STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115561	A. Building B. Wing	01/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook Health and Rehab	4608 Lawrenceville Highway Tucker, GA 30084

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of the facility's policy titled, Exercise of Rights/Resident Rights F550 and Residents Rights, the facility failed to allow one resident (R) (38) to exercise their rights in the facility by making her own choices.Findings include:Review of the facility's policy titled Exercise of Rights/Resident Rights F550, revised November 2025, section titled Policy Statement documented, Our residents have the right to be treated with respect and dignity and care that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Our residents have the right to exercise their rights without interference, coercion, discrimination, or reprisal from the facility and will be supported by our community in the exercise of those rights. 13. C. Allowing residents unrestricted access to common areas open to the public, unless this poses a safety risk for the resident.Review of the policy titled Residents Rights revised November 2025, further review of Guidelines documented, . 2. Residents are entitled to exercise their rights and privileges to the fullest extent possible. 3. Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.Review of the electronic medical record (EMR) revealed R38 was admitted to the with pertinent diagnoses including but not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety and repeated falls.Review of R38's annual Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 8, which indicates moderate cognitive impairment. Section GG, Functional Status, revealed R38 required supervision/touching assistance with eating and mobility regarding wheeling 50 ft (feet) and two turns. Review of R38's care plan indicated a problem of R38 has a behavior problem r/t (related to) going in and out of other resident's rooms and removing their items, and then will say the items are hers. Goals included but not limited to R38 will have no evidence of behavior problems by review date. Interventions included but not limited to provide a program of activities that is of interest and accommodates residents status, anticipate and meet R38's needs, and monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes.Observation on 01/28/2026 at 1:27 PM in E Hall dining room during lunch revealed Licensed Practical Nurse (LPN) DD entering the dining room announcing they had trays for residents who had not yet eaten and other residents who had already eaten were asked to go to their room while the other residents ate so it didn't look as if the residents who did not have a tray in front of them had not been fed yet. LPN DD directly spoke with R38 making the statement to R38 to please leave the dining room so that the residents who had not been fed could eat since R38 had already eaten. R38 proceeded to wheel out of the E Hall dining room. R38 came back in the E Hall dining room at 1:35 PM. LPN DD redirected R38 back out of the E Hall dining room stating the other residents had not yet finished (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eating.Interview on 01/28/2026 at 1:42 pm with LPN DD revealed she did ask residents to leave the dining area so that it didn't look like a dignity issue. LPN DD revealed some families did not understand. She further stated she didn't feel that it infringed on the rights of R38 because the resident didn't know. LPN DD further revealed the resident had some dementia and memory issues but she would explore more to make sure it didn't infringe on the resident's rights.Interview on 01/30/2026 at 10:00 AM with the Director of Nursing (DON) revealed that it was not ok for staff to ask residents to leave a preferred space if that was where they wanted to be at the moment. If that was where they wanted to be, then they should be allowed to stay there. The DON further revealed she felt that it was a dignity issue for the resident to be asked to go to their room. She further stated it was R38's right to be there and it was an issue. The DON revealed R38 could have a negative effect of possibly isolating the resident in what was her home and it could be embarrassing to the point of where she would not come out of her room.Interview on 01/30/2026 at 5:47 PM with the Administrator revealed dignity and respect was all residents were treated with dignity and respect and if not treated with dignity and respect, people tended to respond more negatively if not treated that way.

