STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115327	A. Building B. Wing	01/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crossroads of Flowery Branch of Journey Llc, The	4595 Cantrell Road Flowery Branch, GA 30542

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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 0570 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Assure the security of all personal funds of residents deposited with the facility. Based on staff interviews and record review, the facility failed to ensure the security of all personal funds of residents deposited with the facility. Specifically, the facility failed to maintain a surety bond sufficient to cover the total funds in the resident trust account. This deficient practice had the potential to affect the residents with trust fund accounts managed by the facility. The census was 93 residents.Findings included:A facility policy on surety bonds was requested but not provided.A review of the State of Georgia Department of Community Health Long-Term Care Facility Residents' Fund Bond, dated 11/1/2024, revealed a surety bond for $75,000.00.A review of the Resident Trust Fund statement for 8/1/2025 to 9/1/2025 revealed a balance of $54,268.70 on 8/1/2025, a balance of $89,735.10 on 8/21/2025, a balance of $89,765.10 on 8/29/2025, and a balance of $89,766.98 on 8/31/2025.A review of the Resident Trust Fund statement for 9/2/2025 to 9/30/2025 revealed a balance of $89,766.98 on 9/2/2025, a balance of $92,763.98 on 9/3/2025, a balance of $92,399.48 on 9/9/2025, a balance of $92,176.43 on 9/12/2025, a balance of $92,006.43 on 9/15/2025, a balance of $81,289.91 on 9/16/2025, a balance of $77,745.31 on 9/17/2025, a balance of $75,463.05 on 9/22/2025, a balance of $75,603.05 on 9/23/2025, and a balance of $75,214.29 on 9/24/2025.During an interview on 1/16/2026 at 5:08 pm, the Business Office Manager (BOM) revealed that for resident trust funds, she is responsible for giving the residents cash. She stated she was not sure what a surety bond is. She further stated that she only handles individual resident trust funds and does not look at the whole balance of the account. She confirmed that $89,766.98 was the documented current balance for 8/31/2025 and $89,766.98 was the documented starting balance for 9/2/2025.During an interview on 1/16/2026 at 5:17 pm, the [NAME] President of Operations revealed that the BOM oversees the total amount of the resident trust fund account. He confirmed the amount from August 2025 to Septemebr 2025 was over the surety bond of $75,000. He confirmed that the total amount of the resident trust fund should not go over the amount of the surety bond and that the current surety bond is $75,000.During an interview on 1/16/2026 at 6:09 pm, the Administrator revealed his expectations for the resident trust fund is that the balance should not exceed the surety bond and that if it does, the facility should increase the surety bond.

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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(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 observations, staff and resident interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to develop and implement care plans that describe the resident's medical, nursing, physical, mental, and psychosocial needs for six of 46 sampled residents (R) (R90, R12, R74, R57, R1 and R16).Findings included:A review of the facility's policy titled Comprehensive Care Plans, revised 3/20/2025, revealed that the comprehensive care plan will be developed within seven days after the completion of the comprehensive Minimum Data Set (MDS) assessment. All Care Assessment Areas (CAAs) triggered by the MDS will be considered in developing the plan of care. The services that are to be furnished to attain or maintain the residents' highest practicable physical, mental, and psychosocial well-being. Further review revealed, under number five, The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 1. A review of the electronic medical record (EMR) revealed that R90 was originally admitted to the facility on [DATE] and was re-admitted to the facility on [DATE] with pertinent diagnoses, including but not limited to, displacement of nephrostomy catheter, malignant neoplasm of bladder, gram-negative sepsis, acute cystitis with hematuria, acute kidney failure, and chronic kidney disease stage 3.A review of R90's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of seven, which indicated R90 had severe cognitive impairment. During an observation on 1/11/2026 at 3:24 pm, R90 was lying in bed, color pale, eyes closed. He had two