STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115423	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Ridge Nsg & Rehab Ctr	125 Samaritan Drive Cumming, GA 30040

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, record review, and facility policy titled Housekeeping Operations Manual, the facility failed to ensure the dining room, and 2 of 2 communal shower rooms were maintained in a safe, clean, comfortable and homelike environment. The deficient practice had the potential to affect patient comfort and safety. Findings include:Review of the undated document titled Housekeeping Operations Manual, documented The main area of concern to a housekeeping department in a healthcare facility is the transmission of bacteria.Observation of the women's communal bathroom on 03/02/2026 at 11:48 AM, 03/04/2026 at 12:18 PM and 2:48 PM, revealed on a shelf: numerous bottles of shampoo, lotion, grooming items scattered across the surface; hairbrush, scissors, wipes, lotions, and cleaning products were observed intermixed and unlabeled. There were small pieces of debris scattered across the shower room floor and appeared unclean and unsanitary with residue along the lower portion of the tile wall. Used washcloths were observed on the hand grab bar, a resident gown was draped over a wheelchair holding both clean and used linen and a dirty slipper sock was on the floor in front of the toilet. The foam pad on the shower stretcher had small openings with debris accumulation in the foam. In addition, observation of the men's communal shower revealed clutter with multiple personal items including thera-gel shampoo, a resident hat, a used electric shaver, baby lotion, open containers of wipes and briefs.Observation of the dining room on 03/03/2026 at 3:03 PM, revealed used silverware, trash and a cookie on the floor and trash on the dining area tables. The dining tables and floor were sticky and did not appear to have been recently wiped or mopped.Interview with CNA QQ on 03/04/2026 at 12:20 PM, stated the nursing assistants are supposed to clean the shower rooms after each resident use.Interview with the Housekeeping Director (HKD) on 03/04/2026 at 12:30 PM, stated the multi-use showers are cleaned at 8:00 AM, 12:00 PM, and 3:00 PM, and the CNAs are supposed to clean them following each use and make sure the towels are removed following use. Interview with the Regional Nurse Consultant n 03/04/2026 at 2:56 PM, confirmed the lack of cleanliness during a tour of the men's and women's bathrooms. Interview with CNA SS on 03/05/2026 8:25 AM, stated the shower chair and bath stretcher should be sanitized between uses, even if it's just rinsed, the water still has body fluids from the previous resident. CAN SS stated she has not been trained to sanitize the equipment, but the equipment should be sprayed off after use.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observations, record review, staff interviews, review of the facility's policies titled Administering Medications, the facility failed to ensure accurate administration of medications for six of 25 medication opportunities observed, resulting in a medication error rate of 24% (percent.) The deficient practice increased the risk of adverse clinical outcomes. Findings Include:Review of the facility's policy titled, Administering Medications, dated 2/2020 documented that Medications shall be administered in a safe and timely manner, and as prescribed.Observation on 03/04/2026 at 9:26 AM on A-Hall with Licensed Practical Nurse (LPN) DD revealed resident (R) R106 had physician orders for Glipizide 10 mg {milligrams}, give 1 tablet by mouth twice daily for Diabetes Mellitus (DM), and Fluticasone-Salmeterol inhalation powder 500/50 mcg {micrograms}, inhale 1 puff orally twice daily for Chronic Obstructive Pulmonary Disease (COPD). These medications were not administered due to lack of availability, and the physician was not notified of the missed doses. During the same medication administration observation, LPN DD administered Isosorbide Mononitrate ER {extended release} 120 mg, ordered as 1 tablet by mouth in the morning for hypertension (HTN), incorrectly by giving one 60 mg tablet instead of two tablets to equal 120 mg. The medication card contained a written note stating Give 2 tablets to equal 120 mg. The nurse also administered Clonidine HCL {hydrochloride} 0.1 mg, ordered every 12 hours as needed for HTN if systolic blood pressure >160 or diastolic >100; however, the medication was given when the resident's blood pressure was 150/59, which was outside the ordered parameters. Additionally, the nurse administered Allopurinol incorrectly by giving three 100 mg tablets (300 mg total) when the physician's order was Allopurinol 300 mg, give 2 tablets by mouth in the morning (600 mg total) for gout flare.Observation on 03/04/2026 at 10:29 AM on A-Hall with LPN DD revealed R103 had physician orders for Pantoprazole Sodium oral tablet Delayed Release 40 mg, give 1 tablet by mouth one time a day for GERD (Gastroesophageal Reflux Disease). The medication was observed to be crushed; however, Pantoprazole is a delayed-release medication and should not be crushed.Interview on 03/04/2026 at 2:05 PM with LPN DD regarding medication administration errors revealed that she acknowledged that Pantoprazole should not have been crushed, stating she knew it was a delayed-release medication that would act faster than intended and that she would notify the physician. Regarding Clonidine, the nurse stated she usually administers it in the morning and has never noticed those parameters before. Regarding Allopurinol, the nurse stated she did not realize the dosing error and requested the Unit Manager to pull additional medication from Pyxis {med dispensing machine.}Interview on 03/05/2026 at 11:05 AM with Director of Nursing (DON) revealed that she expects to maintain medication error rates below 5 percent and emphasized that nursing staff should consistently follow proper medication administration procedures.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, staff and resident interviews, record review, and review of the facility policies titled Handwashing/Hand Hygiene, Insulin Administration, Housekeeping-Infection Control Procedures, and Cleaning and Disinfection of Resident-Care Items and Equipment, the facility failed to follow proper infection control practices for one of four nursing units and two of two shower rooms. Specifically, top of an insulin vial not disinfected, blood pressure cuff not disinfected between residents, Housekeeping Aide pouring liquid from resident cup into mop water, and nursing staff exiting resident rooms without removing gloves and performing hand hygiene. In addition, multiple personal items in the communal shower rooms were unlabeled. The deficient practice increased the risk of cross contamination and spread of infection. Facility census was 127.Findings Include: Review of the facility's policy titled, Handwashing/Hand Hygiene, dated 2/2020, revealed that This facility considers hand hygiene the primary means to prevent the spread of infections. Further review of item 5. Hand hygiene is the final step after removing and disposing of personal protective equipment. Item 6. The use of gloves does not replace hand washing/hand hygiene. Review of the facility's policy titled, Insulin Administration revised September 2014, revealed under Steps in the Procedure (Insulin Infections via Syringe) step 8. Disinfect the top of the vial with an alcohol wipe. Review of the facility's policy titled, Cleaning and Disinfection of Resident-Care Items and Equipment dated 1/2023 revealed that Resident-care equipment, including reusable and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA Bloodborne Pathogens Standard. Further review of Item 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturer's instructions. Review of the facility's policy titled Housekeeping-Infection Control Procedures revised 11/2024 on page 69 documented under Infection Control Guidelines that The solution to controlling infection lies not in technology, but in human behavior. Further review revealed that The role of a housekeeping department in the infection control process is to halt the transmission of infectious organisms. 