STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115270	A. Building B. Wing	03/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Perimeter Rehabilitation Suites by Harborview	5470 Meridian Mark Road, Bldg E Atlanta, GA 30342

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and facility policy review, the facility failed to develop a comprehensive Care Plan for four of four residents (Resident (R) 13, R29, R114, and R242) reviewed for activities and one of four residents (R117) reviewed for Pre-admission Screening and Resident Review (PASARR). The Care Plan failed to address activity needs and interventions for R13, R29, R114, and R242 and failed to address a diagnosis of post-traumatic stress disorder (PTSD) and related interventions. These failures placed the residents at risk for unmet physical and psychosocial care needs and the inability to meet their maximum practicable level of functioning.Findings include: Review of the facility's policy titled, Comprehensive Care Plans, dated 03/01/2025, revealed, The care planning process will include an assessment of the resident's strengths and needs . and incorporate culturally competent and trauma-informed care as indicated . All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care. The facility's rationale for deciding whether to proceed with care planning will be evidenced in the clinical record . The comprehensive care plan will describe . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . [and] Any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASARR recommendations. Review of the Minimum Data Set (MDS) 3.0 Resident Assessment Instrument (RAI) Manual, dated October 2025 indicated .The RAI consists of three basic components: The Minimum Data Set (MDS) Version 3.0, the Care Area Assessment (CAA) process and the RAI Utilization Guidelines.This process is designed to assist the assessor to systematically interpret the information recorded on the MDS. Once a care area has been identified or triggered, nursing home providers use current, evidence-based clinical resources to conduct an assessment of the potential problem and determine whether or not to care plan for it. The CAA process helps the clinician to focus on key issues identified during the assessment process so that decisions as to whether and how to intervene can be explored with the resident.The RAI process, which includes the Federally mandated MDS, is the basis for an accurate assessment of nursing home residents. The MDS information and the CAA process provide the foundation upon which the care plan is formulated. There are 20 problem-oriented CAAs, each of which includes MDS-based trigger conditions that signal the need for additional assessment and review of the triggered care area. 1. Review of R13's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including encephalopathy, respiratory failure, dementia, malnutrition, and dysphagia. (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R13's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/02/2026 and located under the MDS tab of the EMR, revealed a score of ten out of 15 on the Brief Interview for Mental Status (BIMS), indicating moderately impaired cognition. He was assessed to exhibit moderate mood symptoms of depression. The MDS documented it was very important for R13 to participate in religious and group activities. Review of the Care Area Assessment indicated additional activities assessment was indicated due to R13's Little interest or pleasure in doing things - symptom presence. The CAA directed staff to proceed to care planning for activities needs and interventions. Review of R13's EMR under the Care Plan tab revealed there was no Care Plan addressing his activity needs, goals, or interventions. During a concurrent interview on 03/18/2026 at 7:57 AM, MDS Coordinator 1 (MDSC1) and MDSC2 confirmed that once a care area has been triggered in the CAA and directed the staff to develop a Care Plan, the Care Plan was to be developed. The [NAME] President of Clinical Reimbursement (VPCR) stated the activities staff was responsible for the activity Care Plan. 2. Review of R29's admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including stroke, epilepsy, hemiplegia and hemiparesis, muscle weakness, respiratory failure with tracheostomy, and gastrostomy tube. Review of R29's admission MDS with an ARD of 01/29/2026 and located under the MDS tab of the EMR, revealed he was unable to complete the BIMS and staff assessed him with short-and long-term memory problems and severely impaired cognition. R29's activities interests were unable to be assessed due to his inability to respond. Review of the CAA indicated additional activities assessment was indicated due to R29's Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities. The CAA directed staff to proceed to care planning for activities needs and interventions. Review of R29's EMR under the Care Plan tab revealed there was no Care Plan addressing his activity needs, goals, or interventions. During a concurrent interview on 03/18/2026 at 7:57 AM, MDSC1 and MDSC2 confirmed that once a care area has been triggered in the CAA and directed the staff to develop a Care Plan, the Care Plan was to be developed. The VPCR stated the activities staff were responsible for the activity Care Plan. During an interview on 03/18/2026 at 2:21 PM, the Activities Assistant (AA) confirmed R13 and R29 did not have an activities Care Plan. The AA stated she had been serving as the Activity Director since the previous director left the position; however, she had not yet been trained in care planning and was not involved in developing the Care Plan. During an interview on 03/19/2026 at 4:30 PM, the Administrator stated the MDSC would be completing the activity Care Plan, as the MDSC was expected to ultimately ensure the Care Plan was complete. 3. Review of Resident (R)242's admission Record found under the Profile Tab of the EMR indicated an admission date of 10/07/2025 with diagnoses of type 2 diabetes, multiple sclerosis, dementia, post-traumatic stress syndrome, and major depressive disorder. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R242's MDS CAA Triggers Summary found under the MDS Tab of the EMR with an ARD of 10/10/2025 and signed on 10/20/2025 indicated R242's activity triggering condition was little interest or pleasure in doing things and would be addressed the care plan. Review of R242's CAA Summary, found under the MDS Tab of the EMR, with an ARD of 10/10/2025 indicated that Activities triggered with a yes for care plan decision. Review of R242's Care Plan, found under the Care Plan Tab of the EMR, with an admission date of 10/07/2025 indicated that there was no care plan for activities. During an interview on 03/19/2026 at 10:53 AM, MDSC1 stated that they realized on 03/18/2026 that a care plan had not been completed for R242's activity preferences. During an interview on 03/19/2026 at 2:30 PM, the Director of Nursing (DON) stated that activity preferences needed to be in a care plan to care for the residents. 4. Review of R114's EMR titled admission Record located under the Profile tab of the EMR, indicated the facility admitted the resident on 01/30/2026. Review of R114's admission MDS with an ARD of 02/02/2026 located under the MDS tab of the EMR, indicated the resident had a BIMS score of 12 out of 15, which revealed the resident was moderately cognitively impaired. The assessment indicated that activities were somewhat important. The assessment for mood indicated the resident scored 11 which means the resident had moderate depression. Under the CAA, the resident triggered under activities and directed the staff to develop a care plan. Review of R114's Care Plan located under the Care Plan tab of the EMR, failed to contain evidence that the facility developed a care plan for the resident for activities. During an interview conducted on 03/18/2026 at 7:57 AM, MDSC1 and MDSC2 confirmed that once a care area has been triggered in the CAA and directs the clinician to develop a care plan, the care plan was to be developed. The VPCR was present during this interview. Both MDSC1 and MDSC2 confirmed R114 did not have a care plan developed for activities. Both MDSC1 and MDSC2 stated the resident triggered under activities due to his response to the mood assessment 5. Review of R117's EMR titled admission Record located under the Profile tab of the EMR indicated the facility admitted the resident on 10/08/2024 with a diagnosis of PTSD. Review of R117's EMR titled quarterly MDS with an ARD of 01/11/2026, located under the MDS tab of the EMR, indicated the resident had a BIMS score of 15 out of 15, which revealed the resident was cognitively intact. The resident was identified with a diagnosis of PTSD. Review of R117's EMR titled Care Plan located under the Care Plan tab of the EMR, failed to contain evidence that the resident's diagnosis of PTSD was care planned. During an interview on 03/18/2026 at 7:29 AM, R117 confirmed he had a diagnosis of PTSD and was military related. R117 stated he was currently stable since he was on medication and currently had no triggers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/18/2026 at 8:21 AM, an interview was conducted with MDSC1 and MDSC2. Both confirmed that there was no care plan in place for R117's diagnosis of PTSD. Both stated they were to speak with the Social Services Director (SSD) since she was responsible for the care plan. During an interview on 03/18/2026 at 2:06 PM, the SSD stated it was important to care plan a resident's diagnosis of PTSD since there were different stressors and different responses. SSD stated it was the MDS team that would develop the care plan for a diagnosis of PTSD. An interview was conducted on 03/19/2026 at 4:06 PM and the following were in attendance: the Administrator, Director of Nursing (DON), Chief Compliance Officer (CCO), and National Director of Risk Management (NDRM). The DON stated a diagnosis of PTSD was to be care planned since the facility wanted to ensure the safety of residents and protect them from reactions to triggers. The DON stated the MDSC were to do the development of the care plans until social services and activities were trained to do so.