STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	106150	A. Building B. Wing	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth-North Tampa, LLC	18940 Sunlake Blvd Lutz, FL 33558

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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 - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and policy review the facility failed to ensure dignity was maintained for residents during dining in one dining room (between 400 & 500 halls) out of three dining rooms. Findings included: On 6/17/2025 at 11:45 a.m. an observation of the lunch meal service occurred in the dining room between the 400 and 500 hallways. The dining room was full of multiple residents (a total of 14) and several family members/visitors. Multiple staff members were observed assisting with passing out trays from the tray cart. One of the tables had three residents seated, two residents were served their meals and started eating, while the third resident did not have their meal. Another table had three residents seated, one resident was served their meal, the other two residents did not receive their meals at that time. Staff L, Certified Nursing Assistant (CNA), was observed delivering the tray to one resident who needed assistance. The staff member sat down and proceeded to assist the resident with eating. Staff L, CNA did not remove the food items from the tray and the other two residents at the table were not served their meal at that time. Staff M, CNA, was observed pushing a resident into the dining area. Staff M, CNA was observed approaching a table in the corner of the dining room and loudly stated to another staff member, who was across the dining room, the resident is a feeder and the feeders should be together. This conversation occurred between the staff members who were referring to the residents as feeders loud enough for all residents and visitors to hear. Staff M, CNA left the resident who was just wheeled into the dining room, approached another resident who was at a different table and stated, she is a feeder. At 11:50 a.m. Staff M, CNA proceeded to remove this resident from the table, pushed her to another table, and started to assist this resident with the meal. The table at this time had two residents being assisted and one resident did not have a meal. At 11:54 a.m. a staff member noted the one resident at the table did not have a meal, while the other two residents were being assisted. The staff member removed the resident from the table, and requested staff look for the resident's meal. At 11:56 a.m. the meal was found, and the resident was wheeled back to the table and assisted. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/17/2025 at 1:45 p.m. Staff L, CNA stated all residents at a table should be served at the same time. He stated the food items, drinks etc. should be removed from the tray, and residents should not be called feeders. He stated the dining room was hectic today as there were more staff than usual assisting the residents. During an interview on 6/19/2025 at 11:52 a.m. Staff G, Licensed Practical Nurse (LPN) stated residents should be served one table at a time, the meal should be placed on the table, not left on the tray and certainly residents should not be referred to as feeders. Review of the facility's policy titled Dining Program, dated: 8/3/2017 revealed: Policy Statement: It is the policy of [Facility Name] to enhance the meal experience for all patients/residents who participate in the dining program. Procedure: . 4. When serving patient/resident in the dining room(s), plates, side dishes, glasses/tumblers, etc. will be removed from the tray and placed on the table in front of the patient. 6. Domes, lids, trays, paper/wrapping, etc. will be removed from the table. Paper will be discarded and domes, trays, etc. will be stacked neatly in a designated place. The Nursing Home Administrator stated the facility does not have a policy specific to Dignity and stated they follow the regulation.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record review the facility failed to develop a baseline care plan within 48 hours of a resident's admission for one resident (#5) of one resident reviewed. Findings included: Review of Resident #5's face sheet, showed an admission date of 6/15/25, with diagnoses to include metabolic encephalopathy, mood disorder, anxiety disorder, difficulty in walking, cognitive communication deficit, left hip osteoarthritis, cognitive impairment, and fall. Review of Resident #5's medical certification for Medicaid long-term care services and patient transfer form (3008), undated Showed the following Section B. Hearing is impaired, Section E. Medical Conditions generalized weakness, urinary tract infection (UTI) and lactic acidosis, Section G. Patient risk alerts is falls, Section O. Vitals Signs dated 6/15/25 at 7:55 A.M., Section P. Patient Health Status the resident is incontinent, Section S. physical function required two assistants to transfer, Section T. Skin Care - resident has a skin tear on the right lower leg. Review of Resident #5's observation detailed list report showed nursing admission assessment dated [DATE] at 5:45 P.M. The assessment showed Resident #5's Morse Fall Risk score was 45 indicating a high risk of falling. There are skin tears on the resident's left upper extremity and right lower extremity. On 6/18/25 at 4:04 P.M. an interview and record review of Resident #5's record was conducted with the Minimum Data Set (MDS) Director. The MDS Director said she used to complete baseline care plans, but recently the facility has transitioned to a process where it is the admitting nurse' responsibility. She said Resident #5 did not have a baseline care plan which should be completed within 72 hours of admission. On 6/18/25 at 4:30 P.M. during an interview the Director of Nursing (DON) said the baseline care plan should be completed by the admitting nurse and some nurses do not understand the process. On 6/19/25 at 8:40 A.M. during an interview with Staff N, Licensed Practical Nurse (LPN), she said approximately two weeks ago they started the process where the resident's admitting nurse is responsible to initiate the baseline care plan. She said, It takes an additional 30-40 minutes to complete. On 6/19/25 at approximately 9:00 A.M., a copy of Resident #5's baseline care plan was requested and was not provided. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled, Care Plans, revised 7/7/23 showed the following - Policy Statement: It is the policy of the health care center for each patient/resident to have a person-centered baseline care plan followed by a comprehensive care plan. Definitions: Baseline Care Plans-Must include the minimum healthcare information necessary to properly care for each patient/resident immediately upon their admission, which would address patient/resident specific health and safety concerns to prevent decline or injury, and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. Procedure -1.) Upon a new admission, a baseline care plan will be developed by the admitting nurse/nurses in conjunction with other IDT (Interdisciplinary Team), the patient/resident and/or patient/resident representative. The baseline care plan should be initiated in 24 hours and will be completed and implemented within 48 hours of admission.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review the facility failed to revise an Activity of Daily Living (ADL) care plan to reflect a resident's condition for one resident (#29) out of eight residents reviewed. Finding included: During an interview on 06/16/25 at 11:42 a.m. Resident #29 stated she was getting weaker due to no one at the facility assists her with walking. She stated therapy instructed her to ensure someone is supervising her while walking. During a follow up interview on 06/18/25 at 09:41 a.m. the resident stated loosing endurance since being discharged from therapy as no one was available to supervise except when family visits. Review of the admission Record revealed Resident #29 was admitted to the facility on [DATE], with diagnoses to include: Parkinson's disease without dyskinesia, hypertension, Difficulty in walking, anxiety disorder, and other co-morbidities. Review of Resident #29's Minimum Data Set (MDS) dated [DATE] revealed Resident #29 is cognitively intact. Review of Resident #29's therapy discharge note dated 05/28/25 revealed the resident is able to walk 50-feet with standby assist with a four-wheel walker. During an interview on 06/18/25 at 10:53 a.m., Staff B, CNA stated not having time to complete Range of Motion(ROM) or walking residents around if requested and stated usually the restorative aide completes the task. Staff B stated they don't really need to worry about not getting it done. During an interview on 06/18/25 at 11:58 a.m. Staff M, Restorative CNA stated they had not started in the restorative position, yet. Staff M said currently, assists with residents weights, meals if needed. Staff M, stated not having a specific assignment but assists when requested by a CNA or nurse. The staff member stated the restorative program had not been started and there was no one to oversee the program. During an interview on 06/18/25 at 12:20 p.m. the Director of Rehabilitative Services (DOR) stated Resident #29 was discharged from therapy services on 05/28/25 and was able to walk long distances with just standby assistance with a four-wheel walker. Resident #29 was discharged from therapy with a home exercise program, which usually would mean restorative but the facility does not have restorative at this time as there was no one in nursing to oversee the program. Review of Resident #29's Care Plan dated 8/22/24 revealed: Problem category: Activities of Daily Living (ADLs) Functional Status/Rehabilitation Potential Resident #29 is at risk for ADL Decline related to History of head trauma, Lewy body dementia, Parkinson's, adult failure to thrive, weakness, and reduced mobility. Goal dated: 04/07/25 revealed: Patient/ Resident's ADL needs will be met and independence potential maximized within constraints of disease through next review. Approach dated 08/22/24: Provide assistive device as ordered. Set up Resident for ADLs. Assist with toileting PRN. Encourage resident to do as much as possible. Resident needs assistance with transfers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility's policy titled Care Plans dated reviewed 07/27/2023 revealed: Policy Statement: It is the policy of the health care center for each patient/resident to have a person-centered baseline care plan followed by a comprehensive care plan developed following completion of the Minimum Data Set (MDS) and Care Area Assessment (CAA) portions of the comprehensive assessment according to the Resident Assessment Instrument (RAI) Manual and the patient/resident choice. Procedure: . admission Comprehensive Plan of Care (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1.The schedule for the care plans will be developed, reviewed, and distributed to the IDT member of the IDT as designated by the administrator. 2. A comprehensive person-centered care plan will be developed by the interdisciplinary team for each patient/resident within seven days after the completion of the comprehensive assessment. * The patient/resident and or the patient/resident's representative will participate to the extent practicable in the care planning process. * An explanation must be included in a patient/resident's medical record if the participation of the patient/resident and their patient/resident representative is determine not practicable for the development of the patient/resident's care plan. 3. The comprehensive person-centered care plan is developed to include measurable gold and time frame to meet a patient/residence medical, nursing and psychological needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan should describe the following- * the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being * Any services that would otherwise be required but are not provided due and action taken by the facility staff to educate the resident and resident representative, if applicable, regarding alternatives and consequences. *Any specialized services or specialized rehabilitative services the nursing facility will provide because of PASARR recommendations. If a facility disagrees with the * findings of the PASARR, it must indicate its rationale in the patient/resident's medical record. * In consultation with the resident and the resident's representative(s) - * The resident's goals for admission and desired outcomes * The resident's preference and potential for future discharge. Documentation to whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. 4. The care plan will contain 4 main components: Problem, Goal, Approaches and Role or Accountability. * Problems should be written as actual problems or conditions, potential problems, or conditions, at risk for problems or conditions, or may address patient/resident limitations, maintenance level or improvement possibilities, and resident discharge goals. Problem statements to be stated to the extent possible, in functional or behavioral terms (i.e., how is the condition a problem for the patient/resident; how does the condition limit or jeopardize the patient/resident's ability to complete tasks of daily life or affect the patient/resident's well-being). Discharge goals should indicate who made the discharge goal decision and if not the patient/resident, why. *Problems Statement Example: Potential for dehydration due to decreased fluid intake. * The goal is an expected outcome the patient/residents should achieve by implementing specific interventions. Goals are to be established by the interdisciplinary team, with input from the patient/resident, and/or resident representative. All goals should be realistic and attainable considering the patient/ resident's current clinical status. Types of goals may include discharge goals, improvement goals, prevention goals, palliative goals and/or maintenance goals. A well-developed goal will contain the following: * The Goal is a statement of what the patient/resident will accomplish. * The Goal is measurable. * The Goal contains a reasonable timeframe for achievement or reevaluation. * The care plan approach serves as instructions for the patient/resident's care and provides continuity of care by all partners. Short and concise instructions, which can be understood by all partners, should be written and have a relationship to the problem and goal(s), and should include any PASSAR Level II intervention as needed. Some interventions require all disciplines to be involved in the implementation, while others may only involve specific team members. When approaches that involve the CNA have been added to the care plan, those approaches should also be included on the CNA Care Record or Resident Profile/Care Plan. * Intervention Statement Example: Offer patient/resident fluids every shift in addition to fluids provided with meals. * Upon the completion of a comprehensive care plan for an admission Assessment, each discipline will then sign the care plan on the appropriate discipline signature line of the printed care plan. Document review with patient/resident and/or representative using Care Conference notes. 7. During all care plan meetings other than admission Comprehensive Care Plan that was conducted during a Post admission Care Conference: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review each problem, goal and approach * When a change is necessary, mark through wording to be changed with a single line, sign, and date entry. * When applicable, write a new goal, discontinue approaches and/ or add approaches. * All care plan updates to the problem, goal, or approach should be dated and signed. Care Plan Review and Update: 1. Comprehensive care plans should be reviewed not less than quarterly according to the OBRA MDS schedule, following the completion of the assessment. Care plan updates/ reviews will be performed within 7 days of each quarterly assessment, each acute change in condition, and as needed following each hospital stay. 2. Discontinued problems, goals or approaches should be indicated directly on the care plan. A line should be drawn through the discontinued item. Updates to the care plans should be made with any changes in condition at the time the change in condition occurred. For [Name of softwareusers, all updates are made electronically. 3. All updates to care plans are to be dated and signed. The Master Care Plan will be electronically updated and printed following the completion of Comprehensive OBRA assessments. 4. Care plans will be updated by nurses, Case Mix Directors (CMD), or any other needs at any given moment.