STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115410	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Limestone	2560 Flintridge Road Gainesville, GA 30501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on resident and staff interview, record review, review of the Resident Assessment Instrument (RAI) manual, and review of the facility's policy titled MDS Assessment Accuracy, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurate for two of 34 sampled residents (R) (R47 and R102). The failure to accurately code/assess the resident's condition had the potential to affect the care planning for the resident to receive all required services or services post-discharge. Findings include: Review of the October 2024 Resident Assessment Instrument (RAI) Manual, page N-3 revealed: Steps for Assessment 1. Review the resident's medication administration records for the 7-day look-back period (or since admission/entry or reentry if less than 7 days). 2. Determine if the resident received insulin injections during the look-back period. 3. Determine if the physician (or nurse practitioner, physician assistant, or clinical nurse specialist if allowable under state licensure laws) changed the resident's insulin orders during the look-back period. 4. Count the number of days insulin injections were received and/or insulin orders changed. Page 2-39: Discharge Assessment-Return Not Anticipated. -Must be completed when the resident is discharged from the facility and the resident is not expected to return to the facility within 30 days. -Must be completed . within 14 days after the discharge date -Consists of demographic, administrative, and clinical items. Page 2-42 (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Item Rationale -This item documents the location to which the resident is being discharged at the time of discharge. Knowing the setting to which the individual was discharged helps to inform discharge planning. -Demographic and outcome information. Steps for Assessment 1. Review the medical record, including the discharge plan and discharge orders, for documentation of discharge location. Review of the facility's policy titled MDS Assessment Accuracy, reviewed 1/11/2024, revealed: Policy Statement: It is the policy of this healthcare center that each Minimum Data Set (MDS) reflect the acuity and the medical status of each patient/resident in accordance with acceptable professional standards and practices. Procedure: . 6. All MDS Assessments must be completed following the guidance set forth in the RAI manual as directed by the Centers for Medicare and Medicaid Services (CMS). 1. Review of R47's admission MDS located under RAI 3.0 MDS tab of electronic medical record (EMR) with an assessment reference date (ARD) of 3/19/2025, showed in Section N Medications R47 was coded for having received insulin injections for seven of the seven days of the assessment look-back period. The admission MDS also showed R47 had a Brief Interview for Mental Status score of 13 out of a possible 15, indicative of being cognitively intact. Review of R47's EMR Resident Orders tab showed no insulin currently ordered, and review of the Medication Administration Record (MAR) for March showed no insulin administered. During an interview on 6/10/2025 at 9:07 am, R47 denied she used insulin. During an interview 6/10/2025 at 4:25 pm with the MDS Coordinators (MDSC) 1 reviewed the medications MDS section and confirmed R47 had been coded for seven days of insulin injections. MDSC1 and MDSC3 reviewed R47's EMR, and MDSC1 stated, She didn't have any, I don't see any. MDSC1 confirmed that the insulin was coded incorrectly. 2. Review of R102 closed record revealed that R102's Resident Progress Note located under the Progress Notes tab of the EMR indicated, 3/18/2025 at 11:43 am Discharge. Follow-up call placed to resident. She stated that she doing well and will be partaking in therapy PT [physical therapy] with a local company near her home. [sic] (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R102's MDS located under the RAI MDS 3.0 tab of the EMR revealed a Discharge Return Not Anticipated with an ARD of 3/12/2025. Section A showed R102 was coded as discharged to a Short-Term General Hospital. During an interview on 6/10/2025 at 4:32 pm, MDSC1 read the progress note aloud, and MDSC3 stated, It looks like she went home. MDSC1 replied, no, it states she is receiving PT near her home. MDSC2 pulled up the discharge summary and stated, she went home alone MDSC1 reviewed the Discharge Return Not Anticipated (DCRNA) MDS and stated it was coded she went to the hospital - that's wrong too. During an interview on 6/12/2025 at 4:54 pm, the Director of Nursing (DON) stated that the expectation was that the MDS assessments are very accurate and timely.