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and policy review, the facility failed to ensure five of six residents (Resident (R) 11, R13, R29, R190, and R204) reviewed for bed rails out of 196 residents who used bed rails were assessed for safety with and need for bed rails before their use. This deficient practice had the potential to place the residents at risk of injury or entrapment related to bed rail use.Findings include: Review of the facility's policy titled, Bed Rail Safety dated 03/01/25, revealed, As part of the resident's comprehensive assessment, the following components will be considered when determining the resident's needs, and whether or not the use of bed rails meets those needs: a. Medical diagnosis, conditions, symptoms, and/or behavioral symptoms; b. Size and weight; c. Sleep habits; d. Medication(s); e. Acute medical or surgical interventions; f. Underlying medical conditions; g. Existence of delirium; h. Ability to toilet self safely; i. Cognition; j. Communication; k. Mobility (in and out of bed); l. Risk of falling. The resident assessment must also assess the resident's risk from using bed rails . The resident assessment should assess the resident's risk of entrapment between the mattress and bed rail or in the bed rail itself. 1. Review of R11's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including chronic obstructive pulmonary disease, shortness of breath (SOB), and pneumonia. Review of R11's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 02/06/26 and located under the MDS tab of the EMR, revealed a score of six out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. He required substantial/maximal assistance with bed mobility and sitting up and was dependent on staff for transfers. Review of R11's Admission/readmission Data Collection, dated 02/03/26, and located under the Assessments tab of the EMR, revealed R11 did not desire to use bed rails. Review of R11's Admission/readmission Nursing Evaluations, dated 02/03/26, and located under the Assessments tab of the EMR, revealed R11 was not using bed rails and did not desire to use them. The assessment documented the use of bed rails would not assist R11 with turning in bed or add to his ability to transfer. The entrapment review was not completed, and the assessment documented bed rails were not indicated at this time. Review of R11's Care Plan dated 02/04/26 and located under the Care Plan tab of the EMR revealed, [R11] has an ADL [activities of daily living] self-care performance deficit r/t [related to] impaired mobility, SOB/chronic respiratory failure. The approaches included, SIDE RAILS: (SPECIFY) Mobility Bars up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury. During an observation on 03/16/26 at 3:46 PM in R11's room, R11 was observed in bed with bed rails approximately half the length of the bed in the up position on both sides of the bed. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 03/19/26 at 10:36 AM in R11's room, the bed rails were again observed on R11's bed in the up position. In a concurrent interview, Unit Manager (UM) 2 confirmed that R11 had bilateral bed rails in the up position but was unsure if they were 1/2 or 1/4 rails as the bed and the rails were provided by hospice. UM2 stated when R11 was first admitted , he was on a facility bed without any bed rails; however, when he was admitted to hospice, the hospice brought in the bed with rails. UM2 stated she was unsure whether an assessment of the appropriateness of and need for the rails needed to be completed when hospice bed rails were implemented. 2. Review of R13's admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including encephalopathy, respiratory failure, dementia, malnutrition, and dysphagia. Review of R13's admission MDS with an ARD of 01/02/26 and located under the MDS tab of the EMR, revealed a score of ten out of 15 on the BIMS, indicating moderately impaired cognition. He required substantial/maximal assistance with bed mobility and was dependent on staff for transfers. Review of R13's 12/30/25 Admission/readmission Data Collection, dated 12/30/25 and located under the Assessments tab of the EMR revealed R13 did not desire to use bed rails. Review of R13's Admission/readmission Nursing Evaluations dated 12/30/25 and located under the Assessments tab of the EMR, revealed R13 was not using bed rails and did not desire to use them. The assessment documented the use of bed rails would not assist R13 with turning in bed or add to his ability to transfer. The entrapment review was not completed, and the assessment documented bed rails were not indicated at this time. Review of R13's Care Plan dated 12/31/25 and located under the Care Plan tab of the EMR revealed, [R13] has an ADL self-care performance deficit r/t pain, weakness, impaired mobility, debility, dementia. The approaches included, SIDE RAILS: Mobility bars up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury. During an observation on 03/17/26 at 8:51 AM in R13's room, R13 was observed in bed with bed rails approximately half the length of the bed in the up position on both sides of the bed. During an observation on 03/18/26 at 11:10 AM in R13's room, the bed rails were again observed on R13's bed in the up position. In a concurrent interview, UM1 confirmed that R13 had bilateral bed rails in the up position but was unsure if they were 1/2 or 1/4 rails as the bed and the rails were provided by hospice. UM1 stated when R13 was first admitted , he was on a facility bed without any bed rails; however, when he was admitted to hospice, the hospice brought in the bed with rails. UM1 confirmed there was no assessment of the appropriateness of and need for the rails when hospice bed rails were implemented. UM1 confirmed there was no assessment in hospice documentation 3. Review of R29's admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including stroke, hemiplegia and hemiparesis, epilepsy, muscle weakness, and respiratory failure. Review of R29's admission MDS with an ARD of 01/29/26 and located under the MDS tab of the EMR revealed he was unable to make himself understood or understand others and had severely impaired cognition. The assessment documented R29 was dependent on staff for all mobility and activities of daily living. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R29's Admission/readmission Nursing Evaluations dated 03/09/26 and located under the Assessments tab of the EMR, revealed R29 was not using bed rails and did not desire to use them. The assessment documented the use of bed rails would not assist R29 with turning in bed or add to his ability to transfer. The entrapment review was not completed, and the assessment documented bed rails were not indicated at this time. Review of R29's Care Plan dated 01/20/26 and located under the Care Plan tab of the EMR, revealed, [R29] has an ADL self-care performance deficit r/t weakness, impaired mobility. The approaches included, SIDE RAILS: Mobility bars up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury. During an observation on 03/16/26 at 3:33 PM in R29's room, R29 was observed in bed with bed rails approximately a quarter of the length of the bed in the up position on both sides of the bed. During an observation on 03/19/26 at 10:39 AM in R29's room, the bed rails were again observed on R29's bed in the up position. In a concurrent interview, UM2 confirmed that R29 had bilateral bed rails and stated she did not know he had them on the bed. UM2 stated R29 was unable to use the bed rails as he had hardly any movement except for his hands. UM2 stated R29 did not need bed rails and added they may have just been left on his bed from the last resident who used it. During an interview on 03/19/26 at 4:30 PM, the Director of Nursing (DON) stated the assessment should be completed whenever bed rails were implemented and the bed rails should only be used when indicated as necessary and safe in the assessment. The DON stated the facility was responsible for conducting an assessment when hospice brought in a bed with rails. The National Director of Risk Management (NDRM) - concurrent interview with DON - confirmed the staff should have completed the side rail assessment when the resident received a bed with rails. 