1.Observation and interview on 03/04/2026 at 10:03 AM during medication administration revealed Licensed Practical Nurse (LPN) DD drew insulin for Resident (R) (R106), Lantus (insulin glargine) 34 units subcutaneously for diabetes mellitus, and failed to clean the top of the insulin vial prior to drawing the medication. During interview, LPN DD stated she usually wipes the top of the insulin vial but did not do so on this occasion and acknowledged the infection control concern, stating that contaminants could be introduced onto the needle. Observation and interview on 03/04/2026 at 10:36 AM, during medication administration revealed Licensed Practical Nurse (LPN) DD used the same blood pressure cuff for two residents A04-A and A04-B, who were both on Enhanced Barrier Precautions (EBP), without cleaning or disinfecting the cuff between residents. During interview, LPN DD stated she forgot to wipe down the blood pressure cuff and did not have disinfectant wipes in her medication cart. She left the area to obtain disinfectant wipes and acknowledged the concern for potential contamination and infection transmission. Observation and interview on 03/04/2026 at 3:07 PM revealed Housekeeping Aide GG removed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	several dated resident cups from Room C38 and emptied the contents into the mop bucket she was using to clean resident rooms on the C-Hall. During interview, Housekeeping Aide GG indicated she spoke Creole and no English. At that time, the Director of Housekeeping was present, was informed of the observation, and spoke with Housekeeping Aide GG in English, instructing her to stop pouring used resident cups into the mop bucket. Observation and interview on 03/04/2026 at 3:20 pm revealed Certified Nursing Assistant (CNA) II exited a resident room wearing one glove and carrying a bag of used soiled linen while walking down the hallway to dispose of the bag. During interview, CNA II stated she was not aware that gloves should not be worn in the hallway and believed it was acceptable to do so. Observation and interview on 03/05/2026 at 10:28 AM revealed Registered Nurse (RN) JJ exited a resident room wearing one glove and walked into the hallway toward the medication cart. RN JJ removed the glove, disposed of it, and immediately opened the medication cart, removed items, and walked back toward the resident room without performing hand hygiene. During interview, RN JJ confirmed he did not perform hand hygiene after removing the glove and acknowledged walking through the hallway wearing one glove and touching items in the medication cart without performing hand hygiene. Interview on 03/05/2026 at 11:05 AM with Director of Nursing (DON) revealed that staff should clean the top of insulin vials prior to injecting air or withdrawing medication to maintain a clean surface and prevent infection. The DON stated that gloves should not be worn in hallways after resident care, as they may carry contaminants from resident rooms, and emphasized that staff should perform hand hygiene after glove removal. Additionally, the DON stated that housekeeping staff should dispose of liquids from resident water cups, which may contain saliva, in designated areas such as the restroom, and use appropriate stations for filling mop buckets to maintain sanitation standards. 2. On 03/02/2026 at 11:48 AM, a general tour was conducted of the C Hall communal women's shower room. Observation revealed that Stall 1 contained an unlabeled bottle of shampoo/skin cleanser; in the second stall an open bottle of shampoo/skin cleaner, and a used washcloth was observed on the shower bench; on a shower room shelf there was a half-used bottle of VO5 shampoo, a reusable water bottle, resident clothing and a cell phone. On 03/04/2026 at 12:18 PM, during a follow up tour of the woman's shower room on C Hall, observation revealed an unlabeled container of secret deodorant was open and sitting on the shelf, next to an open, unlabeled bottle of shampoo, power stick 2-in-1 shampoo and conditioner, clean towels and washcloths were sitting on a resident wheelchair with a dirty resident gown. An open bottle of shampoo was observed on the shower stretcher. A used washcloth was left hanging over the shower rail, and a used slipper sock was on the floor in front of the toilet. None of the items were labeled with resident identification. On 03/04/2026 at 12:20 PM, during an interview with CNA QQ, she stated the aides use the residents' personal products for their bathing/showers and if the resident does not have anything they should use the multi-use bottle/product. CNA QQ stated the shower rooms are supposed to be cleaned following each use. CAN QQ confirmed the personal care products were not labeled. She stated she did not know whose belongings were in the shower room. On 03/04/2026 at 12:30 PM, the Housekeeping Director (HKD) stated the communal showers are cleaned at 8:00 AM, 12:00 PM, and 3:00 PM. The HKD stated CNA staff are supposed to clean the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showers following each resident use and make sure the towels/washcloths are removed at the completion of the task. On 03/04/2026 at 2:48 PM, an observation tour of the men's communal shower room revealed personal items comingled. The items included a partially used bottle Thera-gel shampoo, an electric razor, Pantene shampoo and conditioner, and 2 open half used bottles of fresh scent baby lotion. Additionally, the men's shower stretcher had a greenish colored liquid pooling in the center of the foam stretcher. On 03/04/2026 at 2:56 PM, the Regional Nurse Consultant verified the personal care items were mixed in the men's and woman's communal bathrooms and stated she would have the personal items removed.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, observations, staff and resident interviews, and a review of the facility's policy titled Personal Property, the facility failed to promote dignity by not exercising reasonable care and protection to prevent damage to the glasses for one resident (R) (R109) from a sample of 47 residents. The deficient practice had the potential to affect R109 from reaching the highest practicable level of function. Findings include:Review of the Personal Property policy dated 03/2023, documented the facility will promptly investigate any complaints of misappropriation or mistreatment of resident property.On 03/02/2026 at 10:50 AM, R109 was observed in bed wearing broken glasses. R109 showed the arm broken off one side of the glasses and demonstrated that a staff person broke the glasses when something was placed on top of them. R109 stated she informed the nurse when it happened a couple weeks ago and had not heard if they would be repaired or replaced. On 03/04/2026 at 8:55 AM, R109 was observed in bed, wearing glasses that were seated crooked on her face. R109 stated no one has given her any information about getting her glasses replaced/repaired. Record review revealed a physician order for R109 dated 07/16/2024, documented R109 could have ophthalmic (vision care) as needed.Record review of the admission Minimum Data Set (MDS) assessment dated [DATE], coded in Section B that R109 could see adequately and required corrective lenses. Section C coded that R109 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderate cognitive impairment. Section I coded for diagnoses including but not limited to cerebral vascular accident (stroke), and high blood pressure.Record review of R109s care plan initiated 10/22/2024, documented deliver newspaper, or other appropriate reading material, on a regular basis for resident's reading pleasure. The care plan did not specify R109 required glasses for reading.Record review of nursing progress note for R109 dated 02/22/2026 at 6:50 PM, documented resident requested for her brother to buy her new prescription glasses as a CNA {Certified Nursing Assistant} broke them when a meal tray was placed on top of the glasses, notified desk clerk to inform social services for eyeglass replacement.Record review of a follow up social service progress note by Social Service Assistant (SSA) SSA RR dated 02/24/2026 at 1:50 PM, documented received notice resident broke her glasses. Contacted her responsible party who is requesting vision services for R109 to have a new pair of glasses made for her and provided information on [3rd party provider] completed and submitted paperwork for resident to be added to next vision clinic.On 03/04/2026 at 10:30 AM during an interview, SSA RR stated the vision provider makes quarterly visits to the facility and were last here 02/09/2026. The SSA stated if they can't come before the next visit in May, R109 will have to wait. Glasses would take a week or so later to arrive after the vision appointment. He confirmed that it may be mid-May before R109's glasses would be repaired/replaced. On 03/04/2026 at 10:50 AM, licensed practical nurse (LPN) LPN MM stated social services has a list and dates of when vision providers are coming. They are unable to schedule an appointment without an additional order from the provider. There is no order in the system currently for R109 to have a vision appointment scheduled. On 03/04/2026 at 11:29 AM, the Director of Nursing (DON) stated the facility would not delay treatment to get service and confirmed R109's glasses were broken on 02/22/2026. The DON verified the CNA put the meal tray on the glasses and broke them. The DON also confirmed the facility would absorb the cost of the glasses replacement.