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on staff interview and record review, the facility failed to submit a Pre-admission Screening and Resident Review (PASRR) Level I Assessment after a new mental illness diagnosis and treatment was prescribed for one of three residents (R) (R84) reviewed for PASRR. This had the potential for inadequate care planning, increased risk of behavioral issues, and/or missed opportunities for specialized services. Findings include: A facility policy for PASSR was requested, and the Administrator stated they do not have a PASRR policy. Review of R84's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 5/5/2025, located in the Resident Assessment Instrument (RAI) tab of the Electronic Medical Record (EMR), revealed an admission date of 3/1/2024, had a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating moderate cognition impairment, and had diagnosis of unspecified dementia, severe, with agitation, depression, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Review of R84's Pre-admission Screening/Resident Review (PASRR) Level I Assessment, dated 3/1/2024, located in the EMR under the Resident Document tab, revealed 1. Does the individual have a primary (Axis I) diagnosis of dementia? No. 4. Does the individual have a Primary Diagnosis of Serious Mental illness, developmental disability, or related condition? No. b. Does the treatment history indicate the individual has experienced at least one of the following? . (2) An episode of significant disruption to the normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials. Review of R84's care plan, dated 1/11/2025, located in the EMR under the Care Plan tab, revealed R84 has socially inappropriate/disruptive behavioral symptoms as evidenced by: hitting other residents. An intervention included Assess whether the behavior endangers the resident and/or others. Intervene if necessary. Review of R84's State reported investigation, dated 2/26/2025, provided by the facility revealed [Resident's name] entered R84's room. R84 instructed her to get out of her room and then hit [Resident's name] with her shoe. No injury to either patient. Police were notified. Review of R84's February 2025 medication administration record located in the EMR under the Order tab revealed haloperidol tablet 2 mg [milligrams]; Amount to Administer: 2 mg; oral, dated 2/26/2025, with the indication of use indicating unspecified psychosis not due to a substance or known physiological condition. Review of R84's CCD [Continuity of Care Document] located in the EMR under the CCD tab revealed a diagnosis of Unspecified psychosis not due to a substance or known physiological condition, dated 2/26/2025. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/9/2025 at 2:05 pm, the Social Services Director (SSD) was asked who completed the PASRR Level I's. The SSD stated she did not complete the PASRRs but thought it was the admission Director (AD)1 who did the PASRRs. During an interview on 6/11/2025 at 1:27 pm, AD1, was asked about PASRRs. AD1 stated she completed the initial PASRR Level I's if a resident was not admitted with one from the hospital. AD1 was asked if she submitted another Level I if a resident had a new mental illness diagnosis that was treated with an antipsychotic medication, such as R84. AD1 stated she did not do that, and she wasn't sure who did the updates, but thought it might be MDS Coordinator (MDSC)1. During an interview on 6/12/2025 at 8:32 am, MDSC1 was asked if she had completed the PASRRs. MDSSC1 stated she doesn't do the PASRRs. During an interview on 6/12/2025 at 8:37 am, the Administrator was asked if another PASRR was submitted for R84's new diagnosis of psychosis that was added on 2/26/2025, along with the treatment with Haldol related to the new diagnosis. The Administrator stated the DON would have completed a new PASRR, but she would look to see if it's a new diagnosis and get back with the surveyor.