urinary bags on either side. The right-side bag has cloudy, dark yellow fluid in it, approximately 50ml (milliliters) volume. The bag on the left side had clear yellow fluid with a volume of approximately 150ml. These bags were attached to the residents' backs (nephrostomy tubes).During an observation of R90 on 1/11/2026 at 5:10 pm, Registered Nurse (RN) AA confirmed that R90 had nephrostomy tubes. A review of R90's most recent comprehensive care plan revealed no mention of a nephrostomy.During an interview on 1/11/2026 at 5:17 pm, the Director of Nursing Services (DNS) confirmed that there is no order for dressing changes or care orders on R90 for the nephrostomy tubes, and the care plan that is present in the electronic medical record was not up to date to reflect care for the nephrostomy tube sites.During an interview on 1/15/2026 at 11:24 am, the Regional Director of Nursing Services revealed that comprehensive care plans should be developed within a week of admission and should be revised with a new medication, a change of condition, and any change in a resident and that care plans should include diagnoses, medications, wounds, skin concerns, resident preferences, code status, risk factors, and specific care needs such as oxygen, dialysis, and nephrostomy care.2. A review of R12's EMR revealed he was admitted to the facility on [DATE]. Pertinent diagnoses included, but were not limited to, hemiplegia and hemiparesis following cerebral infarction affecting the left non-dominant side, muscle weakness, need for assistance with personal care, contracture, other lack of coordination, stage 2 pressure ulcer of the sacral region, stage 4 pressure ulcer of the left heel, and contracture of the left hand. A review of R12's quarterly MDS dated [DATE] revealed R12 had a BIMS score of one, indicating R12 had severe cognitive impairment at the time of the assessment. A review of R12's physician orders revealed an order dated 11/21/2025 for adaptive/ assistive devices of prevalon boots for offloading. A review of R12's care plan revealed a focus dated 10/31/2025 that documented R12 has a stage 2 wound to sacrum and stage 4 wound to left heel. Goals included, wound will be free from infection and heal within 30 days. Interventions included, but were not limited to, follow wound care treatment as ordered, new order for prevalon boots, and reposition resident every two hours and offload heel. During an observation on 1/11/2026 at 1:14 pm and on 1/12/2026 at 8:15 am, R12 had no pressure-relieving boots on.During an interview on 1/12/2026 at 8:15 am, the Unit Manager confirmed that R12's pressure-relieving boots were not on (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but should be. During an interview on 1/15/2026 at 11:24 am, the DNS confirmed that if R12 had a care plan intervention of pressure-relieving boots, then they should have been on.3. A review of R74's EMR revealed she was admitted to the facility on [DATE]. Pertinent diagnoses included, but were not limited to, alcohol abuse, depression, insomnia, and unspecified mood affective disorder. A review of R74's physician orders revealed an order dated 12/16/2025 for aripiprazole oral tablet 2mg with instructions to give one tablet by mouth one time a day, an order dated 12/16/2025 for duloxetine Hcl oral capsule delayed release particles 60 mg with instructions to give one capsule by mouth one time a day, an order dated 12/16/2025 for mirtazapine oral tablet 15 mg with instructions to give one tablet by mouth one time a day, an order dated 12/26/2025 for aripiprazole oral tablet 2mg with instructions to give 0.5 tablet by mouth one time a day for mood for 1 week, an order dated 1/4/2026 for aripiprazole oral tablet 2mg with instructions to give 2mg by mouth one time a day, an order dated 1/8/2026 for aripiprazole oral tablet 2mg with instructions to give one tablet by mouth one time a day for mood disorder, an order dated 1/8/2026 for mirtazapine oral tablet 15 mg with instructions to give one tablet by mouth one time a day for depression, and an order dated 1/8/2026 for duloxetine Hcl oral capsule delayed release particles 60 mg with instructions to give one capsule by mouth one time a day for depression.A review of R74's care plan revealed no focus or interventions mentioning a diagnosis or risk factors related to alcohol.During an interview on 1/15/2026 at 11:24 am, the DNS confirmed R74's comprehensive care plan did not include her diagnosis and risk factors related to alcohol, but should have.4. A review of R1's EMR revealed R1 was admitted to the facility on [DATE]. Pertinent diagnoses included, but were not limited to, acquired absence