4.Review of R190's admission Record, located under the Profile tab of the EMR, revealed R190 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, other lack of coordination, seizures, muscle weakness (generalized), cognitive communication deficit, and major depressive disorder. Review of R190's Care Plan, dated 07/20/23 and located under the Care Plan tab of the EMR, revealed a focus Activities of Daily Living (ADL) self-care performance deficit. Interventions included mobility bars up for safety during care provision, to assist with bed mobility and staff were to observe for injury or entrapment related to side rail use and reposition as necessary to avoid injury. Review of R190's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 12/28/25, revealed R190 had multiple sclerosis, depression, seizures, upper and lower extremity impairments on one side, required moderate help with rolling from side to side and from sitting to standing. It was recorded R190 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R190's Quarterly Nursing Evaluation, dated 12/25/25, which included a Side Rail Evaluation, and located in the Assessment tab of the EMR, indicated R190 was not using side rails for positioning, support, or bed mobility and did not express a desire to use side rails. The evaluation did not assess R190 for the use of side rails or the risk of entrapment. The evaluation documented side rails were not indicated. During an observation on 03/18/26 at 10:26 AM, Certified Medication Technician (CMT) 2 confirmed R190's right hand mid-bed side rails on his bed were loose and posed a risk for injury. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 03/19/26 at 12:31 PM, the Assistant Director of Nursing (ADON) 3 reviewed R190's bed rail evaluation dated 12/22/25 and stated, It says he [R190] doesn't need side rails. He should have an assessment completed. 5. Review of R204's admission Record, located under the Profile tab of the EMR, revealed R204 was admitted to the facility on [DATE] with diagnoses of paraplegia. Review of R204's Care Plan, dated 09/03/24 and located under the Care Plan tab of the EMR, revealed a focus ADL self-care performance deficit. Interventions included mobility bars up for safety during care provision, to assist with bed mobility and staff were to observe for injury or entrapment related to side rail use and reposition as necessary to avoid injury. Review of R204's quarterly MDS, located under the MDS tab of the EMR and with an ARD of 12/19/25, revealed R204 had paraplegia, had no upper and lower extremity impairments, required minimal help with rolling from side to side and from lying to sitting. It was recorded R204 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R204's Quarterly Nursing Evaluation, dated 12/01/25, which included a Side Rail Evaluation, and located in the Assessment tab of the EMR, indicated R204 was not using side rails for positioning, support, or bed mobility and did not express a desire to use side rails. The evaluation did not assess R204 for the use of side rails or the risk of entrapment. The evaluation documented side rails were not indicated. During an observation on 03/18/26 at 10:26 AM, Certified Medication Technician (CMT) 2 confirmed R204 had side rails in use on his bed. During an interview on 03/18/26 at 11:06 AM, Unit Manager (UM) 1 stated, the procedure for bed rails included Complete an assessment, assess restraint, and sign consent. The assessment is completed in the computer. The consent is on paper with signature. Assess for entrapment, look to see if arms or leg stick between rails that could cause injury. Maintenance would install the rails or bring a bed with rails. The assessment would include the size of bed rails. The assessment is in the initial nursing assessment, and is also an individual assessment. It is completed on admission and I believe quarterly. There should bed rail an order. I believe it would be on the care plan. The MDS nurse makes all changed on care plans. During an observation and interview on 03/19/26 at 12:31 PM, the Assistant Director of Nursing (ADON) 3 reviewed R204's bed rail evaluation, dated 12/01/25, and stated It says he [R204] doesn't need side rails. I see side rails more of a risk for entrapment than mobility bars. I go with what the resident is using it for. I don't think they [siderails] have ever been up [for R204]. ADON3 observed the side rails on R204's bed and stated, That is a mobility bar not a side rail. Mobility bars don't have a risk of entrapment. When asked about the difference between a mobility bar and a side rail, ADON3 stated, Physically the bars are the same. I agree there could still be a risk of entrapment with mobility bars as with side rails.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident, resident guardian and staff interviews, record review, facility policy review, and review of the facility's investigation, the facility failed to ensure three residents (Resident (R) 35, R236, and R5) out of five residents reviewed for abuse were free from abuse out of 51 total residents sampled. R236 crawled into bed with R35 and began to kiss her. In addition, R5 was verbally abused and threatened by a Resident Care Aide (RCA)1. This had the potential for R5 to suffer emotional and psychological harm (Cross Reference F607, F609, F610).Findings include: Review of a facility policy titled Abuse, Neglect and Exploitation dated 07/15/2025 indicated . Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Sexual Abuse is non-consensual sexual contact of any type with a resident. 1. Review of R35's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/05/2024 with a diagnosis of dementia without behavioral disturbances. Review of R35's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/08/2025 located under the MDS tab indicated that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 revealed that the resident was cognitively intact. Review of R35's EMR titled Care Plan located under the Care Plan tab dated 09/06/2024 indicated that the resident had impaired cognitive function/dementia related to a stroke. The care plan failed to address that the resident fluctuated with mental status even though her cognition was identified through the BIMS score of 15. Review of R236's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 10/26/2023 with a diagnosis of delirium with known psychological disorder. Review of R236's EMR titled quarterly MDS with an ARD of 12/26/2025 located under the MDS tab indicated the resident had a BIMS score of 10 out of 15, which revealed the resident was moderately cognitively impaired. Review of R236's EMR titled Care Plan located under the Care Plan tab dated 11/17/2023 indicated the resident had impaired functional/dementia or impaired thought process related to dementia, with impaired decision making. Review of a document provided by the facility titled Facility Incident Report dated 01/13/2026 indicated that on 01/11/2026 R236 was found in R35's bed. R236 was observed to kiss R35 on the lips. Review of a document provided by the facility titled Abuse-Resident to Resident dated 01/20/2026 indicated that R35 had a BIMS score of 15 which revealed the resident's cognition was intact with occasional confusion. The report indicated R236 had a BIMS score of 10 which revealed that the resident had moderate cognitive impairment. The investigation indicated that staff attempted to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview R35, but she refused. Review of the facility's investigation revealed a written statement from Certified Nurse Aide (CNA) 9, dated 01/11/26, who wrote that she witnessed R236 in the bed of R35, and she asked R236 to get out of R35's bed. Before getting out of bed, R236 kissed R35 on the lips. CNA9 stated that she reported the incident to a nurse. Part of the investigation included police involvement. Per the investigation the police officer attempted to interview both residents and the officer stated they were unsuccessful in obtaining information since both residents were confused. The facility investigation included an interview with R35's roommate, R21. R21 reported that the curtain was pulled between she and R35. R21 reported that she saw R236 and could not see specifically what occurred but overheard smacking noises and stated R236 asked R35 if she wanted more and R35 laughed. The investigation determined that since both residents seemed to enjoy themselves and were not distressed from the interaction, the facility was unable to substantiate resident-to-resident sexual abuse. There was evidence that the facility moved R236 to another room away from R35 on 01/13/0226 and began 30-minute checks on the whereabouts of R236. During an interview conducted on 03/16/2026 at 3:22 PM, R35 stated she did not remember being touched or being with in bed with a male resident while being kissed and stated she felt safe. R35 did not have a resident representative. During an interview conducted on 03/18/2026 at 9:03 AM, the Legal Guardian for R236 stated that this was the first time the resident was involved in a resident-to-resident incident and stated that the resident was not able to consent since he was not capable of signing any paperwork and was not capable of making decisions. During an interview conducted on 03/17/2026 at 4:15 PM, the Administrator stated that sexual abuse did not happen between R35 and