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, record review, and review of the facility's policy titled Occurrences, the facility failed to thoroughly investigate falls that resulted in injuries for four of 10 residents (R) (R306, R43, R73, and R204) reviewed for accidents. This had the potential to fail to identify risk factors, prevent future falls, understand the circumstances of the incident, and improve safety measures. Findings included: Review of a facility policy titled Occurrences, revision date 1/11/2024, revealed, The healthcare center recognizes that due to the frailty of the patients/residents served, there is an increased risk of occurrences that may result in injury to the patient/resident and/or others. To prevent occurrences, each patient/resident will be observed and assessed for risks. Appropriate, realistic interventions will be implemented in accordance with their plan of care .If occurrence is noted without direct staff observation, the incident entry must be completed in the software system on the shift the occurrence was reported .Upon arrival, the licensed nurse will be responsible for providing immediate medical attention as follows: .Notifies attending physician or designee, informing them of the occurrence and patient/resident's condition .Notifies the responsible party .The licensed nurse will be responsible for completing the following occurrence documentation requirements prior to the end of the shift when the occurrence took place. This documentation will be noted in the patient/resident's clinical record .obtain any witness statements that may be needed before end of shift .Clinical record occurrence documentation will include: .The date and time the occurrence happened .The circumstances surrounding the occurrence .Where the occurrence happened . The time the injured person's attending physician was notified, as well as the time the physician responded back .The time and name of the responsible party notified .Addition of care plan interventions in effort to decrease the risk of additional occurrences .Occurrence investigation and follow-up is a joint responsibility within the healthcare center .Director of Health Services (DHS) will be responsible to review each occurrence for thorough investigation, documenting the investigation in the patient/resident care software occurrence report and appropriate care plan interventions are put in place to decrease risk for repeated occurrences. 1. Review of R306's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 8/6/2024, located in the Resident Assessment Instrument (RAI) tab of the Electronic Medical Record (EMR), revealed an admission date of 8/2/2024, had a Brief Interview for Mental Status (BIMS) score of 99 indicating severe cognition impairment, and had diagnosis of a stroke, traumatic subarachnoid hemorrhage without loss of consciousness, subsequent encounter, and unspecified fracture of occiput, subsequent encounter for fracture with routine healing. Review of R306's fall risk evaluation, dated 8/2/2024, located in the EMR under the Observation tab, revealed R306 was high risk for fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R306's care plan, revised 8/2/2024, located in the EMR under the RAI tab revealed Problem: R306 is at risk for falls related to recent hospitalization, hx [history] of falls. Fall score = 75. 8/27/2024 unwitnessed fall, non-injury,8/28/2024 unwitnessed fall no injury, 8/29/2024 unwitnessed fall, unwitnessed Fall on 8/31/202024 & sent to [hospital] for eval [evaluation]. Approaches include Redirect R306 to resident common areas, dated 8/29/2024, R306 to wear non slip socks while out of bed to decrease chances of falling, dated 8/29/2024, Keep R306's door open for better visualization while she is in the room as she allows, outside of care, dated 8/28/2024, Keep environment safe, dated 8/02/2024, Assist for toileting and transfers PRN [as needed], dated 8/2/2024, Cue for safety awareness, dated 8/2/2024, and Place call light within reach, dated 8/2/2024. Review of R306's Safety Events located in the EMR under the Observation tab revealed a fall history that included: on 8/27/2024 an unwitnessed fall in R306's room with no injury; on 8/28/2025 an unwitnessed fall in the kitchen with no injury; on 08/29/2025 an unwitnessed fall in R306's room with no injury, and on 8/31/2025 an unwitnessed fall in R306's room with a head injury and was sent to the hospital. Review of R306's progress note, dated 8/31/2024, located in the EMR under the Progress Note revealed about 8:30 pm, when CNA [Certified Nurse Aide] checked, Resident found lying on floor with head injury. Resident LOA [leave of absence] to hospital for eval [evaluation]. family notified Dr [name] notified it un