks AND as needed for leakage/blockage or dislodgement every day shift every 1 month(s) starting on the 21st for 28 day(s) ., with an order date on 4/21/26 and discontinued on 5/14/26. Further review of the order revealed the following note, NP [nurse practitioner] gave orders for suprapubic to be changed tomorrow per resident visit today.- Change suprapubic foley catheter 18 Fr 10 cc, every 28 days routinely every night shift every 28 day(s) AND as needed for blockage or dislodging, with an order date on 5/16/26.- cleanse sacral wound with. lightly pack depth and undermining with moistened collagen, cover with silicone super absorbent dressing everyday shift . d/c once wound VAC applied AND as [sic] needed ., with an order date on 4/15/26 and discontinued on 4/25/26.- Wound Vac - black foam/ white foam to undermining (be sure black foam touches white foam) Pressure settings @ [at] 125 mm Hg [millimeters of mercury], change 3 times per week. every evening shift every Mon [Monday], Wed [Wednesday], Fri [Friday] for wound care AND as needed for soiled/ dislodged, with an order date on 4/27/26. - Appointment every Tuesday [hospital name] wound clinic @1245, [clinic phone number] every day shift every Tue [Tuesday] for wound care., with an order date on 4/1/26 and discontinued on 4/14/26. A review of Resident #5's progress notes revealed the following:-3/31/26, . Subjective: Patient seen in his room. Aidejust [sic] finished feeding him lunch. He says that he still has not received the wound vac [vacuum assisted closure] yet. Nurse is not sure about this. I sent message to wound care nurse to check on this. Patient says they haven't flushed his suprapubic catheter as well, so I requested nurse to do this and placed order in [electronic health record vendor]. has not come to check his bed yet so I asked aide to please check into this as well.-4/16/26, .Subjective: to have wound vac placed today. Unhappy w [with] care at Aventura and want to transfer to [facility name]. Its also close to his house. Staff aware.-4/24/26, Patient seen in his room. He is upset and saws it has been 4 1/2 hours since he was turned. He says he is having pain over the sacrum from lying on the area for that long. I notified DON [Director of Nursing] of patient concerns and she will investigate.-4/28/26, . Subjective: Patient seen in his room. He is upset for several reasons today. He missed his appointment with the wound care clinic yesterday because they were late getting him downstairs and the ride left. They are still not flushing the catheter in the mornings as ordered. Yesterday it was clogged and had to be changed. He doesn't feel he is getting enough to drink. Labs showed hyponatremia so will give him IVF [intravenous fluids]. He says they also haven't changed anything on the wound vac since it was (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the SSD. The DON said the SSD would follow up with the resident's resolved grievance, then file it for documentation. She said even if a concern was resolved right away, it should be documented as a grievance. The DON said if a provider documented their notes about a resident's concerns, she would expect them to communicate with her, the UM, the ADON, or the grievance official. She said if a provider's progress note was uploaded immediately, they would see the notes in the clinical meeting the next day. Regarding Resident #5, she said a care plan meeting was held with him and his family members, in May 2026, to discuss his multiple concerns. She said she gave him her personal number as he would have more complaints over the weekend when the UM or herself was not there. She said he would call her anytime he had concerns. The DON said there was an issue with repositioning him, but they took care of it on the spot and did not have a grievance for it. A review of the provider's progress note on 3/31/26 was conducted with the DON; the grievance form on 4/1/26 did not show the same concerns as documented in the progress note. She said the concerns expressed in the provider's progress note on 4/16/26 were not new complaints and it was about care in general; she said the grievance on 3/31/26 addressed those concerns. She said the resident did not want to be at the facility and a transfer was being worked on, therefore that did not require a grievance to be completed. The DON said the provider's progress note on 4/28/26, that had multiple concerns documented, was addressed in a nursing huddle meeting on 4/28/26. A review of the nursing huddle meeting minutes, dated 4/28/26, showed catheter flushing and repositioning concerns, but did not include concerns about Resident #5's missed appointment or that he may not be receiving enough fluids. On 6/24/26 at 3:22 p.m., an interview was conducted with Staff D, Licensed Practical Nurse (LPN). He said Resident #5 always expressed his concerns. Staff D, LPN said the resident was on top of his care and wanted to be turned and repositioned every two hours. He said he communicated Resident #5's concerns to the nursing supervisor and the UM. Staff D, LPN said there were about three to four occurrences where the resident expressed the same concerns. A review of the facility's policy titled Resident and Family Concerns and Grievances Policy and Procedure, revealed the following, Purpose To provide for the prompt resolution of medical and non-medical grievances while maintaining confidentiality, in accordance with applicable federal and state statutes and regulations. Further review of the policy, under procedure, revealed the following, .II. Documentation of Grievances A. The Facility's Compliance and Ethics Officer or a designated Associate will document and keep a log of all grievances expressed either orally and/or in writing on the day that it is received or as soon as possible after the event or events that precipitated the grievance. IV. Responses to and Resolution of Grievances . D. The Facility will provide the resident with a written Grievance Decision, which shall include: a. the date the grievance was received; b. a summary statement of the resident's grievance; c. the steps taken to investigate the grievance; d. a summary of the pertinent findings or conclusions regarding the resident's concern(s); e. a statement as to whether the grievance was confirmed or not confirmed; f. any corrective action taken or to be taken by the Facility as a result of the grievance; and g. the date the written decision was issued.		

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NAME OF PROVIDER OR SUPPLIER Aventura at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 4th St N Saint Petersburg, FL 33716	
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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect one (Resident #17) of three sampled residents from neglect and failed to ensure a safe, clean, and supervised environment. The facility failed to provide adequate supervision to prevent Resident #16, a male resident with severe cognitive impairment, from entering Resident #17's room; failed to maintain Resident #17's room in a sanitary condition as evidenced by a mattress with dried fecal material; failed to ensure Resident #17 received necessary bathing and hygiene services as evidenced by caked, dried fecal material on both feet; and failed to ensure Resident #17 received meaningful activities or room based engagement. These failures resulted in Resident #17 being exposed to an unsafe, unsanitary environment and placed her at risk for psychosocial harm and neglect. Findings included: On 06/22/2026 at 9:49 a.m., during the initial tour of the secure memory unit, Resident #16, a male resident with severe dementia, was observed independently ambulating down the high 200 hallway. He entered and exited multiple resident rooms without staff monitoring or redirection. No staff were present in the hallway during this observation. On 06/22/2026 at 4:30 p.m., Resident #16 was observed exiting Resident #17's room and closing the door behind him. He then proceeded down the hallway and entered another resident's room. No staff were present monitoring him. Surveyors knocked on Resident #17's closed door, and a female voice responded. Resident #17 was observed lying in her window side bed with the head of the bed elevated approximately 30 degrees. A hospital gown was draped loosely over her torso, and her breast was visible at the side of the gown. She was alert with eyes open but unable to answer questions in complete sentences. A soiled brief was on the floor at the bedside. Resident #17's right foot was crossed over her left foot. Both feet had visibly caked, dried, cracked brown material on the soles and toes, with an odor of bowel movement present. Resident #17 was unable to answer when asked what was on her feet and did not respond when asked whether she felt safe. The room had no television. A radio was present but not turned on. The bed on the door side of the room had no linens. The mattress surface had dried brown smears consistent with fecal material and emitted an odor of bowel movement. On 6/22/2026 at approximately 5:00 p.m., an interview was conducted with Staff J, Registered Nurse (RN). She stated she was working the 3:00 p.m. to 11:00 p.m. shift. She confirmed she had Resident #17 on her assignment. She stated she had come onto her shift at 2:30 p.m. When asked if she had checked her residents when she came on her shift, she said, for the most part. Resident #17, no concerns. On 06/23/2026 at 10:09 a.m., Resident #17 was observed in a low bed with eyes open. The caked fecal material on both feet had been removed; however, dark discoloration remained on the soles and toes. The previously soiled mattress on the door side of the room had been cleaned. On 06/23/2026 at 10:30 a.m., Staff F, RN, stated Resident #16 was new, and she was not aware of him wandering into resident rooms. She also stated that nurses were not expected to visually check all assigned residents at the start of the shift, while confirming Certified Nursing Assistants (CNAs) were expected to conduct walking rounds within 15-20 minutes of shift start. On 06/23/2026 at 10:55 a.m., interview with Staff F, RN was continued. Staff F stated Resident #17 did not speak much and required total care in bed. She was unaware of any fecal smearing behaviors and stated such behaviors should be documented if present. On 06/23/2026 at 11:13 a.m., Staff F again reviewed Resident #17 and stated the discoloration now present on the soles of her feet looked like dirt. She confirmed that no one had informed her of the fecal soiled mattress and stated she would have wanted to know due to infection control concerns. She also stated she had been the only nurse on the 40-bed secure unit on 06/22/2026. On 06/24/2026 at 12:20 p.m., Staff L, Activities Aide, stated she did not go back to the secure unit, assists only with the other three units, A, C, D. She stated Staff K; Activities Aide is the activity aide for the secure memory unit. Staff L stated room bound residents, are asked if they would like an activity; sometimes they want nothing; if they like (continued on next page)		

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	music, we provide them with a player. She stated the facility does not provide a television. She stated most of the residents on the A, C, D wings had televisions, even if they did not want them. On 06/24/2026 at 1:25 p.m., Staff K, Activity Aide stated she only conducted group activities in common areas and did not perform room visits in the secure unit. Staff K reported Resident #17 sometimes attended activities but often returned to her room. On 06/24/2026 at 1:40 p.m., an interview was conducted with the Social Service Director (SSD). The SSD stated being unaware Resident #17 did not have a television and that room-based activities were completed by activities staff. On 06/24/2026 at 1:50 p.m., an interview was conducted with the Business Office Manager. The BOM stated Resident #17 had a guardian and stated no one had asked him to contact the guardian about obtaining a television. He stated he could assist with such requests. On 06/24/2026 at 2:05 p.m., an interview was conducted with the Activity Director. The Activity Director stated activities staff were expected to perform daily room visits for room-bound residents. For the secure unit, she was unsure whether these visits occurred. At 2:31 p.m., she reported she had no documentation of room visits for Resident #17. Resident #17 was admitted in 12/2025 and had diagnoses including dementia, COPD, coronary artery disease, and depression. Her care plans indicated she required assistance with all activities of daily living, including bathing, grooming, and toileting, and that she should appear neat, tidy, and free from body odor. Her activity care plan indicated a need for stimulation, encouragement, and daily interaction. Resident #17's Brief Interview for Mental Status (BIMS), dated 06/15/2026, documented a score of 99, which indicated the resident refused to participate or 4 (four) or more items were coded 0 because the individual chose not to answer or gave a nonsensical response. Resident #16 was admitted [DATE] with diagnoses including Alzheimer's disease and severe dementia with agitation. His care plan documented the need for redirection for wandering behaviors but had no interventions specific to entering other residents' rooms. Resident #16's BIMS, dated 06/18/2026, documented at score of 6, which indicated severe cognitive impairment On 06/23/2026 at 1:08 p.m., an interview was conducted with the Minimum Data Set (MDS) Coordinator/RN. The MDS Coordinator confirmed Resident #16's care plan did not address Resident #16's room to room wandering and stated such behaviors should be documented and added through the 24 hour report system. When asked why it would be important for a male resident to be care planned for room to room wandering, she stated, Wandering in and out of a female room can cause anguish; especially if the male shows off parts of his body. When asked how staff provide a safe environment for a female resident that likes to stay undressed, she stated, Make sure the male wanderer has it on his Kardex to keep an eye on him. Keep him in common areas to keep him busy. On 06/23/2026 at 1:19 p.m., an interview was conducted with the MDS Coordinator/RN. The MDS Coordinator/RN stated Resident #17's preference for being unclothed was not documented and that she would want this information to ensure safety and honor preferences. The MDS Coordinator/RN stated Resident #17 does not have a care plan for behaviors related to fecal smearing. On 06/24/2026 at 10:10 a.m., the DON observed Resident #17 with clean feet and a clean room. The DON stated Resident #17 preferred staying in her room. A review of the facility Abuse, Neglect, Exploitation, Misappropriation, Mistreatment, Injury of Unknown Source (ANEMMI) and Grievances policy and procedure documented: Each resident has the right to be free from abuse, including verbal, sexual, physical and mental abuse, neglect, corporal punishment, involuntary seclusion, misappropriation of property, exploitation, and any physical or chemical restraint not required to treat the resident's medical symptom. Abuse includes deprivation of goods and services necessary to attain or maintain physical, mental, and psychosocial well-being. The Elder Justice Act requires that a nursing home must immediately report crimes that occur inside of facility. Reporting: Report any reasonable suspicion of a crime to State Agency AND Local Law Enforcement and Reasonable suspicion a crime has occurred. If serious bodily injury within 2 hours. Within 24 hours: Financial abuse/ exploitation Confinement Passive neglect. Definitions: Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, (continued on next page)		

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Signs of psychological abuse: Caregiver isolates the elderly person. Caregiver is aggressive, controlling, or uncaring toward the elder person. Signs of Neglect: Elder person lacks basic hygiene. Elder person lacks medical aids (e.g. glasses, walker, hearing aid, medications). Bed-bound person left without care. People with dementia left without care. Types of Abuse: Identify facility characteristics that could increase the risk for abuse include, but are not limited to: Unsympathetic or negative attitude towards residents. Chronic staffing problems. Lack of administrative oversight, staff burnout, and stressful working conditions. Poor or inadequate preparation or training for care giving responsibilities. Deficiency of the physical environment. Facility policies operate in the interests of the institution rather than the residents. In addition, the risk of abuse may increase when a resident exhibits any behavior(s) that may provoke a reaction by staff, residents, or others such as: Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting race or ethnic group, intimidating. Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/shoving, biting, spitting, threatening gestures, throwing objects. Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing. Taking, touching, or rummaging through other's property. Wandering into other's rooms/space. Resistive to care and services. Prevention of ANEMMI Observe resident behavior and their reaction to other residents and staff. Observe for signs of post-traumatic stress disorder, any signs of substance use disorder, and intervene as appropriate. Maintain an environment that is calm. Inform residents and family members to whom they may report concerns, incidents, and grievances without the fear of reprisal. Identify areas of the environment that may make abuse or neglect more likely to occur, such as secluded areas. Always provide instructions to staff regarding the care plan of the residents, care needs, and follow-through with implementation. Adequate supervision of staff related to caregiving activities and interactions with residents. Recognize burnout, frustration and stress in employees that may lead to abuse. Take immediate action when complaints, concerns and grievances are brought up by residents/ resident families. Evaluate residents and ensure necessary medical care or treatment is provided and notify treating physicians as appropriate. A review of a second policy and procedure provided by the facility, Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and procedure, dated 2025 compliance consulting group, documented the purpose: To ensure that all of (the facility) residents are free from abuse, neglect misappropriation of their property, and exploitation. Procedure: Associates must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion against any resident. The Facility will ensure that residents are free from physical or chemical restraints. The facility shall review altercations from resident to resident as a potential situation of abuse. Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to: Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group intimidating; Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/ shoving, biting, spitting, threatening gestures, throwing objects; Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing; Taking, touching, or rummaging through other's property; and Wandering into other's room/space . When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: Taking steps to prevent further potential abuse. Reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations. Conducting a thorough investigation of the alleged violation. Taking appropriate corrective action. The facility will revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse. The facility will develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program to allow the QAA Committee to determine: If a thorough (continued on next page)		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	investigation is conducted;Whether the resident is protected;Whether an analysis was conducted as to why the situation occurred;Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); andWhether there is further need for systemic action such as: Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/ misappropriation/exploitation (ANME).Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about.Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions.Measures to verify the implementation of corrective actions and timeframes, andTracking patterns of similar occurrences.The facility will not employ or otherwise engage individuals who: .The Facility will report to the State nurse aide registry or licensing authorities .The Facility explicitly and expressly prohibits, and will take steps to prevent any Associates from engaging in any behavior or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident property.The Facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property.The Facility will ensure that all Associates are properly trained.The Facility will ensure that any suspicion of resident ANME is coordinated with the Facility's QAPI program.The Facility will ensure compliance with the Elder Justice Act .Response:In response to allegations of ANME, the Facility shall:Ensure that all alleged violations involving ANMEI of resident property are reported in the proper time frame pursuant to this policy.Have evidence that all alleged violations are thoroughly investigated.Prevent further potential ANME while the investigation is in progress.Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey agency within 5 working days of the incident, and if alleged violation is verified appropriate corrective action must be taken.		

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on record review and interviews, the facility failed to ensure an allegation of resident-to-resident physical abuse was reported within 24 hours for two (#8 and #9) out of three sampled residents. This failure resulted in delayed notification to facility leadership and created the potential for unidentified injury and inadequate protection of the residents involved. Findings include: A review of Resident #9's clinical record, including the face sheet, documented an admission in September 2024. Resident #9's diagnoses included, but were not limited to, unspecified dementia with mood disturbance; unspecified heart failure; chronic obstructive pulmonary disease; muscle weakness; unsteadiness on feet; need for assistance with personal care; and a cognitive communication deficit. A Brief Interview for Mental Status (BIMS), dated June 11, 2026, documented a score of 99, indicating the resident refused to participate or four or more items were coded 0 due to refusal or nonsensical responses. A review of Resident #8's face sheet documented an admission in December 2023. Diagnoses included dementia with anxiety; unspecified acute kidney failure; and the need for assistance with personal care. A BIMS dated May 26, 2026, documented a score of 8, indicating moderate cognitive impairment. A review of Resident #8's care plan, initiated November 25, 2024, documented the following: Focus: Resident #8 has the potential to demonstrate verbally abusive behaviors and may hit staff or other residents due to ineffective coping skills. Goal: Resident #8 will demonstrate effective coping skills through the review date. Interventions: Analyze triggers and de-escalation strategies; intervene early when agitation occurs; guide resident away from distress; speak calmly; if aggressive, staff should walk away and re-approach later. A review of Resident #8's progress note, dated June 22, 2026, at 4:17 a.m., documented: upon leaving nursing station observed resident sitting on the floor in hallway[sic]. approached resident to assess what happened. resident states i was walking in the hallway and she [Resident #9] and she [sic] called me a [expletive] which made me upset and i hit [sic] her , [sic] she grabbed my arm ,[sic] I [sic] lost my balance and fell onto the floor.' resident [sic] states she did not hit her head and c/o [complained of] some pain to L [left] knee. no injuries noted [sic] at this time. On June 23, 2026, at 11:05 a.m., an interview was conducted with Staff F, Registered Nurse (RN), regarding the June 22 progress note. Staff F stated the incident occurred at approximately 3:30 a.m. When asked if the incident should have been reported to leadership, Staff F stated yes, because it involved resident-to-resident contact and was a potential abuse situation. On June 23, 2026, at 3:35 p.m., an interview was conducted with the Director of Nursing (DON) regarding the incident. The DON stated she was not notified until 7:00 a.m. on June 22, 2026. She stated the Risk Manager (RM) began an investigation after seeing the note entered in Resident #8's chart. The DON confirmed that Resident #9's record did not contain documentation of the incident and stated that a skin sweep was completed that morning. The DON stated it is a resident-to-resident potential abuse and unsure if the RM reported. On June 24, 2026, at 9:44 a.m., an interview was conducted with the Licensed Practical Nurse (LPN) serving as Risk Manager. The Risk Manager stated the incident was not reported to her, the Nursing Home Administrator, or the DON when it occurred. She stated the incident was discovered upon reviewing the progress note and had to determine whether it met criteria for an abuse allegation. She reported she was still gathering information and attempting to obtain a statement from the nurse involved. The Risk Manager stated she was uncertain whether the incident was abusive in nature and noted that staff are required to report incidents to the DON and Administrator. The RM stated she was investigating the incident but had to figure out what happened first to see if it meets the abuse definitions. The RM confirmed the nurse progress notes states one resident admitted to striking another resident. A review of a policy and procedure provided by the facility, Residents Right to Freedom from Abuse, Neglect, and Exploitation Policy and procedure, dated 2025 compliance consulting group, documented the purpose: To ensure that all of (the facility) residents are free from (continued on next page)		