of left leg below knee, acquired absence of right leg above knee, legal blindness, and type 2 diabetes.A review of R1's quarterly MDS dated [DATE] revealed R1 had a BIMS score of 15, which indicates R1 was cognitively intact.A review of R1's physician orders revealed an order dated 11/14/2025 for Humulin subcutaneous solution with instructions to inject 100 units subcutaneously one time a day for diabetes mellitus before breakfast.A review of R1's care plan dated 1/11/2026 revealed a focus initiated on 11/12/2025 revealed a focus of diabetes mellitus. Goals included, The resident will have no complications related to diabetes through the review date. Interventions included, but were not limited to, Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.During an interview on 1/11/2026 at 1:51 pm, R1 revealed he had concerns with his insulin, which has to be given to him before he eats. He has reminded before, but sometimes he does not receive his insulin until after meals.During an interview and observation on 1/12/2026 at 8:32 am, R1 was observed eating breakfast in his room. He stated that he has not been offered his insulin yet.During an interview on 1/13/2026 at 8:09 am, Licensed Practical Nurse (LPN) KK revealed that she has been working at the facility for about a year. When asked about insulin administration, she explained that she usually tries to administer insulin before breakfast. She confirmed that R1 had not been offered or administered his insulin before breakfast today and explained that she was having technical difficulties with her computer when she arrived on the shift.During an interview on 1/15/2026 at 11:24 am, the DNS confirmed R1's care plan intervention for diabetes related to the following physician orders for R1 were not followed, but should have been. The DNS further stated that a potential negative outcome for missing the insulin before meals is hyperglycemia.5. A review of R57's EMR revealed he was admitted to the facility on [DATE]. Pertinent diagnoses included, but were not limited to, cerebral infarction, hemiplegia, and hemiparesis following unspecified cerebrovascular disease affecting the unspecified side.A review of R57's quarterly minimum data set (MDS) dated [DATE] revealed a BIMS of 12, indicating R57 had moderate cognitive impairment at the time of the assessment.A review of R57's physician orders revealed an order dated 7/12/2025 for clopidogrel bisulfate tablet 75 mg with instructions to give one tablet by mouth one time a day for blood clot prevention.A review of R57's care plan dated 7/12/2025 revealed only two focuses: full code and discharge. There was no indication of the level of assistance needed or a mention of R57's usage of anticoagulants.During an interview on 1/15/2026 at 11:24 am, the DNS confirmed that R57's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	comprehensive care plan only had focuses related to advance directives and discharge, but should have contained more, including the level of assistance and the use of anticoagulants.The DNS further stated that comprehensive care plans should be developed within a week and revised with a new medication, a change of condition, and any change in a resident. The DNS further stated that care plans should include diagnoses, medications, wounds, skin concerns, resident preferences, code status, risk factors, and specific care needs. The DNS confirmed these processes were not followed and stated that staff were not following the facility process for care plans.6. A review of R16's EMR revealed she was admitted to the facility on [DATE]. Pertinent diagnoses included, but were not limited to, displaced fracture of the lateral malleolus of the right fibula, fracture with routine healing, benign neoplasm of the parathyroid gland, unspecified injury of the head, and generalized anxiety disorder.A review of R16's physician orders revealed an order dated 9/25/2025 for Apixaban Oral Tablet 5mg (milligram) (Apixaban); give one tablet by mouth two times a day (anticoagulants).A review of R16's care plan revealed no focus or interventions mentioning a risk factor related to anticoagulant medication administration.An interview on 1/15/2026 at 11:24 am with the DNS revealed that comprehensive care plans should be developed within a week. They should be revised with a new medication, a change of condition, and any change in a resident. Care plans should include diagnoses, medications, wounds, skin concerns, resident preferences, code status, risk factors, and specific care needs.During an interview on 1/16/2026 at 12:19 pm, DNS stated that R16 absolutely should have a care plan related to anticoagulants.