witness fall. [sic] Review of R306's hospital records, dated 8/31/2024 to 9/01/2024, provided by the facility revealed Principal Problem: Subdural hematoma . During an interview on 6/11/2025 at 4:03 pm, Licensed Practical Nurse Unit Manager (LPNUM) 2 was asked about R306's four falls. LPNUM2 stated she didn't remember R306 too much or her falls, as it was a while ago, and R306 was discharged ten months ago. LPNUM2 was asked if she would expect a new intervention to be put in place after a fall. LPNUM2 stated, Yes, absolutely. LPNUM2 was asked when R306 fell in her room, was R306 in her wheelchair or bed, as the fall incident report only reflected in room. LPNUM2 stated it's been too long since, but thought R306 had a problem sleeping at night. LPNUM2 went on to say R306 would transfer herself into her wheelchair, and that was most likely when she would fall. During a follow-up interview on 6/11/2025 at 4:23 pm, LPNUM2 stated that after reviewing the EMR, her assumption would be that R306 was transferring herself from the bed to the wheelchair or vice versa during the times she fell. LPNUM2 was asked who completed R306's Safety Event investigation reports. LPNUM2 stated, Safety Events are completed by the charge nurse. LPNUM2 confirmed the Safety Events lacked documentation of an established pattern of R306's falls and pertinent details of what led to her falls, such as Was R306 in her wheelchair or bed at the time of her fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2025 at 4:55 pm, the Director of Nursing (DON) was asked about R306's falls and investigations. DON stated that the investigations are initiated by the nurse on duty, and the next day, they are completed by the Unit Manager. DON stated that the fall investigations should have shown which interventions were in place, to show whether something did or did not work. DON went on to say, We want a complete picture. The DON confirmed that the actual interviews with the staff were not being documented, and the nurses should be doing that. The DON stated that the Safety Event form is the initial, and the post form should include the root cause analysis. The DON stated the nurses should also do an SBAR [Situation, Background, Assessment, and Recommendation], a Morse fall, and a skin assessment. The DON confirmed these items were not completed for R306. DON stated R306's information included in the Safety Events report lacked pertinent details. DON acknowledged that the care plan interventions were not documented, whether they were used or not, in the Safety Events, which prevented them from being evaluated to determine if the interventions were effective or not. 2. Review of 43's quarterly MDS, dated [DATE], located in the EMR under the RAI tab, revealed that for chair/bed-to-chair transfers, R43 required Partial/moderate assistance. Further review of R43's quarterly MDS, with an ARD of 5/22/2025 located in the EMR under the RAI tab revealed an admission date of 7/02/2024, had a BIMS score of five out of 15, indicating severe cognition impairment, and diagnosis of unspecified fracture of lower end of right humerus, subsequent encounter for fracture with routine healing, hypertension, and atrial fibrillation. Review of R43's care plan, revised 7/2/2024, located in the EMR under the RAI tab, revealed R43 is at risk for falls related to: CVA [cerebral vascular accident] and a History of falls. Fall noted on 9/13/2024. Fall noted on 10-30-2024, Witnessed Fall 1/18/2025, Unwitnessed Fall 2/8/2025. Approaches include Requires 2 Person Assist with Transfers dated 5/9/2025. Staff to apply gripper socks to R43 to prevent slipping when getting out of bed, dated 2/10/2025; Add Concave Mattress to Bed, dated 2/8/2025; Staff Education Transfers, dated 1/18/2025; Keep most used items within reach. (Purse), dated 10/30/2024; Staff to frequently check on and provide reorientation to resident, dated 9/13/2024, Assist for toileting and transfers PRN, dated 7/2/2024, Cue for safety awareness, and Place call light within reach. Review of R43's fall risk evaluation, dated 9/13/2024, revealed low risk for falls, and R43's fall risk evaluations dated 10/30/2024, 1/18/2024, and 2/18/2024 revealed high risk for falls. Review of R43's Safey Events fall history, located in the EMR under the Observation tab revealed on 9/13/2024 an unwitnessed fall in R43's room with no injury, on 10/30/2024 an unwitnessed fall in R43's room with no injury, on 1/18/2025 a witnessed fall in R43's room with no injury, and on 2/8/2025 an unwitnessed fall in R43's room with an injury to the right humerus and R43 was sent to the emergency room (ER). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R43's progress note, dated 2/8/2025 at 7:17 am, located in the Progress Note tab revealed This nurse was called by Nurse [name] to help w/ [with] neuro [neurological] checks following a fall from bed at 5:20 am. VS [vital signs] stable and neuro checks good. At 6:10 am, resident was noted to be holding the left side of her head and c/o [complaint of] a headache and pain to her right arm. Upon inspection, a bump was noted to her head along with localized pain to her right elbow. At 6:15 am, on call physician ordered her sent to ED [emergency department] due to resident being on Eliquis [a medication used to prevent blood clots]. Paramedics transferred her along with bed hold policy. 3 attempts were made to contact her emergency contact, but calls went straight to VM [voice mail], which was full. [sic] Review of R43's progress note, dated 2/8/2025 at 10:32 am, revealed Placed call to family member to update on R43's fall. This nurse spoke with [family member], [name], and provided update that patient had fallen from bed and was sent to the ER [emergency room] at [name] for eval per MD [physician] order. [Family member] asked to be called back once an update was provided from the ER. Review of R43's progress note, dated 2/8/2025 at 11:00 am, revealed Approximately 1100 resident returned from [hospital name] via stretcher in stable condition. Alert, calm, cooperative, and incontinent. Arrived with a new diagnosis of closed nondisplaced fracture of distal end of right humerus post fall. Ace bandage in place and sling also in place to her rue [right upper extremity] . [sic] On 6/10/2025 at 10:25 pm, R43 was observed asleep in her bed with a purse on her lap, an overbed table in reach, and the television next to her. R43 had a concave mattress in use. During an interview on 6/11/2025 at 1:14 pm, the DON was asked about R43's falls on 2/8/2025 and 1/18/2025, and if there was more information in the investigation other than the fall occurring in R43's room. DON stated she would have to review the record. DON was also asked why R43 fell out of bed on 2/8/2025. The DON stated she would look into it and get back. During an interview on 6/11/2025 at 2:19 pm, LPNUM1 was asked about R43's falls. LPNUM1 stated she thought R43 had a UTI [urinary tract infection] and was getting up to go to the bathroom. LPNUM1 was asked what was in place currently to prevent future falls. LPNUM1 stated that a concave mattress was placed on R43's bed, and her UTI was treated. LPNUM1 stated, R43 was not able to take herself to the bathroom, and she gets confused. LPNUM1 was asked if that was all the interventions. LPNUM1 stated R43 was in the first room on the hall for frequent checks, and her bed was in a lower position. During an interview on 6/12/2025 at 2:51 pm, Certified Nurse Aide (CNA)5 was asked what fall interventions were in place to keep R43 from falling out of bed. CNA5 stated just to keep her bed in a low position, but she wasn't aware R43 had fallen. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/12/2025 at 5:02 pm, the DON was asked about R43's fall on 2/8/2025 and the investigation. DON stated that the investigations are initiated by the nurse on duty, and the next day, they were completed by the Unit Manager. The DON was asked for more information on R43's fall interventions. DON stated she would need to look at the care plan. The DON was asked if only marking the fall occurred in the Resident Room on the Safety Event reports was enough, and not including what the resident was doing or where the resident was in the room was sufficient and the DON stated, No, pertinent details needed to be added to the Safety Events report. The DON confirmed the Safety Event reports should include the full picture of events, and the post-fall was the follow-up, which should include what worked or didn't work for R43. The DON stated that the root cause analysis should be included in the Safety Event post-fall report. The DON further stated R43's Safety Events reports also lacked pertinent details. The DON acknowledged that the care plan interventions were not documented to determine if they were used in the Safety Events, which prevented them from evaluating whether the interventions were effective or not. 3. Review of R204's Face Sheet, located in the resident's EMR under the Face Sheet tab revealed