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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 record review, staff interviews, and review of the facility policy titled, Abuse Prevention Program, the facility failed to ensure safety and freedom from an act of physical abuse for one resident (R) (R84) from a sample of three residents reviewed for abuse. The deficient practice had the potential to affect the quality of life and safety for other residents. Findings include:Review of the policy titled Preventions of Resident Abuse, Neglect, Mistreatment or Misappropriation of Property, revised 7/2025, section titled Policy documented, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual, or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms.Review of R84 quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed R84 was admitted to the facility on [DATE] with a Brief Interview for Mental Status (BIMS) score of 04, which indicated severe cognitive impairment. Section GG: (Functional status,) revealed R1 has no impairment with upper/lower extremities benefits from the use of a wheelchair, Self-Care: range from all forms of physical assistance, and Mobility: Is independent in most areas can wheel independently in manual wheelchair.Interview with Licensed Practical Nurse (LPN) AAA on 03/05/2026 at 2:50 PM, stated on a Sunday at the end of the shift a CNA came running towards the nurses' station stating, he stabbed him, he stabbed him. The CNA stated R135 had a knife and stabbed R84. LPN AAA stated when he got down there, he saw the nurse (agency) come out of the room where the incident happened. LPN AAA stated R84 had a laceration that was bleeding, so gauze and pressure were applied to stabilize bleeding. LPN AAA stated he went into R135's room and R135 cane out of the bathroom that is shared. LPN AAA stated there was another resident who was bedbound in the room, so he made R135 sit down and relax while another staff member was calling 911 and knew law enforcement was on the way. R135 wanted to go back to the bathroom but LPN AAA stated he made sure R135 did not go to the bathroom. The police arrived and searched the room and could not find the weapon and went to the bathroom and the knife was in the toilet. Afterwards, LPN AAA called the Administrator who was already at the facility by the time he walked out of the room. R135 was arrested and R84 was sent to the hospital. LPN AAA revealed he made the necessary calls to the family of R84, does not believe R135 had a contact on the list of who to call. R135 was very independent and took care of self. LPN AAA stated he did not make calls to anyone else. He confirmed after the incident happened, the facility implemented checking residents in order to make sure the other residents were safe. He stated R135 was typically pleasant and nice and did not have any outburst that he could recall but was up and walking around. He stated R84 does have behavioral outburst.Phone interview on 03/05/2026 at 3:27 PM with the daughter of R84 revealed she was notified of the incident by a male nurse at the facility and was able to speak to the police officer. She stated the officers told her there was a resident who entered the room and cut her dad on his head and the perpetrator was removed from the facility and her dad was stable and the ambulance was at the facility to transport him to the hospital. The daughter stated she received daily updates from the Administrator when the resident returned back to the facility from the hospital and went over the plan of care and a safety plan. She stated the facility changed the entrance door code and the other resident was not allowed back into the facility. The daughter stated R84 was moved to another room and confirmed that anytime something happens with her dad the facility calls her no matter what time it happens. She does not have any issues with the treatment of the facility. Interview on 03/05/2026 at 5:17 PM with the Administrator revealed when he came into the facility, he was informed that there was a stabbing from resident to resident. The Administrator was able to speak to the police officer who let him know R135 was going to be handcuffed and taken with them to intake. The Administrator revealed he interviewed LPN AAA at that time but was unable to speak with (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Agency Nurse. The Administrator stated he spoke to a CNA who no longer works in the facility and this CNA gave a statement that the bathroom door was locked and R135 was upset that he could not get in the bathroom. The Administrator stated he spoke with the Regional Nurse and told her what happened. In addition, he spoke with R84's daughter while he was on his way to the hospital via ambulance. The Administrator stated R135 was put in handcuffs and left with the police. He revealed R135 does not have family involved because he is his own responsible person. He stated R84 was referred to psych services, and he stayed in touch with R84s daughter. He confirmed abuse education was started at the time of the event.

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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 resident and staff interviews, record reviews, and review of the facility's policy titled Transfer of Discharge Notice, the facility failed to ensure two of two sampled residents (R) (R131 and R133) were provided with a written bed hold notice or reason for transfer at the time of transfer. This failure had the potential to place the resident or resident's representative at risk of being uninformed about their rights related to hospital transfer and subsequent return to the facility.Findings include:Review of the policy, Transfer or Discharge Notice, revised [DATE], documented Our facility shall provide a resident and/or the resident's representative a notice of transfer or discharge and the reason for the move in writing (Notice Form for Transfer or Discharge). 3. The resident and or representative will be notified in writing of the following information: the reason for the transfer or discharge; the effective date; the location to which the resident is being transferred or discharged ; a statement of the residents rights to appeal . the facility bed hold policy; the name, address, and telephone number of the Office of the State Long-term Care Ombudsman . 4. A copy of the notice will be sent to the Office of the State Long-Term Care Ombudsman. 5. The reasons for the transfer or discharge will be documented in the resident medical record. 