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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, staff and resident interviews, record review, and review of the facility policies titled, F 689 Accidents and F 689 Accidents-Elopement, the facility failed to ensure the environment remained free of accident hazards for three of 61 sampled residents (R) (R45, R78, R92) and failed to maintain a safe environment to prevent resident elopement for one of 14 R's (R62) reviewed for elopement risk. Specifically, the facility allowed over-the-counter (OTC) flu and cold medications and shaving razors to be present and accessible in resident rooms without appropriate supervision or safety controls, and failed to adequately secure and monitor exit doors, allowing a resident to leave the building unsupervised. This deficient practice had the potential to cause injury, medication misuse, adverse drug events, elopement, serious injury, or death.Findings include: Review of the facility policy titled F 689 Accidents revised August 2022, revealed under Policy, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Further review of section Guidelines – Facility-Oriented Approach to Safety revealed that Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes. and that When accident hazards are identified, the QAA (Quality Assessment and Assurance) /Safety Committee shall evaluate and analyze the cause(s) of the hazards and develop strategies to mitigate or remove the hazards to the extent possible. Review of section Resident-Oriented Approach to Safety revealed that Our resident-oriented approach to safety addresses safety and accident hazards for individual residents, and that Staff shall use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident, and the MDS. Further review revealed that Implementing interventions to reduce accident risks and hazards shall include. ensuring that interventions are implemented; and documenting interventions, and that Monitoring the effectiveness of interventions shall include. ensuring that interventions are implemented correctly and consistently. Review of the facility policy titled Wandering, Unsafe Resident revised October 2025, under Policy revealed, The facility will strive to prevent unsafe wandering while maintaining the least restrictive environment for residents who are at risk for elopement. Wandering – random or repetitive locomotion. The movement may be goal directed (e.g. appears to be searching for an exit) or non-goal directed or aimless. Under Policy Interpretation and Implementation documented, . 2. The staff will assess at-risk individuals for potential correctable risk factors related to unsafe wandering. 3. The resident care plan will indicate the resident is at risk for elopement and other safety issues. 4. Interventions to try to maintain safety will be included in the resident's care plan. 6. Nursing staff will document circumstances related to unsafe actions, including wandering, by a resident. 1. Review of the electronic medical record (EMR) revealed R45 was admitted to the facility with pertinent diagnoses including but not limited to essential hypertension, unspecified convulsions, schizophrenia, and depression. Review of R45's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated R45 was cognitively intact. Section GG (Functional Status) revealed R45 was independent with all Activities of Daily Living (ADLs). Review of Section D (Mood) revealed R45 reported little interest or pleasure in doing things and feeling down, depressed, or hopeless nearly every day over the prior two weeks. (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 R45's care plan dated 12/9/2025 indicated a problem of risk for injury due to seizure disorder, need for staff assistance with ADLs, hypertension, anticoagulant therapy, mood/depression, schizophrenia, and potential for impaired judgment related to medication or self-care tasks. Goals included but were not limited to remaining free from injury and avoiding adverse effects from medications. Interventions included but were not limited to monitoring and documenting seizure activity and implementing seizure precautions, supervising medication administration and monitoring for adverse reactions. Review of the Physician Orders for R45 included but was not limited to: Order dated 08/22/2025 for Xarelto 20 mg (milligram), give 1 tablet by mouth daily for cardiovascular disease; monitor for bleeding due to anticoagulant therapy. Order dated 07/31/2025 for Furosemide 40 mg, give 1 tablet by mouth daily for edema; monitor for dizziness, hypotension, and fall risk. Order dated 07/31/2025 for Metoprolol Succinate ER (extended release) 100 mg, give 1 tablet by mouth daily for hypertension; hold for pulse < (under) 60 or systolic BP (blood pressure) <120; monitor for hypotension, dizziness, and fall risk. Order dated0 8/19/2025 for Levetiracetam 1000 mg, give 2 tablets by mouth twice daily for epilepsy; monitor and document seizure activity every shift. Order dated 07/30/2025 for Oxcarbazepine 600 mg, give 1 tablet by mouth twice daily for epilepsy; monitor and document seizure activity every shift. Order dated 01/21/2026 for Aripiprazole 15 mg, give 1 tablet at bedtime for schizophrenia; monitor for sedation, unsteady gait, or confusion. Observation on 01/27/2026 at 1:19 PM of R45 in room E41-2 revealed two bottles of Brand name Cold and Flu over-the-counter medication located on a shelf at the foot of the resident's bed. One bottle was nearly empty, and the second bottle was approximately half full, indicating prior use. The medications were unsecured and accessible. Interview on 01/28/2026 at 3:12 PM with R45 in his room revealed that he was upset about returning from his outing yesterday and discovering that his cough medication had been discarded. R45 stated that the reason he purchased his own was because the amount they give him at the facility was not enough for him, stated that he had a bad cough and