R236 but believed that the incident still needed to be reported to the State Survey Agency (SSA). The Administrator stated that neither of the residents were upset after the encounter. The Administrator stated that the room change and the 30-minute checks were implemented by facility protocol. The Administrator stated that both residents were seen by mental health providers to ensure that harm did not occur. The definition of sexual abuse did not align with the regulatory requirements. During an interview conducted on 03/18/2026 at 6:32 AM, the Assistant Director of Nursing (ADON) 1 stated Certified Nursing Assistant (CNA) 9 reported the resident-to-resident incident to Licensed Practical Nurse (LPN)1 immediately after witnessing the incident. ADON 1 stated that R236 was moved to another room and then the 30-minute checks began two days later. ADON1 stated that this was a one-time incident with R35 and R236 and it never happened again. ADON1 stated that he did not believe that it was abuse. ADON1 stated that R35 had days in which she was coherent and there were days that she was not. During an interview conducted on 03/19/2026 at 4:06 PM, the Administrator defined sexual abuse included when a resident was upset and crying and not wanting to be touched. The Administrator stated both R35 and R236 were capable of making their own decisions and did not believe that sexual abuse had occurred. Also present during this interview was the Director of Nursing, Chief Compliance Officer (CCO), and National Director of Risk Management (NDRM). The Administrator stated that consent was determined if both residents were able to make their needs known. The Administrator stated after speaking with the two residents, R35 told the facility to mind your own business. The Administrator stated they interviewed R21 and the roommate reported that they were both laughing and giggling. CCO stated that both R35 and R236 were not deemed incompetent and both he and the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated that both residents had rights. The Administrator stated that the resident-to-resident was reported to the SSA out of an abundance of caution. 2. Review of R5's admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including metabolic encephalopathy, end stage renal disease, osteoarthritis, neuropathy, chronic obstructive pulmonary disease, Parkinsonism, liver cirrhosis, chronic pain, fatigue, anxiety, seizures, and bilateral leg amputation. Review of R5's admission MDS with an ARD of 04/25/2025 and located under the MDS tab of the EMR, revealed a score of 15 out of 15 on the BIMS, indicating intact cognition. He did not exhibit any behavioral symptoms. Review of R5's quarterly MDS with an ARD of 01/25/2026 and located under the MDS tab of the EMR, revealed a score of 15 out of 15 on the BIMS and no behavioral symptoms. Review of R5's Facility Incident Report Form, dated 07/06/25, and provided by the facility, revealed, During the resident smoke break, [R5] stated he asked the staff member, a RCA [Resident Care Assistant], to roll his wheelchair back towards the door and he said the staff member told him that since he rolled himself out he should roll himself back in. The resident said the staff member called him an expletive. Review of R5's Abuse – Staff to Resident Final Report, dated 07/14/2025 and provided by the Administrator, revealed RCA1 was immediately suspended pending investigation and the police department was contacted and conducted an investigation as well. Interview with R5 confirmed RCA1 refused to assist him to wheel into the building and RCA1 cussed at him and threatened him physically. Interviews with other residents who witnessed the incident confirmed a verbal altercation between R5 and RCA1 and RCA1's refusal to assist R5 with wheeling back into the building. A written statement from RCA1 revealed he confirmed he refused to assist R5 and had cussed at R5. The facility's investigation substantiated the allegation of verbal abuse and RCA1's employment was terminated. During an interview on 03/19/2026 at 10:06 AM, R5 stated about nine months ago, RCA1 refused to assist him to wheel into the facility and they got into an argument. R5 stated RCA1 threatened to pull him out of his wheelchair and stomp on him and also cussed at him. R5 stated, I was so angry, I wanted to kill him . I want him to go to hell. R5 confirmed he had not seen RCA1 since the incident and was waiting for follow-up from the police department. During an interview on 03/19/2026 at 4:30 PM, the Administrator stated R5 reported the allegation of abuse to him, and he immediately conducted an investigation. The Administrator stated he substantiated the abuse occurred due to R5's statement, witness accounts of events, and RCA1's admission of guilt.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interviews, record review, and facility policy review, the facility failed to implement their abuse policies for capacity to consent for sexual activity for two residents (Resident (R) 35 and R236), of five, out of 51 sampled residents sampled. In addition, the facility failed to implement their abuse policies by failing to immediately separate both residents and implement supervision. This had the potential for on-going sexual contact. (Refer to F600)Findings include:Review of a facility policy titled Abuse, Neglect and Exploitation dated 07/15/2025 indicated . The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves.Establishing a safe environment that supports, to the extent possible, a resident's consensual sexual relationship and by establishing policies and protocols for preventing sexual abuse. This may include identifying when, how, and by whom determinations of capacity to consent to a sexual contact will be made and where this documentation will be recorded; and the resident's right to establish a relationship with another individual, which may include the development of or the presence of an ongoing sexually intimate relationship. The facility will have written procedures to assist staff in identifying the different types of abuse.mental, verbal abuse, sexual abuse, physical abuse.The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. The facility will make efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation. Examples include but are not limited to:A. Responding immediately to protect the alleged victim and integrity of the investigation;B. Examining the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed;C. Increased supervision of the alleged victim and residents;D. Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator;E. Protection from retaliation;F. Providing emotional support1. Review of R35's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/05/2024 with a diagnosis of dementia without behavioral disturbances.Review of R35's EMR titled quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 12/08/2025 located under the MDS tab indicated that the resident had a Brief Interview for Mental Status (BIMS) of 15 out of 15 revealed that the resident was cognitively intact.2. Review of R236's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 10/26/2023 with a diagnosis of delirium with known psychological disorder.Review of R236's EMR titled quarterly MDS with an ARD of 12/26/2025 located under the MDS tab indicated the resident had a BIMS score of 10 out of 15, which revealed the resident was moderately cognitively impaired.Review of a document provided by the facility titled Facility Incident Report dated 01/13/2026 indicated that on 01/11/2026, R236 was found in R35's bed. R236 was observed to kiss R35 on the lips. Included in the investigation was a document titled Abuse-Resident to Resident dated 01/20/2026, which revealed the facility moved R236 to another room on 01/13/2026 instead of on 01/11/2026 when the resident-to-resident occurred. The facility failed to implement 30-minute checks on 01/11/2026. Police were notified on 01/13/2026 instead of on 01/11/2026 when the resident-to-resident occurred. The report indicated that the police officer attempted to interview both residents and the officer stated they were unsuccessful in obtaining information since both residents were confused. There was no evidence cited in the document that the facility showed that capacity assessments were completed and consent was evaluated by a qualified professional.During an interview conducted on 03/19/2026 at 4:06 PM, the Administrator defined sexual abuse included when a resident was upset and crying and not wanting to be touched. The Administrator stated both R35 and R236 were capable of making their own decisions and did not believe that sexual abuse had occurred. The Administrator stated that both residents consented to the interaction. The facility's misunderstanding of the definition of resident-to resident sexual abuse resulted in failure to initiate capacity and protective interventions.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interviews, record review, and facility policy review, the facility failed to ensure an allegation of sexual abuse was reported timely to the Administrator and to the State Survey Agency (SSA) for two of five residents (Resident (R) 35 and R236) reviewed for abuse out of 51 sampled residents. This failure increased the risk of other vulnerable residents being abused. Findings include:Review of a facility policy titled Abuse, Neglect, and Exploitation dated 07/15/2025 indicated .Reporting of all alleged violations, regardless of residents cognitive status, to the Administrator, state agency.regardless of cognitive status.and to all other required agencies within specified timeframes.Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.1. Review of R35's electronic medical record (EMR) titled admission Record located under the Profile tab indicated the facility admitted the resident on 09/05/2024.2. Review of R236's EMR titled admission Record located under the Profile tab indicated the facility admitted the resident on 10/26/2023.Review of a document provided by the facility titled Facility Incident Report, dated 01/13/2026, indicated that on 01/11/2026, R236 was found in R35's bed. R236 was observed to kiss R35 on the lips.Review of a document provided by the facility titled Abuse-Resident to Resident, dated 01/20/2026, indicated that Certified Nurse Aide (CNA) 9 wrote a statement on 01/11/2026 and indicated she witnessed R236 in R35's bed and R236 kissed R35 when CNA9 directed R236 to get out of R35's bed. CNA9 stated she reported the incident to a nurse (there was no name identified in the investigation). The facility identified Licensed Practical Nurse (LPN)1 as the nurse who received the report from CNA9. There was no information on the reasons for the delay in reporting to the SSA.During an interview conducted on 03/17/2026 at 4:15 PM, the Administrator stated the Assistant Director of Nursing (ADON)1 reported the resident-to-resident incident. The Administrator stated when he was notified of the sexual incident on 01/13/2026 and that was when he reported the resident-to-resident to the SSA. The Administrator stated CNA9 reported the sexual encounter with R35 and R236 to Licensed Practical Nurse (LPN) 1. The Administrator stated that the incident between R35 and R236 was not considered sexual abuse. The Administrator stated once he learned about the resident-to-resident incident he reported the encounter to the SSA out of an abundance of caution.During an interview conducted on 03/18/2026 at 6:32 AM, ADON1 confirmed he learned about the sexual encounter which involved R35 and R236 two days after the incident. ADON1 stated the staff involved were CNA9 and LPN1 and he verbally counseled them both on timely reporting of resident-to-resident incidents. ADON1 confirmed he notified the Administrator of the resident-to-resident incident two days later. ADON1 was unable to identify how he obtained the information regarding R35 and R236 prior to reporting the allegation to the Administrator. During an interview on 03/18/2026 at 3:11 PM, LPN1 stated she was not the nurse that CNA9 reported the resident-to resident to.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and facility policy review, the facility failed to provide the resident's responsible party a written notice of transfer, notice of bed hold practices and complete information on the process to appeal the transfer, including appeal agency contact information for a sample of two of two residents (Resident (R)144 and R238) reviewed for hospitalizations in a total sample of 51 residents. This failure had the possibility to negatively impact residents and their responsible parties due to them not being aware of the reason for a transfer and how to appeal the transfer. Findings include:Review of the facility's policy titled, Transfer and Discharge (including AMA) reviewed 11/01/2025 indicated, .Policy Explanation and Compliance Guidelines:.2. Once admitted , the resident has the right to remain in the facility unless their transfer or discharge meets one of the following specified exemptions: a. The transfer.is necessary for the resident's welfare and the resident's needs cannot be met in the facility.The facility's transfer/discharge notice will be provided to the resident and resident's representative in a language and manner in which they can understand. The notice will include all of the following at the time it is provided: a. Specific reason of transfer.b. The effective date of transfer.The specific location .to which the resident is to be transferred.d. An explanation of the right to appeal the transfer.e. The name, address (mailing and email) and telephone number of the State entity which receives such appeal hearing requests. F. Information on how to obtain an appeal form.Review of the facility's policy titled, Bed Hold Notice revised 07/01/2025 indicated, Policy: It is the policy of this facility to provide written information to the resident and/or the resident's representative regarding the bed hold practices.at the time of a transfer. Policy Explanation and Compliance Guidelines: 1.at the time of a transfer to the hospital.the facility will provide the resident and/or the resident representative written information that specifies:.b. The reserve bed payment policy. C. The facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed.2. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file and/or medical record.1. Review of R144 's Face Sheet located under the Profile tab of the Electronic Medical Record (EMR) revealed R144 was admitted to the facility on [DATE] with the diagnoses of non-traumatic intracerebral hemorrhage, cerebral edema, pneumonia, osteoarthritis, hemiplegia and hemiparesis affecting the right dominant side, aphasia, and seizures.Review of R144's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/25/2026 located under the MDS tab of the EMR indicated R144 was dependent for all tasks. The MDS revealed a Brief Interview for Mental Status (BIMS) score of 99, indicating R144 was severely cognitively impaired. Review of R144's EMR under the Progress Notes tab indicated a progress note, dated 02/11/2026, .Patient daughter request for patient to be transfer to the hospital. Stating that pt [patient] is getting worse.Also stating that pt having apnea when breathing and pt is not breathing well.Responsible party notified.2. Review of R238's Face Sheet located under the Profile tab of the EMR revealed R238 was admitted to the facility on [DATE] with the diagnoses of non-traumatic subacute subdural hemorrhage, seizures, cerebral infarction, atrial fibrillation, unspecified dementia, malnutrition, and type II diabetes.Review of R238's admission MDS with an ARD of 02/22/2026 located under the EMR MDS tab indicated R238 was dependent for all tasks. The MDS revealed a Brief Interview for Mental Status (BIMS) score of memory problem, severely impaired. Review of R238's EMR under the Progress Notes tab indicated a progress note, dated 02/22/2026, .change in condition.at 11:30 AM family reported resident finger nail beds became blue.his doctor communicated by phone, ordered oxygen 3 L (liters) via nasal cannula.Reason for transfer: further diagnosis and treatment.Responsible party notified. During an interview on 03/19/2026 at 12:40 PM with the National Director of Risk Management (NDRM) revealed they always call the responsible party when a resident was being discharged but we did not send (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notification in writing. The NDRM explained that a bed hold notification form was sent with the resident to the hospital, but they did not retain a copy of the form in the resident's EMR. NDRM stated, In my 29 years I have never heard of this.During an interview on 03/19/2026 at 4:50 PM with the Administrator revealed he was not aware that the responsible party needed to receive a written notice of transfer and information regarding the bed hold notice upon any resident transfer to the hospital.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to ensure an adequate and ongoing program of activities to meet the needs of one of four residents (Resident (R) 29) reviewed for activities who was dependent on staff for all stimulation and engagement. This failure placed R29 at risk for increased self-injurious behaviors and unmet psychosocial needsFindings include:Review of the facility's policy titled, Activities, dated 01/01/2026, revealed, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being.Review of R29's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed he was admitted to the facility on [DATE] with diagnoses including stroke, epilepsy, hemiplegia and hemiparesis, muscle weakness, respiratory failure with tracheostomy, and gastrostomy tube. R29 was out of the facility at the hospital from [DATE] through 03/09/2026.Review of R29's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/29/2026 and located under the MDS tab of the EMR, revealed he was unable to complete the BIMS and staff assessed him with short-and long-term memory problems and severely impaired cognition. Per the MDS, R29 had no speech, was unable to make himself understood or understand others, and was totally dependent on staff for mobility and activities of daily living. R29's activities interests were unable to be assessed due to his inability to respond. Review of the CAA indicated additional activities assessment was indicated due to R29's Staff assessment of daily and activity preferences did not indicate that resident prefers participating in favorite activities. The CAA directed staff to proceed to care planning for activities needs and interventions.Review of R29's 03/12/26 Activities assessment dated [DATE] and located under the Assessments tab of the EMR, revealed R29 could not participate in group activities physically or cognitively. R29 was unable to respond and had no one to speak for him. No activity interests were identified in the assessment. The form documented, Resident requires [one-to-one] activities. Reading and music.Review of R29's EMR under the Care Plan tab revealed there was no Care Plan addressing his activity needs, goals, or interventions. Cross reference F656: Comprehensive Care Plan.Review of R29's Individual Activity Participation Records dated January 2026, February 2026, and March 2026 and provided on paper by the Activities Assistant (AA) revealed:-In January, nine one-to-one visits (01/02/2026, 01/05/2026, 01/09/2026, 01/12/2026, 01/13/2026, 01/18/2026, 01/19/2026, 01/23/2026, 01/28/2026) were documented that included reading, spiritual, talking, and sensory activities. However, five of these visits were documented between 01/02/2026 and 01/13/2026, which was prior to R29's initial facility admission.