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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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, resident interviews, record review, and review of the facility's policy titled Comprehensive Care Plans, the facility failed to provide one of 46 sampled residents (R) (R1) the right to participate in the development of his person-centered plan of care. This deficient practice had the potential to deprive R1's inclusion of personal goals, choices, and preferences in the plan of care.Findings included:A review of the facility's policy titled Comprehensive Care Plans, revised 3/20/2025, documented under section titled Policy Explanation and Compliance Guidelines number one, The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care. Further review revealed, under number four, The comprehensive care plan will be prepared by an interdisciplinary team, which includes, but is not limited to: e. The resident and the resident's representative, to the extent practicable.A review of R1's electronic medical record (EMR) revealed R1 was admitted to the facility on [DATE]. Pertinent diagnoses included, but was not limited to, acquired absence of left leg below knee, acquired absence of right leg above knee, obesity, insomnia, legal blindness, major depressive disorder, anxiety disorder, and type 2 diabetes.A review of R1's quarterly minimum data set (MDS) dated [DATE] revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 was cognitively intact.A review of R1's care plan dated 1/11/2026 revealed a focus initiated on 12/1/2025 that stated R1 was resistive to care, occasionally refuses medications related to resident's choice. Interventions included, but were not limited to, allowing the resident to make decisions about the treatment regimen to provide a sense of control and providing the resident with opportunities for choice during care provision.Further review of R1's EMR revealed no documentation indicating R1's attendance or refusal of attendance for the development of the comprehensive care plan.During an interview on 1/16/2026 at 1:54 pm, R1 revealed he had never had a care plan conference, asked what it was, and said he would like to attend one.During a phone interview on 1/16/2026 at 3:08 pm, the Regional Reimbursement Specialist revealed she provides oversight and assistance with MDS Coordinators and updates care plans. She stated that social services and the MDS coordinator are responsible for care plan conferences, and these conferences are documented in the EMR. She further stated she did not locate documentation of a care plan conference for R1.During an interview on 1/16/2026 at 4:33 pm, the Business Office Manager (BOM) revealed that she has been assisting with social services responsibilities as the facility has not had a social services director for several months. She stated that care plan conferences are usually conducted a couple of days after admission, quarterly, annually, or upon request. She stated she was not aware of where care plan conferences are documented and that the social worker did the documentation for care plan conferences.During an interview on 1/16/2026 at 5:44pm, the Director of Nursing Services (DNS) revealed that she expects care plan conferences to be completed within 30 days of admission and quarterly and usually includes nursing, social services, therapy, dietary, activities, and the resident or resident representative. She confirmed she did not see any care plan conference documentation for R1 and was not sure why.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, record review, and review of the facility's policy titled Residents' Rights Regarding Treatment and Advance Directives, the facility failed to ensure that the advance directive status was consistently documented in the clinical record for two of 46 sampled residents (R) (R16 and R112).Findings included:A review of the facility policy titled Residents' Rights Regarding Treatment and Advance Directives dated February 2024 revealed under Definitions, Advance Directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State, relating to the provision of health care when the individual is incapacitated. Under the section titled Policy Explanation and Compliance Guidelines revealed: .9. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.1. A review of R16's medical record (EMR) revealed she was admitted to the facility on [DATE], with pertinent diagnoses including, but not limited to, displaced fracture of lateral malleolus of right fibula, fracture with routine healing benign neoplasm of parathyroid gland, unspecified injury of head, generalized anxiety disorder.A review of R16's Physician Orders reveal an active order for FULL CODE STATUS with date of 9/25/2025.A review of Medical Summary of R16's EMR revealed special Instructions: FULL CODE.A review of R16's care plan revealed: Advanced Directives Do Not Attempt Resuscitation (DNR) with interventions: honor code status directive and keep family informed of change in condition; with a revision date of 9/30/2025.Further review of EMR revealed Physician Orders for Life-Sustaining Treatment (POLST) form with a code status: Allow Natural Death and Do Not Attempt Resuscitation. Signed by R16 on 1/12/2026 and signed by Physician on 1/13/2026.2. A review of R112's EMR revealed she was admitted to the facility on [DATE] with pertinent diagnoses, including, but not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, anxiety disorder, and major depressive disorder.A review of R112's Physician Orders reveal an active order for FULL CODE STATUS with date of 1/8/2026.A review of Medical Summary of R112's EMR revealed special Instructions: FULL CODE.A review of R112's care plan revealed: Advanced Directives Do Not Attempt Resuscitation (DNR) with interventions: honor code status directive and keep family informed of change in condition. Date initiated: 1/8/2026.Further review of R112's EMR on 1/16/2025 revealed Physician Orders for Life-Sustaining Treatment (POLST) form with a code status: Allow Natural Death and Do Not Attempt Resuscitation. Signed by R112 on 1/12/2026 and signed by Physician on 1/13/2026.Interview with Director of Nursing Service (DNS) on 1/16/2026 at 12:19 pm confirmed that R16's and R112's EMR were not updated consistently with new code DNR. The DNS stated that all EMR entries must be consistent with a code status from the Advanced Directive.