taking more of the medication was what worked for him. Review of a Nursing Progress note dated 01/28/2026 revealed R45 had Brand name cold medication in his room without a physician's order and had been taking the medication at his discretion. The note indicated the medication was removed from the room, and the Nurse Practitioner (NP) and Responsible Party were notified. Review of the EMR revealed R78 was admitted to the facility with pertinent diagnoses including but not limited to unspecified sequelae of cerebral infarction, vascular dementia, visual loss-both eyes, difficulty in walking, muscle weakness, cognitive communication deficit. (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 R78's quarterly MDS assessment dated [DATE] revealed a BIMS score of 6, which indicated R78 was severely cognitively impaired. Section GG revealed R78 was dependent or required substantial assistance with most ADLs. R78 used a manual wheelchair and was dependent on staff for all wheelchair mobility. Review of Section D revealed R78 reported little interest or pleasure in doing things, feeling down, depressed, or hopeless, trouble falling or staying asleep, and feeling tired or having little energy nearly every day over the prior two weeks. R78 also reported trouble concentrating nearly every day. Review of R78's care plan dated 12/9/2025 indicated problems including risk for falls, visual impairment, muscle weakness, difficulty walking, vascular dementia, diabetes, hypertension, incontinence, pain, and potential for verbal/physical aggression. Goals included but were not limited to remaining free from injury and participating in ADLs. Interventions included but were not limited to assisting with ADLs and transfers, providing a safe environment, supporting mobility, and monitoring for behavioral changes. Review of the Physician Orders for R78 included but was not limited to: Order dated 01/14/2024 for Aspirin 81 mg chewable, give 1 tablet by mouth daily for blood thinner. Order dated 12/15/2025 for Losartan-HCTZ (hydrochlorothiazide) 50-12.5 mg, give 1 tablet by mouth daily for hypertension. Order dated 01/06/2026 for Hydralazine 100 mg, give 1 tablet by mouth three times daily for hypertension, hold if systolic BP ≤ (lower than or equal to)130. Order dated 01/13/2024 for Memantine 10 mg, give 1 tablet by mouth twice daily for dementia. Order dated 01/13/2024 for Insulin Lispro, inject per sliding scale subcutaneously before meals and at bedtime for type 2 diabetes. Observation on 01/27/2026 at 12:12 PM of R78 in room E51-1 revealed several shaving razors located inside a clear plastic bag placed on top of the bedside nightstand. The razors were unsecured and accessible. Interview on 01/27/2026 at 12:13 PM with R78 revealed that the shaving razors belonged to him, reported he uses the razors, and stated that was why the razors were present in his room, indicating they were his personal belongings. 2. Review of the EMR revealed R92 was admitted to the facility with pertinent diagnoses including but not limited to hemiplegia and hemiparesis following cerebral infarction (left non-dominant side), hemiplegia and hemiparesis following cerebrovascular disease (right non-dominant side), difficulty walking, contracture, left knee, stiffness of left hand, need for assistance with personal care, and essential hypertension. Review of R92's annual MDS assessment dated [DATE] revealed a BIMS score of 15, which indicated R92 was cognitively intact. Section GG revealed R92 required supervision, partial, or substantial/maximal assistance with most ADLs, including eating, personal hygiene, bathing, dressing, and transfers. Review of R92's care plan dated 12/31/2025 indicated a problems including left-sided (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hemiplegia/hemiparesis with contractures, risk for falls, fatigue, impaired balance, limited mobility, pain, hypertension, risk for infection, depression, and potential for verbal/physical aggression. Goals included but were not limited to maintaining safety, participating in ADLs to the highest practicable level, and remaining free from complications related to stroke or hemiplegia. Interventions included but were not limited to assisting with ADLs and transfers and providing pain management and medication monitoring. Review of the Physician Orders for R92 included but was not limited to: Order dated 12/10/2025 for clonidine transdermal patch 0.2 mg/24 hr weekly, apply every Wednesday for hypertension and noncompliance with oral medications. Order dated 03/19/2025 for lisinopril 40 mg tablet by mouth once daily for hypertension, hold if SBP (systolic blood pressure) <120 mmHg, DBP (diastolic blood pressure) <60 mmHg (millimeters of mercury), or HR <60 bpm (beats per minute). Order dated 06/13/2023 for resident to wear left hand splint daily 4–6 hours as tolerated for contracture management. Observation on 01/27/2026 at 12:24 PM of R92 in room E50-1 revealed a shaving razor located inside a cup placed on top of a dresser adjacent to the resident's bed. The razor was unsecured and accessible. Interview on 01/27/2026 at 12:25 pm with R92 revealed the resident stated he shaved independently, reported he did not require assistance from staff, and stated he also shaved his head. Interview on 01/27/2026 at 3:36 pm with Unit Manager Registered Nurse (RN) AA revealed that she confirmed the presence of shaving razors on top of the dresser in room E51-1 and removed them and discarded them into a sharps container. At 3:37 PM confirmed the presence of shaving razors on top of the dresser in room E-50-1, again removing and discarding from the room. At 3:38 PM confirmed the presence of Brand name Cold and Flu OTC medication, 2 bottles, on a shelf in room E41-2 and stated, No, how was this missed? Stated that these items were a safety concern. Specifically, the OTC medication may be easily abused and this would not be an approved medication for a resident to keep at