-In February, eight one-to-one visits (02/01/2026, 02/03/2026, 02/05/2026, 02/12/2026, 02/13/2026, 02/15/2026, 02/23/2026, 02/26/2026) were documented that included reading, talking, and sensory activities.-In March, four one-to-one visits (03/04/2026 (x2), 03/12/2026, 03/15/2026) were documented that included reading, religious, talking, and sensory activities. However, two activities were documented on 03/04/2026, which was during the time R29 was out of the facility at the hospital.During an observation on 03/16/2026 at 3:33 PM in R29's room, R29 was lying in bed without any music or television on in his room. There were no items in his hands or near him for sensory stimulation or to keep his hands busy.During an observation on 03/17/2026 at 9:42 AM in R29's room, R29 was lying in bed without any music or television on in his room. There were no items in his hands or near him for sensory stimulation or to keep his hands busy.During an observation on 03/17/2026 at 1:47 PM in R29's room, R29 was lying in bed without any music or television on in his room.R29 had pulled out his tracheostomy tubing. There were no items in his hands or near him for sensory stimulation or to keep his hands busy. In a concurrent interview, Respiratory Therapist (RT) 1 stated R29 would get restless (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at times and would use his hands to pull on the tubing.During an observation on 03/18/2026 at 7:27 AM in R29's room, R29 was lying in bed without any music or television on in his room. There were no items in his hands or near him for sensory stimulation or to keep his hands busy.During an interview on 03/18/2026 at 2:21 PM, the AA stated she had been serving as the Activity Director since the previous director left and had not yet completed a training course. She stated she did not have corporate assistance with developing an activities program. The AA stated R29 received one-to-one visits by staff since he was unable to participate in group or independent activities. The AA stated staff would read to him or talk to him, play music, or provide hand massage or sensory stimulation. The AA stated the visits should occur two to three times per week. The AA stated R29 did not have a radio in his room, but he would benefit from TV on during the day when staff were not visiting with him for sensory stimulation.During an observation on 03/19/2026 at 10:39 AM in R29's room, R29 was lying in bed without any music or television on in his room. There were no items in his hands or near him for sensory stimulation or to keep his hands busy.During an interview on 03/19/2026 at 12:57 PM, the AA stated she did not know why participation was reflected for R29 on days when he was not in the facility, as another activity assistant completed the participation records. The AA stated since R29 did not participate in activities and only received two to three one-to-one visits weekly, he would benefit from additional in-room stimulation like TV.During an interview on 03/19/2026 at 3:25 PM, the AA stated she was mistaken and she had been the one to complete the participation records. She stated she transcribed the information from other attendance sheets, incorrectly transposing another resident's information. The AA stated she had no additional records of participation for R29.During a concurrent interview on 03/19/2026 at 4:30 PM, the Administrator stated he expected activities staff to keep accurate records of participation including provision of one-to-one activities. The National Director of Risk Management (NDRM) stated the facility could be offering TV shows, music, or additional activities/objects for sensory stimulation and engagement and the staff could be doing more for R29.

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the activities program is directed by a qualified professional. Based on staff interviews, record review, and review of the Activities Director (AD) Job Description, the facility failed to ensure that a qualified activity professional was employed. This deficient practice had the potential to affect the 210 residents who resided in the facility. Findings include: Review of a document provided by the facility titled Activities Director job description, undated indicated . The activities program must be directed by a qualified professional who is.a qualified therapeutic recreation specialist or an activities professional who.licensed or registered, if applicable, by the state in which practicing.Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990.Has 2 years of experience in a social or recreational program within the last 5 years.one of which was full-time in a therapeutic activities program.qualified occupational therapist or occupational therapy assistant.Has completed a training course approved by the State. During an interview on 03/18/26 at 2:21 PM, the Activity Assistant (AA) stated she had been serving as the AD since the previous director left and had not yet completed a training course. She stated she did not have corporate assistance with developing an activities program. The AA stated she had not received any training in care planning and had not been involved in developing or revising activity care plans. The AA stated she did not attend Quality Assurance and Performance Improvement (QAPI) meetings and was not involved in any quality improvement projects. During an interview conducted on 03/18/26 at 2:56 PM, the Administrator stated the last day of the former AD's employment was on 08/07/25. The Administrator stated the AA was not the AD. The Administrator stated that the facility had the AA signed up for classes in April to obtain her AD credentials.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure emergency tracheostomy care supplies were kept within close proximity for one of four residents (Resident (R) 243) reviewed for tracheostomy care. This deficient practice had the potential to place R243 at risk of going without oxygen for over two minutes in the event of tracheostomy failure, which could lead to oxygen deprivation and brain damage. Findings include:Review of Anoxic Brain Injury: How Long Can the Brain Survive Without Oxygen, accessed on 03/23/26 at https://www.spinalcord.com/anoxic-brain-injury#:~:text=How%20Long%20Can%20the%20Brain,the%20potent revealed, two minutes without oxygen often leads to the beginning of brain cell damage, loss of consciousness, and cognitive impairment. While one minute may only cause dysfunction, by two to three minutes, brain cells begin to die, making it a critical emergency. Severe, irreversible damage is highly likely around five minutes.Review of R243's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including chronic respiratory failure, tracheostomy, quadriplegia, and encephalopathy. Review of R243's Care Plan dated 03/16/26 and located under the Care Plan tab of the EMR revealed, [R243] has a tracheostomy r/t [related to] chronic respiratory failure. The approaches included, Ensure that trach ties are secured at all times . [and] suction as necessary. Review of R243's EMR under the Orders tab revealed the physician's orders, dated 03/13/26, for tracheostomy care, including Trach care daily and PRN [as needed] for disposable: remove and dispose of inner cannula. Replace with new inner cannula . Change trach ties every night shift and as needed . Change respiratory supplies and setup every [Sunday] and as needed . Suction via trach every day and night shift for patency or to keep the airway open . [and] Trach Type: Shiley Flexcuff Trach Size: 4. During an observation on 03/17/26 at 8:46 AM in R243's room, there were no suction machines or tracheostomy supplies observed. R243 had a capped tracheostomy in place. During an interview on 03/17/26 at 2:10 PM and concurrent observation in R243's room, Respiratory Therapist (RT) 1 stated it was important for tracheostomy care supplies, including a suction machine, spare tracheostomy, inner cannula, trach ties, and mask, to be kept accessible in a resident's room so that the nursing staff did not have to go searching for supplies in the event of an emergency. RT1 confirmed there were no