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to provide meal assistance for one resident (#43) out of two residents sampled. Findings Included: During an interview and observation on 06/16/2025 at 12:20 p.m. Resident #53 was observed scooping mashed potatoes onto a spoon feeding Resident #43. Resident #53 stated I am feeding my [family member] (Resident #43). I feed her and try to eat my food in-between. If I don't feed, her then no one helps her. Review of Resident #43's admission record revealed an admission date of 09/21/2023. Resident #43 was admitted to the facility with diagnosis to include need for assistance with personal care, Muscle weakness (generalized), Mild protein-calorie malnutrition, Other specified joint disorders, right hand, other lack of coordination, Aphasia, Aphasia following cerebral infarction, Dysphagia, oropharyngeal phase. Review of Resident #43's Quarterly Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns a Brief Interview Mental Status (BIMS) of 08 out of 15 showing moderate cognitive impairment. Review of Resident #43's Orders revealed: 04/03/2025 No Added Salt, Mechanical Soft Special Instructions: thin liquids. 05/01/2025 Occupational Therapy (OT) Evaluation and treatment, related to utensils and bowels. Review of Resident #43's Care Plan Dated 09/22/2023 revealed: Problem: Resident #43 has an ADL decline related to Hypertension, Spondylolisthesis, Spinal stenosis, Right hand Contracture and other comorbidities Patient requires assistance in ADLS and presents with incontinence of Bowel and bladder. The approach showed- Assist with feeding at meals, and Physical Therapy (PT)/OT to evaluate and treat as needed. Review of an observation form dated 03/28/2025 Description showed - Interdisciplinary Referral to Rehab Services (Occupational Therapy) for decline in feeding. Review of Resident #43's Progress note dated 03/28/2025 revealed: Psych - Patient noted to have decline in self-feeding, eats 100% with assistance with meals. Will refer to OT services and provide assistance with meals from nursing staff Review of a nutritional note dated 04/03/2025 showed - Hand contractures noted. - Resident needs assistance with meals. Met with family to review weights and nutritional concerns. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 06/17/2025 at 1:23 p.m., staff C, Certified Nursing Assistant (CNA), stated Resident #43 needs help with scooping the food onto the utensil. She stated recently she has needed more assistance with eating her meals. She said, I assisted Resident #43 on 06/16/2025 after I finished passing the lunch trays for the other residents, normally her family member is here to help, but she left in the beginning of lunch. During an interview on 06/18/2025 at 11:40 a.m., Staff G, Licensed Practical Nurse (LPN) stated she was not too familiar with all of the residents in the 500 unit, but knows they have quite a few residents who need assistance with meals. She stated Resident #43 is a resident who needed assistance with eating during meals. During an interview on 06/18/2025 at 3:50 p.m. the Director of Nursing (DON) stated CNAs, Nurses or the restorative nurse should be helping residents with meal assistance. The DON said, We have a lot of involved families, who are here constantly to help with every meal. It is not an expectation for family to be here, but it is kind of assumed that they will be here during mealtimes. Review of the facility's undated policy titled Assisting with ADLS revealed, Section 1: Introduction, about this course, assisting a person with activities of daily living, or ADLS, is an essential part of your job. Many of those you care for will need some level of assistance with completing personal care period this course discusses how to provide person centered care and promote independence when assisting with ADLS. It also discusses how to help a person with dementia and performing ADLS, .when a person needs help with their ADLS, it is important to provide competent, respectful care. ADLS include eating, bathing, grooming, dressing, toileting, shaving in oral care or denture care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews the facility failed to ensure wound care was done in a timely manner and dressings were dated for three residents (#182, #277, #51) out of four residents reviewed for non-pressure skin conditions. Findings included: An observation and interview was conducted on 6/16/25 at 12:38 p.m. with Resident #182. The resident was observed to have a bandage on his throat area dated 6/11/25. The resident said the bandage covered a stoma (an artificial opening) from having a tracheostomy (trach). He said he had been in the facility for two days and nothing had been done with the dressing. Review of Resident #182's admission Record showed the resident was admitted on [DATE] with diagnoses including gram-negative sepsis and pneumonia due to klebsiella pneumoniae. Review of Resident #182's admission Minimum Data Set (MDS), Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of Resident #182's physician orders revealed no orders in place for wound care/dressing changes for the trach site. An order for Clean tracha [sic] with moisten normal saline gauze. Apply dressing. Once A Day, entered on 6/17/25. Review of Resident #182's Medication Administration Record (MAR) showed the trach site bandage was changed on 6/17/25. An interview was conducted on 6/18/25 at 10:45 a.m. with Staff H, Licensed Practical Nurse (LPN). Staff H said Resident #182 had his dressing changed the evening of 6/16/25 for the first time. When asked who should enter wound care orders upon admission, Staff H did not know if the nurse was supposed to enter them or if wound care entered the orders when they saw the resident the first time. Staff H said Resident #182's trach site dressing was changed on 6/16/25 but it was not dated. An interview was conducted on 6/19/25 at 10:48 a.m. with Staff J, Registered Nurse (RN)/Unit Manager (UM). Staff J said for a newly admitted resident the nurse should see if there are wound care orders from the hospital, which was sometimes on the discharge medication list or given verbally in the nurse-to-nurse report from the hospital. Staff J said if there were no wound care orders the admitting nurse should have obtained orders when they called the primary care provider to confirm admission and orders. Staff J said if a resident came in with a bandage, per protocol and education, the nurse should remove it to look for signs and symptoms of infection and put a dry dressing on until orders are received. Staff J reviewed Resident #182's medical record and confirmed there were no wound care orders in place and no wound care was documented until 6/17/25. Staff J said orders should have been placed on 6/14/25 when the resident was admitted . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/18/25 at 12:52 p.m. with Staff K, RN/Wound care. Staff K said Resident #182 had a skin assessment and dressing change late afternoon on 6/16/25. Staff K confirmed the hospital dressing from 6/11/25 remained in place until wound care was provided on 6/16/25. Staff K said the wound care of 6/16/25 was not documented. Staff K stated the admitting nurse should have removed the bandage to assess the area on 6/14/25. As for dating bandages, Staff K, said the facility did not have a policy to date bandages and that was the reason no bandages in the facility were dated. An interview was conducted on 6/19/25 at 9:29 a.m. with the facility's medical director. He said the admitting nurse should have looked at Resident #182's wound and called the doctor for orders if there were not any. He said there was an opportunity there to improve this. He agreed the dressing from the hospital should not have remained in place after two days while in the facility. On 06/16/25 at 11:31 a.m., and 06/17/25 at 8:58 a.m., Resident #51 was observed laying in bed with a dressing on the left side of the back of the neck underneath the left ear. There was no date observed. Resident #51 stated, I'm not sure when they changed the dressings. (Photographic Evidence Obtained). Review of the admission Record revealed Resident #51 was admitted to the facility on [DATE], with diagnoses to include Non-ST elevation (NSTEMI) myocardial infarction (heart attack), hypertension, and congestive heart failure. Resident #51's Clinical admission Assessment marked the resident as Alert & Oriented x 3, communicates verbally, speech is clear, can understand and be understood when speaking. Review of Resident #51's physician orders showed Left posterior ear wound, Cleanse with [brand] wound cleanser, apply skin prep to the peri wound, apply Santyl nickel thick in the wound bed covering edge to edge, and cover with an island border gauze, daily. A review of the Treatment Administration Record (TAR) for June 2025 revealed that treatment was provided on 06/11 - 16/25. During an interview on 06/19/25 at 11:40 a.m. Staff F, RN stated the dressings should be dated and changed if soiled, does not know why it was not. During an interview on 06/18/25 at 4:50 a.m. the Director of Nursing (DON) stated bandages should be clean, dry and dated. She stated this was the expectation and standard of care. During an interview on 06/19/25 at 9:29 a.m. the Medical Director of the facility stated bandages should be dated, and completed as ordered. He stated if a dressing is soiled, the dressing should be changed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Documentation of Skin and Wound Care dated reviewed 06/14/2024 revealed: Policy Statement: It is the policy of the Healthcare center to complete documentation that reflects the current resident status as related to skin/wound care. Documentation will provide current and timely documentation on resident's condition related to skin/wound care, accurate information on resident's status as it pertains to skin/wound care, record care rendered and interventions in place and provide a detailed history of the wound assessments that have occurred in the healthcare center. Procedure: *On pressure ulcers, venous insufficiency/stasis ulcers, arterial ischemic ulcers, diabetic wounds and any other chronic or complex wounds (weekly). *Upon admission or re-admission of residents. *On skin tears, rashes, etc. (weekly) in narrative notes kept with the Treatment Assessment Record (ETAR). *Whenever there is an unexpected change in condition of the wound. *As needed, per clinical judgment. 2. Documentation should occur on: admission Documentation: *admission assessment (completed by Admitting Nurse; Skin Integrity Coordinator [SIC], or designee): *admission skin assessment reflects current skin condition, noting wounds, areas of skin compromise, etc. at the time of admission. Wound Manager is to be completed at admission on any noted skin conditions. *Braden Risk Assessment to start risk determination process. Consider adjusting risk according to known clinical condition (including refusals of care). *Baseline admission care plan related to risk for skin breakdown as well as for actual breakdown. *Obtain orders as needed. Orders to be placed on ETAR and initiated per order. Any delay or concern related to orders or products - contact physician or adjunct for clarification/interim order. *This is often completed by the admitting nurse and will be followed up by the SIC (Skin Integrity Coordinator) or designee. SIC may perform these observations. *If SIC does not perform initial assessments, SIC is to review observations and confirm results. Complete skin assessment, Braden, and care plan overview. Clarify/update as needed. *SIC will document a brief overview of admission findings and follow-up in progress notes. Documentation completed by the SIC in wound manager. Daily Documentation of Treatments: *Daily documentation is done by signing the [electronic record] that the dressing was completed. No other documentation is required unless a change is noted then documentation will be completed in wound manager. *Wound measurements are completed when there is significant change in wound status. Weekly Documentation: Weekly Documentation of Treatments will be completed on Wound Manager in the EHR and Focus Observation to include Skin observation. Review of an undated facility's Wound Care Treatment protocol revealed: Dressing Change 5. Label the dressing with the date and your initials. During an observation on 06/16/2025 at 10:53 a.m., Resident #277 was observed dressed in a hospital gown, lying in bed. Resident #277 was observed with a white undated bandage on the top of his right hand, and undated gauze wrapped around his left forearm/elbow area. The bandage on Resident #277's left elbow/forearm was observed to be wet with dark red liquid seeping onto the sheet of his bed. (Photographic Evidence Obtained) During an observation on 06/16/2025 at 11:18 a.m., Resident #277 was observed dressed in a hospital gown, lying in bed. Resident #277 sheets were noted to have several pink and red spots on them. Resident #277's bandage to his left forearm/elbow was noted to be wet with a dark red liquid. Review of Resident #277's admission record revealed an admission date of 06/11/2025. Resident #277 was admitted to the facility with diagnoses to include Parkinson's disease without dyskinesia, Paroxysmal atrial fibrillation, Muscle weakness (generalized), Difficulty in walking, not elsewhere classified, and Unspecified fall, subsequent encounter. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #277's 5-Day Minimum Data Set (MDS) dated [DATE] revealed Section C. Cognitive Patterns revealed a Brief Interview Mental Status (BIMS) of 14 out of 15 showing intact cognition. Review of Resident #277's Orders revealed: Bacitracin ointment; 500 unit/gram; amount: 1 application; topical Twice A Day. Cleanse Skin tear to Right Hand with normal saline apply bacitracin cover with dry clean dressing twice a day until healed. Cleanse Skin tear to Right Hand with normal saline apply bacitracin cover with dry clean dressing twice a day until healed. Treatments: Clean left forearm laceration with Normal Saline. Apply Xeroform to area cover with 4 x 4 wrap with rolled gauze once a day on Monday, Wednesday, and Friday. Treatments: Clean left-hand laceration with Normal Saline. Apply Xeroform to are cover with 4 x 4 wrap with rolled gauze once a day on Monday, Wednesday, and Friday. Treatments Non-RX (non prescription): Clean left upper arm with Normal Saline. Apply Xeroform to are cover with 4 x 4 wrap with rolled gauze once a day on Monday, Wednesday, and Friday. Treatments Non-RX: Clean Right elbow with Normal Saline. Apply Xeroform to are cover with 4 x 4 wrap with rolled gauze once a day on Monday, Wednesday, and Friday. Review of Resident #277's Care Plan Dated 05/13/2025 revealed: Resident #277 has skin tears to the right and left upper extremities, left elbow and left forearm, right forearm and right palm related to unwitnessed fall. Approach: Monitor and report signs of localized infection (localized swelling, redness, pain or tenderness, heat at the infected area, purulent drainage, loss of function). Problem: Risk for abnormal bleeding or hemorrhage because of anticoagulation usage: Diagnosis -Paroxysmal atrial fibrillation. Approach: Monitor for and report to the physician signs and symptoms of abnormal bleeding and/ or hemorrhage. Review of Resident #277's Progress Notes revealed there were no progress or nurses notes found related to the resident's bandages being soiled. During an interview on 06/16/2025 at 11:20 a.m., the resident's Physician Assistant stated, I was just about to go check with the nurse to find out what is going on with his bandages and all of this (pointed to the pink and reds spots on Resident #277's sheets). During an interview on 06/16/2025 at 11:26 a.m., Staff E, Licensed Practical Nurse (LPN), stated If you are talking about Resident #277's bandages I saw them and will get to them. He likes to mess with them. We are not allowed to date bandages here. Have you ever heard of this? During an interview on 06/19/2025 at 10:11 a.m., the Medical Director stated he would expect the bandages to be clean and dry. Staff should notify the physician if they have had to change the residents' bandages a few times throughout the shift, and if they are continually saturated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/19/2025 at 6:20 p.m., Regional Nurse reviewed Resident #277's photographic evidence of bandages from 06/16/2025 and stated she would expect the bandages to be changed upon noticing them being soiled. The Regional Nurse stated if the bandages needed to be changed because they are continually draining, that is soiling the bandages and staff should notify the physician. The nurse stated they have had to change out the bandages.