bedside. Interview on 01/27/2026 at 3:49 PM with the Director of Nursing (DON) revealed that OTCs should not be accessible to residents at all, and the only exception would be an inhaler, and the resident would have to be assessed to keep this medication. The concern was that if a wondering resident came into contact with the medication they may take it, a child who is visiting, or the resident themselves not knowing how much to take. In regards to shaving razors, residents were assessed during admission for ability to use them, and they were allowed to keep them, however, these must be in an enclosed bag and out of reach, inside the night stand, and also care planned for their use. 2. Review of the EMR for R62 revealed admission to the facility with pertinent diagnoses including but was not limited to unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety, restless legs syndrome, depression, unspecified. Review of the EMR revealed R62 had a care plan conference dated 12/02/2025 which documented, R62 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	has been having exit seeking behaviors and staff have been redirecting her very much. Review of the EMR revealed resident R62 had a Behavioral Health Evaluation dated 11/25/2025 which documented, wandering behaviors which occurred 1-3 days, Under 1. Prior Level of Function, Stressors or Trigger H: R62's daughter states behaviors are recent as of 18 months ago. 3. Successful interventions: Resident has been difficult to re-direct. Review of R62 annual MDS assessment dated [DATE] revealed BIMS score of 14, which indicates R62 was cognitively intact. Section GG revealed R62 was independent in all areas with the exception of shower/bathe assistance (supervision or touching assistance) and eating (setup/clean up assistance). Review of R62's care plan dated 12/4/2025 indicated a problem of R62 has a behavior problem r/t (related to) walking the halls with her belongings and refusing to take them to her room. Goals included but not limited to R62 will have fewer episodes of by review date. Interventions included but not limited to Administer medications as ordered. Monitor/document for side effects and effectiveness, Anticipate and meet R62's needs, Explain all procedures to R62 before starting and allow to adjust to changes. Review of R62 care plan dated 12/30/2025 indicated a problem of R62 is at moderate to high risk for an elopement and currently wanders. Packs belongings to go home, Stays near exit doors. Goals included but not limited to R62 will remain safe within the designated confines of the community through the next review period. Interventions included but not limited to Provide lodging on a secure unit; Utilize a wanderguard (device to alert staff of wandering outside a preferred area), check placement to right wrist each shift and function each day. Utilize per manufacturer recommendations. Review of the Physician's Orders for R62 included but was not limited to: Order dated 12/30/2025 Wanderguard placed to resident's right wrist. Order dated 12/30/2025 to Check Placement of Wander Guard each shift and document where it is placed. Right wrist ID# FOC969 expiration date 02/2029. Observation on 01/29/2026 at 2:10 PM on D Hall, a locked unit, revealed all exits on first hall to the left led to the parking lot and the door was locked, first hall to the left exit led to the back of the building with a covered area which included ashtrays and a chair. The door was locked and there was a fenced in area beyond the exit. Observation 01/30/2026 12:45 PM on D hall, a locked unit, revealed R62 was in her room standing at her door. She spoke to me about her day. She stated she was having an alright day but was about to go soon. R62's bags were observed at the exit doors. Interview on 01/29/2026 at 2:22 PM with Licensed Practical Nurse (LPN) DD revealed that R62 went out the front exit during an electrical outage. She was dressed for the weather appropriately. Interview on 01/30/2026 at 12:54 PM with Certified Nursing Assistant (CNA) TT revealed he was walking by the exit door and felt a breeze and noticed the door was open. He ran to the gate directly outside of the door to see if he could see anyone. He stated there was a gate in front of the door but was not sure if she went out of that door since he was not able to open the gate. He further stated he could not open or figure out how to open the gate, which was the only way off of the porch. He (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	further revealed he suspected she went out of an alternate door that was on the side by the activities area because it was easier and there was a ramp she could have gone down. He then ran to tell the RN he was going to the street to check for the resident. He ran to the street by the road while looking both ways and noticed R62. She was cross five lanes of traffic [and was continuing to walk] about 4 or 5 houses down from the house that you see when you look directly out of the door [from the facility]. Once he saw her, he ran down towards R62 to make sure she was safe. R62 was not willing to walk back so he stayed in place until assistance arrived. He was not able to look at the time. He revealed she was not upset but she was not wanting to come back to the facility. He stated she came back to the facility and was still attempting to get out again [later that day] which was normal. Stated the doors had not been locked when he made it back to the facility around 10:15-10:30 AM and was instructed to stand by the doors but could not remember who told him to do that but the Unit Manager and the DON were present on the hall. When asked about the resident, he stated she exit sought daily and constantly was going to the doors shaking on them. He further stated her bags were always packed and at the door. Interview on 01/30/2026 at 2:38 PM with the DON revealed the sprinkler system was being serviced and was not supposed to trip the electrical system [power]. Stated the care plan was updated that same day to include a wanderguard since R62 did not have an elopement prior to 12/30/2026. Interview on 01/30/2026 at 5:47 PM with the Administrator revealed he was not onsite from when he received the call of the elopement, the staff had already noticed that R62 was gone, and they had gone out and received the message they had located her outside. At that time, apparently the sprinkler guys were there, and all the doors were open and they [all staff] had started fire watch on the doors. The Maintenance Assistant was put on the line/phone and once the sprinkler technician realized the problem (when the facility called the code), another supervisor from the sprinkler company did the test wrong, which had never happened before.