the resident was admitted to the facility on [DATE] with diagnoses that included spondylosis without myelopathy or radiculopathy, cervical region, unsteadiness on feet, difficulty in walking, muscle weakness, and history of unspecified fall. The resident was discharged to the hospital on 5/17/2024. Review of R204's admission MDS with an Assessment Reference Date (ARD) of 5/2/2024, located in the resident's EMR under the MDS tab, indicated the facility assessed R204 to have a BIMS score of seven out of 15, indicating R204 had significant cognitive impairment. The MDS also indicated R204 was dependent on staff for toileting, and required substantial/maximal assistance for sit-to-stand, toilet transfer, and chair/bed-to-chair transfer. The resident had a fall in the last month prior to admission/entry or reentry. Review of R204's Care Plan, dated 4/30/2024 in the EMR under the Care Plan tab, indicated the resident was at risk of falls related to a recent hospitalization. The interventions included to assist with toileting and transfers as needed, place call light within reach, to keep environment safe and path free from obstruction, and to cue for safety awareness to verify R204 understood the need for fall prevention measures. Record review of R204's Progress Notes in the EMR under the Progress Notes tab, documented a progress note on 5/17/2024 at 5:30 am, that CNA notified resident was on the floor. The resident was bleeding from the head and arm. CNA put towel on resident head to stop bleeding .resident was alert but didn't know where he was .the nurse called EMS (emergency medical services). EMS personnel put a bandage on his head and took to hospital . [sic] Record review of R204's Transfer Form documented that the resident was discharged to the hospital on 5/17/2024 at 5:30 am due to a fall and hitting his head. The physician and resident representative were not documented as having been notified of the transfer. Record review of R204's Fall Form documented on 5/17/2024 and completed on 5/23/2024 revealed that the CNA notified resident was on the floor. The event detail noted that the resident was going to the refrigerator in his room just prior to the fall; however, the fall was documented as not witnessed. The documentation of the fall investigation failed to document staff interviews, observations of the resident at the time of the fall, including interventions in place, a resident interview, or a root cause analysis. (continued on next page)

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	115410	A. Building B. Wing	06/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pruitthealth - Limestone	2560 Flintridge Road Gainesville, GA 30501

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of R204's Post Fall Observation documented on 5/17/2024, revealed that the CNA reported that the resident had fallen on the floor. The fall was unwitnessed. The event detail again noted that the resident fell on the floor trying to get to the refrigerator. Again, the documentation failed to record staff interviews, a resident interview, or the potential root cause analysis. 4. During an interview on 6/9/2025 at 1:40 pm, R73 was observed seated in her wheelchair in her room with an observed large yellowing left orbital bruise and a cast over her left hand, wrist, and forearm. When asked what happened, R73 responded, I guess I fell. When asked if that fall happened at home or here in the facility, R73 did not know. Review of R73's EMR Resident Progress Notes tab showed: 5/24/2025 at 2:28 PM Resident found on floor of room after CNA [Certified Nursing Assistant] had just left room, noticed two small lacerations to left eyebrow outer edge and swelling to left wrist noted. R73 was sent to the hospital, admitted , and returned to the facility on 5/29/2025. Review of the Fall Event completed the date of the fall showed the same information as in the progress note, did not include any staff interviews or root cause analysis of why the fall happened. Review of the Post Fall Observation showed a completion date of 6/9/2025 but did not include any interviews of staff that was working with R73 the shift of the fall or a root cause analysis of why the fall happened to add an intervention that could keep the fall from recurring. During an interview on 6/11/2025 at 1:46 pm, the LPNUM2, author of the Post Fall Observation, was asked about the delay from the 5/29/2025 readmit date to the 6/9/2025 completion date, LPNUM2 stated, I try to do them as