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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 record review, staff interviews, and review of the facility's policy titled Baseline Care Plan, the facility failed to develop a Baseline Care Plan for three of 46 sampled residents (R) (R14, R109, and R90). The deficient practice had the potential for residents' needs to go unmet. Findings included:A review of the facility's policy titled Baseline Care Plan implemented on 2/1/2024, documented under Policy Explanation and Compliance Guidelines: 1. The baseline care plan will: a. Be developed within 48 hours of a resident's admission. b. Include the minimum healthcare information necessary to properly care for a resident, including, but not limited to: i. Initial goals based on admission orders. ii. Physician orders. iii. Dietary orders. iv. Therapy orders. v. Social services.3. A supervising nurse shall verify within 48 hours that a baseline care plan has been developed. 1. A review of R14's Physician Orders revealed an order dated 12/13/2025 for next day labs PT/INR (Prothrombin Time / International Normalized Ratio) one time a day every 1 month starting on the 15th, an order dated 12/10/2025 for anticoagulation medication observation, an order dated 12/11/2025 for Occupational Therapy Clarification Order - Skilled Occupational Therapy 5 times a week, and an order dated 12/12/2025 for Occupational Therapy Clarification Order - Skilled Occupational Therapy 5 times a week. A review of R14's EMR revealed no baseline or comprehensive care plan. During an interview on 1/16/26 at 12:19 pm, the Director of Nursing Service (DNS) confirmed that residents should have a baseline care plan within 48 hours of admission. She stated that currently, corporate employees help nurses with comprehensive care plans, but nurses are responsible for creating a baseline care plan. The DHS also confirmed that there was no care plan for R14 in the EMR. 2. A review of R109's EMR revealed R109 was admitted to the facility on [DATE] with diagnoses including, but not limited to, acquired absence of right leg below the knee, type 2 diabetes mellitus with foot ulcer, dependence on renal dialysis, and end-stage renal disease. A review of R109's EMR revealed no baseline or comprehensive care plan. An interview on 1/12/2026 at 3:06 pm, the DNS confirmed there was no baseline care plan or comprehensive care plan completed for R109. 3. A review of the electronic medical record (EMR) revealed that R90 was originally admitted to the facility on [DATE] and was re-admitted to the facility on [DATE] with pertinent diagnoses, including but not limited to, displacement of nephrostomy catheter, malignant neoplasm of bladder, gram-negative sepsis, acute cystitis with hematuria, acute kidney failure, and chronic kidney disease stage 3. During an observation on 1/11/2026 at 3:24 pm, R90 was lying in bed, color pale, eyes closed. He had two urinary bags on either side. The right-side bag has cloudy, dark yellow fluid in it, approximately 50ml (milliliters) volume. The bag on the left side had clear yellow fluid with a volume of approximately 150ml. These bags were attached to the residents' backs (nephrostomy tubes). During an observation of R90 on 1/11/2026 at 5:10 pm, Registered Nurse (RN) AA confirmed that R90 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had nephrostomy tubes. A review of R90's EMR revealed no baseline careplan upon admission related to the nephrostomy. During an interview on 1/11/2026 at 5:17 pm, the DSN confirmed that there was no baseline careplan upon admission for R90 to reflect care for the nephrostomy tube sites.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, resident interviews, record review, and review of the facility's policy titled Medication Administration, the facility failed to follow physician orders in accordance with professional standards related to insulin, blood testing, and non-pressure related wound care for three of 46 sampled residents (R) (R1, R14, and R53). This deficient practice had the potential to create a diminished quality of care.Findings included:A review of the facility's policy titled Medication Administration, revised on 2/14/2024, revealed under the section titled Policy, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Under the section titled, Policy Explanation and Compliance Guidelines, number 11 revealed, Compare medication source with MAR (medication administration record) to verify resident name, medication name, form, dose, route, and time. b. Administer within 60 minutes before or after the scheduled time unless otherwise ordered by the physician. A review of R1's electronic medical record (EMR) revealed R1 was admitted to the facility with pertinent diagnoses, including, but not limited to, acquired absence of left leg below knee, acquired absence of right leg above knee, legal blindness, and type 2 diabetes. A review of R1's quarterly minimum data set (MDS) dated [DATE] revealed that R1 had a Brief Interview for Mental Status (BIMS) score of 15, indicating R1 was cognitively intact. A review of R1's physician orders revealed an order dated 11/14/2025 for Humulin (insulin) subcutaneous solution with instructions to inject 100 units subcutaneously one time a day for diabetes mellitus before breakfast, an order dated 11/14/2025 for Humulin (insulin) subcutaneous solution with instructions to inject 80 units subcutaneously one time a day for diabetes mellitus before lunch, and