1.Review of R131's clinical record revealed an admission date of [DATE], with diagnoses including, but not limited to, malignant neoplasm of colon, unspecified, anemia, ileostomy, diverticulitis, schizoaffective disorder, bipolar type, and schizophrenia.Review of R131's entry Minimum Data Set (MDS) assessment dated [DATE] revealed, Section C: (Cognitive Patterns) Brief Interview for Mental Status (BIMS) score of 15 indicating little to no cognitive impairment. Review of R131's Clinical Census revealed R131 was transferred to the hospital from the oncologist office on [DATE], and from the facility to the hospital on [DATE]. The bed hold expired [DATE], at which time billing was stopped. R131 was readmitted to the facility on [DATE].Review of R131's clinical record revealed no evidence of a notice of bed hold or reason for transfer provided to R131 on [DATE].Review of R131's electronic medical record (EMR) revealed Licensed Practical Nurse, (LPN) LL, documented on [DATE] at 8:00 PM, During shift change patient presents to hallway at med cart that she's in severe abdominal pain that start since last night and has progressively got worse. Patient has low-grade temp 100.9, chills, abdominal pain to R quadrant, pain upon palpitation, patient reports nausea and emesis x 1 after dinner. Patient reports a history of diverticulitis and had flare up in December. Covid test negative. Also documented at 8:13 PM, by LPN LL Received an order to send R131 to the emergency department. Sent by ambulance. The transfer note revealed no documentation that the bed hold policy was provided to R131 who was her own representative.2.Review of R133's clinical record revealed an admission date of [DATE], with diagnoses including but not limited to, chronic obstructive pulmonary disease and weakness. Review of R133's Clinical Census revealed R133 was discharged on [DATE]. R133's clinical record review revealed no evidence of a bed hold or if the bed hold policy was reviewed. There was no entry MDS completed, and no care plan had been developed at the time of discharge. Review of R133's clinical record revealed no evidence of a notice of bed hold or reason for transfer provided to R133 on [DATE].An interview with the Business Office Manager (BOM) on [DATE] at 1:35 PM confirmed through chart review there was no bed hold notice located and no note of any contact with R133 to inform him of the bed hold policy. An interview with LPN MM on [DATE] at10:39 AM, stated when a resident transfers they have to go with a bed hold policy. Two copies are made, one remains at the facility, and one is sent with the resident. LPN MM stated it is explained to residents that the bed hold policy is 48 hours, and we notify the responsible party of the facility rates after the bed hold expires. The copy is sent to the business office for them to follow up. LPN MM was unable to find a copy of the bed hold agreement in the record for either R131, or R133.During a follow up telephone interview, a representative from the Office of the State Long-term Care Ombudsman office stated there was no notification of discharge or transfer for either R131, or R133.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chestnut Ridge Nsg & Rehab Ctr	125 Samaritan Drive Cumming, GA 30040

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews, the facility failed to ensure that Minimum Data Set (MDS) assessments were accurate for two of four residents (R) (R112 and R113) reviewed for elopement risk. This deficient practice had the potential to place R112 and R113 at increased risk of not receiving care and services according to their assessed needs. Findings include: Review of the policy titled Wandering, Unsafe Resident, dated 05/2023, documented Policy Interpretation and Implementation: 3. Monitoring and Managing Residents at Risk for Elopement and Unsafe Wandering: a. Residents shall be assessed for risk of elopement and unsafe wandering upon admission and throughout their stay by the interdisciplinary care team. B. The interdisciplinary team will evaluate the unique factors contributing to risk in order to develop a person-centered care plan. C. The effectiveness of interventions shall be evaluated, and changes will be made as needed. Any changes or new interventions will be communicated to relevant staff. 1. Review of the electronic medical record (EMR) revealed resident R113 was admitted to the facility on [DATE] and pertinent diagnoses including but not limited to Vascular Dementia, Mild, With Mood Disturbance, Psychotic Disturbance and Mood Disturbance, And Anxiety. Review of R113's quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. Section P: (Functional Status) coded for alarms not used. Review of R113's care plan dated 11/20/2024, documented a problem At risk for elopement and exhibits exit-seeking behavior. I have a wander guard. Goals included but not limited to I will not successfully elope the facility and will be monitored of my whereabouts on an ongoing basis through review date. Interventions included but not limited to observe me for 'tailgating' when visitors are in the building. provide direct staff supervision for me when attending an out of facility activity. Reassess elopement risk as least quarterly. Seek a referral for a mental health evaluation from primary care physician as needed. Use audible monitoring system to alert staff of exit seeking behaviors. Use diversional activities when exit-seeking behavior is occurring (offer food, activities, one on one, company). Review of the Physician's Orders for R113 revealed there was no evidence an order for the wander guard was written. Review of the document titled Wander Guard List, provided by the facility revealed R113 was on the list. Observation of R113 on 03/05/2026 at 3:00 PM revealed a wander guard bracelet applied around her ankle. Interview on 03/05/2026 at 4:22 PM with the Director of Nursing (DON), stated that for those residents who wander, an elopement assessment is completed to see if there is a need for a wander guard. The DON further stated for those residents who wander and attempt to exit seek, they may be a good candidate for the wander guard, and the social worker is the one who would make sure the assessment is completed as well as the doctor order in place. The DON added nursing is also able to complete the assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/05/2026 at 5:17 PM with the Administrator stated when it comes to having a doctor order for anything, the nurses should call the emergency line after hours once the Nurse Practitioners (NP) leaves the facility. Anytime they call a Medical Doctor (MD), the MD will call back in 15-20 minutes. If there is a problem staff have been instructed to let him know what is going on. There is a possibility of a negative effect on resident needs if there is no order to follow. 2. Review of the EMR revealed resident R112 was admitted to the facility on [DATE] and pertinent diagnoses included but were not limited to unspecified dementia, unspecified mood, major depressive disorder, anxiety disorder, other symptoms and signs involving appearance and behavior. Review of R112's quarterly MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 03, which indicated severe cognitive impairment. Section P: (Functional Status) coded for alarms not used. Review of R112 care plan dated 10/24/2025, documented a problem including wanderer and sometimes goes into other resident's rooms related to disoriented tplace. Interventions included but not limited to distracting resident from wandering, identify pattern of wandering and wander guard placement on 01/07/2026. Review of the Physician's Orders for R112 revealed there was no evidence an order for the wander guard was written. Review of the document titled Wander Guard List, provided by the facility revealed R112 was on the list. Observation of R112 on 03/02/2026 at 11:15 AM, revealed a wander guard bracelet applied around her ankle. Interview with MDS Coordinators LPN NN, and LPN OO on 03/05/2025 at 2:10 PM, confirmed that R112's quarterly MDS assessment and R113's quarterly MDS assessment were inaccurately coded in Section P. The MDS Coordinators acknowledged the coding errors and indicated that modifications would be completed to correct the assessments.