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	abuse, neglect misappropriation of their property, and exploitation.Procedure:Associates must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion against any resident.The Facility will ensure that residents are free from physical or chemical restraints.The facility shall review altercations from resident to resident as a potential situation of abuse.Staff shall monitor for any behaviors that may provoke a reaction by residents or others, which include, but are not limited to:Verbally aggressive behavior, such as screaming, cursing, bossing around/demanding, insulting to race or ethnic group intimidating;Physically aggressive behavior, such as hitting, kicking, grabbing, scratching, pushing/ shoving, biting, spitting, threatening gestures, throwing objects;Sexually aggressive behavior such as saying sexual things, inappropriate touching/grabbing;Taking, touching, or rummaging through other's property; andWandering into other's room/space . When the Facility has identified abuse, the Facility will take all appropriate steps to remediate the noncompliance and protect residents from additional abuse immediately. The Facility will increase enforcement action, including, but not limited to: Taking steps to prevent further potential abuse.Reporting the alleged violation and investigation within required timeframes pursuant to Federal and State statutes and regulations.Conducting a thorough investigation of the alleged violation.Taking appropriate corrective action.The facility will revise the resident's care plan if the resident's medical, nursing, physical, mental, or psychosocial needs or preferences change as a result of an incident of abuse.The facility will develop written policies and procedures that define how staff will communicate and coordinate situations of abuse, neglect, misappropriation of resident property, and exploitation with the QAPI program to allow the QAA Committee to determine:If a thorough investigation is conducted;Whether the resident is protected;Whether an analysis was conducted as to why the situation occurred;Risk factors that contributed to the abuse (e.g., history of aggressive behaviors, environmental factors); andWhether there is further need for systemic action such as: Insight on needed revisions to the policies and procedures that prohibit and prevent abuse/neglect/ misappropriation/exploitation (ANME).Increased training on specific components of identifying and reporting that staff may not be aware of or are confused about.Efforts to educate residents and their families about how to report any alleged violations without fear of repercussions.Measures to verify the implementation of corrective actions and timeframes, andTracking patterns of similar occurrences.The facility will not employ or otherwise engage individuals who: .The Facility will report to the State nurse aide registry or licensing authorities .The Facility explicitly and expressly prohibits, and will take steps to prevent any Associates from engaging in any behavior or actions that may result in the abuse, neglect, and exploitation of residents and misappropriation of resident property.The Facility will investigate any allegations made alleging abuse, neglect, and exploitation of residents and misappropriation of resident property.The Facility will ensure that all Associates are properly trained.The Facility will ensure that any suspicion of resident ANME is coordinated with the Facility's QAPI program.The Facility will ensure compliance with the Elder Justice Act .Response:In response to allegations of ANME, the Facility shall:Ensure that all alleged violations involving ANMEI of resident property are reported in the proper time frame pursuant to this policy.Have evidence that all alleged violations are thoroughly investigated.Prevent further potential ANME while the investigation is in progress.Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey agency within 5 working days of the incident, and if alleged violation is verified appropriate corrective action must be taken.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, observation, and interviews, the facility failed to develop and implement person centered care plan interventions for three of three sampled residents (Residents #9, #16, and #17). Specifically: For Residents #9 and #16, the facility failed to develop care plan interventions for identified wandering behaviors, including entering other residents' rooms. For Resident #9, the facility failed to develop care plan interventions for defecation behaviors in other residents' rooms, failed to complete and document accurate skin assessments, failed to notify the physician of a new wound and obtain treatment orders, and failed to implement activities of daily living (ADL) care related to dressing, including ensuring shoes were worn correctly. For Resident #17, the facility failed to implement care and services related to bathing, hygiene, and skin assessments; failed to identify and address unclean, dried fecal matter on the feet and a fecal soiled mattress; and failed to complete timely weekly skin checks. In addition, the facility failed to develop person centered care plan interventions for room based activities, resident preference for staying in the room, and podiatry services. These failures resulted in residents not receiving services necessary to maintain physical, mental, and psychosocial well being. Applying a reasonable person concept, these failures placed Residents #9, #16, and #17 at risk for compromised dignity, infection, unsafe wandering, unmet ADL needs, and unaddressed changes in condition. Findings included: 1.A review of Resident #9's clinical chart, the Face Sheet, documented an admission in 09/2024. Resident #9's diagnosis information included but not limited to: Unspecified dementia with mood disturbance, heart failure, chronic obstructive pulmonary disease (COPD), muscle weakness, unsteadiness on feet, need for assistance with personal care and cognitive communication deficit. A review of a Brief Interview for Mental Status (BIMs), dated 06/11/2026, revealed a score of 99, which documented the individual refused to participate or 4 (four) or more items were coded 0 because the individual chose not to answer or gave a nonsensical response. A review of Resident #9's Care Plan revealed the following: Focus: I am at risk for impaired skin integrity r/t (related to) decrease in mobility, incontinence, initiated 09/12/2024. Goal: Risk for skin impairment will be decreased by review date, initiated 09/12/2024. Interventions included: Weekly skin checks. Report abnormalities to Dr. (doctor), initiated 09/12/2024. Focus: The staff have identified that I am at moderate risk for falls because of these risk factors: Unaware of safety needs, dementia, muscle weakness, unsteady on feet, initiated 09/12/2024. Goal: My risks for falls and fall related injuries will be minimized with interventions daily through the next review date, last revised on 01/28/2026. Interventions included: Anticipate resident's needs, initiated 09/12/2024; I should have sneakers, shoes, slippers with rubber soles or non-slip socks when I am out of bed, initiated 09/12/2024. Focus: The resident is on Antiplatelet therapy r/t: disease process, initiated 09/12/2024. Goal: The resident will have minimized discomfort or adverse reactions related to anticoagulant use through the review date, initiated 09/12/2024. Interventions included: Weekly skin inspection. Report abnormalities to the nurse, initiated 09/12/2024. Focus: I need assistance with activities of daily living because of weakness, dementia, COPD (chronic obstructive pulmonary disease), HF (heart failure), anxiety, HTN (hypertension), HLD (hypersensitivity lung disease), initiated 09/12/2024. Goal: Staff will help me with all my ADL needs so that I appear neat and tidy with absence of foul body odor through next review, initiated 09/12/2024. Interventions included: Anticipate resident's needs, initiated 09/12/2024; Assist me with toileting promptly when requested, initiated 09/12/2024; Dressing-Assist of 1, Toileting-Assist of 1, Transfers-Assist of 1, initiated 10/25/2024. Review of the care plan revealed no care plan interventions addressing the resident's wandering into other residents' rooms or defecation behaviors. The care plan documented needs for assistance with ADLs and weekly skin checks with reporting of abnormalities but did not include interventions to address observed behaviors. On 06/22/2026 at 9:46 (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Aventura at the Bay		STREET ADDRESS, CITY, STATE, ZIP CODE 10300 4th St N Saint Petersburg, FL 33716	
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a.m., Resident #9 was observed ambulating independently in the hallway with visibly oily and matted hair, wearing mismatched shoes with one shoe on the wrong foot. On 06/22/2026 at 5:10 p.m., she was observed seated in the dining area with the same mismatched shoes and an uncovered nickel sized open wound on her chest with surrounding dark pink tissue. On 06/23/2026 at 10:13 a.m., Resident #9 was again observed ambulating independently with the open chest wound visible and oozing. She was observed touching the wound with her hands and wiping her fingers on her clothing and the hallway handrail. Resident #9 was not able to answer questions. On 06/23/2026 at 10:51 a.m., Staff F, Registered Nurse, (RN) was interviewed. When asked if Resident #9 had any wounds, she stated, I have to look. Staff F was observed to review Resident #9's clinical record and stated, the resident is getting triple antibiotic to her arms. Her last skin check was yesterday, 06/22/2026, she had no issues. During the review, Staff F, also reviewed Resident #9's progress notes and stated, no report of any new skin issues. Staff F stated Resident #9 needed assistance getting dressed. She stated Resident #9 does not always use the toilet and will drop her pants and poop. Yes, she goes into other residents' rooms, when this happens, we clean up the area and take her to the bathroom and clean her up. When asked if staff documented when she had the defecation behavior in other resident's rooms, she stated, Don't think they do. On 06/23/2026 at 11:10 a.m., an observation and interview of Resident #9 was conducted with Staff F, RN and she confirmed the open area on the resident's chest. She stated no one had brought the skin issue to her attention. On 06/23/2026 at 12:57 p.m. an interview was conducted with the MDS (Minimum Data Set) Coordinator regarding Resident #9. The MDS coordinator stated Resident #9 had a care plan for wandering, but she did not see a care plan for the behavior of the resident entering and exiting other resident's bedrooms and having the behavior of pulling her pants down and defecating. The MDS Coordinator stated the behaviors of entering rooms and defecation were not care planned but should have been. She stated the shoes of a resident should be on the correct foot. On 06/24/2026 at 9:43 a.m., the Director of Nursing (DON) was interviewed. The DON stated the expectation for new skin area concerns a new skin issue form be completed. This form is different from the skin assessment form completed weekly. When a resident is observed with a new skin issue, the nurse should put a progress note in the clinical record along with the skin issue form. Then new skin issue form would go to the wound care provider. On 06/24/2026 at 9:50 a.m., review of skin assessments with the Director of Nursing (DON) revealed skin assessments dated 06/16/2026, 06/22/2026, and 06/23/2026 with no documentation of the observed chest wound. The DON stated the assessments should have reflected the wound. The DON stated her expectation was for the nurses to document accurate skin assessments. 2.Record review showed Resident #16 was admitted on [DATE] with diagnoses including COPD, Alzheimer's disease, and dementia with agitation. A BIMS dated 06/18/2026 reflected a score of 6, indicating severe cognitive impairment. A review of Resident #16's Care Plan revealed the following:Focus: Due to Resident #16's memory impairments and limited ability to understand he needs more supervision and assistance to maintain his safety, the benefit of the secured unit is to provide more direction and supervision appropriate for his abilities, initiated 06/08/2026. Goal: Resident #16 will have care which is focused on the level of his mental and physical abilities to participate and understand through next review, initiated 06/08/2026.Interventions: Provide redirection during wandering behaviors or exit seeking attempts, initiated 06/08/2026.The care plan included redirection during wandering but did not identify or address wandering into other residents' rooms. On 06/22/2026 at 9:49 a.m., Resident #16 was observed independently entering and leaving multiple resident rooms without staff redirection. At 4:30 p.m., he was observed exiting Resident #17's room a female resident room, closing the door behind him, and entering another room. On 06/23/2026 at 1:08 p.m., the MDS Coordinator confirmed there was no care plan addressing room to room wandering. She stated that such behaviors would be added only if documented on the 24-hour report or communicated in clinical meetings. When asked why it would be important for a male resident to be care planned for room to room wandering, she stated, (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Wandering in and out of a female room can cause anguish; especially if the male shows off parts of his body. When asked how staff provide a safe environment for a female resident that likes to stay undressed, she stated, Make sure the male wanderer has it on his Kardex to keep an eye on him. Keep him in common areas to keep him busy. 3. Record review showed Resident #17 was admitted in 12/2025 with diagnoses including COPD, unspecified dementia, coronary artery disease, and depression. A BIMS dated 06/15/2026 scored 99. A review of Resident #17's Care Plan documented the following: Focus: I need assistance with activities of daily living because of a diagnosis of dementia with memory impairment, tremors, initiated 12/11/2025; Goal: Staff will help me with all my ADL needs so that I appear neat and tidy with absence of foul body odor through next review, initiated 12/11/2025. Focus: When planning activities for me I need staff to consider: I have a great desire to practice my religious beliefs. I have memory impairments and stimulation will help me to maintain or slow further decline, initiated 03/18/2026. Goal: I will be