an order dated 11/14/2025 for Humulin (insulin) subcutaneous solution with instructions to inject 80 units subcutaneously one time a day for diabetes mellitus before dinner. A review of R1's care plan dated 1/11/2026 revealed a focus initiated on 11/12/2025 revealed a focus of diabetes mellitus. Goals included, The resident will have no complications related to diabetes through the review date. Interventions included, but were not limited to, Diabetes medication as ordered by the doctor. Monitor/document for side effects and effectiveness. During an interview on 1/11/2026 at 1:51 pm, R1 revealed he had concerns with his insulin, which has to be given to him before he eats. He has reminded staff before, but sometimes he did not receive his insulin until after meals. During an interview and observation on 1/12/2026 at 8:32 am, R1 was eating breakfast in his room. He stated that he had not been offered his insulin yet. During an interview on 1/12/2026 at 8:34 am, the Unit Manager confirmed that she had not given R1 his insulin before breakfast as ordered. During an interview and observation on 1/13/2026 at 8:05 am, R1 was eating breakfast in his room. When asked if he had his insulin yet, he stated no, and further stated that his last insulin was yesterday, before dinner. When asked if he refused any insulin this morning, he stated that he had not been offered it and is still waiting to be offered his insulin. When asked if he had his blood sugar taken (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this morning, he stated that it had been taken around 5:00 am this morning, and it was over 200. An interview on 1/13/2026 at 8:09 am with License Practical Nurse (LPN) KK revealed that when asked about insulin administration, she explained that she usually tries to administer insulin before breakfast. She confirmed that R1 had not been offered or administered his insulin before breakfast today and explained that she was having technical difficulties with her computer when she arrived on the shift. When asked what his last blood sugar levels were, she stated that it was 249 at 4:26 am. An interview on 1/15/2026 at 11:24 am with the Director of Nursing Services (DNS) confirmed the physician orders for R1 were not followed, but should have been. The DNS further stated that a potential negative outcome for missing the insulin before meals is hyperglycemia (low blood sugar). 2. A review of R14's EMR revealed R14 was admitted to the facility with pertinent diagnoses, including, but not limited to, fracture of unspecified part of neck of left femur, muscle weakness, type 2 diabetes mellitus, endocarditis, pathological fracture, and encounter for other orthopedic aftercare. A review of R14's physician orders revealed an order dated 12/13/2025 for next-day labs PT/INR (Prothrombin Time / International Normalized Ratio) one time a day every 1 month starting on the 15th. During an interview on 1/16/2026 at 12:19 pm, the Director of Nursing Service (DNS) confirmed that the physician ordered a PT/INR blood test on 12/15/2025, but there were no test results in the EMR. She was not able to say why the blood test was not done. 3. A review of the EMR revealed R53 was admitted to the facility with diagnoses that included a non-pressure chronic ulcer of unspecified part of unspecified. A review of the most recent quarterly MDS documented that R53 had a BIMS score of 15, indicating the resident had intact cognition. A review of the Care Plans for R53 revealed that the care plan documented that the resident was to receive wound care treatment daily A review of the Treatment Administration Record (TAR) revealed that wound care should be performed daily for R53. During an observation of R53 on 1/12/2026, it was noted that the wound dressing was dated 1/9/2026. During an interview on 1/14/2026 at 10:05 am, Licensed Practical Nurse (LPN) BB revealed that she assisted with wound care as needed and expressed interest in becoming the facility's wound care nurse. She stated that nursing staff was sometimes overwhelmed and unable to complete ordered wound care, and that she filled in to assist when this occurred. During an interview on 1/12/2026 at 10:10 am, LPN CC revealed that when asked about wound care, LPN CC stated that the Unit Manager was responsible for completing wound care on the unit and typically checked the TAR. She further stated that if she observed a wound requiring a dressing change, she would either complete the dressing change herself or notify the Unit Manager. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/12/2026 at 10:00 am with the Registered Nurse (RN) Unit Manager who stated that the assigned unit nurse was responsible for completing wound care treatments. She mentioned that if the unit nurse became overwhelmed or requested assistance, she would provide support and help with wound care. She further acknowledged that she was not aware that wound care treatments had not been completed as ordered. Interview on 1/14/2026 at 10:19 am with the Director of Nursing (DON) revealed that the floor nurse was responsible for completing wound care for residents on the unit. The DON stated that when the floor nurse was overwhelmed, the nurse was expected to inform the Unit manager, who would then assist with wound care or assign another staff member to assist. The DON stated that the expectation was for the floor nurse to complete wound care, and that this responsibility was communicated to nursing staff during orientation.

