STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	105882	A. Building B. Wing	04/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winkler Court	3250 Winkler Avenue Extension Fort Myers, FL 33916

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41155 Based on observation, review of facility policy and procedure, record review and staff interviews, the facility failed to treat 5 (Resident's #94, #26, #3, #220 and #221) of 5 residents observed with respect and dignity during in room meal tray administration. The findings included: On 4/21/25 at 9:01 a.m., during an observation of the morning in room tray service on the Ford Unit the following was noted: Resident #94 had a diagnosis of polyarthritis and dementia. She was observed drinking the milk from the carton. Resident's #26, #3 and #220 had no glass and the milk cartons were not opened. Resident #221 had no glass for the milk, the tray was sitting uncovered in front of him for 14 minutes with no assistance provided. Resident #221 was unresponsive to verbal stimuli. On 4/22/25 at 8:51 a.m., during an observation of morning meal tray pass noted residents who received milk did not receive glasses to serve the milk and had to drink from the carton. On 4/23/25 at 9:23 a.m., Resident #3 had no glass for her milk and the staff did not open the carton for her. Resident #3 said she was not able to open the milk herself. No cups, glasses or straws were provided to serve the milk and residents had to drink from the carton. On 4/22/25 at 9:05 a.m., in an interview Certified Nursing Assistant Staff B said I know the residents do not have glasses for the milk and it shouldn't be like that. The kitchen never sends the cups, and I have to get them straws so they can drink the milk.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on interview and record review, the facility failed to ensure the physician signed the State of Florida Do Not Resuscitate (DNR) order in a timely fashion for 3 residents (#39, #72, and #78) of 3 reviewed who chose a DNR status. Failure to have the physician sign the Florida DNR order. leaves the resident at risk of receiving cardiopulmonary resuscitation (CPR) against their wishes during transfer by Emergency Medical Services (EMS). The findings included: A Florida DNR form is considered an advance directive. It's a specific type of advanced directive that instructs healthcare providers not to perform cardiopulmonary resuscitation (CPR) if the patient's heart or breathing stops. In Florida, a DNR order is a legal document, specifically DH Form 1896, directs medical professionals not to perform CPR on a person in the event of cardiac or respiratory arrest. The form must be on yellow paper and signed by both the resident (or their authorized representative) and the resident's physician. Review of the Standard and Procedure for CPR Code Status Orders and Response updated February 2023, page 1 of 5: Code status physician's orders (DNR or Full Code), state specific forms and/or resident preference documentation will be filed as the first item within the medical record. Review of the Standard for Physician Orders, effective [DATE], page 1 of 3: .Physician orders will be dated and signed at next physician visit . Page 2: 7. Obtain physician's countersignature within the required time frame as defined by State Law. In the absence of State law, the countersignature will be obtained on the next visit. 8. Receive and utilize a physician's faxed orders. Photocopy the facsimile to maintain the integrity of the order in the medical record if necessary if subject to fading . Page 3 of 3: Physician signature will be required on next visit. Place signed orders in the medical record. Review of the Policy and Procedure for Advance Medical Directives - DNR: Page 2 of 2: #2. Obtain any current Advance Medical Directive from the resident or their representative and place in the medical record. Resident #78 was admitted to the facility on [DATE]. Diagnoses included diabetes, cerebrovascular disease, paralysis on one side, and depression. On [DATE], a DNR order was initiated by the physician and placed in the medical (paper) chart. On [DATE] review of the paper and electronic charts revealed there was no corresponding Florida State specific yellow DNR order signed by the physician. The yellow DNR form is necessary for transport out of the facility and prevents CPR in a medical emergency. On [DATE], Registered Nurse (RN) Staff G documented in a progress note Resident #78 wanted to change to a DNR status. On [DATE] at 10:00 a.m. Resident #78 said she told the facility she wanted to be DNR status. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 5:36 p.m. RN Staff G, responsible for care plan meetings and care plan revisions, said she wrote the progress note, but did not update the care plan or have the resident or physician sign the state specific form. On [DATE] at 6:04 p.m., the Social Services Director (SSD) said she did not have Resident #78 sign the state specific DNR order. On [DATE] at 6:08 p.m., the Unit Manager RN Staff I said he did not have the resident sign the state specific DNR order. On [DATE] at 9:10 a.m., the SSD said she had the resident sign the Florida State specific yellow DRN order yesterday, only after learning it had not been done yet. The SSD said they are waiting for the physician to sign the form. Resident #39 was admitted on [DATE]. Diagnoses included chronic obstructive pulmonary disease (COPD), diabetes (DM), heart failure, and dementia. On [DATE], the resident's responsible party signed the state specific DNR order. On [DATE], review of the paper chart revealed there was no state specific DNR form in the paper chart. On [DATE], the Director of Nursing (DON) located the form in the physician's folder. It was not signed by the physician. Resident #72 was admitted on [DATE]. Diagnoses included diabetes, hypertension, and surgical aftercare. On [DATE], the physician wrote an order for DNR. On [DATE], the resident signed the state specific DNR order. On [DATE], the resident signed a 2nd state specific DNR order. On [DATE], review of the hard chart determined there was no state specific form in the chart as required. On [DATE], the state specific form was located in the physician's folder. It was not signed by the physician. On [DATE], the DON said the Florida State specific DNR order form is necessary to transport the resident out of the facility. She said the forms are handed to EMS personnel upon transfer out of the facility. She said the forms are necessary and should be signed timely by residents and physicians and placed in the chart.