satisfied with present activity program through review; I will continue to interact with staff and other residents every day through next review; I will engage in self-directed activities both in and out of room on a daily basis through next review; I will practice my religious beliefs as I desire through next review, last revised 03/18/2026. Interventions included: Assure that the activities I attend are compatible with my physical and mental capabilities, initiated 03/18/2026; I am very restless and can't pay attention very long so provide short non demanding activities for me to do, initiated 03/18/2026; Sometimes I need encouragement to attend activities. Engage me in conversation by letting me know about upcoming events and the positive effects it has on mood and overall well-being, initiated 03/18/2026. Focus: I have alteration in skin integrity or risk for impairment skin integrity r/t advanced age with fragile skin, incontinence, initiated 12/11/2025. Goal: My skin will remain free from pressure ulcers through next review, initiated 12/22/2025. Interventions included: Inform resident/family/Dr (doctor) of any new areas of skin breakdown, initiated 12/22/2025; Monitor for incontinence frequently and provide prompt care, initiated 03/25/2026; Skin checks on resident's shower days. Report any abnormalities to nurse, initiated 12/22/2025; Weekly skin checks. Report any abnormalities to Dr., initiated 12/22/2025. The care plan included assistance with ADLs and skin monitoring but did not include room based activities, preferences for room stay, or podiatry needs. On 06/22/2026 at 4:30 p.m., Resident #17 was observed lying in bed with a hospital gown draped loosely across her torso exposing the side of her breast. A soiled brief was on the floor. Both feet had caked, dried brown material covering the soles and toes. A strong fecal odor was present. The mattress on the door side bed had dried brown fecal matter smeared across the surface with no linens present. Resident #17 was observed to have a dime sized dark maroon colored scab on her right lower shin with multiple smaller discolored scabs on both legs. The resident did not respond to questions. The room had no television. A radio was observed on a nightstand not turned on. On 06/23/2026 at 10:09 a.m., an observation of Resident #17. The residents' feet remained darkly discolored after partial cleaning, and the mattress had been cleaned. At 10:55 a.m., Staff F, RN, stated that CNAs should perform walking rounds at shift start but did not identify when Resident #17 had last been assessed. She stated fecal smearing should be documented, though no documentation existed. On 06/23/2026 at 11:13 a.m., an observation of Resident #17 was conducted with Staff F, RN. Staff F, RN was observed to review the bottom of Resident #17 feet, and she stated, it looks like dirt. Staff F, RN confirmed Resident #17's feet were dirty. Resident #17's toenails on the big toes were observed to be approximately 0.5 centimeters beyond the toe and cracked in appearance. Staff F, RN, stated, her toenails could be cut. She stated toenails would have to be cut by a podiatrist. During the review of Resident #17, Staff F, RN, stated she would want to know about an unclean mattress with BM on it. Staff F stated it was important to clean up bodily fluids, etc. due to infection control; it is gross and would need to get someone to clean it. On 06/23/2026 at 4:40 p.m., the DON confirmed no weekly skin assessment had been completed on 06/22/2026 and no documentation explained the omission. Review of the last 30 days of bathing documentation showed only one shower on 06/11/2026, despite scheduled Monday and Thursday (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathing. The DON confirmed there were no refusal notes. The MDS Coordinator confirmed on 06/23/2026 at 1:19 p.m. that Resident #17 was not care planned for her preference to stay unclothed or stay in her room, and podiatry services had not been arranged until the date of interview. On 06/24/2026 at 10:10 a.m., an observation of Resident #17 conducted with the DON. The bottoms of her feet were observed to be clean with no residue present. The DON reviewed the scabs on the lower legs; she did not comment on the source of the scabs. The DON stated her toenails, the big toes, she would contact social services for podiatry services. The DON stated the Resident #17 prefers to be in her room. 06/24/2026 at 12:20 p.m., an interview occurred with Staff L, Activities Aide. Staff L stated that she did not provide any assistance to the secure unit. On 06/24/2026 at 1:25 p.m. an interview was conducted with Staff K, Activities Aide. Staff K stated she was assigned to conduct activities in the secure unit area. Staff K stated she did not conduct room visits. The Activities Director later confirmed no documentation of room visits was available for Resident #17. A review of the facility's policy and procedure for Care Plans, Comprehensive Person-Centered, dated 2001 med-Pass, Inc, documented the policy statement: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The Policy interpretation and implantation: The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, . The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. Each resident's comprehensive person-centered care plan is consistent with the resident's right to participate in the development and implementation of his or her plan of care, including the right to: Participate in the planning process; Identify individuals or roles to be included; Request meetings; Request revisions to the plan of care; Participate in establishing the expected goals and outcomes of care; Participate in determining the type, amount, frequency and duration of care; Receive the services and/or items included in the plan of care; See the care plan and sign it after significant changes are made. The resident is informed of his or her right to participate in his or her treatment and provided advance notice of care planning conferences. If the participation of the resident and his/her resident representative in developing the resident's care plan is determined to not be practicable, an explanation is documented in the resident's medical record. The explanation should include what steps were taken to include the resident or representative in the process. The comprehensive, person-centered care plan: Includes measurable objectives and timeframes; Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: Services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment; Any specialized services to be provided as a result of PASARR recommendations; and Which professional services are responsible for each element of care; Includes the resident's stated goals upon admission and desired outcomes; Builds on the residents' strengths; and Reflects currently recognized standards of practice for problem areas and conditions. Services provided for or arranged by the facility and outlined in the comprehensive care plan are: Provided by qualified persons; Culturally competent; and Trauma-informed. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' condition change. The interdisciplinary team reviews and updates the care plan: When there has been a significant change in the resident's condition; When the desired outcome is not met; When the resident has been readmitted to the facility from a hospital stay; and At least quarterly, in conjunction with the required quarterly MDS (Minimum Data Set) assessment. The resident has the right to refuse to (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies.		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to 1) follow wound care orders for one resident (#5), and 2) conduct accurate skin assessments to identify skin integrity concerns for one resident (#11), out of three residents reviewed for wounds. These failures resulted in discomfort for Resident #5 and worsening of the wound and a failure to identify a sacral pressure injury in Resident #11. Findings include: 1. A review of Resident #5's admission record documented admission on [DATE] and discharge on [DATE]. Diagnoses included a stage 3 pressure ulcer to the sacral region, unspecified protein-calorie malnutrition, and quadriplegia. A review of Resident #5's care plan, dated 03/28/2026, documented impaired skin integrity related to a sacral pressure injury, paralysis, malnutrition, colostomy, and incontinence. The goal included healing the pressure injury and remaining free from infection. Interventions included evaluation and treatment by a wound care specialist per order. A review of Resident #5's Brief Interview for Mental Status (BIMS), dated 04/02/2026 and 06/05/2026, documented a score of 15, indicating intact cognition. A review of Resident #5's physician orders documented: On 04/15/2026, orders to cleanse the sacral wound and lightly pack with collagen daily until wound vac initiation. The order was discontinued on 04/25/2026. On 04/27/2026, orders for negative pressure wound therapy (wound vac) using black and white foam, with pressure set at 125 mmHg (millimeters of mercury), to be changed three times weekly and as needed. On 04/01/2026, orders for weekly wound clinic appointments on Tuesdays discontinued on 04/14/2026. A review of Resident #5's Medication Administration Record (MAR) and Treatment Administration Record (TAR) documented that beginning 04/27/2026, the wound vac order required dressing changes three times weekly. In May 2026, the order was coded 16 (hold/see nurses notes) on 05/04/2026 and 05/11/2026. There was no documentation the wound vac was changed on 05/18/2026. A review of Resident #5's progress notes showed: 5/4/26, Wound Vac - black foam/ white foam to undermining (be sure black foam touches white foam) Pressure settings @ 125mm Hg, change 3 times per week. every evening shift every Mon, Wed, Fri for wound care Resident went to wound care center. 5/5/26, Went to see patient. He says that no one has put the wound vac on him since he returned. I requested that nurse please put back on asap [as soon as possible]. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	5/6/26, Patient seen in his room. The wound vac is still not in place and he says they don't have a cannister for it. I spoke with DON [director of nursing] and it was very dirty so they ordered a new one and it should be here today. It was originally supposed to be here yesterday but was delayed. She says as soon as it arrives then they will put the wound vac back on. 5/7/26, Patient seen in his room. Wound vac is now in place. 5/11/26, Wound Vac - black foam/ white foam to undermining (be sure black foam touches white foam) Pressure settings @ 125mm Hg, change 3 times per week. every evening shift every Mon, Wed, Fri for wound care Resident went to wound care today, wet to dry dressing in place. canister not available to place wound vac. Further review of the progress notes showed no documentation on 5/18/26 regarding the wound vac order that was not completed. A review of Resident #5's wound clinic notes documented: 4/15/26, . Wound Clinic Results Review All results: -Sacral Pressure ulcer stage 3: Decreased in length/width, increased in Depth . SNF [skilled nursing facility] has not ordered wound vac as per SNF representative they thought the wound clinic would order the vac. Discontinue santyl treatment, calcium alginate, bordered foam dressing daily. Start Primsa [type of wound dressing], draw tex [hydro conductive wound dressing], and bordered foam dressing 3 times weekly until wound vac initiated. Order to start NPWT [negative pressure wound therapy] @SNF, 125 mmHG, continuous, white sponge to undermining, black sponge to wound bed, change 3 times weekly and prn [as needed] dislodgement. Script for wound vac provided to SNF staff member accompanying patient. Counseling also provided for SNF to call wound clinic with any issues or questions regarding the wound vac. 5/4/26, . Wound Clinic Results Review . Decreased in size, depth decreased 1.1 from 2. SNF did not send wound vac container today. Start calcium alginate Ag [silver] and sacral border foam dressing in clinic; NPWT to be applied on arrival to SNF. 5/11/26, .Subjective . Today---patient came to wound clinic with wound vac dressing and not connected to wound vac. Per patient the vac was off all weekend because the facility had to order a wound vac cannister. No cannister send to the wound clinic today. Wound Clinic Results Review: . Sacral Pressure ulcer stage 3: Increased in size. SNF did not send wound vac cannister today. NPWT to be applied on arrival from SNF from wound clinic. On 6/22/26 at 1:39 p.m., a telephone interview was conducted with the wound clinic Nurse Practitioner (NP). She said on 4/15/26, the facility had not ordered the wound vac as the facility's representative thought the clinic would order and provide it. She stated, It was miscommunication and it never works like that. She said the wound clinic ordered a specific type to be used. The wound clinic NP said Resident #5 had scheduled, weekly clinic appointments. She said they were important especially with a wound vac and debridement. She said on the 5/11/26 appointment, the facility did not send the wound vac with the resident. The wound clinic NP confirmed with Resident #5 the facility had it and it was being used. She said the wound clinic physician saw the resident on 5/18/26 and he was due back on 5/25/26 and 6/1/26, but he did not attend those appointments. She said Resident #5 went to the appointment on 6/8/26, the wound had a lot of undermining, and he did not have the wound vac again. She said she