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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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, observations and record reviews, the facility failed to provide nephrostomy care and services consistent with professional standards of practice for one resident (#328) out of one sampled resident. Findings included: A review of Resident #328's Face Sheet revealed admissions dated 6/4/2025 to the facility with diagnoses included but not limited to obstructive and reflux uropathy, chronic kidney disease, bladder-neck obstruction, hydronephrosis, neuromuscular dysfunction of bladder, and urinary tract infection. On 6/19/25 at 10:16 A.M. an observation and interview was conducted. Resident #328's nephrostomy insertion site dressing was not intact and dated 6/3/25. Resident #328 said the dressing was last changed before I left the hospital. The urine appears serosanguinous (contains blood). Resident #238 said she asked a nurse to change the dressing and was told there were no orders to change the nephrostomy site dressing. (Photographic Evidence Obtained). A review of Residents #328's Minimum Data Set (MDS) dated [DATE], showed a Brief Interview for Mental Status (BIMS) summary score was 15, indicating cognitively intact. Review of Resident #328's medical record did not reveal any physician orders related to her nephrostomy tube. On 6/19/25 at 10:51 A.M. during a follow-up interview and observation of Resident #328's nephrostomy site dressing, the Director of Nursing (DON) was unable to describe the care staff provides for the nephrostomy tube every shift. Resident #328 said the doctor said the nephrostomy tube needed to be flushed. The DON said a nurse will contact the urologist for orders and the dressing will get changed today. A review of Resident # 328's progress note dated 6/5/25, written by nursing . R [right] side nephrostomy in place . A review of care plans showed the following: -Problem: Resident #326 requires enhanced barrier precautions related to right nephrostomy and infection. Goal: Resident will exhibit no signs of infection, such as fever, redness, swelling, or drainage from potential sites of infection through next review, the approaches included observe and report any signs and symptoms of worsening infection. [Redness, swelling, increased pain, purulent discharge from incisions, injury, and exit sites of tubes (IV [intravenous] tubing's), drains, or catheters]. -Problem Resident #326 has an infection: urinary tract infection (UTI). Goal: Resident will be free from signs and symptoms of infection by next review date; the approaches include Report signs and symptoms of worsening infection . (continued on next page)

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Problem Resident has a urinary catheter-Right nephrostomy tube-- related to obstructive uropathy, Goal: Patient/ Resident will not develop any complications associated with catheter usage through the next review. Approaches include, keep catheter tubing free of kinks, keep drainage bag below level of bladder, and provide catheter care per policy. Review of publication titled Nephrostomy Tube Care, medically reviewed by Drugs .com provides the following directions change the bandage around the tube, the bolsters, skin barriers, and tube attachments at least every 7 days. If your bandages, barriers, or devices get dirty or wet, change them right away, and as often as needed. Retrieved on 6/22/2025. Review of facility policy titled Care Plan, revised 7/7/23 revealed .Scope- This policy applies to Case Mix Directors, Social Services, Activities Directors, Dietary Managers, Registered Dieticians, Nursing, Direct Care Staff, and all other members of the Interdisciplinary Team (IDT) that participate in the RAI process admission Comprehensive Plan of Care- A comprehensive person-centered care plan will be developed by the interdisciplinary team for each .resident . 3. The comprehensive person-centered care plan is developed to include measurable goals and timeframes to meet a patient/resident's medical, nursing and psychosocial needs, the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan should describe the following- The care plan will contain 4 main components: Problem, Goal, Approaches and Role or Accountability. Problems should be written as actual problems or conditions, potential problems, or conditions, at risk for problems or conditions, or may address patient/resident limitations, maintenance level or improvement possibilities, and resident discharge goals. Problem statements to be stated to the extent possible, in functional or behavioral terms (i.e., how is the condition a problem for the patient/resident; how does the condition limit or jeopardize the patient/resident's ability to complete tasks of daily life.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews the facility failed to ensure pain was controlled for three residents (#185, #379, #182) out of three reviewed for pain management. Findings included: An interview was conducted on 6/18/25 at 2:15 p.m. with Resident #182. The resident said he had been in the facility for four days and did not have any pain medication for the first two days. The resident said pain had gotten to a 10 out of 10 on the pain scale during that time. The resident said he refused tube feedings because they caused stomach cramps and he couldn't handle any more pain. The resident said he was starting to feel better again after having his medication for the last two days. Resident #182 said the pain was so bad on Sunday, 6/15/25 that he almost left the facility. Review of Resident #182's admission Record showed the resident was admitted on [DATE] with diagnoses including gram-negative sepsis, cutaneous abscess of abdominal wall, spondylosis, and pain, unspecified. Review of Resident #182's admission Minimum Data Set (MDS), Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of Resident #182's physician orders showed: -Methadone 10 mg (milligram).1 tablet. Every 6 Hours for pain. 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p. m. 6/15/25. -Morphine concentrate 100 mg/5 ml (milliliters) (20 mg/ml); 0.75 ml. Every 4 hours as needed (PRN) for pain. 6/14/25. -Baclofen 10 mg. 1 tablet. Three times a day for pain. 6:00 a.m., 1:00 p.m. and 6:00 p.m. 6/14/25. -Gabapentin 300 mg. 2 tablets. Three times a day as needed for pain. 6/14/25. Review of Resident #182's Medication Administration Record (MAR) revealed: -Baclofen 10 mg was documented as Drug/Item Unavailable on 6/15/25 at 9:00 a.m. and 5:00 p.m. and on 6/16/25 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. The resident received the first does of Baclofen on 6/17/25 at 1:00 p.m. -Morphine 0.75 ml PRN was administered for the first time on 6/16/25 at 4:23 p.m. -Methadone 10 mg was documented on 6/15/25 at 11:01 p.m. as 6/16/25 12:00 a.m. does given at 10:00 p. m. due to waiting in pharmacy for code and documented on 6/16/25 at 6:32 p.m. that Drug/Item unavailable. -Gabapentin 300 mg was not documented as given 6/14-6/16/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #182's progress notes revealed a note dated 6/17/25 at 7:54 a.m. showing, Several attempts and efforts made through the night of 6/16 -17 to encourage resident to receive tube feeding without success has[sic] resident refused feeding through out the night stating he would try again later during the day. Review of a progress note dated 6/17/25 at 10:07 a.m. signed by the Pain Management Nurse Practitioner (NP) showed, Pain/Muscle spasms-Reports pain all over, states medicine took a while to get in and has not been consistently taking it. Review of Resident #182's primary care provider NP notes revealed a note dated 6/16/25 showing, Met with patient and unit manager in patient's room. Patient appears unhappy. He notes he stopped his own tube feeds yesterday due to abdominal discomfort. In addition, he notes pain medications are not being administered as prescribed. Received first dose of methadone this AM He would like to discharge home. Notes he lives by himself. Review of Resident #182's Occupational Therapy Evaluation, dated 6/16/25 at 2:21 p.m. noted patient had pain that interfered/limited functional ability, 8/10 neck and back pain. An interview was conducted on 6/19/25 at 12:35 p.m. with Staff H, Licensed Practical Nurse (LPN). Staff H said she had cared for the resident a couple of shifts over the past few days. She said the resident has a lot of pain all the time. An interview was conducted on 6/19/25 at 1:59 p.m. with Staff O, LPN. Staff O said she cared for Resident #182 on 6/15/25. Staff O said the resident kept turning his tube feed off and she didn't know why. Staff O said she believed it was just behaviors. Staff O said she administered the medications she could, but they were waiting on the resident's medication to come in. Staff O said she remembered the resident's methadone was not in, but she couldn't recall the other specific medications. Staff O said she thought she might have pulled baclofen from the medication dispensing machine for the resident. Staff O said Resident #182 informed her he would sign out of the facility if his pain medications couldn't be administered. Staff O said the resident was upset because the pain medication prescriptions came to the facility with the hospital discharge paperwork. Staff O said she found the resident's admission packet with the prescriptions and faxed them to the pharmacy. She said she was unaware if they had been sent to the pharmacy previously. Staff O said, it wasn't like he was in uncontrolled pain. 2- An interview was conducted on 6/19/25 at 4:43 p.m. with Resident #185. Resident #185 said she had been in the facility three days and had problems with receiving pain medication upon admission. The resident said it took a day and half before pain medication was administered. Resident #185 said with any movement, her pain was a 9-10 on the pain scale. The resident said it was reported to multiple staff members and the nurses continually said, it's on its way. The resident said the only medication administered for pain was over the counter Tylenol and that was not really a pain medication. The resident said when lying completely still, the pain was ok, but it was severe with any movement. Resident #185 said pain medication was now being administered and is effective. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Records showed Resident #185 was admitted on [DATE] at 3:10 p.m. with diagnoses including displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, chronic pain, and pain, unspecified. Review of Resident #185's admission MDS, Section C, revealed a BIMS score of 14, indicating she was cognitively intact. Review of Resident #185's physician orders showed: -Acetaminophen 325 mg. 2 tablets. Every 8 hours as needed for mild pain - 6/16/25. -Oxycodone-acetaminophen 5-325 mg. 1 tablet. Every 4 hours as needed for pain - 6/17/25. Review of Resident #185's MAR and physician orders showed: -Oxycodone-Acetaminophen 5-325 mg was administered for the first time on 6/18/25 at 1:33 a.m. -Acetaminophen 325 mg was administered on 6/17/25 at 8:37 a.m. Review of Resident #185's hospital discharge medications from 6/16/25 showed resident should have been on Oxycodone-Acetaminophen 5-325 mg every 4 hours as needed for pain and Tramadol 50 mg every 8 hours as needed for pain. Review of orders showed the Oxycodone-Acetaminophen was not entered into the facility orders until 6/17/25 and the Tramadol order was not entered into facility orders. 3- An interview was conducted on 6/18/25 at 4:01 p.m. with Resident #379. The resident said after admission it took a couple of days for pain medication to arrive and be administered. The resident reported 7-8 out of 10 on the pain scale during that time. Resident #379 said she was told repeatedly her medications weren't here yet. The resident said acetaminophen was administered and didn't do anything to help but, when you are desperate you take it. The resident said the ordered Lyrica wasn't there and for the Morphine that was the problem. Resident #379 was unhappy and said before leaving the hospital she asked multiple times about ensuring the medication would be at the facility because it would mess her up not to have them. The resident said the hospital assured here it wouldn't be an issue. The resident said her pain was reported to multiple staff members, aides and nurses. Review of the admission Record showed Resident #379 was admitted on [DATE] with diagnoses including orthopedic aftercare, spinal stenosis and lumbar region without neurogenic claudication. Review of Resident #379's admission MDS, Section C, revealed a BIMS score of 14, indicating she was cognitively intact. Review of Resident #379's physician orders showed: -Acetaminophen 325 mg. 2 tablets for mild pain 1-3. Every 8 hours as needed. Dated 6/14/25. -Hydrocodone-acetaminophen 5-325 mg. 1 tablet. Every 4 hours as needed for pain. Dated 4/10/23. Discontinued 6/16/25. -Methocarbamol 500 mg. 1 Tablet. Every 6 hours as needed for pain. Dated 6/14/25. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Morphine 15 mg tablet Extended Release (ER). 