effectively as possible. During an interview on 6/12/2025 at 4:55 pm, the DON stated the nurse on duty should immediately do the event report, what was the resident doing, what happened, ask the CNAs what happened, it's the full detail of what happened, and it's used to prevent another fall. The post-fall observation is the follow-up to ensure all the information is there. The post-fall should be done by the next day. When asked about R73's post-fall observation completion date of 6/9/2025, the DON stated, It's late; root cause analysis [RCA] is not possible to be determined that many days later. The DON confirmed the RCA is supposed to be identified in the post-fall analysis, and there were no staff interviews documented in either report.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observations, resident and staff interviews, and record review, the facility failed to follow the menus and/or provided varied menus for four (R) (R8, R4, R803, and R701) of six residents reviewed for food. This deficient practice had the potential to place R8, R4, R803, and R701at risk of weight loss and a decreased quality of life. Findings include: A facility policy for menus was requested, and the Administrator stated there was no menu policy. 1. Review of R8's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) dated 4/24/2025, located in the Resident Assessment Instrument (RAI) tab of the Electronic Medical Report (EMR), revealed an admission date of 10/28/2017, had a Brief Interview for Mental Status (BIMS) score of three out of 15, indicating severe cognition impairment, and had diagnosis of Alzheimer's disease, type 2 diabetes mellitus without complications, and dysphagia, oropharyngeal phase. Review of R8's diet order, dated 5/28/2025, located in the EMR under the Order tab, revealed CCHO [carbohydrate controlled] NAS [no added salt], Puree. Review of R8's care plan, dated 10/20/2024, located in the EMR under the RAI tab, revealed R8 is at risk for alteration in nutritional and hydration status related to HTN [hypertension] and diabetes. R8 receives a therapeutic and mechanically altered diet R/T [related to] missing teeth and comorbidities. An intervention included Diet as ordered. Observation on 6/9/2025 at 1:09 pm revealed R8 was served lunch that included regular textured mixed vegetables with carrots and broccoli, ground pork, regular textured Au gratin potatoes, pudding, and tea. Review of the week-one 2025 spreadsheet revealed that for 6/9/2025, the pureed lunch menu included puree baked pork chop, puree Au gratin potatoes, puree brussel sprouts, and a puree brownie. Observation on 6/10/2025 at 8:58 am revealed R8 was served breakfast that included a portion of firm, partially pureed oatmeal with texture, pureed bacon, yogurt, a supplement, milk, and apple juice. Review of the week-one 2025 spreadsheet revealed that for 6/10/2025, the pureed breakfast menu included pureed hot cereal, pureed scrambled eggs, and pureed bacon. Observation on 6/10/2025 at 12:55 pm revealed R8 was served lunch that included a portion of firm, partially pureed rice with texture, pureed meat, pureed mixed vegetables, pudding, beverage, and a frozen supplement. R8 tried to drink the supplement from a small carton but said, It's frozen. Certified Medication Aide (CMA)3 put a straw in the carton, but R8 was unable to drink it. R8 attempted to use a spoon to consume the supplement. Review of the week-one 2025 spreadsheet revealed that for 6/10/2025, the pureed lunch menu included puree fajita meat, puree rice, and apple sauce. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 6/11/2025 at 8:31 am revealed R8 was served breakfast that included yogurt, a large portion of ground sausage with gravy, milk, juice, a supplement, and a portion of firm pureed oatmeal with texture. CNA8 set up R8's tray and confirmed R8's diet should be pureed, and the sausage appeared to be ground. Review of R8's breakfast meal ticket, dated 6/11/2025, provided by the facility revealed CCHO NAS pureed, disliked eggs. Review of the week-one 2025 spreadsheet revealed that for 6/11/2025, the pureed breakfast menu included puree oatmeal, puree cheese and egg casserole, puree sausage link, and puree bread. During an interview on 6/11/2025 at 9:05 am, the Registered Dietitian (RD) was asked about her oversight for the Dietary Manager (DM) and who was making sure menus were followed, as R8 wasn't always receiving the puree texture. The RD stated that R8 was very particular about her textures. The