had requested the facility put the wound vac on when he had (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	returned from that appointment. The wound clinic NP said the facility would not send the wound vac or cannisters at times. She said the wound orders at the clinic was to complete the debridement then put the wound vac back on, which is why they needed it at his appointments. The wound clinic NP said after his appointments the clinic would send detailed orders to include changes and additional directions. On 06/22/2026 at 5:10 p.m., an interview was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The DON said she had to request Resident #5's records from the wound clinic as the facility did not have them. The ADON said they only had the initial wound vac orders. On 06/22/2026 at 5:12 p.m., a telephone interview was conducted with Resident #5. Resident #5 stated he provided clinic paperwork to whichever nurse was available on return from appointments and confirmed a non-nurse staff member accompanied him to the appointments. On 06/23/2026 at 12:51 p.m., an interview was conducted with Staff B, Certified Nursing Assistant (CNA). Staff B stated Resident #5 would ask her to check whether the wound vac was plugged in and stated she did not observe it functioning. Staff B also stated Resident #5 preferred to be on his side as lying on his back was uncomfortable. On 06/23/2026 at 2:10 p.m., an interview was conducted with the ADON. The ADON stated the facility believed the wound clinic would order the wound vac, and later learned the facility was responsible. She stated there were delays in obtaining cannisters and dressing (foams). The ADON confirmed due to confusion on who was providing the wound vac, Resident #5 did not have the wound vac from admission to 4/27/2026. The ADON stated after receiving the wound vac, Resident #5 was not able to have the wound vac place on different occasions due to not having adequate supplies on hand. On 06/24/2026 at 1:25 p.m., an interview was conducted with the DON. The DON stated a facility nurse discarded a wound vac cannister, leaving no remaining supplies available until additional cannisters were ordered. On 06/24/2026 at 1:59 p.m., an interview was conducted with the ADON. The ADON confirmed there was no documentation explaining why wound vac supplies were not available on certain dates and no documentation concerning unmet wound care orders on 05/18/2026. The ADON stated the facility was responsible for providing the wound vac and obtaining the supplies. 2. On 06/22/2026 at 3:59 p.m., an interview occurred with Resident #11's representative (RR). The RR stated Resident #11 was sent to the hospital after a fall and was identified at the emergency room as having an unstageable sacral wound, which had not been previously identified by the facility. A review of Resident #11's face sheet documented an admission on [DATE]. Diagnoses included hemiplegia, chronic obstructive pulmonary disease, bipolar disorder, vascular dementia, cognitive communication deficit, and muscle weakness. A review of Resident #11's BIMS assessment dated [DATE] documented a score of 12, indicating moderate cognitive impairment. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	A review of Resident #11's care plan documented risk for impaired skin integrity beginning 05/15/2026 with interventions including weekly skin sweeps, use of a pressure relief mattress, prompt incontinent care, application of barrier ointment, and assistance with turning and positioning. A review of Resident #11's Weekly Skin Observation, dated 05/31/2026, at 7:30 a.m., was reviewed and confirmed with the Minimum Data Set (MDS) coordinator, to document three areas on Resident #11, a right knee abrasion, a left knee abrasion, and left elbow skin tear. The document revealed no documentation of redness on Resident #11's Sacrum. A review of Resident 11's progress note dated 06/01/2026 at 1:28 p.m. documented the resident returned from the emergency room without new orders. A review of Resident #11's Weekly Skin Observation dated 06/01/2026 at 8:00 p.m. documented sacral redness with an open area, described without measurements, and dressing intact. A review of Resident #11's progress notes, dated 06/01/2026 at 8:00 p.m. documented a skin progress note: Weekly skin evaluation completed. Findings are as follows: Resident's color is normal. Skin is warm/dry. Edema is not present on assessment. Resident has red/excoriated areas. The resident does not have any skin issues on bony prominences. The resident does not have any skin issues on the right buttocks. The resident does not have any skin issues on the left buttocks. The resident does not have any skin issues on the right heel. The resident does not have any skin issues on the left heel. During an interview with the MDS Coordinator on 06/23/2026 at 1:34 p.m. she stated, Staff M, LPN (licensed practical nurse) put in the progress notes, on 06/01/2026, the resident had no skin issues. Staff M, LPN was also the one that put in the notes the resident had a stage III (full-thickness skin loss where subcutaneous fat is visible) on 06/01/2026. The MDS coordinator stated it was her expectation that accurate notes were documented. A review Resident #11's wound provider's note dated 06/01/2026 documented a stage 3 pressure ulcer to the sacrum/coccyx measuring 1.3 cm &times; 1.2 cm &times; 0.1 cm. A review of Resident #11's clinical record documented she was out of the facility for approximately five and a half hours on 06/01/2026. On 06/23/2026 at 3:55 p.m., an interview was conducted with the DON. The DON confirmed the skin assessment dated [DATE] should have included sacral documentation. On 06/24/2026 at 3:46 p.m., the DON stated the facility had no written policy for weekly skin assessments On 06/24/2026 at 3:46 p.m., interview with the DON, she stated for weekly skin assessments, there was no policy and procedure, we go by best practices. A review of the facility's policy titled Charting and Documentation, revealed the following, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Further review of the policy, under policy (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	interpretation and implementation, revealed the following, .2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered; c. Treatments or services performed; d. Changes in the resident's condition; e. Events, incidents or accidents involving the resident; and f. Progress toward or changes in the care plan goals and objectives.		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide adequate supervision and implement effective interventions to prevent falls for one (#11) out of three sampled residents. This resulted in Resident #11 experiencing eight unwitnessed falls and one witnessed fall over a 30-day period, and transfer to a higher level of care on two separate occasions. Findings included: A review of Resident #11's face sheet documented an admission on [DATE] and discharge date of 06/13/2026. Diagnoses included hemiplegia affecting the left side, chronic obstructive pulmonary disease, bipolar disorder, need for assistance with personal care, cognitive communication deficit, generalized muscle weakness, and vascular dementia. A family member was listed as the emergency contact. A review of Resident #11's Brief Interview for Mental Status, dated 06/05/2026, documented a score of 12, which indicated moderate cognitive impairment. A review of Resident #11's care plan, initiated 05/25/2026, documented the resident was at risk for falls due to dementia, gait and balance problems, impaired cognition, impaired communication, incontinence, history of falls, and inability to recognize safety needs. Interventions included: Created: 05/25/2026 Encourage and assist resident to be out of bed and to common areas when restless Encourage and assist resident to bed after dinner 05/26/2026 I am unable to communicate my need to use the bathroom so check frequently for incontinence and provide prompt care Staff to monitor medications for adverse side effects and therapeutic effectiveness. Staff to ensure call bell is within reach Anticipate resident's needs 05/29/2026 If I appear restless with frequent attempts to get up, check for pain, hunger, thirst, fatigue, incontinence, boredom Keep my call light within reach so I can call for assistance [repeated] 06/03/2026 Maintain bed in lowest locked position Monitor my positioning when OOB (out of bed) in chair and help me to reposition into a safer or more comfortable position 06/08/2026 Encourage and assist resident with rest periods after lunch 06/15/2026 ER (Emergency Room) transfer Neuro consult: Falls program Encourage and assist resident back to bed for rest periods after lunch [repeated] Encourage and assist resident with toileting upon rising Honor residents early rising preferences Honor residents late night preferences Psych consult: med review A review of the facility's fall log documented three fall events for Resident #11 on 05/25/2026 at 1:45 a.m., 05/31/2026 at 4:15 a.m., and 06/01/2026 at 7:00 a.m. On 06/22/2026 at 3:59 p.m., a phone interview was conducted with Resident #11's family representative. She stated she was aware Resident #11 had multiple falls, she stated for the first fall, she was notified by the facility, and the resident was not sent to the hospital. On the second fall, Resident #11 was sent to the hospital and returned the same day. On the third fall, she was sent to a different hospital and they kept her. The first fall, she (Resident #11) was complaining about seeing floaters in her eyes. I was there for one of the falls, I found (Resident #11) yelling from the bathroom. Two staff came, one said she had a bad back and couldn't assist, they need better training. On the third fall, she was face down. On 06/24/2026 at 11:27 a.m. an interview was conducted with the Risk Manager (RM) to review Resident #11's fall events, the RM stated each fall should be thoroughly documented and interventions put into place to assist in attaining the resident's goal. The RM stated the following reviewing the documentation: 05/15/2026, 8:00 p.m., unwitnessed the location was stated to be the hallway across from the nurses' station. They said they could not see her clearly, there was no one at the nurses' station. The resident was in a manual wheelchair (w/c), fell out of the w/c, they found her sitting next to the chair. The resident was not able to state what she was doing. RM stated the resident had no injury. When asked the last time someone saw the resident prior to the fall, the RM stated she would have to look at the clinical record, she stated we double check the clinical record at the time, but I do not put it in the investigation. She stated she would have to look for the Neuro-check documentation for this fall; she did not have it available for review at the time of the interview. She stated the physician and family were notified at 8:00 p.m. No Neuro-check documentation was (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	provided for this fall during the survey. No interventions were found in the fall care plan for this time frame 05/16/2026, 9:15 p.m., unwitnessed the location was stated to be the resident's room. The resident was found in her room, sitting on her butt, in front of her bed, the foot of the bed. Resident was not able to say what happened, she was not soiled at the time of the fall. I do not have where the w/c was. They said the last time they had seen her, she was in her w/c. The RM was not able to state when the resident was last observed by staff prior to the fall. The RM stated there was no injury, and for Neuro-checks, she provided the sheet, starting 05/16, time start at 2115 until 05/18, 1700. She stated the physician was notified at 10:03 p.m. and family at 10:05 p.m. No interventions were found in the fall care plan for this time frame 05/25/2026, 12:45 p.m., unwitnessed the resident was found lying on her back in the hallway with her wheelchair next to her. The resident was unable to report how she fell. A bruise to the right forehead near the eyebrow was documented. Neuro checks were documented from 1:45 p.m. on 05/25/2026 through 06/27/2026 at 6:00 a.m. 05/29/2026 at 4:15 a.m., unwitnessed, the location was stated to be the resident's room at the bedside. The resident was on her floor mat lying down. Resident stated she was awake and getting up. The bed was in low position. The RM could not state whether the resident was found in a prone or supine position. She stated it did not specify. She stated, they are supposed to paint a picture. The RM was not able to state when the resident was last observed by staff prior to the fall. The RM stated the resident had no injury and Neuro checks were provided for 05/29, 0430 through 05/31/2026, 0400. The RM stated the new intervention was honor resident's early rising preference. Physician and family were notified on 05/29/2026 at 4:30 a.m. During a review of Resident #11's progress notes, the fall documented to have occurred on 05/29/2026 at 04:30, the resident was documented to have a skin tear to left knee, re-opened, with bleeding observed. The documentation in the progress note did not match the investigation conducted by the RM, as she reported the resident had no injury during the fall. No interventions were found in the fall care plan for this time frame 05/31/2026 at 4:15 a.m., unwitnessed, the location was the resident's room, observed lying on the floor, next to the bed on the floor mat. She said she was trying to get out of the gate. The RM was not able to state whether the resident was found in a prone or supine position or when the last time the resident had been observed by the staff prior to the fall. The RM stated the resident had no new injury. When asked what no new injury meant, the RM read the note, not anything new. The RM stated she found the injury, on 05/29/2026, there was a skin tear, abrasion to the left knee; the resident received treatment. The RM stated, the resident re-opened the skin tear on her left knee. During the review, the Neuro check for the 05/29 fall was reviewed, and it was noted that a staff member, DT had signed as having completed the Neuro check on 05/31/2026 at 0400, fifteen minutes prior to the fall event. When the RM was asked who the staff member was and if a witness statement had been obtained, she stated she would have to follow up. No further information was provided during the survey. Neuro checks were provided for 05/31, 04:15 a.m. through 06/01/2026, 0400. The physician and family were stated to be notified on 05/31/2026 at 4:30 a.m. The RM stated the new intervention was a neurological consult and the resident was assisted to the chair since she was up. No neurological consult was provided by the facility during the survey. No interventions were found in the fall care plan for this time frame 06/01/2026 at 7:00 a.m., witnessed, the location was the small dining room on A wing. Resident was observed by CNAs (certified nursing assistants) throwing self onto floor, she was in her w/c. Injury, a bruise to the forehead, left side; hematoma; it does not say the size. The RM stated the immediate intervention was to transfer the resident to the emergency room. A psych consult was requested. Resident #11 was seen on 06/02/2026, they changed her medication. The physician was notified at 7:20 a.m. and the family at 7:25 a.m. Neuro checks were reviewed, which documented the resident was out to the hospital from 10:15 a.m. and return documentation at 18:15. 