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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, staff interviews, resident interviews, record review, and review of the facility's policies titled, Oxygen Administration and Medication Orders, the facility failed to obtain physician orders for oxygen therapy for one of 13 residents on oxygen and physician orders for Bi-level Positive Airway Pressure (BiPAP) for one of one resident with a BiPAP Mask. Specifically, the facility failed to obtain physician orders for oxygen therapy for residents (R) (R112 and R50). This failure had the potential to cause respiratory distress and inconsistent care for residents receiving oxygen therapy.Findings included:A review of the facility policy titled Medication Orders, revised 2/14/2024, under the section titled Policy Explanation and Compliance Guidelines, number 5, Specific Procedures for Medication Orders: c. Written Transfer Orders (sent with a resident by a hospital or other health care facility). Implement a transfer order without further validation if it is signed and dated by the resident's current attending physician, unless the order is unclear or incomplete, or the date signed is different from the date of admission. If the order is unsigned, or signed by another physician, or the date is other than the date of admission, the receiving nurse should verify the order with the current attending physician before medications are administered.A review of the facility policy titled Oxygen Administration, revised 2/14/2024, under the section titled Policy Explanation and Compliance Guidelines, number 2 documented, Personnel authorized to initiate oxygen therapy include physicians, RNs (Registered Nurses), LPNs (Licensed Practical Nurses), and respiratory therapists.A review of R112's electronic medical record (EMR) revealed R112 was admitted to the facility on [DATE]. Pertinent diagnoses included, but were not limited to, acute and chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, and shortness of breath.A review of R112's physician orders revealed an order dated 1/8/2026 for oxygen at night during sleep, 2L (liters)/min (minute) via nasal cannula every night shift.A review of R112's physician orders revealed an order dated 1/11/2026 for oxygen at night during sleep, 4L/min via nasal cannula every night shift.A review of R112's EMR revealed a hospital Discharge summary dated [DATE] that documented, under Diagnosis and Reason for Visit, Reason for visit: SOB - Shortness of breath; difficulty breathing. A review of the EMR of the Hospital Course noted, During her admission, she was found to have acute respiratory failure secondary to influenza A and COPD exacerbation. Pulmonology followed up and treated her with a course of steroids, antibiotics, Tamiflu, and bronchodilators. With this treatment, she was able to wean off oxygen during the day but continues to require oxygen at night.A review of the EMR revealed, under the section titled Assessment and Plan, number one documented, acute-on-chronic hypoxic respiratory failure. Sp02 dropped to 87% on RA [room air] at one point during the day. Acute resolved, now stable on baseline RA [room air] during the day and 2-4L HS [at bedtime].A review of the EMR revealed, under the section titled Vitals and Measurements, Oxygen flow rate: 4L/min.During an interview on 1/11/2026 at 2:18 pm, R112 stated she was supposed to be sleeping with oxygen, but has not been because she has not been provided an oxygen concentrator, and that has been the case for a couple of nights since her admission to the facility. R112 further stated that last night she woke up at 3:00 am and had a headache and difficulty breathing, which required her to do a breathing treatment this morning. R112 further stated that she has asked her night nurses about it each night for three nights and has not received an answer. She further stated that she usually received 4L per night at the hospital.During an interview on 1/15/2026 at 11:24 am, the DNS revealed the start date of R112's oxygen order was documented as 1/8/2026, the day of R112's admission, and R112 should be receiving the oxygen at night during sleep. The DNS stated the reason for the delay in R112's oxygen is that the staff did not bring R112 her oxygen concentrator at admission.During an interview on 1/16/2026 at 5:59 pm, the DNS revealed that if a resident has an order for oxygen, the facility should provide the resident with oxygen. 2. During a review of the facility policy titled Oxygen Administration, revised 2/14/2024, under the section titled Policy Explanation (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and Compliance Guidelines, number 2 documented, Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists. Further review documented under number 9, Types of delivery systems include: e. Bi-level Positive Airway Pressure (BiPAP) Mask--This mask is part of a system that is capable of generating two adjustable pressure levels during inhalation and exhalation.A review of R50's EMR revealed R50 was admitted to the facility on [DATE], with diagnoses that included, but were not limited to, acute respiratory failure with hypoxia, obstructive sleep apnea, simple chronic bronchitis, and shortness of breath.A review of R50's admission Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicates R50 had moderate cognitive impairment.A review of R50's physician orders printed on 