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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 and resident interviews, record review, and review of the facility's policies titled Administering Medications, Provision of Care, and Change in a Resident's Condition or Status, the facility failed to ensure that residents received care in accordance with physician orders and facility policy for five residents (R) (R47, R72, R106, R137, and R128) of 47 sampled residents. Specifically, the facility failed to: ensure a wound vac was applied and connected; ensure medications were administered by the nurse who pulled the medication; notify the physician of deviations from orders; accurately document medication administration; obtain resident weights as ordered; and provide timely pain medication. These deficient practices increased the risk of adverse clinical outcomes. Findings Include: Review of the facility's policy titled, Administering Medications, dated 2/2020 revealed that Medications shall be administered in a safe and timely manner, and as prescribed. Further review of item 4. The individual administering medications should check the label to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Item 6. The individual administering the medication should document the administration on the eMAR. Review of the facility's policy titled, Provision of Care undated revealed that Based on comprehensive assessments, the facility will ensure that residents receive treatment and care by qualified persons in accordance with professional standards of practice, the comprehensive person-centered care plans, and the resident's choices. Further review of item 3, The standards of care shall include person-centered care, clinical care standards, safety and prevention protocols, and accurate documentation. Item 5. Qualified persons shall provide care and treatment in accordance with professional standards of practice, the resident's care plan, and the resident's choices. Review of the facility's policy titled, Change in a Resident's Condition or Status date 05/2023 revealed that Our facility shall promptly notify the resident, his or her Attending Physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g. changes in level of care, billing/payments, resident rights, etc.). Further review of item 1. The nurse will notify the resident's Attending Physician or physician on call when there has been a (an): f. refusal of treatment or medications. 1. Observation and interview on 3/4/2026 at 2:50 pm revealed Licensed Practical Nurse (LPN) EE handed a medicine cup containing pills to LPN FF, who was walking by in the hallway, and asked her to administer the medication to a resident in a specified room. During interview, LPN EE stated the medication in the cup was Tylenol and reported that she only hands medications to another nurse to administer in emergency situations. When asked to clarify the emergency at that time, LPN EE stated the surveyors were in the facility. Interview with LPN FF upon her return confirmed she administered the medication but did not know what medications were in the cup, as she was not the nurse who pulled the medication or verified the medication order prior to administration. 2. Review of the EMR revealed that R106 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, Type 2 Diabetes Mellitus (DM) with Diabetic Neuropathy, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Chronic Obstructive Pulmonary Disease (COPD), and emphysema. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R106 quarterly MDS assessment dated [DATE], revealed a BIMS score of 15, indicating little to no cognitive impairment. Section GG: (Functional Status) indicated the resident required use of a wheelchair. Section N: (Medications), indicated the resident received insulin. Review of the Physician's Orders for R106 included but was not limited to: Order dated 09/18/2025 for Glipizide, give 1 tablet by mouth two times a day for DM Order dated 01/07/2026 for Fluticasone-Salmeterol, 1 inhalation inhale orally two times a day for COPD Review of the Medication Administration Record (MAR) for R106 revealed that LPN DD documented administration of Glipizide and Fluticasone at the scheduled 9:00 AM medication pass on 03/04/2026. However, these medications were not available in the facility and were not administered. Despite the medications not being available, LPN DD documented them as given on the MAR, resulting in inaccurate documentation. Interview on 03/04/2026 at 2:11 PM with LPN DD confirmed that she had documented administering R106's Glipizide and Fluticasone when the medications were not given. She stated, I will strike them out. I just corrected it. 3. Review of the EMR revealed that R47 was admitted to the facility on [DATE], with pertinent diagnoses including, but not limited to, other intervertebral disc degeneration-lumbar region, spinal stenosis-lumbar region without neurogenic claudication, intervertebral disc disorders with radiculopathy-lumbar region, Type 2 DM with Diabetic Polyneuropathy, and pain-unspecified. Review of R47 annual MDS assessment dated [DATE], revealed a BIMS score of 14, indicating little to no cognitive impairment. Section GG: (Functional Status), revealed that R47 required partial to moderate assistance with activities of daily living and used a walker. Section N: (Medications), indicated R47 received antidepressant, opioid, and anticonvulsant medications. Section J: (Health Conditions) reflected that R47 received pain medication, with pain present occasionally at a moderate intensity. Review of R47 care plan, revised 01/14/2026, indicated a problem of pain management related to chronic conditions, including back pain from disc degeneration and lumbar spinal stenosis and neuropathic pain. Goals included but were not limited to reducing the impact of pain on daily life, achieving adequate pain relief or the ability to cope with partially relieved pain, and preventing adverse reactions to opioid or anticonvulsant medications. Interventions included but were not limited to administering opioid and anticonvulsant medications as ordered, monitoring and documenting side effects and reporting them to the physician, assessing pain levels and medication effectiveness, responding promptly to complaints of pain, and observing and reporting changes in functional ability, sleep patterns, or resistance to care. Review of the Physician's Orders for R47 included but was not limited to: Order dated 12/9/2025 for Tramadol HCL oral tablet 50 mg, give 1 tablet by mouth as needed for pain (5-10) may have between 1pm-5pm Order dated 1/20/2026 for Tramadol HCL oral tablet 50 mg, give 1 tablet by mouth two times a day for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain Order dated 3/3/2026 for Tramadol HCL oral tablet 50 mg, give 1 tablet by mouth as needed for pain (4-8) 1 tab prn pain between 1300-1700 Review of R47's controlled substance records and physician orders revealed that the PRN Tramadol HCL 50 mg order dated 12/09/2025 expired on 01/23/2026, leaving a six-week gap during which no refill was obtained until a new order was placed on 03/03/2026. Observation and interview on 3/2/2026 at 2:02 pm with R47 and daughter who was on the phone at the time, revealed that R47 has been having issues with her pain medications, many times they have run out and there have been re-ordering delays. Additionally, they stopped giving her the prn pain medication even when she asks for it and does not know why. Interview on 3/3/2026 with LPN CC revealed that R47 did not have the PRN Tramadol in the medication cart and did not know when it had run out. 4. Review of the EMR revealed that R137 was admitted to the facility on [DATE] with pertinent diagnoses including, but not limited to, unspecified severe protein-calorie malnutrition, adult failure to thrive, unspecified dementia, altered mental status-unspecified, and depression. Review of R137 comprehensive MDS assessment dated [DATE] revealed BIMS was not completed. The Staff Assessment for Mental Status indicated short and long-term memory problems, inability to recall usual information, and severe impairment in daily decision-making, demonstrating that R137 had severe cognitive impairment. Section GG, functional status, revealed that R137 was fully dependent on staff for all activities of daily living, including eating, hygiene, dressing, and transfers. Mobility was also fully dependent, with transfers and bed mobility not attempted due to medical or safety concerns. Functional limitations were noted in both lower extremities, while upper extremities had no impairment. Section K, swallowing/nutritional status, revealed no signs of a swallowing disorder. R137 was 63 inches tall and weighed 92 pounds, requiring a mechanically altered diet (pureed or thickened foods). Review of the Care Area Assessment (CAA) on the comprehensive MDS dated [DATE] indicated R137 was identified with cognitive loss/dementia, communication impairment, urinary incontinence/indwelling catheter, falls, nutritional status issues, dehydration/fluid maintenance needs, pressure ulcer risk, and psychotropic drug use. Review of R137 care plan, dated 11/05/2025 indicated a problem of nutritional deficits and risk for