06/03/2026 at 4:30 a.m., unwitnessed, the location was the resident's room at bedside. The resident was lying on the floor. The resident said she was going to the bathroom. The RM was not able to state whether the resident was found in a prone or supine position or when the last time the resident had been observed (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	by the staff or the last time the resident had been assisted to toilet prior to the fall. When asked if the position of the resident at the time of the fall was relevant, the RM stated, yes, depending on the circumstances, it is important to help determine the injury and possible cause. The RM confirmed Resident #11 needed assistance to use the bathroom, I would say she is one person assist. The new intervention was encourage and assist resident with toileting at rising. The physician was notified 06/03 at 4:33 a.m. and family at 6:30 a.m. 06/13/2026 at 5:14 p.m., unwitnessed, the location was the resident's room. A family member found the resident lying face down on the floor in her room in front of her wheelchair. Swelling to the left eye was documented, and the resident was transferred to the hospital. The facility documented no further interventions as the resident was not returning. During a review of Resident #11's progress notes, a fall was documented on 05/29/2026 at 0009; the fall was documented to have occurred at approximately 2000 on 05/28/2026, the RM did not provide information on this fall; no physician or family was documented to have been notified. The progress note revealed: 05/29/2026, 0009: Resident was placed in bed by staff. At approximately 2000, resident was found on the floor next to the bed. Upon assessment, resident was alert and responsive. Resident denied pain/discomfort and denied hitting head. No visible injuries noted at the time of assessment. Vitals wnl (within normal limits) Resident denies pain/discomfort. Bed in lowest position. Call light within reach. Observation continues. No interventions were found in the fall care plan for this time frame During a review of Resident #11's progress notes, a fall was documented 05/29/2026, 0430: Resident found on floor mat next to bed after self transferring from bed. Resident alert upon assessment. Skin tear to left knee noted to have reopened with small amount of bleeding observed. Area cleansed and dressing applied per treatment order. No additional injuries or new bruising noted during head to toe assessment. Resident denied pain or discomfort. Previous bruising remain (sic) on resident right side of face. Safety precautions reinforced with resident. Bed in low position with floor mat in place and call light within reach. MD and responsible party notified of resident. Resident to continue to be monitored for changes in condition. The RM did not provide information on this fall. No new interventions were found in the fall care plan after this incident. A review of the facility Post Fall Management Guidelines, undated, documented the policy: This facility is committed to safety and amplifying each resident's physical, mental, and psychosocial well-being. The objectives of the facility's Fall Prevention and Management Program are to: Deliver our residents with an interdisciplinary approach to assess risk of falls. Provide applicable interventions to prevent falls. Make sure that in the event a fall occurs: The incident will be investigated. Appropriate emergency interventions will be provided. Other interventions will be executed to prevent another fall from occurring as much as possible. The Fall Prevention and Management Program uses clinically accepted guidelines to guide the prevention and management of falls. The program includes but is not limited to: Identification risk for falls Implementation of person-centered interventions to decrease the incidence of falls. Implement interventions to decrease the incidence of fall with injuries. Guidelines: Post fall physical assessment .C. Skin observation for bruises, lacerations, hematoma, discoloration, swelling. F. Neurologic. 5. Neuro checks are completed for falls where the resident hit his/her head or if fall was unwitnessed and head injury is demonstrated. May be documented on the Neuro Check Flowsheet. III. Accident/ Incident Report and Investigation: Complete risk Management after each fall. Location Description Immediate action taken Injuries observed Level of pain Mental status Injury report post fall Predisposing environmental factors Predisposing psychological factors Predisposing situational factors Witnesses Notifications Notes Investigation of the fall Interviews of resident, staff, and others as appropriate Where was the resident? What was the resident doing before the fall? What was the resident trying to do? How did the resident feel when he/she fell? Did the resident hit any part of the body during or after the fall? What may have put the resident at risk? Activity at time of the fall Medications taken within the 24 hours before the fall; medications placing resident at risk. Functional and mental status at the time of the fall. Fall risk and history of falls Medical conditions that increase risk of falls Environmental factors that may have contributed to (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the fallAnalysis of the findings.IV. Implement additional interventions to reduce risk.The Fall Prevention Strategies/Interventions may be used as a guide to develop appropriate interventions.AlarmsAdditional use of appliances, positioning aidsAdditional assessments (therapy screen, restorative programs, vision, audiology, psychosocial, etc.)Environmental adaptationsMonitoringIncreased use of activities.VI. DocumentationFall is documented in the medical record.Date and timeLocation and any facts necessary to describe the fallAssessment post fallAny injuries and care provided.Notification of physician and family.Suggested documentation up to seventy-two (72) hours after the fall.Fall risk and care plan are reviewed and updated.Completed fall risk assessmentComplete pain assessment.Review interventions to prevent falls.Revise or implement additional individualized interventions as appropriate . A review of the facility's Fall Prevention & Management Program guidelines, undated, documented the Guidelines: Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.Steps:Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk.The nurse will document the resident's fall risk in the resident's records and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk.For high fall risk identified, the facility will develop a plan to address the risk.Each resident's risk factors, and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.Interventions will be monitored for effectiveness.The plan of care will be revised as needed.When any resident experiences a fall, the facility will:Assess the resident.Complete a post fall assessment.Complete an incident reportNotify physician and family.Review the resident's care plan and update as indicate.Document all assessments and actions.Complete an investigation.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide proper catheter care for two (Resident #4 and Resident #20) out of three residents reviewed. Findings include: A review of the medical record for Resident #4 showed the resident to be admitted to the facility in January of 2023 with diagnoses of breakdown (mechanical) of cystostomy catheter, urinary tract infection, parkinsonism, unspecified dementia with psychotic disturbance, major depressive disorder, neuromuscular dysfunction of bladder, Asperger's syndrome, chronic kidney disease stage 3a, benign prostatic hyperplasia with lower urinary tract symptoms, and retention of urine. A review of the resident's Minimum Data Set (MDS), section C, showed the resident to have a Brief interview for mental cognition (BIMS) score of 08, indicating moderate impaired cognitive ability. Resident 4's functional abilities showed resident to be independent for eating, toileting, dressing and minimal assistance needed for personal hygiene, oral hygiene, and sit-to-stand mobility. Resident #4 to have an indwelling urinary catheter. A review of the medical record, Progress Notes, for Resident #4 showed the following progress notes: 05/29/2026 Progress Note: Positive for Urinary Tract Infection (UTI), provider notified new orders received responsible party notified 06/03/2026 11:27 Progress Note: This writer is reporting patient (pt) is on Intramuscular (IM) antibiotic therapy (ABT) Ertapenem for UTI pt tolerated well no adverse reactions reported or observed vital signs (v/s) stable afebrile no signs & symptoms (s/s) of respiratory distress call bell within reach for safety. 6/07/2026 17:09 electronic Medication Administration Record (eMAR) communication: Change indwelling urinary catheter 16_Fr with 10cc balloon and drainage bag for clinical indications such as infection, obstruction, leaking or dislodgement as needed. Progress Notes from 06/17/2026-06/19/2026 stating resident refused catheter site cleaning. 6/22/2026 08:56 Provider follow up Note: male long term resident admitted to the facility in January of 2023 post hospitalization for toxic encephalopathy. re-admitted on [DATE] diagnosis (dx) chest pain. His past medical history (PMH) of urine retention, hypertension (HTN), anemia and Parkinson. Patient has had multiple re-admission for Foley catheter re-insertion and chronic UTI infection and falls. A review of the orders for Resident #4 showed the resident to have the following order: Cleanse suprapubic catheter (sp cath) site daily with mild soap and water, pat dry, and apply CDD [clean dry dressing]. A review of the Treatment Administration Record (TAR) for Resident #4 showed no catheter care, or documentation of the resident refusing, was recorded for dates 05/05/2026 and 05/28/2026 and June dates 06/17/2026-06/19/2026. An interview was conducted with the family and representative of Resident #4 on 06/22/2026 at 9:42AM. Resident representative (RR) stated Resident #4 had been in the facility for years and had many hospitalizations due to recurring UTIs. The RR stated discussed many times with staff at the facility her concerns regarding his catheter care and his frequent UTIs. The RR stated she had many discussions with the facility, including care plan meetings, for staff to call her when/if Resident #4 refused any care, as she can talk to him and get him to comply within a few minutes. The RR stated expressing her concerns to the facility many times and did not understand why they were not calling her. An interview with Staff F, Registered Nurse (RN), was conducted on 06/22/2026. Staff F, RN stated Resident #4 had a suprapubic catheter and confirmed the order for catheter care. Staff F, RN stated the site cleaning was not done on day shift, it was scheduled to be done daily on the overnight shift. Staff F, RN pulled up resident's progress notes on catheter site cleaning noting the times were between 2:50AM and 6:15AM. Staff F stated no one had ever tried moving the timing of catheter site cleaning to see if the resident would be more cooperative to their knowledge. An interview was conducted on 06/22/2026 with the Assistant Director of Nursing (ADON) at 11:50AM. The ADON confirmed Resident #4 does refuse care frequently and confirmed staff knowing to call their family member which usually got the resident to then comply with their care. The ADON stated they did not (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	know of a reason why the catheter site cleaning needed to be scheduled for the overnight shift so early in the morning, stating that was just how it was ordered. The ADON confirmed no one had ever thought to move the scheduling to later in the morning or day to see if it could keep the resident from refusing care as often, also allowing them to call the family member for assistance. The ADON confirmed frequent refusals of catheter site cleaning could possibly be contributing to frequent UTIs. Resident #20 is an [AGE] year old female, admitted to the facility in June 2026 with diagnoses Urinary Tract Infection (UTI), Unspecified dementia, neuromuscular dysfunction of bladder, personal history of transient ischemic attack (TIA), nonrheumatic aortic valve stenosis, muscle weakness, and need for assistance with personal care. A review of the MDS dated [DATE], Resident #20 has a BIMS score of 00 indicating highly impaired cognitive function. Functional abilities showed resident to require minimal assistance for eating, oral hygiene, and some bed mobility. Resident required moderate assistance for shower/bathing, putting on/off footwear, and personal hygiene. Resident #20 to have an indwelling urinary catheter. A review of the resident's medical record, Progress Notes, showed the following progress note:06/16/2026 Admit Visit: [AGE] year old female seen for initial stabilization after hospital stay for increased confusion and possible UTI. Started on Macrobid (antibiotic) in hospital. Currently still very confused, unable to coordinate or make needs known. 