tracheostomy care supplies, including a suction machine, spare tracheostomy, inner cannula, trach ties, and mask, in R243's room. RT1 placed the necessary equipment in R243's room from the supply cart, which was kept in the closet across from the nurses' station, approximately a two-minute round trip from R243's room. During an interview on 03/17/26 at 4:14 PM, Unit Manager (UM) 2 stated the nursing staff was responsible for setting up the room of a new admission with tracheostomy supplies if needed. During an interview on 03/17/26 at 4:29 PM, Licensed Practical Nurse (LPN) 6 stated that when R243 was admitted , she was admitted to a shared room, which had been set up with her tracheostomy care supplies. However, R243 was subsequently moved to a private room upon her representative's request, and the supplies must not have been moved as well. LPN6 stated spare trach kits, inner cannulas, mask, and suction should be in the resident's room so it was easily accessible. During an interview on 03/17/26 at 4:53 PM, Regional Risk Nurse (RRN) 1 stated R243's representative was angry about the suction machine being placed in R243's room and asked the staff to remove it from the room. RRN1 stated R243's representative was educated on the importance of having emergency care equipment at the bedside for easy access, but stated there was a suction machine on the crash cart, an approximately two-minute round trip from R243's room. During an interview on 03/19/26 at 4:30 PM, the Director of Nursing (DON) stated she expected staff to ensure tracheostomy care supplies were kept in the resident's room for access during an emergency.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observations, interviews, record review, and policy review, the facility failed to ensure one of one Resident (R) (R43) reviewed for the provision of dental services was provided with routine services out of a survey sample of 51. This deficient practice had the potential to place R43 at risk of infections and pain associated with the lack of routine dental services.Findings include:Review of a facility policy titled Dental Services dated 10/01/25 indicated .It is the policy of this facility to assist residents in obtaining routine (to the extent covered under the State plan) and emergency dental care .Routine dental services .means the facility will, if necessary or required, assist the resident with making dental appointments. Review of R43's titled admission Record located in the electronic medical record (EMR) under the Profile tab, indicated the facility admitted the resident on 12/26/24. Review of R43's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/21/26 located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of six out of 15, which revealed the resident was severely cognitively impaired. The MDS indicated no broken or missing teeth. Review of R43's clinical record failed to show evidence that the resident received routine dental services within the 14 months of the resident's stay. During an observation conducted on 03/16/26 at 11:09 AM, the resident opened her mouth and exposed her teeth. There was heavy white substance buildup around all of her upper teeth. There was a reddish color to her two front top teeth. During an interview conducted on 03/17/26 at 2:30 PM, the Social Services Director (SSD) and the Regional [NAME] President of Operations (RVPO)1and both confirmed that R43 did not have prior appointments with a dentist for routine dental care during her stay at the facility. An observation was conducted of R43's teeth, and there was a heavy white substance around each of her upper teeth. There was a pink substance on her top two front teeth. Both SSD and RVPO1 verified the observation. The SSD stated that the resident's teeth were in this condition upon admission. The facility failed to provide any additional information for R43 for dental care or the status of her teeth. During an interview conducted on 03/18/26 at 10:17 AM, R43's Family Member (FM)1 stated he was looking for a community dentist to come in and evaluate and treat the resident's teeth. FM1 stated he was not aware that a dentist contracted with the facility could come in and provide routine dental care to the resident. During an interview conducted on 03/19/26 at 4:06 PM, the Chief Strategy Officer stated R43 should be seen annually by a dentist.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, and policy review, the facility failed to ensure one of three residents (Resident (R) 13) reviewed for nutrition was served thickened liquids as ordered by the physician. This deficient practice had the potential to place R13 at risk of choking or aspiration of liquids into the lungs Findings include:Review of the facility's policy titled Therapeutic Diet Orders, dated 02/01/26, revealed, All diet orders are to be communicated to the dietary department in accordance with facility procedures. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. Review of R13's admission Record, located under the Profile tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses including malnutrition and dysphagia. Review of R13's admission MDS with an ARD of 01/02/26 and located under the MDS tab of the EMR, revealed a score of ten out of 15 on the BIMS, indicating moderately impaired cognition. He required a mechanically altered diet. Review of R13's EMR under the Orders tab revealed a physician's order, dated 01/01/26, for thickened liquids at nectar consistency. Review of R13's Care Plan dated 02/16/26 revealed, [R13] is at risk for alteration in nutritional and hydration status r/t . Adult FTT [failure to thrive], . poor PO [oral] intake, refuses weights, and fracture. The approaches included Diet as ordered. During an observation on 03/18/26 at 8:09 AM in R13's room, R13 was eating breakfast and had a glass of regular (thin) juice, a carton of regular (thin) milk, and a cup of regular (thin) water on his bedside table. Half the liquids had been consumed. R13 stated his liquids were not thickened, but he was drinking them without any trouble. Review of R13's 03/18/26 breakfast tray card revealed he was to receive nectar-thick liquids, including milk and a beverage of choice During an interview on 03/18/26 at 8:11 AM, Licensed Practical Nurse (LPN) 3 confirmed R13 had thin juice, thin milk, and thin water with his meal. She stated she did not know why he was not given nectar-thickened liquids. During an interview on 03/18/26 at 8:41 AM, LPN3 stated R13 was supposed to receive nectar-thickened liquids only, and the thin liquids had been removed and replaced with nectar-thickened liquids. LPN3 stated the juice and milk were provided by the kitchen. During a concurrent interview on 03/19/26 at 4:30 PM, the Director of Nursing (DON) stated that the thin liquids were served from the kitchen. The Administrator stated the kitchen staff should be checking the orders during the tray line to ensure the correct consistency of beverages was served, and the nursing staff serving the meals should be double-checking to ensure the appropriate thickened liquids were served.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and staff interviews, the facility failed to ensure the clinical records were complete for one of one resident (R) 79) reviewed out of a total sample of 34 residents. This deficient practice had the potential to create the opportunity for inaccurate medical records to be accessible to staff. Findings include: Review of the facility policy titled Medication Administration with a revision date of 05/01/25, provided by the facility, indicated 20. Sign the MAR after administered. Review of a facility's policy titled Documentation in Medical Record, dated 03/01/25, indicated that .Each resident's medical record shall contain an accurate representation of the actual experience of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Review of Resident (R)79's admission Record found under the Profile tab of the electronic medical record (EMR) indicated an admission date of 12/27/25 with diagnoses of appendicitis, hemiplegia and hemiparesis, type 2 diabetes, major depressive disorder, and dementia. Review of R79's Medication Administration Record (MAR) found under the Physician's Orders tab in the EMR for 03/01/26 - 03/19/26 indicated no administration documentation for the following medication:The 9:00 PM dose on 03/12/26 for Eliquis (a medication used to thin blood), 5 milligrams (mg), give one tablet by mouth two times a day.On 03/12/26 for Atorvastatin calcium (a medication used to treat high cholesterol) 80 mg one tablet by mouth at bedtime, and for Ezetimibe (a medication used to treat high cholesterol) 10 mg tablet by mouth at bedtime. During an interview on 03/19/26 at 11:40AM, Licensed Practical Nurse (LPN)8 confirmed working on the night shift on 03/12/26. LPN8 stated that the medications were given, and she forgot to go back and click them off in the computer system. LPN8 stated that documentation should have been done before the end of the shift. In an interview on 03/19/26 at 2:30 PM, the Director of Nurses (DON) stated that if it is not documented, it is not done, and timely documentation is emphasized over and over.