significant weight changes related to UTI (Urinary Tract Infection), dementia, epilepsy, and adult failure to thrive. Goals included but were not limited to maintaining stable weight, preventing further malnutrition, and ensuring adequate intake and hydration. Interventions included but were not limited to monitoring and documenting weight, observing and reporting signs of malnutrition, monthly and as-needed weights, dietitian evaluation and recommendations, and promoting adequate hydration and nutrition. Review of the Physician's Orders for R137 included but was not limited to: Order dated 11/05/2025 for Weights: Weekly one time a day every Wed for 3 Weeks screening x3 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Order dated 11/09/2025 for Weekly weights x 3 weeks every day shift every Sun for monitoring for 3 Days Review of R137 weight monitoring revealed underweight status with a BMI of 16.5. Recorded weights were 91.6 lbs on 11/5/2025 and 93.1 lbs on 11/16/2025. Missed weights were noted on 11/9/2025, 11/12/2025, 11/19/2025, and 11/23/2025. No weights were documented between 11/16/2025 and 11/27/2025. The resident presented to the emergency department on 11/27/2025 with a weight of 76 lbs, reflecting a total weight loss of approximately 17 lbs since the last recorded weight on 11/16/2025. Interview on 03/03/2025 at 3:36 PM with Unit Manager LPN BB revealed that weights are obtained on admission for a baseline, then on days 1, 2, and 3, followed by weekly weights for three weeks, and then monthly thereafter, usually on the first of the month. LPN BB stated that she did not notice R137 sustaining any weight loss. Interview on 03/05/2026 at 2:26 PM with Unit Manager LPN MM revealed that she is responsible for monitoring resident weights, entering the orders, and ensuring weights are obtained monthly, typically before the 10th of the month, and recorded in her weight tracking log. She explained that during SOC (Patients at Risk) meetings, weight trends are reviewed to identify residents who may need appetite stimulants or other interventions. LPN MM confirmed that R137 did not have her weight checked for over a week, resulting in a missed weight. She noted that weights are not always obtained consistently due to staffing challenges, as only two staff members are trained to obtain weights and agency staff are unable to perform them. Interview on 03/05/2026 at 11:05 AM with Director of Nursing (DON) revealed that staff are expected to follow physician orders and facility policies when providing care and administering medications. If medication is not available, staff should first contact the pharmacy to follow up on the refill, and if the issue is not resolved, they must notify the Unit Manager, DON, and physician for further direction. The DON emphasized that nurses must only administer medications they are familiar with and have prepared themselves; medications should not be handed off to another nurse, as improper administration could result in adverse outcomes. Regarding respiratory care, staff are expected to document the resident's preferences, perform assessments, and notify the in-house NP as needed, who then determines whether a weaning process is appropriate or if therapy should be changed to PRN, with all assessments and communications thoroughly documented. The DON also stated that weights must be obtained as ordered, particularly for new admissions, to establish baseline measurements. Accurate weights are essential for identifying changes in a resident's condition, including potential disease processes or nutritional decline. A follow-up interview at 12:32 PM, the DON further stressed that timely and accurate documentation of medication administration as they are administered is critical, as delays or inaccurate recall of medication administration can negatively impact clinical outcomes. 5. R72 was admitted to the facility on [DATE]. Diagnoses included vascular dementia, type 2 diabetes mellitus with other diabetic neurological complications and long-term use of insulin. Record review of the physician orders for medications included Jardiance 10 mg once daily for diabetes with a start date of 08/26/2025; Metformin HCL extended release 500 mg twice daily for diabetes with a start date of 10/30/2025; Lantus Solostar 10 units inject subcutaneously at bedtime for diabetes. AccuChecks (blood sugar checks) were ordered to be checked before every meal and at bedtime, with a start date of 03/25/2025. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R72's Care plan noted Type 2 diabetes with long term use of insulin initiated 09/23/2022, and last revised on 10/05/2023. Record review of R72's blood sugar record showed blood sugars being checked once daily at bedtime. There was no record of blood sugar checks before meals as ordered by the physician. On 03/05/2026 at 2:21 PM, LPN MM stated R72 has a physician order to check blood sugar before meals and at bedtime. LPN MM verified blood sugars being checked once daily at bedtime. She stated she needed to clarify the order with hospice, currently it looks like they are not doing what is ordered. On 03/05/2026 at 2:32 PM, during a joint interview the DON and Regional nurse consultant (RNC), stated if a resident had orders for accuchecks {fingerstick blood sugar} before meals and at bedtime, they should be checked according to that order. On 03/05/2026 at 2:45 PM, The nurse practitioner (NP) stated during a telephone interview if there were active orders she would expect them to be followed, if not she would expect the nurse to notify the provider. On 03/05/2026 at 3:40 PM, during a follow up interview the RNC stated she contacted hospice and was told the resident no longer needed before meals and at bedtime, and they would fax over an order for blood sugars to be checked at bedtime. She stated she felt the order was initially entered incorrectly in the electronic health record. 6.Resident (R) 128 was admitted to the facility on [DATE]. R128's diagnoses included Acute osteomyelitis, left ankle and foot. (infection of the bone). R128 was admitted to the facility with a wound vac medical device which used controlled suction to pull fluid and infection away from a wound to help the wound heal. Clinical record review of the physician order dated 02/28/2026 included monitor wound vac dressing site every shift for intact seal, proper suction, function drainage output, and signs of infection. Ensure VAC is functioning properly and dressing remains intact. Suction set to 100mmHg. Notify provider of any abnormal findings. If vac suction is lost and cannot be patched, remove vac dressing and resume wet to dry dressing utilizing moistened gauze with quarter strength Dakin's to wound bed cover with ABD dressing, secure with tape, notify WCN. Additionally, cleanse left foot hell surgical wound bed with ns/wc {normal saline or wound cleanser] or equivalent. Apply black foam to wound. Seal and apply wound vac. Set suction to 100 mm/Hg. Change [wound vac] dressing every day shift Tuesday and Friday. R128's care plan did not specify any focus, goal or interventions related to the wound vac device, monitoring or dressing changes. Record review of the medication administration/treatment administration record for February and March 2026 showed two entries to monitor the wound vac. One entry specified wound suction to be set at 100mmHg. The second entry noted to monitor wound vac suction set to 125mmHg. Record review of a nursing progress note dated 03/02/2026 at 16:47 PM, documented resident currently has wound vac in place. On 03/02/2026 at 3:35 PM, R128 stated the wound vac was placed at the hospital and it was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to be on until she followed up with the podiatry surgeon. R128 stated staff took the wound vac off but she did not know why because it seemed to be working well. She stated it had not alarmed and the dressing was in place. The wound vac was observed disconnected, sitting on the bedside table. On 30/03/2026 at 8:20 AM, The wound vac was observed still sitting on the bedside table. R128 stated wound vac taken off yesterday and the nurse said they were waiting to hear back from the podiatrist to determine if the wound vac needed to remain on. On 03/03/2026 at 1:38 PM, during an interview R128 stated there had not been any wound care done yet today to R128's foot. The wound vac machine was observed not connected and remained on the bedside table. 03/03/2026 1:45 PM, During an interview LPN YY stated she was assigned to R128. LPN YY was not aware the wound vac was not on or connected. She verified there were no orders for the wound vac to be off or on hold. She verified there were no new dressing change orders, and stated, I don't know why it's off. I was not aware that it was off. I don't see any order for it to be off. Nurse confirmed wound vac was not on or connected to the resident. On 03/03/2026 at 2:39 PM, during an interview, LPN AA stated he removed the wound vac on 03/02/2026 for the NP to take pictures of the wound to send to the podiatrist. The resident was discharged from the hospital following left calcaneal surgery and came to the facility with the wound vac. LPN AA stated there was no order to discontinue or hold the wound vac and that it had been disconnected for about 24 hours. LPN AA stated he was busy making rounds yesterday and did not put it back on but would put it back on today. 03/05/2026 at 2:45 PM, The nurse practitioner (NP) stated during a telephone interview if there were active orders she would expect them to be followed, if not she would expect the nurse to notify the provider