RD stated she just met the new DM today, 6/11/2025. During an interview on 6/12/2025 at 8:01 am, the Certified Dietary Manager (CDM) was asked why R8 received ground sausage and no bread at breakfast on 6/11/2025. The CDM stated she wasn't sure, as she was from another facility and was here assisting the DM in his new position. On 6/12/2025 at 12:11 pm, a puree test tray was sampled with the CDM that included puree turkey with gravy, Au Gratin potatoes, and mixed vegetables. The CDM confirmed that the mixed vegetables included broccoli and carrots. Review of the week-one menus for 2025 revealed that mixed vegetables, which included broccoli and carrots, were served at lunch and dinner the day before, on 6/11/2025. During an interview on 6/12/2025 at 12:14 pm, the CDM was asked about the pureed texture of foods served during the survey. The CDM stated she was aware of the problem with the puree texture, and she had retrained the dietary staff. The CDM was asked if she was aware of residents' complaining about too many of the same foods on the menu, such as too many of the same vegetables, and she stated that she would review the menus. 3. During an interview on 6/11/2025 at 5:06 pm, R4 stated she couldn't eat her lunch, as she had been served too much of the same thing. Review of the week-one 2025 spreadsheet revealed that for 6/11/2025, the lunch menu included chicken alfredo, a Bahama vegetable blend (including broccoli and carrots), and peaches. 4. During the Resident council interview on 6/11/25 at 1:52 pm, R803 and R701 expressed complaints about too much of the same foods being served, a lack of variety, especially with the vegetables. Review of the week-at-a-glance week-one, dated 6/8/2025 through 6/14/2025, provided by the facility, revealed that side dishes of a similar type of mixed vegetables that included broccoli, carrots, and other vegetables were listed on the menu five times, and potatoes were listed six times. During an interview on 6/12/2025 at 6:23 pm, the Administrator stated the facility had a Performance Improvement Plan (PIP) for food palatability and provided a binder with details such as food temperature logs, meal delivery times, dietary in-services on food temperatures, and initiation of a food committee. No information was found pertaining to resident complaints of repetitive menus. The Administrator confirmed the menus were not included in the PIP.

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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. Based on observation, staff interviews, and review of the facility policy titled Infection Prevention - Hand Hygiene, the facility failed to provide resident care in accordance with infection control standards of care for two of three sampled residents (R) (R21 and R56) observed for incontinence care of sample of 49 residents. This deficient practice had the potential to lead to the transmission of infections between residents. Findings include: Review of the facility's policy titled, Infection Prevention - Hand Hygiene dated 10/15/24 provided by the facility indicated: .D. Indications Requiring Hand Wash or Hand Rub included 6. When hands move from a contaminated body site to a clean body site during resident care. and 7. Immediately after removal of personal protective equipment (e.g., gloves, gown, facemasks). During an observation on 6/11/2025 at 10:45 am, of R21's incontinent care, Certified Nurse Aide (CNA)5 failed to wash her hands after she discarded the dirty brief and dirty gloves prior to donning clean gloves to apply the clean brief. During an observation on 6/11/2025 at 11:05 am, of R56's incontinent care, CNA8 failed to wash her hands after she discarded the dirty brief and dirty gloves prior to donning clean gloves to apply the clean brief. During an interview on 6/11/2025 at 11:20 am, CNA8 stated that she had received training on handwashing and that she was trained to wash her hands after discarding the dirty brief and dirty gloves, but missed this step. During an interview on 6/12/2025 at 11:30 am, the Infection Preventionist (IP) stated that the CNAs were expected to wash their hands after doffing dirty gloves. The IP stated that she audited hand hygiene one to two times a week by staff observation. During an interview on 6/11/2025 at 2:50 pm, the Director of Nursing (DON) stated that her expectation going forward regarding handwashing practices during care is that staff will wash their hands in between clean and dirty care processes.