1/11/2026 revealed no orders for BiPAP.A review of R50's physician orders printed on 1/12/2026 documented, BiPAP settings: ASVAuto Mode Min EPAP- 5cm (centimeters), Max EPAP-15.0cm Min PS- 4.0cm Max PS- 19.0 Ramp time- 20 min.Further review of R50's physician orders printed on 1/12/2026 documented, Resident to wear BiPAP at night. Document vital signs and oxygen saturation before use. Document if the resident refuses to use BiPAP every night shift.A review of R50's EMR revealed a document titled, Hospital SNF Initial Placement report Paperwork with a print date of 11/7/2025. Under the section titled MD (medical doctor) Progress Note with a date of service of 11/5/2025, the subsection titled Assessment and Plan documented, Patient required BiPAP and high-flow oxygen, with intermittent improvement and subsequent worsening necessitating transfer to (Acute Care Facility) for respiratory distress and increased work of breathing.An observation and interview on 1/11/2026 at 1:16 pm with R50 revealed a BiPAP mask uncovered, unbagged, and on the resident's nightstand. When asked if he uses it, R50 responded that he uses it every night.During an observation on 1/12/2026 at 8:16 am, a BiPAP mask was uncovered, unbagged, and on the resident's nightstand.During an interview on 1/12/2026 at 8:17 am, the Unit Manager confirmed that the BiPAP mask was uncovered and should be placed in a bag.During an interview on 1/15/2026 at 11:24 am, the DNS revealed that BiPAP masks and tubing should be placed in a bag. The DNS further stated that potential negatives outcomes of not following this process could lead to the equipment not being clean and exposure to germs. The DNS further confirmed that the BiPAP orders were added on 1/12/2026 and acknowledged that it was after the observations of the unbagged BiPAP.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observations, resident and staff interviews, and record review, the facility failed to ensure that one of two residents (R) (R9) received care and services for the provision of hemodialysis in accordance with professional standards of practice, including ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. This failure had the potential to cause delays in the identification and treatment of dialysis and related complications, including fluid overload, electrolyte imbalances, and access site complications.Findings included:The facility was unable to provide a dialysis policy. A review of the electronic medical record (EMR) for R9 revealed no communication documents to indicate that information was exchanged with the dialysis center. The record revealed multiple instances of missing or incomplete documentation related to communication between the facility and the dialysis center. A review of R9's physician orders dated 1/12/2026 documented, Location: Right upper extremity AV fistula DO NOT use the access site arm to take blood samples, blood pressure, administer IV fluids, or give injections. 1/12/2026 A review of R9's physician orders dated 1/12/2026 documented, Dialysis: Appointment Monday, Wednesday, Friday. During an interview on 1/12/2026 at 10:21 am, R9 revealed she attended dialysis three times weekly and did not voice concerns regarding her dialysis care or transportation. During an interview on 1/12/2026 at 10:10 am, Licensed Practical Nurse (LPN) CC revealed that when asked about the process for sending the resident to the dialysis center and whether any communication was sent with the resident, she said she believed a book was used for communication, but was not sure. When asked if any documentation of communication was entered into the resident's medical record, she replied that she was not sure. During an interview on 1/16/2026 at 10:55 am, LPN BB revealed that when asked about dialysis resident management, she stated that vital signs were obtained before leaving for dialysis and again upon return from dialysis treatment. She stated that she was unsure whether residents were weighed before and after dialysis, explaining that she had not personally prepared a resident for transport to the dialysis center. During an interview on 1/16/2026 at 11:45 am, Certified Nursing Assistant (CNA) JJ revealed that he was responsible for obtaining resident weights in the facility. He stated that he did not always obtain weights for residents who attend dialysis treatments, explaining that staff generally relied on the weights obtained at the dialysis center. During an interview on 1/14/2026 at 2:40 pm, the Director of Nursing Services (DNS) stated that R9 was expected to have a dialysis communication book that accompanied the resident to and from the dialysis center. The DON further confirmed that there was no documentation in R9's medical record reflecting daily communication with the dialysis center. Following the interview, the DON provided printouts of the dialysis center's vital sign reports for review. During an interview on 1/12/2026 at 3:03 pm, the Unit Manager stated she was unaware of R9's (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis appointment today. During an additional interview on 1/12/2026 at 3:06 pm, the DNS confirmed that there were no orders for R9's dialysis in the EMR, but confirmed that there should be. The DNS further confirmed that a skin assessment was completed for R9 upon admission, but there was no indication of R9 having a shunt or being a dialysis resident from the skin assessment.