06/12/2026 Health Status Note: Per 3-11 Nurse resident had previously pulled out her foley catheter and had not voided on 3-11 shift. physician informed, new orders received for 3-11 nurse that foley catheter is to be reinserted. An 18fr/5cc catheter reinserted without difficulty at this time, resident tolerating (tol) well, plan of care (poc) ongoing. A review of the progress notes after the 06/12/2026 note regarding a foley catheter no other progress notes to be found regarding the catheter care for Resident #20 or a removal of the urinary catheter. A review of the medical records, Orders, for Resident #20 showed no orders, active or discontinued, for catheter care or the removal of a catheter, for the resident. A review of the TAR for Resident #20 showed no catheter care documentation. An observation of Resident #20 on 06/22/2026 at 4:56PM found the resident to be in her bed, dressed appropriately and pleasantly confused. The resident did not have visible catheter tubing or a a catheter drainage bag. An interview with the Director of Nursing (DON) was conducted on 06/22/2026 at 5:15PM. DON stated Resident #20 did not currently have an indwelling urinary catheter. DON stated she did not know why there were no orders regarding the catheter and confirmed without any orders or anything documented in the TAR or Progress Notes there is no way to see that the catheter care was completed for Resident #20 nor how long the catheter was in before it was removed. Regarding missing documentation in the TAR for Resident #4, the DON confirmed it would be her expectation for each day to have documentation with no blank days even if the resident had refused. The facility failed to follow their policy & procedure for the following policies: Documentation in the Residents' Records guidelinesGuidelines:The facility will ensure that each resident's medical record shall contain an accurate representation of the actual experiences of the resident during his/her stay in the facility and will ensure that the documentation the resident's progress are complete, accurate, and timely.Importance:False information shall not be documented. Documentation shall be accurate, relevant, and complete, which contains sufficient details about the resident's care and/or responses to care. The facility staff will also document timely and in chronological order.Steps:The IDT (interdisciplinary Team) members shall document all observations, assessments, and services provided in the resident's medical record.The documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred.Documentation may be performed either manually or by using the facility's approved electronic medical record software program.Documentation shall be factual, objective, and resident centered.If there are contradicting information, the information may be clarified by a new entry in the medical record. The documentation will include date and time of the entry, and include details to support that the current information is accurate.Late documentation will be labeled as late entry. Care of Indwelling Catheter guidelinesGuidelines:The facility will follow these guidelines when providing (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care to a resident with indwelling urinary catheter.Steps:The facility will conduct assessments for residents at risk for urinary catheterization or on residents with indwelling catheters to determine if the catheter needs to be continued or removed if the catheter is no longer necessary.If an indwelling catheter is in use, the facility will provide appropriate care for the catheter in accordance with current professional standards of practice and resident care policies and procedures that include but are not limited to:a.Timely and appropriate assessments related to the indication for use of an indwelling catheter;b. Identification and documentation of clinical indications for the use of the catheter; as well as criteria for discontinuation of the catheter when the indication for use is no longer present;c.Response of the resident during the use of the catheter; andd.Observation for changes in condition related to potential catheter-associated urinary tract infections, recognizing, reporting and addressing such changes.3. Appropriate indications for indwelling catheter use include:Acute urinary retention or bladder outlet obstruction;Need for accurate measurements of urinary output;Assistance in healing of open sacral or perineal wounds in incontinent residents (typically stage 3 or 4);d.Residents that require prolong immobilization (e.g. potentially unstable thoracic or lumbar spine, multiple traumatic injuries such as pelvic fractures); ande. To improve comfort for end of life care, if needed.Inappropriate use for indwelling catheters include:As a substitute for nursing care of an incontinent resident; andAs a means of obtaining urine for culture or other diagnostic tests when the resident can voluntarily void.Additional care practices include:Recognition and assessment for complications and their causes, and maintaining a record of any catheter-related problems;Attempts to remove the catheter as soon as possible when continued catheter use is not indicated;Monitoring for excessive post void residual, after removing a catheter that was inserted for obstruction or overflow incontinence;Keeping the catheter anchored to prevent excessive tension on the catheter, which can lead to urethral tears or dislodgement of the catheter; andSecurement of the catheter to facilitate flow of urine, prevention of kinks in the tubing and positioning below the level of the bladder.Catheters and drainage bags should be changed based on clinical indications such as infection, obstruction, or when the closed system is compromised. Routine, fixed intervals is not recommended. Guideline: Orders and administration of medications and treatments will be consistent with principles of safe and effective order writing.Procedure:Medications shall be administered upon the written order of a person duly licensed and authorized to prescribe such medications in this state as soon as practicable.Authorized, licensed practitioners, or individuals authorized to practitioners, shall be allowed to write orders in the medical record.take verbal orders fromDrug and biological orders must be recorded on the Physician's Order Sheet in the resident's electronic chart.The staff and practitioner shall use Approved abbreviations and symbols when ordering and/or charting medications.Verbal orders should be recorded in the resident's chart by the authorized person receiving the order and should include the prescriber's name, credentials, the date and the time of the order.Verbal telephone orders may be received by licensed personnel (e.g., RN, LPN/LVN, pharmacist, physician, etc.). Orders should be transcribed by the authorized person receiving the order, and recorded in the resident's medical record.The entry should contain the instructions from the physician, date, time, and the signature and title of the person transcribing the information.Orders for medications should include:a.Name and strength of the drug;b.Number of doses, start and stop date, and/or specific duration of therapy;Dosage and frequency of administration;d.Route of administration;e.Clinical condition or symptoms for which the medication is prescribed andPhysician orders should be followed as prescribed, and if not followed, this should be recorded in the resident's medical record during that shift. The physician should be notified and the responsible party if indicated.The resident will be informed of medication changes as they occur. If the resident is deemed incapable of making health care decisions, the resident's responsible party will be informed of medication changes as they occur.		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and photographic evidence, the facility failed to ensure sufficient nursing staff with appropriate competencies and skill sets to provide nursing services needed to meet Activity of Daily Living (ADL) needs for six (#4, 5, 7, 9, 16, 17, 18) of twenty-one sampled residents. Applying a reasonable person's concept, the lack of sufficient nursing staff with appropriate competencies and skill sets to provide nursing services necessary to meet ADL needs, in order to attain or maintain physical, mental, and psychosocial well-being, of Residents #4, 7, 9, 16, 17, and 18 experienced harm. Cross reference: F584, F585, F686, F689, Findings included: On 06/22/2026 at 9:35 a.m., an observation was conducted of the posted staff assignment for the secure memory unit. The posting listed one nurse, Staff F, Registered Nurse (RN), and four aides. The census for the unit was posted as 40 residents. On 06/22/2026 at 9:46 a.m., Resident #9 was observed independently ambulating out of her room. Resident #9's hair was matted and oily in appearance. She was wearing mismatched shoes of different colors, and one pink shoe was on the wrong foot. On 06/22/2026 at 9:49 a.m., Resident #16, a male, was observed independently ambulating down the high 200 hall. Resident #16 entered and exited multiple resident rooms on the hall. No staff were observed monitoring or redirecting the resident during this time. On 06/22/2026 at 10:06 a.m., an interview was conducted with Staff F, RN. She stated she worked Monday through Friday, 7 a.m. to 3 p.m. She stated that usually two nurses worked on the unit during this shift, but she was the only nurse that day. Staff F, RN said it is difficult to get all our duties completed. On 06/22/2026 at 4:30 p.m., Resident #16 was observed exiting Resident #17's room, a female resident's room. Resident #16 closed the door behind him, walked down the hall, and entered another resident's room. Surveyors knocked on the closed door of Resident #17's room. A female voice was heard. Upon entering the room, Resident #17 was observed in the window bed. An odor of feces was strong. The bed was at regular height, and the head of the bed was elevated approximately 30 degrees. A hospital gown was draped over her torso, and her breast was exposed at the side of the gown. Resident #17's eyes were open and she was alert but did not respond in sentences. A soiled brief was observed on the floor at her bedside. Her right foot was draped over her left foot. The soles of both feet had visible dried, caked brown matter throughout the bottoms of the feet and toes. A dime-sized dark maroon scab was present on the right lower shin, with multiple smaller discolored scabs on both legs. Resident #17 did not respond when asked what was on her feet or whether she felt safe. The mattress on the door bed had no linens and had dried brown matter smeared across the surface with an odor of feces. The room had no television; a radio was present but not playing. (Photographic evidence obtained.) On 06/22/2026 at 4:44 p.m., Resident #7 was observed in the door bed of his room, verbalizing nonsensical words, pulling at his sheet, and moving around in the bed. The room had a strong odor of feces. The sheet at mid-torso had smeared feces present. The resident was not able to answer questions. On 06/22/2026 at 4:46 p.m., Staff O, Certified Nursing Assistant (CNA), was observed standing at a point-of-care electronic board near the middle of the high 200 hall, reviewing the electronic board. Staff O was not documenting only reviewing. On 06/22/2026 at approximately 5:00 p.m., an interview was conducted with Staff J, RN. She stated she was working the 3 p.m. to 11 p.m. shift and confirmed she had Residents #17 and #7 on her assignment. She stated she arrived at 2:30 p.m. When asked if she had checked her residents upon starting her shift, she stated, for the most part. Staff J could not state when she last visualized all the residents being responsible for. Staff J stated she had no concerns reported for Resident #17 and that Resident #7 was generally in bed and she had no concerns reported. On 06/22/2026 at approximately 5:11 p.m., Resident #18 was observed independently walking back and forth in the high 200 hall. He was dressed in seasonally appropriate clothing, wearing a shirt and shorts, and no shoes, but non-slip socks. A