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Chestnut Ridge Nsg & Rehab Ctr	125 Samaritan Drive Cumming, GA 30040

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, record review, staff interviews, and review of the policy titled, Accidents and Incidents-Investigation and Reporting, the facility failed to ensure the environment remained as free of accident hazards as possible and failed to provide adequate supervision for two residents (R) (R49 and R145) from a sample of 47 residents. The deficient practice increased the risk of avoidable accidents and injury. Findings include: Review of the policy titled, Accidents and Incidents-Investigation and Reporting revised 02/2024 documented The facility shall provide the residents an environment free of accident hazards. Further review of section 7. Supervision item a.Adequacy of supervision is based on the individual's assessed needs and identified hazards in the resident's environment. 1. Review of the electronic medical record (EMR) revealed R145 was admitted to the facility on [DATE], with pertinent diagnoses including but not limited to Alzheimer's disease, unspecified dementia, aphasia, expressive language disorder, depression, chronic obstructive pulmonary disease (COPD), anemia, gastroesophageal reflux disease (GERD), hyperlipidemia, chronic cough, overweight, disorders of the skin and subcutaneous tissue, and a history of falling. Review of R145's entry Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment. Review of R145's care plan dated 02/25/2026, documented a problem of cognitive impairment related to dementia and Alzheimer's disease and a history of falling with prior fractures. Goals included but not limited to maintaining safety and preventing injury or complications through the review period. Interventions included but not limited to monitoring the resident for changes in condition, providing appropriate supervision, and implementing safety measures as indicated for the resident's condition and risk factors. Observation on 03/02/2026 at 2:25 PM in room (A 12-B) belonging to R145 revealed a shaving razor located on the resident's windowsill. The razor was unsecured and accessible. Observation on 03/03/2026 at 12:24 PM, revealed a shaving razor remaining on the resident's windowsill now inside a clear plastic bag. Interview on 03/03/2026 at 5:21 PM with Licensed Practical Nurse (LPN) CC confirmed the presence of a shaving razor on the windowsill in room A 12-B and stated that it was not supposed to be in the room and should be stored in a designated area. LPN CC further stated that the razor would be removed because anyone could walk into the room, take it, and injure themselves. Interview on 03/05/2026 at 11:05 AM with Director of Nursing (DON) revealed items such as razors should not be left in resident rooms, particularly for residents on blood thinners, as this could result in serious injury. She indicated that staff are expected to remove unsafe items if observed and notify appropriate personnel. 2. Review of the EMR for R49 revealed diagnoses including but not limited to type two diabetes mellitus, acquired absence of right leg below knee, polyneuropathy, and dysphagia. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the quarterly Minimum Data Set (MDS) for R49 dated 01/06/2026 revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating little to no cognitive impairment. Review of R49's EMR revealed a physician order dated 06/13/2025 which stated Resident cannot walk or transfer with prosthetic on. Use sliding board with wheelchair to bed transfers. Do not go to the bathroom. Review of R49 care plan dated 02/25/2026, indicated that he has an alteration in musculoskeletal status related to right BKA (below knee amputation). Interventions included but not limited to anticipating and meeting needs. Be sure call light is within reach and respond promptly to all requests for assistance. Further review of R49's EMR revealed skin/wound note from 12/05/2025 documented WCN (wound care nurse) in to evaluate Left Upper Lateral Thigh Blister. Blister intact clear fluid sac. Area cleansed and betadine applied. No discomfort noted. Resident denies discomfort. Dry dressing applied loosely. Review of Facility Incident Report Form from 12/08/2025 documented details of incident: A blister was observed on the resident left out thigh. Resident stated that he was carrying his coffee cup in his wheelchair between his left thigh and the arm of the wheelchair when the burn occurred. Interview with R49 on 03/05/2026 at 11:40 AM revealed that on 12/05/2026, the resident received a cup of very hot coffee from a staff member. R49 stated that while sitting in a manual wheelchair, he needed to free his hands and placed the cup next to his left side. The resident reported that the coffee was extremely hot and had been served in a thin plastic cup that was not appropriate for holding hot liquids. Interview with the Administrator on 03/05/2026 at 1:50 PM revealed that he reported the incident to the State Agency after it was brought to his attention.

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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 and resident interviews, record review, and review of the facility policy titled Oxygen Administration, the facility failed to ensure oxygen (O2) was administered according to physician's order for two of 13 residents (R) (R140 and R75) who use O2. This deficient practice had the potential to result in inappropriate respiratory treatment and adverse clinical outcomes.Findings include:Review of the facility policy titled, Oxygen Administration, undated documented Preparation: 1. Verify that there is a physician order for this procedure. Review the physician's or facility protocol for oxygen administration.1.Record review of the Electronic Medical Record (EMR) revealed R140 was admitted to the facility on [DATE] and pertinent diagnoses including but not limited to acute respiratory failure with hypoxia, sleep apnea, chronic systolic (congestive) heart failure, paroxysmal atrial fibrillation, atherosclerotic heart disease of native coronary artery without angina, presence of aortocoronary bypass graft, and anemia. Review of R140's entry MDS assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated little to no cognitive impairment. Review of R140's care plan dated 02/26/2026, documented a problem of altered respiratory status/difficulty breathing related to underlying cardiopulmonary conditions. The goal included but was not limited to the resident remaining free from complications related to shortness of breath through the next review date. Interventions included but were not limited to observing for signs and symptoms of respiratory distress and reporting to the physician as needed (such as increased respirations, decreased pulse oximetry, tachycardia, restlessness, diaphoresis, headaches, lethargy, confusion, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color changes); and administering oxygen as indicated in the care plan intervention, OXYGEN SETTINGS: O2 via (SPECIFY: nasal prongs/mask) @ (SPECIFY) L (SPECIFY FREQ). Review of the Physician's Orders for R140 revealed that there were no orders for oxygen prior to 03/03/2026. On 03/03/2026, an order was added for oxygen at 2 LPM (Liters Per Minute) via nasal cannula (NC) continuous.Review of R140's oxygen saturations (Sp02) indicates that over the period from 02/26/2026 to 03/04/2026 that SpO2 readings ranged from 93% to 98%. The resident's oxygen saturation revealed brief dips below 94%.Observation on 03/02/2026 at 1:35 PM revealed, R140 was wearing his oxygen via NC and the O2 concentrator was running at the setting of 2.5 LPM.Observation on 03/03/2026 at 5:08 PM revealed, R140 was wearing his oxygen via NC and the O2 concentrator was running at the setting of 2.5 LPM.Observation and interview with Licensed Practical Nurse (LPN) CC on 03/03/2026 at 5:10 PM confirmed that she was unable to locate any oxygen orders in the EMR. She stated that the resident had been admitted yesterday, 03/02/2026, and arrived from the hospital with oxygen set at 2 LPM. However, visual confirmation by LPN CC of the oxygen concentrator revealed it was set at 2.5 LPM, not 2 LPM.Interview with the Director of Nursing (DON) on 03/05/2026 at 11:05 AM, confirmed that residents receiving oxygen should have a physician order specifying the liter flow and monitoring of respirations and signs of respiratory distress. Oxygen should not be initiated without an order unless it is an emergency. Staff should complete and document a respiratory assessment and review nursing notes. Administering oxygen without an order could be unsafe, particularly for a resident with COPD, due to the risk of hyperoxygenation. The DON further stated staff should document the resident's respiratory status, notify the in-house Nurse Practitioner (NP), and