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review, observation, and interview, the facility failed to update/revise the comprehensive care plan related to pressure injuries for 1 Resident (#68) of 3 residents reviewed with pressure injuries. The findings included: Resident #68 was admitted on [DATE] with end stage renal disease, type 2 diabetes, weakness, cognitive communication deficit, heart failure, need for assistance with personal care, feeding tube, colostomy tube, and indwelling urinary catheter. He was admitted to the facility with multiple pressure wounds. He had a Brief Interview of Mental Status (BIMS) score of 3 which indicateshe is cognitively impaired. Record review of the admission assessment did not reflect identification of a Stage 2 flank wound or a Stage 3 coccyx wound. Record review of the weekly skin assessments showed the following newly identified wounds. on 4/8/25, a Stage 2 pressure injury right rear flank, inferior and on 4/8/25, a Stage 3 pressure injury on the coccyx. On 4/21/25, the care plan did not reflect goals or interventions for a Stage 2 pressure injury to the flank, or a Stage 3 pressure injury to the coccyx. Record review of the dialysis communication binder showed no documentation of communication the resident had newly diagnosed pressure injuries or that he required offloading or repositioning. On 4/21/25 at 12:25 p.m., Resident #68 was observed lying in bed with a home health aide sitting next to him. He was laying on an air mattress with multiple dressings seen on his legs. On 4/22/25 at 4:15 p.m., Resident #68 was observed being wheeled to his room after returning to the facility from dialysis. He was sitting low in his wheelchair, with his feet hanging off the footrest. He was not able to reposition himself and said he was in pain. Three staff members from physical therapy, including Staff U, Director of Therapy, arrived to assist the resident using the mechanical lift to get him back to bed. When resident #68 was lifted out of his wheelchair, it was observed that he did not have any type of offloading devices for his flank, and he had been sitting on a thick blanked that covered the offloading cushion. * On 4/23/25 at 9:23 a.m., Staff W, Physical Therapy (PT) said that the provided wheelchair did not provide any offloading support for the right flank wound, and the offloading cushion is intended to prevent pressure injuries to the coccyx. On 4/23/25 at 9:45 a.m., Staff U, Therapy Director, said strict repositioning procedures should be followed by the healthcare provider while using the offloading cushion. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 10:30 a.m., during an interview, Staff X, Occupational Therapy (OT) and Staff Y, OT said that an offloading cushion is sufficient, and repositioning is not required. On 4/23/25 at 10:35 a.m., during an interview, Staff Z, CNA said that you do not need to reposition someone who is sitting on an offloading cushion because it is doing its job. On 4/23/25 at 10:40 a.m., during an interview, Staff AA, CNA, said a resident on an offloading cushion does not need to be repositioned. On 4/23/25 at 11:52 a.m., during an interview, the Risk Manager stated everyone just knows that the resident needs to be turned and repositioned, we don't have a scheduled turning program. On 4/23/25 at 12:00 p.m., the Director of Nursing (DON) said that if a resident has a worsening wound, she would expect to be notified so that she can assist with managing the wound and ensure the orders and interventions are correct. She also stated that, we don't have a turn and reposition program or policy, it depends on the needs of the resident's needs. On 4/23/25 at 4:30 p.m., during a wound care observation, the right flank wound on Resident #68 had black tissue that was not noted in the documentation, and a dressing that was dated 4/22/25. Staff Q, RN Supervisor stated, I would say that due to the slough, this wound is unstageable, I have not seen this wound for at least a week, I would say that it is stable. On 4/23/25 at 5:00 p.m., the resident's physician said that he does not recall seeing the wound on Resident #68 and does not know if there is black tissue in the wound bed because he has staff to address the wounds. He also said that the facility still needs to turn and reposition the resident regardless of whether he is high risk for developing additional wounds. Record reviews show that a significant change in condition was not documented for the unstageable wound that was assessed with three RN managers present, Staff Q, RN, Staff M, RN and Staff I, RN. On 4/24/25 at 9:15 a.m., the DON said that the nursing staff had not reported any black tissue on Resident #68. On 4/24/25 at 9:20 a.m., an observation of Resident #68 was made, he was sitting in a wheelchair in his room, with no offloading to right flank. On 4/24/25 at 9:30 a.m., during a phone interview, the Physician's Assistant said that he relies on the facility's wound team to accurately describe the wound and that he had not seen it. He was not aware that there was black tissue on the wound. He also said that he would want to be informed if the wound tissue was black so he could ensure the resident receives the proper care. *Photographic Evidence Obtained.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review, observation, and interview, the facility failed to ensure residents receive accurate assessments for 1 Resident (#68) of 3 residents reviewed. The findings included: Resident #68 was admitted on [DATE] with end stage renal disease, type 2 diabetes, weakness, cognitive communication deficit, heart failure, need for assistance with personal care, feeding tube, colostomy tube, and indwelling urinary catheter. He was admitted to the facility with multiple pressure wounds. He was also cognitively impaired based on a Brief Interview of Mental Status (BIMS) score of 3. He attends dialysis at an outside facility. Record review showed an admission skin assessment, completed by Staff M, Registered Nurse (RN) Unit Manager, did not document the presence of a wound on the coccyx or on the right flank. Record review of the Admission Minimum Data Set (MDS) dated [DATE] did not assess a Stage 3 pressure injury or an unstageable pressure injury upon admission. There was no slough (yellow, stringy) or eschar (black, hard) tissue assessed. Record review of the weekly skin assessments showed the following newly identified wounds that were not found in the admission assessment. On 4/8/25, a Stage 2 wound right rear flank, inferior, and on 4/8/25, a Stage 3 wound on the coccyx. As of 4/21/25 the resident's care plan had not been updated to include these findings. On 4/21/25 at 12:25 p.m., Resident #68 was observed lying in bed with multiple dressings seen on his legs. His heels were directly on the mattress, and he was laying on his back. On 4/21/25 at 4:14 p.m., Resident #68 seen laying in bed. his heels directly on mattress, laying on his back. On 4/22/25 at 9:30 a.m., during an interview, Staff M, Registered Nurse, (RN) Unit Manager, said that Resident #68 was seen on nursing wound rounds, but there is no wound provider assigned to this resident. She is a designated wound-round nurse and performs weekly skin checks. She said that wound evaluations and measurements are performed on the facility provided tablet which has an app (application). She said there are a number of variables as to why part of an assessment recorded on the app might be inaccurate including the technique of the user. On 4/22/25 at 10:27 a.m., during an interview, Staff I, RN, Unit Manager, said he is a designated wound-round nurse. He stated, the facility uses the tablet, we take the picture, it measures the wound, and we describe and stage it, then it is uploaded to the electronic health record. He also said that the wound measurements and uploaded graphic can be inaccurate due to a number or reasons, including the technique of the person operating the tablet. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 4:12 p.m., during an observation of Resident #68 arriving back to the facility from dialysis, there is no offloading device for right flank present and the offloading device for the coccyx was obstructed by a thick blanket. On 4/23/25 at 10:30 a.m., during an interview, Staff I, RN, Unit Manager, said the coccyx and flank wounds on Resident #68 are improving but are also stable. He said that the coccyx wound he recently assessed has less exudate and is stable. On 4/23/25 at 11:10 a.m., during an interview with the Assistant Director of Nursing (aDON), who is also the Staff Educator said she does not provide staging training for wounds. Education is provided by the dressing supply vendor. On 4/23/25 at 11:52 a.m., during an interview the Risk Manager said the facility has not investigated the resident's right flank wound. She stated that, the assessment was not finalized on 4/6/24 therefore we were not aware of it until 4/22/25. She said she looked at the wound, but used the electronic nursing assessment to describe what she saw. On 4/23/25 at 1:00 p.m., the DON said that the facility has a dressing supply vendor who rounds on Tuesdays with the staff, assesses wounds with them, and provides staging education to the supervisors. She said that she does not go by the wound measurements, only by the description and relies on the nurses assessing the wounds on a weekly basis, to determine the status of the wounds because the measurements can fluctuate depending on the person using the device. Record review of the assessment on 4/22/25 for coccyx wound showed, Stage 3 pressure injury, area 5. 52cm x length 2.37 x width 2.85 x depth 1.2 cm and was described as: 80% granulation, 10% slough, no eschar documented. Light serosanguinous drainage. Record review of the assessment on 4/23/25 for coccyx wound showed, Stage 3 pressure injury, area 74.81 cm x length 10.62cm x 9.31 cm x depth 1.0 cm and was described as 100% slough. No eschar documented. Heavy serous drainage. On 4/23/25 at 5:00 p.m., obsered the wound assessment of Resident #68 right flank performed with Staff I, RN Unit Manager, Staff M, RN Unit Manager and Staff Q, RN, Unit Manager Staff M, RN, Unit Manager said that the wound appeared to be unchanged from 4/22/25 to the best of her recollection. Staff Q, RN, Unit Manager stated, I would say this wound is unstageable, and I will document that it is stable. Staff M, RN, Unit Manager stated, I would say that due to the slough, it is unstageable but is the same as yesterday. Resident #68 observed to have a right flank wound with black tissue in the center of the wound bed. Record review of the right flank wound assessment on 4/22/25 showed, Stage 2 pressure injury, area 7.2 cm x length 2.2 cm x width 6.6 cm, depth 0.2 cm. Wound bed 100% epithelial, no slough, no granulation, no eschar. Record review of the right flank wound assessment on 4/23/25 showed, Pressure injury, Stage 2, area 3.5cm x length 2.85cm x width 2.17cm. Eschar, 100%. Progress: Stable. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 5:30 p.m., during a phone interview, the Physician for Resident #68 stated that he does not recall seeing the wound, but the facility should be making efforts to prevent and assess his wounds. He had not had any recent communication from the nursing staff about changes to the wounds. On 4/24/25 at 9:15 a.m., the DON said that she was not aware of black tissue in the right upper flank wound of Resident #68. On 4/24/25 at 9:30 a.m., during a phone interview, the Physician's Assistant (PA) said that he has not seen the wounds on Resident #68 because he relies on the wound team to assess them. He also said that staff has not informed him of black tissue on the right flank wound. On 4/24/25 at 11:30 a.m., during an interview the dressing supply vendor said the she is not a practitioner, and the facility has not asked her to look at the wound of Resident #68. She said she only gives suggestions. She stated, I do not train them to stage wounds, I tell them that they should not be staging . I tell them to describe what they are looking at. It has been at least 5-6 months since I have observed staff assessing a wound.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52199 Based on record review, staff interviews, and observations, the facility failed to complete a PASRR Level II referral for 1 (Resident #43) resident who demonstrated the return of a serious mental illness. This resulted in a lack of appropriate psychiatric assessment and increased risk of unmet care needs. The findings included: Review of the facilities PASRR Requirements Level 1 and Level 2, effective February 2021. The policy does not address a process for a PASRR assessment after the reemergence of a serious mental illness after the residents have been admitted to the facility. Resident #43 was admitted to the facility on [DATE] from another skilled nursing facility with a diagnosis of schizoaffective disorder. A PASRR Level II determination completed on 6/6/2024 indicated that specialized services were not needed. On 1/29/2025, a psychiatric evaluation documented the resident's schizoaffective disorder was considered resolved. A Gradual Dose Reduction (GDR) was initiated, reducing Ziprasidone from 60 mg to 40 mg daily (nn antipsychotic used for the treatment of schizophrenia). A Significant Change in Status Minimum Data Set (MDS) assessment dated [DATE] coded 0 - No for serious mental illness, despite the resident continuing to receive antipsychotic medication and exhibiting cognitive impairment. Review of nursing progress notes dated between 3/11/2025 and 4/7/2025 revealed progressive behavioral changes, including increased agitation, verbal outbursts, territorial guarding of her room, and physical aggression. On 4/8/2025, Resident #43 struck her roommate in the face after the roommate mistakenly sat in her wheelchair, resulting in bruising and scratches to the roommate's face and neck. Review of a psychiatric evaluation performed on 4/8/2025 confirmed the return of psychotic symptoms, including hallucinations and confusion. Resident #43 was re-diagnosed with schizoaffective disorder. Following the incident, psychiatric interventions were initiated: Ziprasidone was increased back to 60 mg daily, Give 1 capsule by mouth one time a day for Schizoaffective disorder/failed GDR. Clonazepam was prescribed for agitation, and laboratory tests were ordered for medication monitoring. The facility updated the resident's diagnosis list on 4/22/2025 to include schizophrenia (F20.9). On 4/21/25 at 9:30 a.m.: Resident #43 was observed in the hallway seated in a wheelchair. The resident was non-verbal, communicating only through low grunting sounds. When other residents or staff walked by, Resident #43 demonstrated increased tension in her posture and visually tracked their movements with narrowed, guarded expressions. On 4/22/25 at 9:56 a.m., when approaching the resident's room, a staff member cautioned, be careful, she doesn't like anybody in her room. The resident was observed eating breakfast but remained highly vigilant toward the hallway, pausing between bites to look sharply at any movement near her door. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 12:28 p.m., Resident #54 was observed stationed directly in front of her door in her wheelchair. As staff and residents approached, the resident exhibited visible agitation: defensively raising her arms, emitting low guttural vocalizations, and posturing her wheelchair aggressively to block the entrance. On 4/24/25 at 10:00 a.m., in an interview Licensed Practical Nurse, Staff H said Resident #43 displayed increased aggressive territorial behavior, especially when placed on GDR. Although some behavioral notes were documented in nursing progress notes, they were not consistently recorded on the Medication Administration Record (MAR) or addressed in the resident's care plans. On 4/24/25 at 4:00 p.m., in an interview the Director of Nursing (DON) confirmed the active schizophrenia diagnosis following the failed GDR. The DON said after the re-emergence of the schizophrenia, a Level II PASRR should have been completed The DON confirmed there was no documentation in the residents' medical records of a PASRR Level II referral being initiated or completed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41905 Based on interview and record review, the facility failed to develop a comprehensive care plan reflective of the resident's choice of code status for 1 (Resident #78) of 3 residents reviewed for advanced directives care planning. The findings included: Review of Resident #78's record revealed a physician's order dated [DATE] for Do Not Resuscitate (DNR) status, meaning that if breathing or heart beats stop, cardiopulmonary resuscitation (CPR) would not be initiated. Review of the nursing progress note by Registered Nurse (RN) Staff G dated [DATE], shows Resident #78 wanted a DNR code status. Review of Resident #78's care plan for advanced directives initiated [DATE], the resident requests Full Code status, meaning CPR would be initiated. On [DATE] at 10:00 a.m., during an interview Resident #78 said she told the facility she wanted a change to DNR status. On [DATE] at 5:36 p.m., during an interview RN Staff G she said she did not revise the care plan for advanced directives as the resident requested on [DATE]. On [DATE] at 6:08 p.m., Unit Manager RN Staff I said he did not revise the care plan to DNR. On [DATE] at 9:02 a.m., during an interview, the Director of Nursing said the care plan should have been revised at the time the resident requested the DNR status.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52199 Based on observation, interview, and record review, the facility failed to ensure that 1 (Resident #54) of 1 residents reviewed for activities received services designed to meet their interests, physical, mental, and psychosocial well-being. The findings included: Resident #54 was admitted to the facility with diagnoses including dementia and cognitive impairment. Review of the resident's care plan, initiated 2/25 and last revised 4/25, identified goals for Resident #54 to participate in activities of choice daily, with interventions including encouraging engagement with a general activities program and providing in-room activities if preferred. Observations across multiple days (4/21/25 at 8:15 a.m., 4/21/25 at 11:14 a.m., 4/21/25 at 3:00 p.m., 4/22/25 at 9:25 a.m., 4/22/25 at 10:39 a.m., 4/22/25 at 12:32 p.m., and 4/23/25 at 9:53 a.m.) demonstrated a lack of activities. Throughout these observations, no activity materials, music, television, or staff-led activities were present or offered to the resident. The only item observed was a Daily Chronicle paper at the bedside, which contained no individualized activities documented for the resident. A review of Resident #54's activity records revealed no documented refusal of activities and no recorded participation in either individual or group activities over the past 30 days. On 4/23/25 at 10:09 a.m., Licensed Practical Nurse, Staff H, was observed briefly checking on Resident #54 but did not initiate any activity. On 4/22/25 12:32 p.m. in an interview Resident #54 verbalized an interest in watching TV. He pointed at the TV, and indicated there was no TV remote, no TV remote was obsered in residents' room [ROOM NUMBER]/21/25 to 4/24/25. On 4/24/25 at 10:00 a.m., Staff H, LPN stated that Resident #54 is not receiving enough stimulation and said more could be done. Staff H, LPN, said the facility's Director of Activities (DOA) visits the unit about once a month and that engagement is primarily handled by the activity's assistant, Staff DD, or CNAs in her absence. On 4/24/25 at 11:30 a.m. during an interview Registered Nurse Unit Manager, Staff I, stated that Resident #54's situation represented a failure in providing adequate engagement. On 4/24/25 at 12:05 p.m., in an interview the Social Services Director (SSD) said when a resident appears lonely or withdrawn, the intervention would be to talk with the family, involve nursing, and consider a psychiatric consult. There was no evidence of any interdisciplinary team response documented for Resident #54 despite ongoing observations of disengagement. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 1:30 p.m., in an interview the DOA said activity preferences were gathered at admission or quarterly, and daily rounds were conducted. When asked about Resident #54's recent activity participation, the DOA said he had not personally engaged the resident, and that documentation was lacking

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of facility policy and procedures and family and staff interviews, the facility failed to ensure the physician was notified and the residents spouse was properly trained to administer medications for 1 (Resident #93) of 5 residents reviewed for medication observation. The findings included: The facility policy 7.1 Medication Administration General Guidelines documented Medications are administered as prescribed in accordance with manufacturers specifications, good nursing principles and practices and only by persons legally authorized to do so. Medications are administered in accordance with written orders of the prescriber. Medications are to be administered at the time they are prepared. The person who prepares the dose for administration is the person who administers the dose. Review of the clinical record revealed Resident #93 was [AGE] year old with an admitted [DATE]. Diagnoses include protein calorie malnutrition, convulsions, muscle weakness and the need for assistance with personal care. On 4/21/25 at 9:06 a.m., in an interview Resident #93's spouse said my wife is [AGE] years old and they are not giving her the medications like they should. They give them to her on an empty stomach and she is on Keppra, (medication used to prevent seizures) and they gave her a double dose this weekend. They put all the medication in apple sauce and try to force her to take them all at one time and she can't do that, she will vomit. I come in daily, and they give me the cup of pills and I make sure she takes them. I give them to her, they trust me here that I know what I'm doing. No one has to stay and babysit me, I know how to give them to her. On 4/21/25 at 12:54 p.m., a review of the physician orders for Resident #93 revealed no order for the spouse to administer the residents' medications. There was no documentation in the plan of care indicating the spouse would administer the medications and no facility assessment of his capability. On 4/22/25 at 9:03 a.m., in an interview Resident #93's spouse said last night they ran out of her Eliquis (a blood thinner) and they told me there was none in the building. He said I come twice a day to give her the medications. I knew she was missing a pill because I count them before I gave them to her and they were short one pill last night. A review of the Medication Administration Record revealed the nurse had administered the medications including the Eliquis. On 4/22/25 at 9:25 a.m., observed Licensed Practical Nurse (LPN) Staff C taking Resident #93's morning medications into the room and handed them to the spouce, and then returned to the medication cart. Staff C did not stay with the resident to ensure the medications were given. On 4/22/25 at 9:35 a.m., in an interview LPN Staff C said the resident will not take her medications for anyone but the husband. I give them to him, but I stand there and make sure she takes them all. LPN Staff C said he did not know if there was a physician order to allow the spouse to administer the medications. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 10:06 a.m., in an interview the Director of Nursing (DON) said she was not aware the staff were permitting Resident #93's husband to administer the medications and that they were signing the MAR that they had administered the medications. The DON said there was no documentation the physician was notified, no physician order and no assessment of the spouse's ability to administer the medications. On 4/23/25 at 8:45 a.m., in an interview LPN Staff D said Resident #93 will not take the medications for anyone but her husband, I mean no one. I get the medications, and I give them to him, it is the only way she will take them. On 4/23/25 at 4:31 p.m., in an interview the DON confirmed Resident #93's husband was giving her the medications. The DON said I spoke with the nurses, and they said Resident #93 absolutely will not take her medications for anyone but him. They did say they stood there while he gives her the medications. I know what you mean, there is no assessment, and no documentation the spouse can give the medications. The nurse should be administering the medications. 41905

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41155 Based on observation, review of clinical records and resident and staff interviews, the facility failed to assist in making an appointment with a practitioner specializing in the treatment of vision impairments and failed to ensure the resident's glasses were in good repair for 1 (Resident #50) of 1 resident reviewed for vision loss. The findings included: The facility policy Referral - Vision and Hearing Services documented The facility will assist residents in obtaining routine and prompt vision or hearing care period the social services department will work to assist and or coordinate services, such as but not limited to the following: 1. Appointments. 2. Prompt referrals (i.e , broken hearing aids glasses etcetera). 3. Identify those residents who require a prompt referral. Examples include but are not limited to: Damaged or broken hearing aids, glasses, or other assistive devices. Review of the clinical record revealed Resident #50 was [AGE] years old and had an admitted [DATE] with diagnoses including: type 2 diabetes mellitus, hemiplegia of the dominant right side and glaucoma. Review of the Quarterly MDS dated [DATE] noted the residents cognitive skills for daily decision making were moderately impaired. The care plan for Resident #50 identified the resident has potential for impaired visual function related to Glaucoma, and wears glasses while awake. The interventions instructed staff to Assist with cleaning or placing glasses as needed. Report any damage to nurse/social service. On 4/21/25 at 8:16 a.m., Resident #50 was observed in bed with broken bi-focal glasses on that were missing the left arm of the frame. He said he wanted new glasses, but no one would repair or replace them. On 4/22/25 at 9:18 a.m., in an interview and observation Resident #50's glasses remained broken and he glasses were sitting crooked on his face. He said he wanted them to be fixed. On 4/23/25 at 8:19 a.m., in an interview the Director of Nursing (DON) said she was unaware Resident #50 's glasses were broken and she would check into it. On 4/23/25 at 10:14 a.m., in an interview the DON said the process for vision concerns was the staff notify the nurse and a Resident Concern form is initiated by the Social Service Director (SSD), and then we review it in the morning meeting. The DON said no one knew his glasses were broken. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON provided a Physician Order for Eye Care dated 8/20/24 with a plan for a follow up visit in 6 months. The visit on 8/20/24 was for Eye Care Consultation Examination with no mention of the residents glasses. There was no documentation the facility followed up with the recommended 6 month visit. On 4/23/25 at 11:00 a.m., in an interview the SSD said she has been at the facility for 2 months, and the process for anyone requiring a vision or hearing appointment was the nurse identifies the concern during rounds with the residents and notifies me and then I make the appointments. The SSD said she was not aware Resident #50's glasses were broken and in need of repair. On 4/23/25 at 11:12 a.m., in an interview CNA Staff E said Resident #50's glasses have been broken for months. He told me he rolled over in bed with them on and they broke. Everyone knows they have been broken like that for a long time now. You tell the nurse, and they are supposed to take care of it.

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F 0686 Level of Harm - Minimal harm or potential for 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** 51818 Based on record review, interview, and observation, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services and prevention of new ulcers from developing for 1 Resident (#68) of 3 residents reviewed. The findings included: Resident #68 was admitted on [DATE] with end stage renal disease, type 2 diabetes, weakness, cognitive communication deficit, heart failure, need for assistance with personal care, feeding tube, colostomy tube, and indwelling urinary catheter. He was admitted to the facility with multiple pressure wounds. He was also cognitively impaired based on a Brief Interview of Mental Status (BIMS) score of 3. He attends dialysis at an outside facility. Record review of the admission History and Physical said that Resident #68 was high risk for skin breakdown and unavoidable wounds due to malnourishment. Record review showed an admission skin assessment, completed by Staff M, Registered Nurse (RN) Unit Manager, did not find a wound on the coccyx or on the right flank. Record review of the Admission Minimum Data Set (MDS) dated [DATE] did not identify a stage 3 pressure injury or an unstageable pressure injury upon admission. There was no slough or eschar identified. There were no venous or arterial ulcers present. The MDS did not identify a pressure reducing device for the bed, turning/repositioning program, or nutrition/hydration interventions. On 4/21/25, record review of the care plan included interventions for pressure injury prevention such as turn and reposition as needed, and cushion to chair. Record review of the weekly skin assessments showed the following newly identified wounds that were not found in the admission assessment: 4/8/25, a Stage 2 wound right rear flank, inferior. 4/8/25, a Stage 3 wound coccyx. On 4/21/25 at 12:25 p.m., Resident #68 was observed lying in bed with the home health aide sitting next to him. He was laying on an air mattress with multiple dressings seen on his legs. The home health aide said that he does not provide turning or repositioning assistance, he is only there to stimulate him, talk with him, or help with feedings. On 4/22/25 at 9:30 a.m., Staff M, Registered Nurse, (RN) Unit Manager, said that Resident #68 was seen on nursing wound rounds, but there is no wound provider assigned to this resident. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/22/25 at 4:15 p.m., Resident #68 was observed being wheeled to his room after returning to the facility from dialysis. He was found to be sliding out of his wheelchair, with his feet hanging off the footrest. He was not able to reposition himself and was saying he was in pain. Three Staff Members from physical therapy, including Staff U, Director of Therapy, arrived to assist with using the mechanical lift to get him back to bed. When Resident #68 was lifted out of his wheelchair, it was observed he did not have any type of offloading devices or pillows for his flank, and he had been partially sitting on a thick blanket that was obstructing the offloading cushion for the seat of the wheelchair. * On 4/23/25 at 9:23 a.m., Staff W, Physical Therapy (PT) said that the wheelchair did not provide any offloading support for the right flank wound, and the offloading cushion is intended to prevent pressure injuries to the coccyx. On 4/23/25 at 9:45 a.m., Staff U, Therapy Director, said strict repositioning procedures should be followed while using the offloading cushion. On 4/23/25 at 10:30 a.m., during an interview, Staff X, Occupational Therapy (OT) and Staff Y, OT said that an offloading cushion is sufficient, and repositioning is not required while in wheelchair . On 4/23/25 at 10:35 a.m., during an interview, Staff Z, CNA said that you do not need to reposition someone who is sitting on an offloading cushion because it is doing its job. On 4/23/25 at 10:40 a.m., during an interview, Staff AA, CNA, said that while sitting on an offloading cushion, a resident does not need to be repositioned. On 4/23/25 at 11:52 a.m., during an interview, the Risk Manager said everyone just knows the resident needs to be turned and repositioned, we don't have a scheduled turning program. On 4/23/25 at 12:00 p.m., the Director of Nursing (DON) said that if a resident has a worsening wound, she would expect to be notified so that she can assist with managing the wound and ensure the orders and interventions are correct. She stated, we don't have a turn and reposition program or policy, it depends on the needs of the resident. On 4/23/25 at 4:30 p.m., during a wound care observation, the right flank wound on Resident #68 had black tissue that was not previously assessed in the wound assessment. Staff Q, RN Supervisor stated, I would say that due to the slough, this wound is unstageable, I have not seen this wound for at least a week, but since it looks the same, I would say that it is stable. On 4/23/25 at 4:25 p.m., Staff M, RN verified that the wound to the right flank was unchanged from the prior day and agreed that it is an unstageable wound. On 4/23/25 at 5:00 p.m., the resident's physician said that he does not recall seeing the wound on Resident #68 and does not know if there is black tissue in the wound bed because he has staff to address the wounds. He also said that the facility still needs to turn and reposition the resident regardless of whether he is high risk for developing additional wounds. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review showed that a significant change in condition was not documented for the unstageable wound that was assessed with 3 RN managers present, Staff Q, RN, Staff M, RN and Staff I, RN. On 4/24/25 at 9:15 a.m., the DON said that the nursing staff had not reported any black tissue that was identified on Resident #68. On 4/24/25 at 9:20 a.m., an observation of Resident #68 was made, he was sitting in a wheelchair in his room, with no offloading to the right flank. * On 4/24/25 at 9:30 a.m., during a phone interview, the Physician's Assistant said that he relies on the facility's wound team to accurately describe the wound and that he had not seen it. He was not aware that there was black tissue on the wound. He said he would want to be informed if the wound tissue was black so he could ensure the resident receives the proper care.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51818 Based on record review, interview, and observation, the facility failed to offer a therapeutic diet for 1 (Resident #60) of 2 reviewed for nutrition. The findings included: Resident #60 was admitted on [DATE] with muscle wasting and atrophy, type 2 diabetes, anemia, heart failure, chronic ulcers, and kidney failure. He goes to the dialysis center 3 times per week. He scored a 15 on his Brief Interview of Mental Status (BIMS) which indicates he is cognitively intact. On 4/21/25 at 4:08 p.m., Resident #60 was interviewed in his room after arriving from the dialysis center He stated, I'm waiting for dinner, they need to hurry I am starving. On 4/21/25 at 4:25 p.m., during an interview, Staff V, Registered Nurse (RN) said that he ate 100% of his breakfast and the facility provides him a lunch, she does not know why he is so hungry. Record review of the Dialysis Communication log dated 4/21/25 showed that at 8:30 a.m, Resident #60 ate breakfast at the facility, and he traveled to dialysis with a bagged lunch. The dialysis center did not document if the lunch had been eaten. On 4/21/25 at 4:30 p.m. during an observation, Resident #60 had an empty lunchbox in his room hanging from his wheelchair. He said that he didn't remember eating lunch that day but was very hungry and requested something to eat. Record review of the diet order for Resident #60 showed that there was an order for the resident to receive a chronic kidney disease diet (CKD) with extra portions. On 4/22/25 at 9:10 a.m., during an observation, the contents of the dialysis lunchbox for Resident #60 who was leaving for dialysis, included a sandwich, 2 packs of crackers, an empty water bottle, and a napkin. On 4/23/25 at 9:33 a.m., during an interview, Dietician Staff J, said that Resident #60 is stable on a CKD diet, and she is frequently monitoring him. She said that in general, residents going to dialysis should be getting sandwiches, applesauce, water or juice, unless they are to receive large portions for lunch. Staff J said she was not aware Resident #60 had been saying he was starving when he arrived back from Dialysis on 4/21/25. On 4/23/25 at 9:35 a.m., during an interview Kitchen Manager Staff K, said that today, Resident #60 should have received 1 beef sandwich, 1 juice, 2 packs of graham crackers. She read this from a list that was posted on the wall. Staff K, Kitchen Manager, also said that if there is a concern, staff or the resident can come down to the kitchen at any time to let them know. She said she was not aware of an issue with Resident #60's lunch. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/23/25 at 9:40 a.m., Kitchen Manger Staff K said that she does not double check the meal once it's packed by the kitchen staff, instead she picks up the lunch box and checks its weight and contents with her hands, but does not open the box and look. She demonstrated this with another prepacked lunch box. On 4/23/25 at 10:15 a.m., Dietician Staff J, and Kitchen Manager Staff K, said they had reviewed the orders for Resident #60, and he should be receiving double portions, which would include an additional half sandwich, a juice, a fruit and a snack.