0.5 tablet. Every 4 hours as needed for moderate to severe pain. Dated 6/14/25. Discontinued 6/16/25. -Pregabalin (Lyrica) 150 mg. 1 capsule. Twice a day 9:00 a.m. and 9:00 p.m. for spondylosis. Dated 6/14/25. -Cyclobenzaprine 10 mg. 1 tablet. Three times a day as needed for spinal stenosis, lumbar region. Dated 6/14/25. -Ibuprofen 800 mg. 1 tablet every 8 hours as needed for pain. Dated 6/14/25. Review of Resident #379's MAR showed: -Acetaminophen 325 mg was administered on 6/15/25 at 8:39 p.m. with a documented pain level of 5/10. -Hydrocodone-acetaminophen 5-325 mg was not administered on 6/14 or 6/15/25 and was discontinued on 6/16/25. -Methocarbamol 500 mg was not administered on 6/14 or 6/15/25. -Morphine 15 mg. ER (extended release) 0.5 tablet was administered for the first time on 6/16/25 at 9:55 a. m. with a documented pain level of 9/10. It was administered again on 6/16/25 at 4:46 p.m. with a documented pain level of 10/10. -Pregabalin (Lyrica) 150 mg was documented as not available on 9/14, 9/15, 9/16, and 9/17/25. -Cyclobenzaprine 10 mg was not administered on 6/14 or 6/15/25. -Ibuprofen was administered on 6/15/25 at 9:18 a.m. Review of Resident #379's hospital discharge medications showed the morphine 15 mg , 0.5 tablet order was not supposed to be extended release. The discharge medications showed pregabalin was last administered on 6/14/25 at 8:11 a.m. and was due to be administered at bedtime on 6/14/25. The Hydrocodone-acetaminophen 5-325 mg was not on the discharge medications; it was an order from a previous admission on [DATE]. An interview was conducted on 6/19/25 at 12:24 p.m. with Staff F, Registered Nurse (RN). Staff F said she cared for Resident #379 on Sunday night. She said the resident was new and she didn't know them. She said the resident did complain of pain of 5 out of 10 on the pain scale. Staff F reviewed Resident #379's medical records and confirmed the resident had an order for Acetaminophen for pain at a level of 1-2 out of 10. Staff F said she gave the resident the Acetaminophen because she didn't know the resident well. She said she told the resident she would find out about any other medication that had been ordered. Staff F said she did not call the pharmacy to get authorization to get any other pain medication from the electronic medication dispensing machine because she didn't hear any other complaints from the resident. Staff F said she realized around midnight the resident's ordered morphine was in the medication cart, so she administered it that Monday morning. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/19/25 at 12:28 p.m. with Staff G, LPN. Staff G said she cared for Resident # 379 the morning of 6/16/25 and the resident had been concerned about pain medication. Staff G said the resident had morphine administered by the previous nurse that morning. Staff G confirmed the resident's Lyrica was not available and the script had been sent to the pharmacy. She said Lyrica was available in the electronic medication dispensing machine, but the resident needed an approved prescription. An interview was conducted on 6/19/25 at 2:16 p.m. with the facility's Pain Management Physician. He said he saw Resident #182 and #379 on Monday. He said Resident #182 did have concerns about not getting pain medication over the weekend. He said when the resident was admitted on Saturday 6/14/25, he had been called, and orders were sent Saturday. He said the biggest issues was pharmacy didn't get it delivered. He said Morphine should be in the facility's emergency drug supply and he could not answer why the nurse did not pull the medication from there and administer it to the resident. He said if a resident says their pain is 10 out of 10, it is a 10 out of 10. The physician said he did not think Resident #182 had uncontrolled pain all weekend, but he did want to get it back under control and on his regimen before he made any changes to the pain medication orders. He said the facility may not have had Resident #182's methadone in the emergency drug supply, but typically if certain medications aren't available, the nurse would call him and ask for a different dose or medication for a one time administration. The pain management physician said he was only called on admission for Resident #182 and was not notified medications were not available or not being administered; he was not aware until he arrived Monday morning 6/16/25. As for Resident #379, the pain management physician said he was called when they arrived at the facility on 6/14/25 and he sent the prescriptions then. He said he wrote a prescription for Morphine 15 mg 1/2 tablet every 4 hours as needed. He said the nurse later told him they couldn't get Morphine 15 mg out of the electronic medication dispensing machine because they did not have extended release and the pharmacy notified the nurse they couldn't give 1/2 tablet because extended release could not be cut. The physician said there had been a transcription error somewhere because his order was not for extended release, it was for immediate release. An interview was conducted on 6/19/25 at 9:23 a.m. with the facility's Medical Director. He said the facility did seem to struggle more on the weekends with getting medications. He said on admission the nurse should do a head-to-toe assessment and call the doctor to confirm orders. He said the facility should have been able to address a resident's pain and if he had been notified there were issues with getting medications they could have put their heads together and used a different medication temporarily. He agreed that going for two days without pain medication was too long. He said there should have been a mechanism in place to address a resident missing medication. He said it would be expected for staff to notify him or the NP if a resident was not getting their medication. He said there was no notification in the on-call system showing anyone was notified of the residents missing their medications over the previous week. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/19/25 at 5:12 p.m. with the Nursing Home Administrator (NHA). He agreed there was an issue with the admission process and receiving medications, specifically weekend admission. The NHA said the facility did have a backup pharmacy and the facility identified that the nurses were not trained on that. He said the facility also used a local commercial pharmacy and had an electronic medication dispensing machine. The NHA said they had identified concerns for residents admitted on Saturday; their medications were not coming until the next business day. He said they are pausing weekend admissions going forward until the clinical leadership and all direct care staff are proficient in the process and audits are completed to ensure residents did not miss significant medications. The NHA said when medication orders were placed by 6:00 p.m. they came in on the night pharmacy run between 9:00 p.m. and 12:00 a.m. He said nurses should get medication out of the electronic medication dispensing machine if the resident is admitted after 6:00 p.m. He was unaware medications were not being administered that were in the electronic medication dispensing machine. The NHA said there was a weekend supervisor from 3:00-11:00 p.m. to ensure medications are taken from the electronic medication dispensing machine if needed. The NHA was unaware there were issues with residents not getting pain medication administered or that there were issues with residents not getting medications for two or more days on weekday admissions. The NHA said medication administration is a priority and this is not acceptable. An interview was conducted on 6/19/25 at 8:20 p.m. with the facility's consultant pharmacist. She was unaware the facility had concerns with getting medication and pain management. She said she would work with the facility to address the issue. Review of a facility policy titled Pain Management, revised 2/7/25, showed a policy statement: It is the policy of [facility name] to provide comprehensive, effective, and appropriate pain management and assessments for all residents. Residents have the right to be fully informed of their total health status, types of care provided, and the risks and/or benefits of the proposed care and treatment options in a language that they can understand. Residents may choose the options that they prefer. Scope: This policy applies to all nurses and consultant pharmacists employed by [facility name]. Procedures: 1. [facility name] will perform audits to determine if the resident's pain is being managed. -every shift nursing will ask the resident about their pain using the pain scale and document the results. -Quarterly pain observations are completed and documented in the resident's clinical record. 2. The physician will select the pain medication based on the type of pain the resident is experiencing. 3. The consultant pharmacist will assess the pain control as well as side effects the resident is experiencing, based on the assessment, the consultant pharmacist will communicate with the physician if changes are needed or recommended. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Clinicians may consider prescribing immediate release opioids instead of extended release and long acting opioids.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 2. During an interview on 06/16/25 at 11:42 a.m. Resident #29 stated she was getting weaker due to no one at the facility assists her with walking. She stated therapy instructed her to ensure someone was supervising her while walking. During a follow up interview on 06/18/25 at 09:41 a.m. Resident #29 stated having lost endurance since discharging from therapy as no one was available to supervise except when family visits. During an interview on 06/17/25 at 12:13 p.m. Staff V, CNA stated, it is hard sometimes we don't have as many CNAs as needed. Many of the residents are total care and the distance from room to room. Staff V, stated having to cover around corners makes the job tasks even harder to get basic care completed, but certainly at meal times. She stated they did not have time for the extras if asked. During an interview on 06/18/25 at 10:53 a.m., Staff B, CNA stated not having time to complete Range of Motion(ROM) or walking residents around if requested and stated usually the restorative aide completes the task. Staff B stated they don't really need to worry about not getting it done. During an interview on 06/18/25 at 11:58 a.m. Staff M, Restorative CNA stated they had not started in the restorative position, yet. Staff M said currently, assists with residents weights, meals if needed. Staff M, stated not having a specific assignment but assists when requested by a CNA or nurse. The staff member stated the restorative program had not been started and there was no one to oversee the program. During an interview on 06/18/25 at 12:20 p.m. the Director of Rehabilitative Services (DOR) stated Resident #29 was discharged from therapy services on 05/28/25 and was able to walk long distances with just standby assistance with a four-wheel walker. Resident #29 was discharged from therapy with a home exercise program, which usually would mean restorative but the facility does not have restorative at this time as there was no one in nursing to oversee the program. A policy and procedure for staffing was requested and not received. Based on observation, record review and interviews, the facility failed to provide sufficient staffing to ensure residents received assistance with Activities of Daily Living (ADLs) during three days (06/16/25, 06/17/25 and 06/18/25) of four days observed. Findings Included: During an observation on 06/16/2025 at 12:01 p.m., a family member was observed getting coffee cups and coffee from a gray 4-wheeled cart. The family member filled the cups with coffee and began passing coffee, sugar and cream to the residents in the dining room of the 500 hall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/16/2025 at 12:05 p.m., the Family Member spoke loudly, If there was enough staff to do it, I would not have to. I am here every day helping [Resident #43] with her meals and assisting other residents with coffee. There are not enough staff! The family member stated facility was aware she helped during lunch. The family member said, I am a Registered Nurse (RN). During an observation on 06/16/2025 at 12:20 p.m., Resident #53 was observed scooping mashed potatoes onto a spoon and feeding it to Resident #43. During an interview and observation on 06/16/2025 at 12:20 p.m., Resident #53 stated I am feeding my [family member]. I feed her and try to eat my food in between. If I don't feed her then no one helps her. There are not enough staff here to help her during meals. During an interview on 6/16/2025 at 12:03 p.m., Staff A, Certified Nursing Assistant (CNA) identified a family member who was passing out coffee to residents. Staff A said, I don't like it. But she does it all the time and gets upset if we say anything. During an interview on 06/17/2025 at 12:04 p.m., Staff B, CNA stated We have a lot of residents who need assistance with meals on the 500 hall. Families come in and help those residents who need assistance with their meals. During an interview on 06/17/2025 at 1:23 p.m., Staff C, CNA, stated it can be challenging to get all my work completed. I work every other weekend, and it is harder to get everything done. There are 8-7 residents who need assistance with their meals in this hall. Staff C said, We are lucky that some families come in to help with meal assistance. It is challenging when you have residents who need help eating, having to pass out lunch trays, and answer call lights all at the same time. During an interview on 06/18/2025 at approximately 3:30 p.m. Staff D, Staffing Coordinator/CNA, stated she just transitioned into the position. She said, I staff based of census. Depending on what the census is, I determine how many CNA's you get per shift. There are quite a few residents who need assistance with meals on the 500 unit. She stated she was not aware of any concerns with the 500 unit needing more help during meals. Staff D stated weekends fluctuate; there are usually more call outs during the weekends and she tries to fill the shift by reaching out to as needed staff (PRN) or to staff that was scheduled to be off. She stated if she was not able to find another CNA or Nurse to fill the call out, either herself or one of Nurse Managers comes in to fill in. During an interview on 06/18/2025 at 3:50 p.m. the Director of Nursing (DON) stated she was not aware of any concerns with staff not being able to assist residents with their meals and still completing their other tasks. The DON stated there were 7 or so residents who needed assistance with their meals on the 500 unit. She stated the CNAs, Nurses or the restorative nurse should be helping residents with meal assistance. The DON said, We have a lot of involved families, who are here constantly to help with every meal. She state it was not an expectation for family to be here, but it was kind of assumed they will be here during mealtimes. The DON stated on the weekends they have call outs, but they don't have any issues with getting the shifts covered. She stated they now have a weekend supervisor who can cover the floor as needed. During an interview on 06/18/2025 at 3:50 p.m. the Nursing Home Administrator stated he has not had any concerns with sufficient staffing. He stated his expectation was for there to be enough staff to meet the needs of the residents.