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record review, and facility policy review, the facility failed to adhere to infection control practices and policies during incontinence care for two of three residents (Resident (R) 172 and R181) observed for incontinence care in the sample of 51 residents. The deficient practice had the potential to place R172 and R181 at risk of cross-contamination and infection.Findings include: Review of the facility's policy titled Perineal Care with a revision date of 01/01/26 provided by the facility indicated that: It is the practice of this facility to provide perineal care to all incontinent residents during routine bath and as needed in order to promote cleanliness and comfort, prevent infection to the extent possible, and to prevent and assess for skin breakdown. Review of the facility's policy titled Handwashing/Hand Hygiene with a revision date of August 2019 provided by the facility indicated that: 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations; h. Before moving from a contaminated body site to a clean body site during resident care, and j. After contact with blood or bodily fluids. Review of the facility's policy titled, Enhanced Barrier Precautions, revised 03/01/25, provided by the facility indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and gloves use during high contact resident care activities. Initiation of Enhanced Barrier Precautions. for residents with any of the following: wounds.even if the resident is not known to be infected or colonized with MDRO. Implementation of Enhanced Barrier Precautions: . PPE [Personal Protective Equipment] for enhanced barrier precautions is only necessary when performing high-contact care activities . High-contact care activities include: . Changing linens, changing briefs, . and Wound care. Review of the facility's policy titled, Hand Hygiene, revised 03/01/25, provided by the facility, indicated, The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 1. Review of R172's admission Record located under the Profile tab of the electronic medical record (EMR) revealed R172 was admitted to the facility on [DATE] with diagnoses of hemiplegia and hemiparesis following cerebral infarction, need for assistance with personal care, and a fall from a non-moving wheelchair. Review of the admission Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 01/16/26 showed documentation R172 completed a Brief Interview for Mental Status (BIMS) with a score of 11 out of 15, which indicated R172 was moderately cognitively impaired. Review of R172's Care Plan located under the Care Plan tab in the EMR revealed R172 was on enhanced barrier precautions for potential infection related to wounds. During an observation on 03/18/26 at 6:44 AM, Certified Nurse Aide (CNA) 8 entered R172's room to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perform incontinence care. An EBP sign was posted on R172's bedroom door that indicated, Providers and staff must also: wear gloves and a gown for the following high-contact resident care activities.changing linens, providing hygiene, changing briefs, . wound care. CNA8 performed hand hygiene, donned gloves, and performed incontinence care. CNA8 did not wear a gown while performing incontinence care. Midway through care, the Regional Risk Consultant (RRC) instructed CNA8 to put on a gown. CNA8 did not perform hand hygiene during glove changes. CNA8 left the room while wearing the gown and obtained a clean sheet from the linen cart that was outside the room, and deposited R172's soiled brief and linens into the trash bin and linen hamper outside the room without bagging the soiled linens or brief. During an interview on 03/18/26 at 7:24 AM, CNA8 stated, I changed gloves going from soiled to clean. I did not sanitize my hands between glove changes. I should sanitize my hands when I remove gloves. I did not wear a gown in the beginning. During an interview on 03/18/26 at 7:29 AM, the RCC stated, We need to make sure we have everything in the room to start with. We should sanitize our hands anytime we take gloves off. During an interview on 03/19/26 at 12:31 PM, the Assistant Director of Nursing (ADON) 3 stated, For residents with EBP precautions, staff are to put on a gown and gloves. I encourage staff to wash their hands every time they remove or change gloves, before and after providing care. If needing to leave the room, they are to remove the gown. They should have all of their supplies in the room before going in, or ask another staff member to bring the needed supplies, so they don't have to de-gown. Only take what is needed off the linen cart. It is not appropriate to have the linen cart outside the room and grab things off the linen cart while gowned. During an interview on 03/19/26 at 2:00 PM, the Director of Nursing (DON) stated, It was not appropriate for staff to go in and out of the room wearing a gown. Staff should have all of their supplies before going into the room. There is a risk of cross-contamination. The expectation is that staff perform hand hygiene with each glove change. 2. Review of R181's admission Record found under the Profile tab of the EMR indicated an admission date of 05/30/22 with diagnoses cerebrovascular insufficiency, hemiplegia, and hemiparesis affecting the right side, vascular dementia, and major depressive disorder. Review of R181's MDS with an ARD of 12/27/25 found under the MDS tab of the EMR indicated R181 was always incontinent of bowel and bladder. During an observation on 03/17/26 at 1:34 PM of R181's incontinent care, CNA5 donned gloves and provided incontinent care using the same pair of gloves throughout the process. CNA5 wrapped up the urine-soiled brief, applied barrier cream to the perineal area, and put on a new brief without changing dirty gloves and performing hand sanitization. In an interview on 03/17/26 at 1:44 PM, CNA5 stated she did not change gloves, and that handwashing and gloves were put on before she entered the room to provide care.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff interviews, review of maintenance documentation, and review of facility policy, the facility failed to ensure siderails were securely attached to the bed for one (Resident (R) 190) of six reviewed for side rails out of a sample of 51 residents. The deficient practice had the potential to place R190 at increased risk of injury related to side-rail use. Findings include:Review of the facility's policy titled, Side Rail Safety, revised 03/01/25, indicated, Inspecting and regularly checking the mattress and bed rails for areas of possible entrapment; ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a resident's head or body, regardless of mattress width, length, and/or depth, checking bedrails regularly to make sure they are still installed correctly, and have not shifted or loosened over time. Review of R190's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed R190 was admitted to the facility on [DATE] with diagnoses of multiple sclerosis, other lack of coordination, seizures, muscle weakness (generalized), cognitive communication deficit, and major depressive disorder. Review of R190's Care Plan, dated 07/20/23 and located under the Care Plan tab of the EMR, revealed a focus of R190 had limited physical mobility related to repeated falls, multiple sclerosis exacerbation, history of seizures, weakness, and rib fractures. Interventions included staff were to provide supportive care and assistance with mobility as needed. Review of R190's quarterly Minimum Data Set (MDS), located under the MDS tab of the EMR and with an Assessment Reference Date (ARD) of 12/28/25, revealed R190 had multiple sclerosis, depression, seizures, upper and lower extremity impairments on one side, required moderate help with rolling from side to side, and from sitting to standing. It was recorded that R190 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15, which indicated the resident was cognitively intact. Review of R190's Care Plan, dated 07/20/23 and located under the Care Plan tab of the EMR, revealed a focus Activities of Daily Living (ADL) self-care performance deficit. Interventions included mobility bars up for safety during care provision, to assist with bed mobility and staff were to observe for injury or entrapment related to side rail use and reposition as necessary to avoid injury. During an observation and interview on 03/18/26 at 10:22 AM, R190's right-hand mid-bed metal rail was observed loose and unable to remain in the proper location. R190 lifted the bed rail and let it fall to the floor. R190 stated he used it to hold on to while turning in bed. During an observation and interview on 03/18/26 at 10:26 AM, Certified Medication Technician (CMT) 2 confirmed R190's right hand mid-bed side rail was loose and posed a risk for injury. During an interview and observation on 03/18/26 at 10:45 AM, the Maintenance Director stated, I try to inspect five-10 beds with bed rails on each floor daily. Each bed is inspected weekly. I have not inspected any beds on the 4th floor today. I looked at the bed in [R190's] room earlier this week. The Maintenance Director inspected R190's right-hand mid-bed rail. The rail was attached with one bolt near the head of the bed, and when the rail was lifted up, it dropped to the floor. The facility was unable to provide documentation of weekly bed inspections completed by maintenance.