obtain appropriate orders. The NP would evaluate the resident and determine whether oxygen should be initiated, continued, weaned, or changed to PRN (as needed), with all actions documented in the medical record.2. Review of the electronic medical record (EMR) revealed that R75 was admitted to the facility on [DATE], with pertinent diagnoses including, but not limited to, acute respiratory failure with hypercapnia, sleep apnea, morbid obesity, acute on chronic systolic (congestive) heart failure (CHF), cardiac arrhythmia, hypertension, and end-stage renal disease (ESRD).Review of R75's quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 15, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicating little to no cognitive impairment. Section GG (Functional Status) revealed that R75 required substantial to maximal assistance for activities of daily living (ADLs) and use of wheelchair. Section O: (Special Treatments) coded for the use of oxygen.Review of R75 care plan, revised 01/15/2026, indicated impaired oxygenation related to respiratory failure, sleep apnea, and congestive heart failure. Goals included but were not limited to maintaining adequate oxygenation and preventing complications related to respiratory status. Interventions included but were not limited to monitoring respirations and pulse oximetry for signs of respiratory distress, positioning with the head of the bed elevated to promote breathing, administering oxygen therapy per physician orders via nasal cannula, and notifying the physician of worsening respiratory symptoms.Review of the Physician's Orders for R75 included but was not limited to:Order dated 11/04/2024 for O2 2LPM via nasal cannula to keep SpO2 above 92%Observation and interview on 03/02/2026 at 1:03 PM with R75 revealed the resident was seated in a wheelchair wearing a nasal cannula connected to a portable oxygen tank attached to the back of the wheelchair. The oxygen flow rate was observed set at 1 liter per minute. The resident would not have been able to reach the oxygen tank to adjust the flow rate. During interview, R75 stated that she told the nurse to keep the oxygen at 1 liter and acknowledged that the physician order was for 2 liters but stated she prefers it at 1 liter.Observation and interview on 03/03/2026 at 5:04 PM with R75 and Licensed Practical Nurse (LPN) CC revealed the oxygen tank attached to the back of the resident's wheelchair was set at 1 liter per minute. LPN CC stated that the resident prefers the oxygen at 1 liter and staff maintain the oxygen at that level per the resident's request, although the physician order was for 2 liters. LPN CC stated the oxygen had been kept at 1 liter for a long time, but the order had not been changed, and she was unsure whether the prescribing physician had been notified, stating that someone may have informed the Nurse Practitioner (NP) at some

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, staff interviews, and review of facility policies titled Administering Medications, the facility failed to maintain accurate records on controlled substances for resident (R) (R43) on one of three medication carts. The deficient practice increased the risk of medication error for R43 and the potential for drug diversion. Findings include:Review of the facility's policy titled, Administering Medications, dated 2/2020 revealed that Medications shall be administered in a safe and timely manner, and as prescribed.Review of the Physicians Orders for R43 included but was not limited to:Order dated 01/27/2026 for Methadone HCl {Hydrochloride} Oral Tablet 10 MG (Methadone HCl) *Controlled Drug* Give 2 tablet by mouth every 8 hours as needed for Chronic painReview of the electronic medical record (EMR) revealed R43 received Methadone on 03/04/2026 at 10:47 AM.Observation and interview on 03/04/2026 at 3:22 PM, of the nurse's medication cart with Registered Nurse (RN) HH on C-Hall revealed the following:Controlled Substance Record Book: Multiple pages were torn, loose, and no longer secured within the binder. During inspection, these pages easily fell out, creating a risk for inaccurate or incomplete controlled substance accountability.Review of the Controlled Substance Record Book for R43's Methadone administration on 03/04/2026 revealed no documentation by the administering nurse at the time the medication was given, violating facility policy requiring timely and accurate recording of controlled substances.Interview on 03/04/2026 at 3:24 PM with RN HH revealed that she documented the administration in the Medication Administration Record (MAR) at 10:47 AM but failed to make an entry in the controlled substance log. RN HH acknowledged the importance of maintaining an accurate controlled substance count but could not clearly explain why this is critical. She also stated that missing pages were discovered in the controlled substance book. Being an agency nurse, she indicated she was unsure how to address the issue and would need to ask the supervisor.Interview on 03/05/2026 at 11:05 AM with Director of Nursing (DON) revealed that nurses are required to document administration of controlled substances immediately after giving the medication in the controlled substance log and ensure there are no missing signatures or loose pages. The DON explained that maintaining accurate documentation is necessary to ensure medication counts match and to prevent potential medication errors or delays in administration.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assure that two residents (R) (R34 and R90) from a sample of 47 residents, received and consumed foods in the appropriate form as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment, plan of care, in accordance with goals and preferences. The deficient practice increased the risk of adverse clinical outcomes. Findings include:Record review of the facility diet type report dated 03/05/2026, revealed R90's diet was listed as regular, mechanical soft, reduced concentrated sweets, no added salt. The report specified R34 should receive a mechanical soft, regular diet, reduced concentrator sweets, no added salt. 1.R90 was admitted [DATE]. The diagnoses included congestive heart failure, diabetes type 2, dysphagia (difficulty swallowing), and chronic kidney disease. The record also included a history of pneumonitis (aspiration). R90's diet order dated 02/13/2026, documented diet upgraded from pureed to mechanical soft texture, regular consistency.R90's care plan initiated 03/26/2025 and revised 02/26/2026, revealed R90 had a nutritional problem. and needed pureed meat/mech soft consistency for dysphagia. Speech therapy allowed some items per resident's request (see current diet order).The annual nutritional assessment dated [DATE], documented mechanical soft diet consistency/puree meat and bread; may have sandwiches and crackers as tolerated.Observation of R90's lunch meal on 03/02/2026 at 12:26 PM, revealed R90 was served pureed meat, pureed green beans, pureed mandarin oranges and pureed egg noodles. The meal tickets specified R90 could have mechanical soft sides.On 03/04/2026 at 12:38 PM, R90's lunch meal consisted of pureed roast beef, pureed squash and pineapple tidbits. The meal ticket indicated R90 was to receive pureed meat and bread, and mechanical soft sides. The meal ticket also indicated pureed meat, pureed bread, pureed squash, pureed pineapple tidbits and mashed potatoes. The Dietary Manager (DM) verified the meal served did not match the meal ticket and stated she would correct it. 2.Record review showed R34 was admitted to the facility 06/13/2023. R34's diagnoses included congestive heart failure, diabetes type 2, anemia, chronic kidney disease and dementia. R34's diet order dated 02/12/2024, specified reduced concentrated sweets, no added salt diet, mechanical soft texture, regular consistency.Record review of the annual diet assessment dated [DATE], specified reduced concentrated sweets, no added salt, mechanical soft diet. R34s care plan did not document specific dietary instructions or interventions. During lunch observation on 03/04/2026 at 12:39 PM, R34 was observed not eating. The meal consisted of shredded roast beef, with gravy, mashed potatoes, and squash. The meat was in shredded strands and contained pieces large enough that required chewing. The meat did not appear to be mechanically altered. R34 was served with pineapple chunks in place of cinnamon applesauce as was specified on the meal ticket. The meal ticket specified ground roast beef. R34 was unable to answer questions about his lunch. The dietary manager verified the meal served did not match the ticket and stated she would correct it. On 03/05/2026 at 8:46 AM, The dietary manager stated there were three staff working the tray line. There is a cook, a ticket reader and a finisher. The dietary manager stated the aid grabbed the wrong item and put it on the tray. On 03/05/2026 at 9:08 AM, the Director of Nursing (DON) stated the nursing assistants should be checking the tray slips to be sure what is placed on the tray is correct. On 03/05/2026 at 2:27 PM, during a follow up interview the DON confirmed the diet meal tickets did not match the active orders. The DON stated I see the inconsistencies and why that would be confusing.