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure medications for new admissions were available timely for four residents (#182, #185, #379, #228) out of four sampled for admission orders. Findings included: 1. An interview was conducted on 6/18/25 at 2:15 p.m. with Resident #182. The resident said he had been in the facility for four days and did not have any pain medication for the first two days. The resident said pain had gotten to a 10 out of 10 on the pain scale during that time. The resident said he refused tube feedings because they caused stomach cramps and he couldn't handle any more pain. The resident said he was starting to feel better again after having his medication for the last two days. Resident #182 said the pain was so bad on Sunday, 6/15/25 that he almost left the facility. Review of Resident #182's admission Record showed the resident was admitted on [DATE] with diagnoses including gram-negative sepsis, cutaneous abscess of abdominal wall, spondylosis, and pain, unspecified. Review of Resident #182's admission Minimum Data Set (MDS), Section C, Cognitive Patterns, showed a Brief Interview for Mental Status (BIMS) score of 15, indicating the resident was cognitively intact. Review of Resident #182's physician orders showed: -Methadone 10 mg (milligram).1 tablet. Every 6 Hours for pain. 12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p. m. 6/15/25. -Morphine concentrate 100 mg/5 ml (milliliters) (20 mg/ml); 0.75 ml. Every 4 hours as needed (PRN) for pain. 6/14/25. -Baclofen 10 mg. 1 tablet. Three times a day for pain. 6:00 a.m., 1:00 p.m. and 6:00 p.m. 6/14/25. -Gabapentin 300 mg. 2 tablets. Three times a day as needed for pain. 6/14/25. Review of Resident #182's Medication Administration Record (MAR) revealed: -Baclofen 10 mg was documented as Drug/Item Unavailable on 6/15/25 at 9:00 a.m. and 5:00 p.m. and on 6/16/25 at 9:00 a.m., 1:00 p.m. and 5:00 p.m. The resident received the first does of Baclofen on 6/17/25 at 1:00 p.m. -Morphine 0.75 ml PRN was administered for the first time on 6/16/25 at 4:23 p.m. -Methadone 10 mg was documented on 6/15/25 at 11:01 p.m. as 6/16/25 12:00 a.m. does given at 10:00 p. m. due to waiting in pharmacy for code and documented on 6/16/25 at 6:32 p.m. that Drug/Item unavailable. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Gabapentin 300 mg was not documented as given 6/14-6/16/25. Review of Resident #182's progress notes revealed a note dated 6/17/25 at 7:54 a.m. showing, Several attempts and efforts made through the night of 6/16 -17 to encourage resident to receive tube feeding without success has[sic] resident refused feeding through out the night stating he would try again later during the day. Review of a progress note dated 6/17/25 at 10:07 a.m. signed by the Pain Management Nurse Practitioner (NP) showed, Pain/Muscle spasms-Reports pain all over, states medicine took a while to get in and has not been consistently taking it. Review of Resident #182's primary care provider NP notes revealed a note dated 6/16/25 showing, Met with patient and unit manager in patient's room. Patient appears unhappy. He notes he stopped his own tube feeds yesterday due to abdominal discomfort. In addition, he notes pain medications are not being administered as prescribed. Received first dose of methadone this AM He would like to discharge home. Notes he lives by himself. Review of Resident #182's Occupational Therapy Evaluation, dated 6/16/25 at 2:21 p.m. noted patient had pain that interfered/limited functional ability, 8/10 neck and back pain. An interview was conducted on 6/19/25 at 12:35 p.m. with Staff H, Licensed Practical Nurse (LPN). Staff H said she had cared for the resident a couple of shifts over the past few days. She said the resident has a lot of pain all the time. An interview was conducted on 6/19/25 at 1:59 p.m. with Staff O, LPN. Staff O said she cared for Resident #182 on 6/15/25. Staff O said the resident kept turning his tube feed off and she didn't know why. Staff O said she believed it was just behaviors. Staff O said she administered the medications she could, but they were waiting on the resident's medication to come in. Staff O said she remembered the resident's methadone was not in, but she couldn't recall the other specific medications. Staff O said she thought she might have pulled baclofen from the medication dispensing machine for the resident. Staff O said Resident #182 informed her he would sign out of the facility if his pain medications couldn't be administered. Staff O said the resident was upset because the pain medication prescriptions came to the facility with the hospital discharge paperwork. Staff O said she found the resident's admission packet with the prescriptions and faxed them to the pharmacy. She said she was unaware if they had been sent to the pharmacy previously. Staff O said, it wasn't like he was in uncontrolled pain. 2- An interview was conducted on 6/19/25 at 4:43 p.m. with Resident #185. Resident #185 said she had been in the facility three days and had problems with receiving pain medication upon admission. The resident said it took a day and half before pain medication was administered. Resident #185 said with any movement, her pain was a 9-10 on the pain scale. The resident said it was reported to multiple staff members and the nurses continually said, it's on its way. The resident said the only medication administered for pain was over the counter Tylenol and that was not really a pain medication. The resident said when lying completely still, the pain was ok, but it was severe with any movement. Resident #185 said pain medication was now being administered and is effective. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Records showed Resident #185 was admitted on [DATE] at 3:10 p.m. with diagnoses including displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing, chronic pain, and pain, unspecified. Review of Resident #185's admission MDS, Section C, revealed a BIMS score of 14, indicating she was cognitively intact. Review of Resident #185's physician orders showed: -Acetaminophen 325 mg. 2 tablets. Every 8 hours as needed for mild pain - 6/16/25. -Oxycodone-acetaminophen 5-325 mg. 1 tablet. Every 4 hours as needed for pain - 6/17/25. Review of Resident #185's MAR and physician orders showed: -Oxycodone-Acetaminophen 5-325 mg was administered for the first time on 6/18/25 at 1:33 a.m. -Acetaminophen 325 mg was administered on 6/17/25 at 8:37 a.m. Review of Resident #185's hospital discharge medications from 6/16/25 showed resident should have been on Oxycodone-Acetaminophen 5-325 mg every 4 hours as needed for pain and Tramadol 50 mg every 8 hours as needed for pain. Review of orders showed the Oxycodone-Acetaminophen was not entered into the facility orders until 6/17/25 and the Tramadol order was not entered into facility orders. 3. An interview was conducted on 6/18/25 at 4:01 p.m. with Resident #379. The resident said after admission it took a couple of days for pain medication to arrive and be administered. The resident reported 7-8 out of 10 on the pain scale during that time. Resident #379 said she was told repeatedly her medications weren't here yet. The resident said acetaminophen was administered and didn't do anything to help but, when you are desperate you take it. The resident said the ordered Lyrica wasn't there and for the Morphine that was the problem. Resident #379 was unhappy and said before leaving the hospital she asked multiple times about ensuring the medication would be at the facility because it would mess her up not to have them. The resident said the hospital assured here it wouldn't be an issue. The resident said her pain was reported to multiple staff members, aides and nurses. Review of the admission Record showed Resident #379 was admitted on [DATE] with diagnoses including orthopedic aftercare, spinal stenosis and lumbar region without neurogenic claudication. Review of Resident #379's admission MDS, Section C, revealed a BIMS score of 14, indicating she was cognitively intact. Review of Resident #379's physician orders showed: -Acetaminophen 325 mg. 2 tablets for mild pain 1-3. Every 8 hours as needed. Dated 6/14/25. -Hydrocodone-acetaminophen 5-325 mg. 1 tablet. Every 4 hours as needed for pain. Dated 4/10/23. Discontinued 6/16/25. -Methocarbamol 500 mg. 1 Tablet. Every 6 hours as needed for pain. Dated 6/14/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Morphine 15 mg tablet Extended Release (ER). 0.5 tablet. Every 4 hours as needed for moderate to severe pain. Dated 6/14/25. Discontinued 6/16/25. -Pregabalin (Lyrica) 150 mg. 1 capsule. Twice a day 9:00 a.m. and 9:00 p.m. for spondylosis. Dated 6/14/25. -Cyclobenzaprine 10 mg. 1 tablet. Three times a day as needed for spinal stenosis, lumbar region. Dated 6/14/25. -Ibuprofen 800 mg. 1 tablet every 8 hours as needed for pain. Dated 6/14/25. Review of Resident #379's MAR showed: -Acetaminophen 325 mg was administered on 6/15/25 at 8:39 p.m. with a documented pain level of 5/10. -Hydrocodone-acetaminophen 5-325 mg was not administered on 6/14 or 6/15/25 and was discontinued on 6/16/25. -Methocarbamol 500 mg was not administered on 6/14 or 6/15/25. -Morphine 15 mg. ER (extended release) 0.5 tablet was administered for the first time on 6/16/25 at 9:55 a. m. with a documented pain level of 9/10. It was administered again on 6/16/25 at 4:46 p.m. with a documented pain level of 10/10. -Pregabalin (Lyrica) 150 mg was documented as not available on 9/14, 9/15, 9/16, and 9/17/25. -Cyclobenzaprine 10 mg was not administered on 6/14 or 6/15/25. -Ibuprofen was administered on 6/15/25 at 9:18 a.m. Review of Resident #379's hospital discharge medications showed the morphine 15 mg , 0.5 tablet order was not supposed to be extended release. The discharge medications showed pregabalin was last administered on 6/14/25 at 8:11 a.m. and was due to be administered at bedtime on 6/14/25. The Hydrocodone-acetaminophen 5-325 mg was not on the discharge medications; it was an order from a previous admission on [DATE]. An interview was conducted on 6/19/25 at 12:24 p.m. with Staff F, Registered Nurse (RN). Staff F said she cared for Resident #379 on Sunday night. She said the resident was new and she didn't know them. She said the resident did complain of pain of 5 out of 10 on the pain scale. Staff F reviewed Resident #379's medical records and confirmed the resident had an order for Acetaminophen for pain at a level of 1-2 out of 10. Staff F said she gave the resident the Acetaminophen because she didn't know the resident well. She said she told the resident she would find out about any other medication that had been ordered. Staff F said she did not call the pharmacy to get authorization to get any other pain medication from the electronic medication dispensing machine because she didn't hear any other complaints from the resident. Staff F said she realized around midnight the resident's ordered morphine was in the medication cart, so she administered it that Monday morning. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/19/25 at 12:28 p.m. with Staff G, LPN. Staff G said she cared for Resident # 379 the morning of 6/16/25 and the resident had been concerned about pain medication. Staff G said the resident had morphine administered by the previous nurse that morning. Staff G confirmed the resident's Lyrica was not available and the script had been sent to the pharmacy. She said Lyrica was available in the electronic medication dispensing machine, but the resident needed an approved prescription. An interview was conducted on 6/19/25 at 2:16 p.m. with the facility's Pain Management Physician. He said he saw Resident #182 and #379 on Monday. He said Resident #182 did have concerns about not getting pain medication over the weekend. He said when the resident was admitted on Saturday 6/14/25, he had been called, and orders were sent Saturday. He said the biggest issues was pharmacy didn't get it delivered. He said Morphine should be in the facility's emergency drug supply and he could not answer why the nurse did not pull the medication from there and administer it to the resident. He said if a resident says their pain is 10 out of 10, it is a 10 out of 10. The physician said he did not think Resident #182 had uncontrolled pain all weekend, but he did want to get it back under control and on his regimen before he made any changes to the pain medication orders. He said the facility may not have had Resident #182's methadone in the emergency drug supply, but typically if certain medications aren't available, the nurse would call him and ask for a different dose or medication for a one time administration. The pain management physician said he was only called on admission for Resident #182 and was not notified medications were not available or not being administered; he was not aware until he arrived Monday morning 6/16/25. As for Resident #379, the pain management physician said he was called when they arrived at the facility on 6/14/25 and he sent the prescriptions then. He said he wrote a prescription for Morphine 15 mg 1/2 tablet every 4 hours as needed. He said the nurse later told him they couldn't get Morphine 15 mg out of the electronic medication dispensing machine because they did not have extended release and the pharmacy notified the nurse they couldn't give 1/2 tablet because extended release could not be cut. The physician said there had been a transcription error somewhere because his order was not for extended release, it was for immediate release. An interview was conducted on 6/19/25 at 9:23 a.m. with the facility's Medical Director. He said the facility did seem to struggle more on the weekends with getting medications. He said on admission the nurse should do a head-to-toe assessment and call the doctor to confirm orders. He said the facility should have been able to address a resident's pain and if he had been notified there were issues with getting medications they could have put their heads together and used a different medication temporarily. He agreed that going for two days without pain medication was too long. He said there should have been a mechanism in place to address a resident missing medication. He said it would be expected for staff to notify him or the NP if a resident was not getting their medication. He said there was no notification in the on-call system showing anyone was notified of the residents missing their medications over the previous week. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview was conducted on 6/19/25 at 5:12 p.m. with the Nursing Home Administrator (NHA). He agreed there was an issue with the admission process and receiving medications, specifically weekend admission. The NHA said the facility did have a backup pharmacy and the facility identified that the nurses were not trained on that. He said the facility also used a local commercial pharmacy and had an electronic medication dispensing machine. The NHA said they had identified concerns for residents admitted on Saturday; their medications were not coming until the next business day. He said they are pausing weekend admissions going forward until the clinical leadership and all direct care staff are proficient in the process and audits are completed to ensure residents did not miss significant medications. The NHA said when medication orders were placed by 6:00 p.m. they came in on the night pharmacy run between 9:00 p.m. and 12:00 a.m. He said nurses should get medication out of the electronic medication dispensing machine if the resident is admitted after 6:00 p.m. He was unaware medications were not being administered that were in the electronic medication dispensing machine. The NHA said there was a weekend supervisor from 3:00-11:00 p.m. to ensure medications are taken from the electronic medication dispensing machine if needed. The NHA was unaware there were issues with residents not getting pain medication administered or that there were issues with residents not getting medications for two or more days on weekday admissions. The NHA said medication administration is a priority and this is not acceptable. An interview was conducted on 6/19/25 at 8:20 p.m. with the facility's consultant pharmacist. She was unaware the facility had concerns with getting medication and pain management. She said she would work with the facility to address the issue. 4. Review of Resident #228's Resident Face Sheet revealed an admission date of 06/10/25 with diagnoses to include ground level fall resulting in a displaced femur fracture and surgical repair on 06/04/25, hypertension, vascular dementia and other co-morbidities. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008) for Resident #228 dated 06/10/25 revealed Resident #228 requires a surrogate to make decisions and resident is alert, disoriented, but can follow simple instructions. Review of Resident #228's physician order dated 06/10/25 revealed: lisinopril tablet 20 mg daily and metoprolol succinate tablet extended release 25 mg daily. Review of Resident #228's electric Medication Administration Record (eMAR) dated for June 2025 revealed: lisinopril tablet 20 mg daily and metoprolol succinate tablet extended release 25 mg daily were not given on 06/12/2025 and 06/13/2025. Review of Resident #228's progress notes revealed on 06/12/25 and 06/13/25 comment: lisinopril tablet 20 mg daily- drug not available, pharmacy notified. On 06/12/25 and 06/13/25 comment: metoprolol succinate tablet extended release 25 mg showed- drug not available pharmacy notified. During an interview on 06/19/25 at 02:01 p.m. Resident #228's Durable Power of Attorney (DPOA)/Responsible Party (RP) stated not being aware Resident #228's medications were not available for those two days. During an interview on 06/18/25 at 05:30 p.m. Resident #228's attending physician stated he could not recall being notified of the medications not be available for those two days. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 06/19/25 at 09:29 a.m. the facility Medical Director stated the medications should be availbe for administration. The facility did not provide a policy and procedure for Pharmacy Services as requested.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, record reviews, and interviews, the facility failed to ensure the medication error rate was less than 5%. Twenty-five medication opportunities were observed, and two errors were identified resulting in an error rate of 8.0%. Findings Included: During a medication administration observation on 6/17/25 at 8:41 A.M. for Resident #6, Staff F, Registered Nurse (RN), prepared vitamin B-12 (1 tablet), multiple vitamin with minerals (1 tablet), and Gabapentin 300 mg (milligram) capsule (1 capsule) by crushing the medications and administering with applesauce. Review of the facility's list titled, Oral Dosage Forms that Should Not be Crushed 2016, published by the Institute of Safe Medication Practices (ISMP) showed Gabapentin tablet should not be crushed. On 6/17/25 at 8:48 A.M. during a medication administration observation Staff F, RN prepared and administered the following medications to Resident #53, aspirin 81 mg, calcium carbonate 1500 mg, brimonidine-timolol-one drop in each eye, buspirone 15 mg, vitamin D3 (1 tablet), and nifedipine 30 mg extended-release tablet. Staff F, RN, crushed Resident #53's calcium carbonate, buspirone, vitamin D3, and nifedipine before administering. Review of Resident #53's Medication Administration History, dated 6/1/25-6/18/25, showed, DO NOT CRUSH as special instructions for nifedipine administration. During an interview on 6/17/25 at approximately 9:10 A.M. Staff F, RN, stated she does not know where to find the facility's list of do not crush medications. Review of the facility's list titled, Oral Dosage Forms that Should Not be Crushed 2016, published by the Institute of Safe Medication Practices (ISMP) showed nifedipine tablets should not be crushed During an interview on 6/19/25 at 11:07 A.M. the Director of Nursing (DON) said the nursing staff are expected to follow physician orders, pharmacy instruction and the facility's policy during medication administration. Review of the facility's policy titled, medication administration, reviewed 7/22/24 showed under guidelines a policy statement: Medications are administered as prescribed, in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have familiarized themselves with the medication. Procedures: .22. If it is safe to do so, medication tablets may be crushed or capsules emptied out when a patient/resident has difficulty swallowing or is tube-fed, using the following guidelines:-Long-acting or enteric coated dosage forms should generally not be crushed and require a physician's specific order to do so. The physician must record in the medical record that the benefit of crushing the dosage form outweighs any potential risk. -For patients/residents able to swallow, tablets may be crushed together, and along with the contents of opened capsules, may be mixed with the appropriate vehicle (e.g. [such as] applesauce) so that the patient/resident receives the entire dose.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews facility failed to ensure medication was stored appropriately on three halls (100, 200, 500) out of five halls related to unlocked medication/treatment carts, unattended medication, dirty medication carts, and controlled drugs not stored in a permanently affixed compartment. Findings included: An observation was conducted on 6/16/25 at 9:35 a.m. of an unlocked treatment cart containing prescription medications on the 500 hall. No staff were observed in sight. An observation was conducted on 6/16/25 at 10:22 a.m. on the 100 unit of an unlocked medication cart left unattended in the hall. There was a resident in the hall and no staff members were present. An observation was conducted on 6/17/25 at 10:16 a.m. of the 500 hall medication storage room with Staff F, Registered Nurse (RN). A metal box in the refrigerator contained an emergency drug kit with a controlled drugs. The metal box was not permanently affixed. Staff A said she did not know why it was not affixed or if it was supposed to be. An observation was conducted on 6/17/25 at 12:09 p.m. of an unlocked and unattended medication cart on the 100 unit. There were no nurses in sight of the cart. An interview was conducted on 6/19/25 at 7:32 p.m. with the Nursing Home Administrator (NHA). The NHA stated the box containing controlled drugs should be attached to the refrigerator and it would be taken care of. The NHA confirmed controlled medication was in the emergency drug kit. 2. On 6/17/25 at 8:32 A.M., during medication administration observation Staff F, Registered Nurse (RN) left intravenous (IV) antibiotics on top of the medication cart while administering medications in a resident's room. Staff F, RN said, I forgot to lock the cart. On 6/17/25 at 8:48 A.M., during a medication administration observation Staff F, RN, left aspirin, vitamin D3, nifedipine, calcium carbonate, Buspar and Combigan on top of the medication cart when she went to get her stethoscope. Staff F, RN said she thought it was okay because the surveyor was standing by the medication cart. On 6/17/25 at 12:59 P.M. during medication administration observation Staff I, RN walked away from an unsecured medication cart. When notified of the observation, Staff I, RN said, Thank you, I always lock the cart. On 6/17/25 at 1:01 P.M. during a medication administration observation Staff I, RN walked away from an unsecured medication cart. When notified of the observation Staff I, RN said, This is the only two times I have done this today. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/18/25 at 12:36 P.M., the medication cart at the nurses' station between 100 and 200 hallways was observed unlocked and unattended. Staff K, RN, was notified. She secured the cart and said medication carts should be locked when staff is not using them. On 6/17/25 at 8:12 A.M. the bottom drawer of the 300 Hallway medication cart was observed with a build-up of sticky, gummy red and cream-colored material on the surface to the drawer and around the dividers. On 6/17/25 at 8:32 A.M. the 400/500 Hallway's medication cart was inspected and observed with sticky, gummy red and cream colored build- up in the bottom drawer, and more apparent in the corners and around the dividers. Staff F, RN, said the nurses are responsible for cleaning the drawers. During an interview on 6/19/25 at 11:07 A.M. the Director of Nursing (DON) said medications carts should be locked, and medications should not be left unattended on top of the medication cart. The DON said, If the nurse walks away the cart, it should be locked. Review of facility's policy titled, medication storage in the healthcare centers, revised 11/1/24, Policy Statement: Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel and pharmacy personnel. Scope: This policy applies to all licensed nursing staff of [Name of Facility]. Procedure: 2. Only licensed nurses and pharmacy personnel are allowed to access medications . Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. 