visible trail of wetness was (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	present on the floor where the resident had ambulated. His socks were visibly wet and stained. No staff were observed assisting the resident to change his clothing or socks. Staff J, RN, was in the hall during the observation. On 06/23/2026 at 9:45 a.m., Staff G, RN, was observed at her medication cart near the nurses' station. A resident was yelling from a nearby room, I need a towel, I need a towel, continuously. The yelling came from the closed door of Resident #4's room. Staff G, RN, entered the room, looked in the bathroom, spoke to the resident, and the resident stopped yelling. Staff G confirmed Resident #4 was in the shower by himself. On 06/23/2026 at 9:47 a.m., Staff F, RN, was interviewed and stated Resident #4 should receive assistance with showers and that sometimes he did not ask for help. On 06/23/2026 at 10:13 a.m., Resident #9 was observed independently ambulating in the high 200 hall. An uncovered open wound was visible in the middle of her chest. The wound was oozing, with a raised darker pink area surrounding it. The resident was observed rubbing her hands over the wound and then wiping her hands on her clothing and the handrail. Resident #9 could not answer questions posed. On 06/23/2026 at 10:29 a.m., Resident #18 was observed sitting on the porch area of the secure unit, dressed in seasonally appropriate clothing. Staff F, RN, stated Resident #18 was incontinent all the time and staff were supposed to clean him if he had an accident. On 06/23/2026 at 10:30 a.m., an observation of Resident #16, sitting in a chair on the porch area of the secure unit. Resident #16 was dressed in seasonally appropriate clothing. During the observation, Staff F, RN, was interviewed, and she stated Resident #16 was new. I do not know him well. I have not heard of him wandering into other residents' rooms. On 06/23/2026 at 10:30 a.m., an interview was conducted with Staff F, RN. She stated her shift was 7 a.m. to 3 p.m. When asked if observing her assigned residents at the start of her shift was part of her responsibilities, she stated, not really. She stated nurses received report at the desk and that new nurses (new to the unit) were given information about the patients. She confirmed certified nurse aides (CNAs) worked 8-hour shifts (7a-3p, 3p-11p, 11p-7a) and were expected to conduct walking rounds within the first 15-20 minutes of the shift. On 06/23/2026 at 10:51 a.m., Staff F, Registered Nurse, (RN) was interviewed. When asked if Resident #9 had any wounds, she stated, I have to look. Staff F was observed to review Resident #9's clinical record and stated, the resident is getting triple antibiotic to her arms. Her last skin check was yesterday, 06/22/2026, she had no issues. During the review, Staff F, also reviewed Resident #9's progress notes and stated, no report of any new skin issues. Staff F stated Resident #9 needed assistance getting dressed. She stated Resident #9 does not always use the toilet and will drop her pants and poop. Yes, she goes into other residents' rooms, when this happens, we clean up the area and take her to the bathroom and clean her up. When asked if staff documented when she had the defecation behavior in other resident's rooms, she stated, Don't think they do. On 06/23/2026 at 10:55 a.m., interview with Staff F, RN was continued. She stated Resident #17 does not speak a lot. Staff have to change her in bed. Staff F stated Resident #17 had the behavior of refusing care at times, but she was unaware of the resident having any behavior with fecal smearing. She said, if the resident had fecal smearing behavior, it should be documented. On 06/23/2026 at 11:13 a.m., an observation of Resident #17 was conducted with Staff F, RN. Resident #17 was observed in her room, alert, eyes open. The bed was low, a sheet covered her torso. Staff F, RN stated (Resident #17) likes to be naked. Staff F, RN was observed to review the bottom of Resident #17 feet, and she stated, it looks like dirt. I know the aid came in this morning and she refused to put on a gown. Her big toes nails could be cut. She has fragile skin. During the observation of the soles of the feet, the brown dried caked-on material on the bottom of the feet that had been observed on 06/22 had been reduced to a dark color layer on the bottom of the feet. Resident #17's toenails on the big toes were observed to be approximately 0.5 centimeters beyond the toe and cracked in appearance. Staff F, RN, stated, her toenails could be cut. She stated toenails would have to be cut by a podiatrist. During the review of Resident #17, Staff F, RN, stated she would want to know about an unclean mattress with feces on it. No one had told her. She stated it was important due to infection control; it is gross and would need to get someone to clean it. On 6/22/26 at 11:06 a.m., a telephone interview was conducted with (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	Resident #5. Resident #5 said he communicated grievances several times to the facility staff. He said he felt the facility was short staffed. Resident #5 provided an example that he was turned and laying on his side for four hours. He said when the certified nursing assistant (CNA) came to assist him, he was told she was busy with other residents. He said he talked to the nursing supervisor about his concerns but was not sure if the concerns were written down. Resident #5 stated, There should be documentation and some kind of follow up. On 6/24/26 at 3:22 p.m., an interview was conducted with Staff D, Licensed Practical Nurse (LPN). He said Resident #5 always expressed his concerns. Staff D, LPN said the resident was on top of his care and wanted to be turned and repositioned every two hours. He said he communicated Resident #5's concerns to the nursing supervisor and the UM. Staff D, LPN said there were about three to four occurrences where the resident expressed the same concerns. On 06/22/2026 at 3:59 p.m., a phone interview was conducted with Resident #11's family representative. She stated she was aware Resident #11 had multiple falls, she stated for the first fall, she was notified by the facility, and the resident was not sent to the hospital. On the second fall, Resident #11 was sent to the hospital and returned the same day. On the third fall, she was sent to a different hospital and they kept her. The first fall, she (Resident #11) was complaining about seeing floaters in her eyes. I was there for one of the falls, I found (Resident #11) yelling from the bathroom. Two staff came, one said she had a bad back and couldn't assist, they need better training. On the third fall, she was face down. Resident #11 had eleven falls for the one month residency, 5/15/26 to 6/13/26 when discharged to the hospital due to a fall. On 06/23/2026 at 12:13 p.m., the Director of Nursing (DON) was interviewed. She stated she expected CNAs to conduct walking rounds every two hours. She stated CNAs were encouraged to go room to room during report and that they used a walking round sheet. She stated rounding required seeing the resident every two hours at minimum. A review of Resident #7's clinical chart, the Face sheet documented and admission of 12/2022. Resident #7's diagnosis list included: Alzheimer's disease with early onset, need for assistance with personal care and cognitive communication deficit. A review of a Brief interview For Mental Status, dated 04/23/2026, documented a score of 1, which indicated severe cognitive impairment. A review of Resident #7's Care Plan revealed a focus area: The resident has a risk for complications r/t (due to) incontinence of bowel and bladder, initiated 06/11/2023. Interventions included: Monitor for incontinence frequently and provide prompt care, initiated 06/11/2023; provide good hygiene practices, clean peri area will after BM in order to help prevent bacteria in urinary tract, initiated 06/11/2023. On 06/22/2026 at 9:54 a.m. and 4:26 p.m., and on 06/23/2026 at 9:45 a.m., observations were made of a sitting chair located in the small common area at the end of the high end 200 hall - secured unit. The chairs had visible stains and uneven discoloration. Both the chairs and the floor were unclean, with brown streaks and an odor of feces present. In the corner of the common area, a clear trash bag containing soiled incontinent products, an open milk carton, and other trash was observed. In the middle of the high end 200 hall - secured unit, a recessed area contained two sitting chairs with brown stains and varying discoloration to the fabric. The floor beneath this area had a dark brown smear and appeared soiled. On 06/22/2026 at 4:30 p.m. and again on 06/23/2026 at 10:15 a.m., an observation of room [ROOM NUMBER] was conducted. An open closet was observed. On the floor of the closet were dried clumps of feces and smeared fecal matter surrounding them. A noticeable feces odor was present. Additionally, on the floor next to the window-side bed, a semi-dried liquid substance was observed that appeared sticky. On 06/22/2026 at 4:30 p.m., an observation of room [ROOM NUMBER] was conducted. A soiled brief was observed on the floor at the bedside. The door-side bed did not have linens present and had dried brown matter smeared across the top and sides of the mattress, accompanied by a noticeable bowel movement odor. A padded cloth sitting chair positioned in front of the closet was observed with smears and discoloration. A review of the facility's guideline for Nursing Rounds, undated, documented: Guidelines: rounds should be conducted by a nursing staff at least every two (2) hours. This task will be completed to identify residents' needs proactively. Steps: The nursing staff will conduct walking rounds during shift (continued on next page)		

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F 0725 Level of Harm - Actual harm Residents Affected - Few	changes. Additionally, the nursing rounds will conduct nursing rounds at least every two (2) hours to identify residents' needs proactively and promote customer satisfaction. If there is a need for more frequency of rounds, the IDT will determine if an enhance supervision, such as hourly, Q-30 minute, or Q-15-minute checks/rounds is necessary for a specific resident. The IDT (Interdisciplinary Team) will obtain an order from the nurse practitioner/ attending physician if enhance supervision is needed. The resident care plan will be also be reviewed and updated to address the need for enhanced supervision. Any identified concern identified during nursing rounds will be addressed accordingly. Any identified patterns/trends will be discussed during QAPI meetings. A review of the facility's job description for Charge Nurse, undated, documented the position description: Provides direct nursing care to the residents and supervises the day-to-day nursing activities performed by the certified nursing assistants in accordance with current federal, state, and local regulations and guidelines and established facility policies and procedures. Essential Functions included: Observes for changes in residents' status, notifying the physician and resident family or representative and documenting accordingly. Performs rounds to ensure resident needs are being met and personnel are performing their assigned duties. Knowledge/Skills/Abilities included: Treats all residents with dignity and respect. Promotes and protects all residents' rights. Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines. A review of facility's job description for Certified Nursing Assistant (CNA), undated, documented the position description: Provides CNA nursing services to assigned residents in accordance with care plans, facility policies and procedures and at the direction of supervisor(s). Essential Functions included: Assists resident with or performs activity of daily living for residents in accordance with care plans and established policies and procedures. Assists with tracking the condition of the resident's skin. Reports any presence of pressure areas, skin breakdown or skin tears to nurse and supervisor. Assists nursing staff in carrying out toileting program activities. Knowledge/Skills/Abilities included: Treats all residents with dignity and respect. Promotes and protects all residents' rights. Establishes a culture of compliance by adhering to all facility policies and procedures. Complies with standards of business conduct, and state/federal regulations and guidelines. A review of the facility's assessment, last updated on 06/18/2026, Part 2: Services and care we offer based on our residents' needs: General Care included: Activities of daily living: Bathing, showers, oral/denture care, dressing, eating, support with needs related to hearing/vision/sensory impairment; supporting resident independence in doing as much of these activities by himself/herself. Bowel / Bladder: Bowel/bladder toileting programs, incontinence prevention and care, intermittent or indwelling or other urinary catheter, ostomy, responding to requests for assistance to the bathroom/toilet promptly in order to maintain continence and promote resident dignity. Skin integrity: Pressure injury prevention and care, skin care, wound care (surgical, other skin wounds). Mental health and behavior: Manage the medical conditions and medication-related issues causing psychiatric symptoms and behavior, identify and implement interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD (Post Traumatic Stress Disorder), or other psychiatric diagnoses, intellectual or developmental disabilities.		