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52199 Based on observation, interview, and record review, the facility failed to implement an effective Infection Prevention and Control Program (IPCP) for 5 (Residents #111, #25, #27, #68, and #216) of 5 residents sampled for Infection control practices putting the residents at risk for transmission of multidrug-resistant organisms (MDROs). The findings included: Review of the facility's IPCP policy stated, The IPCP is a comprehensive program that addresses detection, prevention, and control of infections and communicable diseases among residents, visitors, volunteers, those individuals providing services under contractual agreement, and personnel. The IPCP, in addition, will facilitate activities to improve antibiotic use to reduce adverse events, prevent the emergence of antibiotic resistance, and promote better outcomes for residents. The goals of the IPCP are to: a. Provision of a safe, sanitary, and comfortable environment b. Decrease the risk of infection and communicable diseases development and transmission to residents, volunteers, visitors, individuals providing services under a contractual arrangement, and personnel. c. Monitor for the occurrence of infections and communicable diseases and implement appropriate prevention measures to reduce occurrences d. Identify and correct problems relating to infection control and prevention practices. e. Focus on activities to optimize the treatment of infections, while reducing potential for the occurrence of adverse events associated with antibiotic use. Review of the facilities Enhanced Barrier precautions (EBP) policy showed EBP refers to an infection control intervention designed to reduce transmission or MDROs that employs targeted gown and glove use during high contact resident activities. EBP are used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) to include donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP is indicated for residents with any of the following: 1. Infection or colonization with a CDC-targeted multi-drug-resistant organism when Contact Precautions do not otherwise apply, or 2. Wounds and/or indwelling medical devices, even if the resident is not known to be infected or colonized with an MDRO. Residents #25 and #111, residing in the Memory Care Unit, were both on EBP related to wound care. A third resident, #68, located outside of the Memory Care Unit, was also under EBP for wounds, a Foley catheter, tube feeding, and a colostomy bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During observation of the Memory Care Unit on 4/21/25 from 8:00 a.m., through 11:30 a.m., staff were not observed wearing gowns at any time when providing care to residents #25 and #111 on EBP. On 4/22/25 at 10:15 a.m., during an interview and resident room audit for PPE, the DON reported the facility's policy is to post EBP signage above the resident's bed, and PPE is to be stored in the resident's bathroom cubby. Observations of Resident #25's and Resident #111's room revealed no gowns stored in the resident bathroom cubby. The DON explained PPE audits are to be done daily but acknowledged the daily PPE audit was not done on 4/22/25. On 4/23/25 at 1:10 p.m., Resident #25 was observed seated in her wheelchair outside her room, repeatedly asking for assistance to use the bathroom. No licensed staff were visible in the hallway. Resident #25 became agitated and began to navigate down the hallway in search of help. On 4/23/25 at 1:25 p.m., Certified Nursing Assistant (CNA), Staff A, responded to Resident #25. The staff member was observed wearing gloves but did not don a gown while providing direct toileting care. After assisting the resident, Staff A said the resident was on EBP and she did not wear a gown when assisting Resident #25 with toileting, and stated she only used gowns when the residents had scabies. On 4/24/25 at 10:00 a.m., in an interview Licensed Practical Nurse (LPN) Staff D said PPE was not consistently available at the entrance of the resident rooms and should be more accessible, especially to staff entering to perform care. She confirmed receiving EBP training this year but could not recall the date. On 4/24/25 at 10:35 a.m., in an interview the Memory Care Unit Manager, Staff E said he relies on frequent rounding of the nursing staff to monitor PPE compliance. When informed of the missing PPE in resident rooms in the memory care unit and Staff A not donning a gown when assisting Resident #25 with toileting, he said There was a failure there. On 4/24/25 at 2:20 p.m., in an interview Infection Preventionist Staff C said she dedicates more than 20 hours a week to infection control, along with daily PPE rounds that are also conducted by the unit managers and nursing staff. She explained that the facility follows CDC guidelines. She said the facility intentionally omits door caddies for EBP residents in Memory Care due to concerns over resident confusion and cost effectiveness. She said she last conducted staff gown donning and doffing training in February 2025, and spot checks for PPE compliance are conducted every other day. Staff C admitted that making PPE more accessible to staff in the Memory Care Unit is an area needing improvement. 41155 The facility Policy obtained from the Director of Nursing from the Lippincott Manual 9th Edition Management of the Patient with an indwelling catheter and closed drainage System documented Maintaining a closed drainage system: a. Keep the drainage bag in a dependent position, below the level of the bladder. b. Keep the bag off of the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 10:16 a.m., in an interview the Director of Nursing (DON) said IV dressings are to be changed every 7 days. Review of the Medication Administration Record (MAR) revealed on 4/17/25 the nurse signed the record indicating Resident #216's dressing had been changed. The DON said I understand. On 4/23/25 at 8:47 a.m., in an interview the DON said I don't understand how you can have a photo of the PICC line and the MAR said the dressing was changed. I had my nurse go through the garbage last night looking for any PICC line dressings and they do not match your photos. The DON reviewed the photo's and verified that they have a date and time stamp on them. No evidence of a dressing change on 4/17/25 was produced by the facility at the time of exit from the facility. On 4/21/25 at 10:27 a.m., Resident #27 said he was receiving antibiotics via a PICC line in the right antecubital, he said he did not know why he was receiving the antibiotics. The resident showed his arm where the PICC line was inserted. The dressing covering PICC was dated 4/12/25 but was difficult to read as it had been written over several times with a darker pen. Review of the clinical record documented a physician order to Change IV Dressing every 7 days as well as PRN for soiling and/or dislodgement., every evening shift, every 7 day(s) and as needed. Review of the MAR documented the PICC line dressing was changed on 4/11/25 and 4/18/25. On 4/22/25 at 10:10 a.m., during an interview the Director of Nursing (DON) said she was not aware the resident had a PICC line. Reviewing the findings with the DON, and the photographic evidence obtained on 4/21/25 showing dates of 4/4/25, 4/11/25 or 4/14/25. The DON confirmed it was not clear when the dressing was actually changed for Resident #27 as it was written over with a darker ink. 51818 Resident #68 was admitted on [DATE] with end stage renal disease, type 2 diabetes, weakness, cognitive communication deficit, heart failure, need for assistance with personal care, feeding tube, colostomy tube, and indwelling urinary catheter. On 4/22/25 at 4:12 p.m., during an observation, Staff R, CNA, and Staff S, CNA, were observed providing urinary catheter care, and changing a adult brief without wearing protective gowns during the care. Above the bed of Resident #68 hangs a sign that reads, providers and staff must wear gloves and gown for the following high contact care activities: changing briefs, and urinary catheter care. On 4/22/25 at 4:15 p.m., Registered Nurse (RN) Unit Manager Staff Q entered the room to assess a sacral dressing while the CNA's were providing care, but did not address the staff about needing to wear gowns. On 4/22/25 at 4:20 p.m., during an interview, Staff Q, said that the staff should be wearing gowns when providing urinary catheter care and changing briefs. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/22/25 at 4:30 p.m., during a interview, Staff R, CNA and Staff S, CNA both said they believed the reason they were not wearing the gowns is because they were in a hurry to help the resident who recently returned from dialysis. *** Photographic evidence obtained ***

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25618 Based on observation and interview, the facility failed to provide a safe, clean, comfortable and home-like environment for residents, staff and the public. The findings included: During an observation of the memory care unit on 4/21/25 from 8 a.m. to 12 p.m. the following was observed: Cracked walls with exposed plaster above air conditioning units, walls and corners including Rooms 208, 205, 204, 201, 206, 203, dining room and main hallway. Missing/broken closet doors including rooms [ROOM NUMBERS]. Foam sprayed in the bottom corner of the window near the back exit door. Chair/Bed rail missing off wall in room [ROOM NUMBER]. Broken window blinds including Rooma 204, 201, 207, 206, and 209. Peeling cove base in common hallway, dining room, and rooms [ROOM NUMBER]. The floors of the common hallway were cracked, stained and missing pieces. Tile was missing from the bathroom wall with exposed plaster in room [ROOM NUMBER]. Sink in Rom 208 was separated from the wall and wiggled when you touched it. On 4/21/25 at 3:15 p.m., the Memory Care dining room cabinets were noted to have ground in dirt in the corners between floor and cabinets, the cabinet under the sink contained a Styrofoam cup with a half-eaten chicken wing, scattered debris, used napkin, dried spilled brown substance and small black particles. A second cabinet was opened which contained an empty opened milk container, and a third cabinet which contained staining, a sandwich bag with some type of bread substance inside it, and assorted debris. On 4/21/25 at 3:25 p.m., the Director of Housekeeping was shown the findings in the dining cabinets. He said his department was responsible for cleaning these. He said they should not look like that and they should be cleaning the cabinets every Monday and Friday. On 4/22/25 at 9:24 a.m., the Director of Housekeeping said he had spoken in error, and the cabinets should have been cleaned on the weekend. He said it had been scheduled to be cleaned on the previous Sunday and it was missed. He said he had been aware of issues with bugs in the memory care unit and agreed leaving the cabinets with half eaten food and debris could attract bugs. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 04/23/25 at 09:43 a.m., the Administrator entered the Memory care unit, was shown the photographic evidence and walked through a few rooms to point out the findings. The Administrator said he had only been with the facility about a month and agreed the unit is old and could use room by room updates. He said half eaten food should not be in the cabinets and the dining room cabinets should not be left in that condition. He also said he would call pest control back in and that it had been an ongoing issue. The facility policy and procedure Work Orders documented Work orders outside of the service reports and equipment records are a mandatory means of maintenance communication. Work orders should be used and completed with priority classification noted by either the department head or the administrator. If upon examination of the job site, outside help is necessary this should be noted and sent to the administrator. On 4/21/25 at 8:00 a.m., during initial rounds, the following was observed: room [ROOM NUMBER] in the shared bathroom a urinal was stored on the handrail of the shared bathroom. The urinal was not labeled to identify the resident using the urinal. The bathroom door did not have a doorknob, only the whole in the door where it once was. Anyone who needed to use the bathroom would need to place their fingers in the hole and pull the door open and closed. The privacy curtain separating the two beds was soiled and had brown stains. room [ROOM NUMBER] had broken blinds on the window with several blinds missing. The corner of the wall next to the closet was chipped and cracked and the molding was pulling away from the wall. Rooms 329 and room [ROOM NUMBER] the closet door was missing on one side of the closet. On 4/22/25 at 8:43 a.m., Resident #75 was observed in his room in bed. He is noted with his feet pressed against the foot board of the bed. He said I'm 6'2 and I have asked for a bigger bed but I never got one. On 4/22/25 at 8:44 a.m., in an interview Licensed Practical Nurse Staff C said he observed the broken blinds in room [ROOM NUMBER] and said we place a concern for maintenance in the Tells system. On 4/22/25 at 8:46 a.m., the Assistant Director of Nursing (ADON) said she observed the broken blinds in room [ROOM NUMBER]. They are visible from the hallway of the nurse's station. On 4/22/25 at 8:48 a.m., the Regional Nurse Consultant said she spoke with maintenance regarding the broken blinds and missing closet doors. On 4/22/25 at 8:55 a.m., during an interview the ADON was notified of Resident #75's request for a longer bed. The ADON said the facility did not have bed extenders. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the documentation presented by the administrator showed no order had been placed for the blinds or closet doors. The documentation was a quoted price for the supplies. In a phone interview the supply company confirmed the facility made no purchase of the blinds or closet doors. On 4/22/25 at 9:30 a.m., during walking rounds with the Regional Plant Manager he confirmed the findings of the necessary building repairs On 4/22/25 at 12:35 p.m., observed Resident #102 in room [ROOM NUMBER]B. Resident #102 said the bifold door panel broke 3 months ago and the facility removed it. The resident said the missing panel has been that way for 3 months. The resident said it bothers her and does not like to have her clothing exposed. On 4/23/25 at 9:12 a.m., observed Resident #102's door panel was still missing. Observed 1/2 the clothing on hangers. On 4/24/25 at 8:47 a.m., during an interview with the Director of Nursing (DON) in room [ROOM NUMBER], she said the closet door should not be that way. On 4/24/25 reviewed the completed work order #4399 created on 12/3/24. Closet Door Broken in room [ROOM NUMBER]B. On 12/19/24, the status was updated as Set to Completed.