3. Nurses are required to check all medications for deterioration or expiration before administration. Nurses are also required to inspect medication storage facilities, including medication carts routinely. Medication storage areas are to be kept clean, well-lit and free of clutter. Nursing staff who administer medications are responsible for the cleaning and organization of medication carts and medication storage areas. (Photographic Evidence Obtained)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review the facility did not ensure residents who entered arbitration agreements understood the contract contents for three residents (#228, #51 and #29) of three residents sampled. Findings included: Review of the admission Agreement dated 06/13/25 revealed Resident #228 electronically signed all documents personally, and the appointed representative was not present. On page 44 of the electronic admission agreement, it showed the Arbitration Agreement was signed by Resident #228 accepting the terms of Arbitration Agreement. Review of the admission Record for Resident #228 revealed an admission date of 06/10/25 with diagnoses to include ground level fall resulting in a displaced femur fracture and surgical repair on 06/04/25, hypertension, vascular dementia and other co-morbidities. Review of the Medical Certification for Medicaid Long-Term Care Services and Patient Transfer Form (3008) for Resident #228 dated 06/10/25 revealed Resident #228 required a healthcare surrogate to make decisions and resident is alert, disoriented, but can follow simple instructions. Review of Resident #228's physician note dated 06/12/25 reveal: Resident #228 was an [AGE] year-old with a history of advanced dementia, Due to her advanced dementia, Resident #228 is unable to provide meaningful information . The resident has a representative appointed for decision making. During an interview on 06/19/25 at 02:01 p.m. with Resident #228's Durable Power of Attorney (DPOA)/Responsible Party (RP) stated having not signed any paperwork for the facility. The DPOA/RP had asked the facility about the paperwork, and they said everything was already taken care of at the hospital. The DPOA/RP stated not being sure Resident #228 was cognitively aware and stated the resident would not be able to sign. Review of the admission Agreement dated 05/26/25 revealed Resident #51 electronically signed all documents personally, and there was no representative appointed. On page 44 of the electronic admission agreement, it showed the Arbitration Agreement was signed by Resident #51 accepting the terms of Arbitration Agreement. Review of the admission Record for Resident #51 revealed an admission date of 05/24/25 with diagnoses to include Non-ST elevation (NSTEMI) myocardial infarction (type of heart attack), hypertension, congestive heart failure and other co-morbidities. During an interview on 06/19/25 at 03:32 p.m. with an alert and oriented Resident #51 and spouse, they both stated not recalling signing any arbitration agreements. Resident #51 stated recalling signing the admission paperwork, but does not recall any conversations regarding arbitration, mediation, jury trials, etc. (and so forth). (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission Agreement dated 02/26/25 revealed Resident #29 electronically appointed a Resident Representative (RP) to sign the agreement on their behalf. The RP was Resident #29's Power of Attorney (POA). On page 44 of the admission agreement, it showed the Arbitration Agreement was signed by Resident #29's RP/POA accepting the terms of the Arbitration Agreement. Review of the admission Record for Resident #29 revealed an admission date of 02/25/25 with diagnoses to include Parkinson's disease, hypertension, congestive heart failure and other co-morbidities. During an interview on 06/18/25 at 02:50 p.m. with Resident #29 and RP/POA both stated not recalling signing any arbitration agreements. They recalled signing admission paperwork, but did not recall any conversations regarding arbitration, nor having the agreement explained. During an interview on 06/18/25 at 03:40 p.m., the Senior Nurse Navigator (SNN) stated being responsible for reviewing the admission agreements with residents or their representatives. The SNN stating the process includes reviewing the arbitration agreement with the resident. The SNN states explaining the agreement and ensures the resident/RP understands what the arbitration is. The SNN informs the resident/RP the agreement can be rescinded in 30 days. Explains if something were to happen in the facility, they are to come to the facility first, to see if they can make it right before seeking legal counsel. The SNN explains the Arbitration is optional and the resident/RP can refuse to sign. The SNN stated if the resident was not cognitively able to sign or speak for themselves, the SNN goes over the agreement with the RP. The SNN stated being able to review the hospital clinical information (physician/nurses notes) including the 3008 to ensure residents are capable of signing the agreement. During an interview on 06/19/25 at 04:30 p.m. the Nursing Home Administrator (NHA) stated the agreement should be explained and only signed by the resident or RP if capable of understanding the agreement. The NHA stated on 06/19/25 at 07:07 p.m. the facility did not have a policy specific to the Arbitration Agreement.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined the facility failed to provide Quality Assurance and Performance Improvement (QAPI) practice that demonstrated identification, monitoring and implementation of an effective Action Plan to improve findings of deficient practice on the annual survey conducted 6/19/25 regarding a medication error rate of greater than 5.0% and infection control during medication administration. Findings included: 1. On 6/17/25 during a recertification survey deficient practice was identified during medication administration and F759 was cited with a scope and severity of D. During a medication administration observation on 6/17/25 at 8:41 A.M. for Resident #6, Staff F, Registered Nurse (RN), prepared vitamin B-12 (1 tablet), multiple vitamin with minerals (1 tablet), and Gabapentin 300 mg (milligram) capsule (1 capsule) by crushing the medications and administering with applesauce.Review of the facility's list titled, Oral Dosage Forms that Should Not be Crushed 2016, published by the Institute of Safe Medication Practices (ISMP) showed Gabapentin tablet should not be crushed.On 6/17/25 at 8:48 A.M. during a medication administration observation Staff F, RN prepared and administered the following medications to Resident #53, aspirin 81 mg, calcium carbonate 1500 mg, brimonidine-timolol-one drop in each eye, buspirone 15 mg, vitamin D3 (1 tablet), and nifedipine 30 mg extended-release tablet. Staff F, RN, crushed Resident #53's calcium carbonate, buspirone, vitamin D3, and nifedipine before administering. Review of Resident #53's Medication Administration History, dated 6/1/25-6/18/25, showed, DO NOT CRUSH as special instructions for nifedipine administration.During an interview on 6/17/25 at approximately 9:10 A.M. Staff F, RN, stated she does not know where to find the facility's list of do not crush medications. Review of the facility's list titled, Oral Dosage Forms that Should Not be Crushed 2016, published by the Institute of Safe Medication Practices (ISMP) showed nifedipine tablets should not be crushed.2-During the revisit survey additional medication administration errors were:An observation was conducted on 8/11/25 during medication administration with Staff B, Licensed Practical Nurse (LPN).-At 10:03 a.m. Staff B prepared medication to be administered to Resident #3. The following medications were prepared:1-Tamsulosin 0.4 mg x 12-Olanzapine 5 mg x13-Jardiance 10 mg x 14-Gabapentin 100 mg x 15-Clonazepam 0.5 mg x 16-Methocarbamol 500 mg x 17-Multivitamin x 18-Valproic acid 250 mg/5ml. Give 5 ml.9-Acetaminophen 325 x 110-Eliquis 5 mg x 1Review of admission Records showed Resident #3 was admitted on [DATE] with diagnoses including other paralytic syndrome following cerebral infarction, polyneuropathy, and pain.Review of Resident #3's physician orders showed medications #1-8 were given per orders. For medication #9, Acetaminophen, only one tablet was administered, and the order dated 7/1/25 was Acetaminophen 325 mg. 2 tablets. Once a day at 9:00 a.m. For medication #10, Eliquis, Staff B dispensed the medication and accidentally dropped it on the floor. Staff B disposed of the dropped tablet but did not dispense another Eliquis to be administered. The order dated 6/20/25 was for Eliquis tablet 5 mg. Twice a day at 9:00 a.m. and 9:00 p.m. Further review of physician orders showed the following orders for medications that were scheduled at 9:00 a.m. but were not administered:-Miralax powder; 17 gram/dose. Every 12 hours 9:00 a.m. and 9:00 p.m. Dated 6/25/25.-Voltaren Arthritis Pain gel; 1 %; 2 grams topical. Apply to neck for pain three times a day. 9:00 a.m., 1:00 p.m., and 5:00 p.m. Dated 8/5/253- On 6/17/25 during a recertification survey deficient practice was identified during medication administration and F880 was cited with a scope and severity of E. Finding included:On 6/17 25 at 8:12 a.m. during a medication administration observation for Resident #29, Staff G, Licensed Practical Nurse (LPN) did not perform hand hygiene (HRH) and did not use ABHR (Alcohol- Based Hand Rub) before preparing medications as well as before and after administering the medications.On 6/17/25 at 10:28 a.m. an interview was conducted with Staff G, LPN about the HH during medication administration, she agreed hand hygiene was not done.On 6/17/25 at 8:32 a.m. Staff F, RN was observed preparing intravenous (IV) antibiotics to administer to Resident #278, she dropped the IV tubing on the floor in the resident's room. Staff F, RN picked up the tubing from the floor and while wearing the same pair of gloves, removed the cap covering the drip chamber, spiked the medication bag and primed the tubing. Before administering Staff F, RN, said the IV tubing is safe to use because the caps on both ends of the tubing had not been removed. When asked about the facility's policy Staff F, RN repeated the IV tubing was safe to use because the caps on both ends of the tubing had not been removed and continued to administer the antibiotic.On 6/17/25 at 8:41 a.m. while preparing and administering medications for Resident #6, Staff F, RN did not perform hand hygiene (HH) of any kind before

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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 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** During an initial on 06/16/25 at 10:21 a.m. Resident #229's door had an 8 ½ by 11 (letter size) CDC Contact Isolation Precautions sign printed in color showing two large fonts STOP signs in all capital letters and the following Contact Precautions written between the two signs. The next line revealed in all capital letters Everyone Must: Clean their hands, including before entering and when leaving the room.The following line in all capital letters showed: Providers and Staff Must Also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. During this tour the PPE cabinet in the hallway outside Resident #229's door revealed only gloves were available and a roll of trash bags at the bottom drawer. On 06/16/25 at 11:30 a.m. Staff W, Occupational Therapist (OT) was observed pushing Resident #229 in a wheelchair down the hallway. Staff W entered the resident's room. Staff W assisted Resident #229 transfer to a chair inside the room, moved the resident's over bed table and drinking cup to be within the resident's reach and exited the room. Staff W did not donn and did not apply hand hygiene prior to or after entering and caring for Resident #229. During an interview on 06/16/25 at 11:35 a.m. Staff W confirmed seeing the sign on the resident's door, and stated the sign meant PPE was only required when assisting the resident with toileting needs, and that was the only time hand hygiene and PPE would be required. On 06/16/25 at 12:11 p.m. Staff V, Certified Nursing Assistant (CNA) was observed removing a meal tray from the food cart, entering room [ROOM NUMBER] and setting up the resident's tray, touched the over bed table and the resident and then exited the room. Staff V walked directly to the food cart, opened and removed another tray for delivery and proceeded to enter another room, without completing any hand hygiene. At 12:18 p.m. Staff V entered room [ROOM NUMBER] which had a Contact Isolation sign on the door. Staff V did not donn PPE prior to entering the room and did not apply hand hygiene. Staff V continued walking down the hall, adjusted long hair into a ponytail at the back of the head. Staff V did not perform hand hygiene and continued passing trays. During an interview on 06/16/25 at 02:30 p.m. Staff V,CNA stated not being aware of the need to complete hand hygiene between tray delivery. Staff V stated not noticing the contact isolation sign on the door in room [ROOM NUMBER]. Staff V stated contact isolation PPE only needed to be worn when caring for resident, and said, I was only delivering the tray. During an interview on 06/17/25 at 02:19 p.m. the Director of Nursing (DON) stated the signs for contact isolation in rooms [ROOM NUMBERS] should have been removed, yesterday morning since the residents in the rooms did not need isolation and everything is ok. The DON said she was not sure why the signs were not removed yesterday. The DON confirmed the signs indicated to the staff and visitors what precautions should be followed to ensure infections are not spread, and if a sign is posted the sign should be followed. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/18/25 at 11:52 a.m. Staff P, CNA was observed during meal pass removing a tray from the cart, entering room [ROOM NUMBER], setting the tray up and assisting resident with tray set up, exited the room, returned to the tray cart, selected another tray and entered room [ROOM NUMBER]. No hand hygiene occurred during the observation. During an interview on 06/18/25 at 11:56 a.m. Staff P stated not being aware of the need for hand hygiene between each room. During an interview and observation on 06/16/25 at 11:42 a.m. Resident #29 was observed drinking from a large reusable plastic facility tumbler/cup with a lid and straw. Resident #29 stated the cup is cleaned once or twice per week. During an interview on 06/18/25 at 11:20 a.m. with the Certified Dietary Manager (CDM) stated, the facility's reusable plastic tumbler/cups are sporadically returned to the kitchen for cleaning through the dish machine. The facility does not utilize the reusable straw that came with the tumbler/cup but replaces it with a disposable straw. The CDM was not aware of a specific schedule for the reusable tumbler/cup sanitation. The CDM stated if the staff needed a clean tumbler/cup there were a few in the kitchen for distribution. About 8 reusable tumbler/cups were observed in the kitchen ready for use. There were no other tumbler/cups observed in the kitchen or dish room. During an interview on 06/18/25 at 11:48 a.m. Staff A, CNA stated, they change the straws every shift, and when the tumbler/cup is dirty they can take it to the kitchen. Staff B, CNA stated not having anything to do with the tumbler/cups except to refill them and was not aware of the cleaning process. During an interview on 06/18/25 at 11:53 a.m. Staff X, CNA stated the tumbler/cup is washed in the nourishment room there is a sink there. Staff X stated if need be they send them to the kitchen twice a week, no specific days. During an interview on 06/18/25 at 11:56 a.m. Staff P, CNA stated not aware of any process, was instructed to wash the cups in the nourishment room with hand soap and water. Staff P said, Although, I usually wash in the resident room sink as it seems cleaner with the room being private. During an interview on 06/18/25 at 12:00 p.m. the Registered Dietitian (RD) stated the expectation for the reusable tumblers/cups are to be cleaned at least daily by the kitchen staff in the dish machine. The RD stated not being aware of the cleaning schedule for the tumbler/cups. During an interview on 06/18/25 at 12:05 p.m. the DON stated the tumbler/cups are changed out daily. The DON stated the tumbler/cups don't have a specific time for distribution or know the process for cleaning of the tumbler/cups. During an interview on 06/18/25 at 12:07 p.m. Staff G, Licensed Practical Nurse (LPN) stated we remove the reusable straw and replace it with a disposable, but was not familiar with a specific process for taking the tumbler/cups to the kitchen for cleaning. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy titled Transmission-Based Isolation Precautions reviewed on 12/11/2023, showed a policy statement, it is the policy of all [Facility Name] to implement and adhere to transmission-based precautions to prevent and protect from exposure and transmission of suspected or confirmed infectious agents within the healthcare setting. Procedures: A. Administrative Responsibilities 1. The Administrator and Director of Health Services of the Healthcare Center are responsible for the implementation of this policy. B. General Principles: 1. Standard Precautions are used in the care of all residents and are never to be discontinued. 2. Promptly initiate isolation precautions for residents with suspected or confirmed communicable diseases to minimize exposure to infectious agents. 5. Personal protective equipment (PPE) is provided for everyone who needs to care for or visit a resident on isolation precautions. 6. Everyone, but not limited to, providers, nurses, environmental services, technicians, are responsible for complying with isolation precautions, donning appropriate PPE, and tactfully calling observed noncompliance to the attention of offenders. 8. Display the appropriate isolation signage on the resident's door frame/door. 11. All residents on isolation are assessed during each shift to determine the need for continued precautions. C. Initiation and Discontinuation of Isolation Precautions 1. Initiation and termination of isolation precaution requires a physician's order for the appropriate type of isolation precautions to be followed. 2. Patients with a known or suspected communicable disease should immediately be placed on appropriate isolation precautions. 4. The appropriate isolation precaution signs should be placed in a readily visible location outside of the resident's room (i.e., resident's door/doorframe). 5. Personal protective equipment (PPE) (e.g., gowns, gloves, masks) should be readily available outside the patient's room and either in a cart outside the patient's room door or in a designated cabinet outside the room door. 6. Discontinuation of isolation precautions requires the order of a physician provider. D. Types of Isolation Precautions 1. Contact Precautions (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Use contact precautions for residents with known or suspected to be infected or colonized with epidemiologically important microorganisms that can be transmitted by direct contact with the resident, (i.e., hand contact or skin-to-skin contact that occurs when performing resident-care activities that require touching the resident's dry skin) or indirect contact (i.e., touching) with environmental surfaces or items in the resident's environment. B. Personal Protective Equipment (PPE) 1) Gloves * perform hand hygiene prior to donning gloves. * Wear gloves(clean, non-sterile gloves are adequate) upon entry into the room.* Wear gloves when touching the residents intact skin, surfaces and items near the resident. 2) Gowns * Perform hand hygiene prior to dawn and gown. * Done a gown upon entry into the room. * Remove gown before leaving the residence environment and perform hand hygiene. C. Signage 1) Place a contact precaution sign on the residence door/door frame. Resident Transport . 3) ensure that infected or colonized open wounds are covered and contained to minimize the risk of transmission of microorganisms to other residents and contamination of environmental services or equipment. Review of the facility's policy titled Medication Administration: Hand Hygiene dated reviewed 10/14/2024 revealed: Policy Statement: It is the policy of [Facility Name] Pharmacy Services that partners will use appropriate hand hygiene during medication administration. Appropriate hand hygiene reduces the spread of germs and decreases the spread of infections. Hand Hygiene: The cleansing of hands by using the organization-approved, alcohol-based hand sanitizer or by washing hands with soap and water. Procedure: 1. During medication administration, use hand hygiene before and after touching a patient, immediately before performing a clean or aseptic procedure, immediately after an exposure risk to body fluids, before moving from a soiled body site, after touching a patient's immediate surroundings, and before and after glove removal. 2. Use an organization- approved, alcohol-based hand sanitizer for hand hygiene, if hands are not visibly soiled or contaminated with bodily fluids. It is faster, more effective, and better tolerated by your hands than washing with soap and water. - To use hand sanitizer, put product on hands and tub hands together, cover all surfaces of hands and fingers until skin feels dry. This should take approximately 20 seconds. 4. Wear gloves during medication administration for IV insertion and removal or when there is contact with blood, mucous membrane, or non-intact skin. Gloves should be worn during eye drop, vaginal, or rectal administration. Glove should be worn while opening capsules during medication preparation or while preparing and administering hazardous agents (NIOSH). Hand hygiene should be performed before donning and after removing gloves. Change gloves and perform hand hygiene during medication administration, if gloves become damaged, visibly soiled with blood or bodily fluids, moving from work on a soiled body site to a clean site, or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Based on observations, interviews, record reviews, and review of the Center for Disease Control and Prevention (CC) guidelines, the facility failed to implement and maintain an infection prevention and control program to mitigate and prevent the spread of infection related to use of Personal Protective Equipment (PEP) during care, medication administration and meal service for four (#29, #278, #6, and #229 of 48 sampled residents, and in two halls (300, 100) of five hallways observed. Findings Included: On 6/17 25 at 8:12 a.m. during a medication administration observation for Resident #29, Staff G, Licensed Practical Nurse (LPN) did not perform hand hygiene (HRH) and did not use ABHR (Alcohol- Based Hand Rub) before preparing medications as well as before and after administering the medications. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/17/25 at 10:28 a.m. an interview was conducted with Staff G, LPN about the HH during medication administration, she agreed hand hygiene was not done. On 6/17/25 at 8:32 a.m. Staff F, RN was observed preparing intravenous (IV) antibiotics to administer to Resident #278, she dropped the IV tubing on the floor in the resident's room. Staff F, RN picked up the tubing from the floor and while wearing the same pair of gloves, removed the cap covering the drip chamber, spiked the medication bag and primed the tubing. Before administering Staff F, RN, said the IV tubing is safe to use because the caps on both ends of the tubing had not been removed. When asked about the facility's policy Staff F, RN repeated the IV tubing was safe to use because the caps on both ends of the tubing had not been removed and continued to administer the antibiotic. On 6/17/25 at 8:41 a.m. while preparing and administering medications for Resident #6, Staff F, RN did not perform hand hygiene (HH) of any kind before preparing medications as well as before and after administering the medications. During an interview with Staff F, RN confirmed HH was not completed. During an interview on 6/18/24 at 12:38 p.m. Staff K, RN stated if during medication administration the IV tubing dropped to the floor, the expectation was for the tubing to be replaced prior to administering the medication. During an interview on 6/19/25 at 11:07 a.m., the Director of Nursing (DON) said if IV tubing falls on the floor, staff are expected to replace the tubing before administering the medications. She stated staff are expected to perform hand hygiene before preparing medications and when administering medications. Review of the facility's policy titled, Intravenous Antibiotic Therapy, reviewed 7/2/24 showed the following under scope - This policy applies to all nurses within a center serviced by [Facility Name] pharmacy Services. Procedure .7. Aseptic technique shall be maintained and standard precautions observed throughout administration of the medication.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to implement an antibiotic stewardship program including developing a system to monitor use of antibiotic-resistant organisms for one resident (#378) out of two residents reviewed for antibiotic stewardship with potential to impact the entire facility. Findings included: Review of the admission Record revealed Resident #378 was admitted to the facility on [DATE] with diagnoses to include other Staphylococcus as the disease classified elsewhere. Review of the June 2025 Medication Administration Record (MAR) for Resident #378 showed the resident was receiving Vancomycin recon 1.25 grams; IV (intravenous), dated 5/29/25 to 6/18/25. The review of the MAR did not show why the resident was on Vancomycin and it was not specified what type of infection she was being treated for. The MAR did not show a specified diagnosis. The review pf physicin orders for Resident #378 showed there was no order for contact precautions and there was no McGreer's Criteria (a set of standardized definitions used primarily in Long term Care facilities to identify and classify infections for surveillance and antibiotic stewardship purposes) in place. Review of daily progress notes for Resident #378 dates 5/30/25 to 6/17/25 showed, Resident continues IV ABT VANCO (antibiotic vancomycin) to RUE (right Upper extremity) with no adverse reactions to medications. Resident tolerated well with no s/s (signs/symptoms) of infection of IV site and is secure and flushes without difficulty. Resident denies pain or discomfort with no SOB (Shortness of Breath) to note. The progress notes did not show why the resident was on the antibiotic. During an interview on 6/19/25 at 4:56 p.m. the Director Of Nursing (DON) said, The interdisciplinary team conducts a weekly Patient At Risk (PAR) meeting as part of the antibiotic stewardship program, at this meeting we discuss residents on antibiotics. The DON stated after the PAR discussion of who is on antibiotics she documents on a map of the facility, showing which residents have which infections using a color-coded chart. She stated documenting on the chart is what consists of their antibiotic stewardship program. The DON confirmed there was no McGreer's Criteria for monitoring the residents on antibiotics. During an interview on 6/19/25 at 7:04 p.m. the Nursing Home Administrator (NHA) stated there had not been an Infection Control Program or antibiotic monitoring program. The NHA said the facility just started looking at antibiotic stewardship about two weeks ago, but nothing had been done with the data. The NHA stated Resident #378 had not been tracked for her use of antibiotics and the use of McGreer's did not start until 6/16/25. He stated Resident #378 was admitted with an unspecified bacterial infection and a history of Methicillin-resistant Staphylococcus aureus. The NHA confirmed there was no follow up with the physician regarding any type of contact precautions. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of an undated facility policy titled Antibiotic Stewardship Program, showed: As part of the Infection Prevention and Control Program, [Name of Facility] will implement and maintain an Antibiotic Stewardship Program (ASP). Under the direction of the Medical Director and Director of Health Services (DHS) the ASP is designed to promote appropriate use of antibiotics and improve patient health outcomes. The goal of ASP is to promote appropriate use of antibiotics to treat infections and reduce possible adverse events associated with antibiotic use.