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and review of the facility's policies titled, Administering Medications F 760, Administering Oral Medications, Medication Administration Schedule, and Insulin Administration, the facility failed to ensure accurate administration of medications to four residents (R) (R47, R113, R114, and R50) for four of 25 medication opportunities observed, resulting in a medication error rate of 16% (percent). This deficient practice has the potential to negatively impact residents, leading to complications of current health status.Findings include:Review of the facility's policy titled, Administering Medications F 760 revised [DATE] revealed under Guidelines, step 3. Medications must be administered in accordance with the orders, including any required time frame. Step 7. The individual administering the medication must check the label THREE (3) times to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication. Further review revealed step 22. Each nurse's station will have access to a current medication reference manual.Review of the facility's policy titled, Administering Oral Medications revised [DATE] revealed under Steps in the Procedure . step 6. Check the label on the medication and confirm the medication name and dose with the MAR (medication administration record). Further review under Reporting . step 2. Report other information in accordance with facility policy and professional standards of practice.Review of the facility's policy titled, Insulin Administration revised [DATE] revealed under Preparation . step 3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order. Further review of step 5. The nursing staff will have access to specific instructions (from the manufacturer if appropriate) on all forms of insulin delivery system(s) prior to their use.Review of the facility's policy titled, Medication Administration Schedule revised [DATE] revealed under Policy Interpretation and Implementation . step 3. A physician's order for specific times supersedes any routine schedule.Review of the facility's reference guide by Omnicare pharmacy titled, Guidance for Using Insulin Products dated 2025 revealed Prime pen-like devices prior to each and every injection to minimize bubbles. Dial units as per below guidance and push until a drop of insulin is seen at the top of the needle. with the guidance for Other Insulin Pen Devices: 2 units. Further review revealed After injection, hold the needle in the skin in order to ensure complete delivery of the dose. Large doses may require the needle be left in the skin longer than the time given below. The time given for Lantus insulin is indicated as At least 10 seconds.Observation on [DATE] at 08:59 AM on A-hall with Licensed Practical Nurse (LPN) BB, it was observed that R47 had physician orders for Multiple Vitamins-Minerals Tablet Give 1 tablet by mouth one time a day for Supplement. During medication administration, the nurse administered a One-Daily Multivitamin without minerals, which did not match the ordered medication.Observation on [DATE] at 09:02 AM on A-hall with LPN BB, it was observed that R113 had physician orders for Lidoderm External Patch 5 % (Lidocaine) Apply to Lower Back topically every 12 hours for Back Pain and remove per schedule, however, the nurse did not administer due to lack of availability. There was no notification to the physician regarding the missed dose.Observation on [DATE] at 09:35 AM on the A-hall with LPN BB, it was observed that R114 had physician orders for Metoprolol Tartrate Oral Tablet 25 MG (milligram) (Metoprolol Tartrate) Give 1 tablet by mouth one time a day for HTN (hypertension) hold if HR 50 or lower, SBP systolic blood pressure) below 120. At the time of administration, R114's vital signs were BP 109/54 mmHg (millimeters of mercury) and HR (heart rate) 56. The nurse administered the medication despite the SBP being below the prescribed threshold, giving the medication outside the ordered parameters.Observation on [DATE] (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 1:11 PM on the B-hall with RN CC, it was observed that R50 had physician orders for Insulin Glargine Solution (Lantus) 100 UNIT/ML (milliliter) Inject 26 unit subcutaneously every morning and at bedtime for diabetes. The insulin was administered outside the prescribed time, as the order specified morning administration, but it was given at 1:11 PM. Additionally, the nurse did not prime the insulin pen before use and did not hold the pen in place after injection, which was not consistent with proper administration technique.Interview on [DATE] at 9:18 AM with LPN BB revealed that the ordered Lidoderm (Lidocaine) patch was not administered due to unavailability. LPN BB checked the medication cart and then searched the medication room for available house stock, with none found. The automated medication system did not stock Lidoderm patches. LPN BB consulted another nurse on the unit, who searched her medication cart for house stock, and additionally contacted the nurse on C-Hall on the first floor; no patches were available. LPN BB stated that she would submit a reorder request to the pharmacy and expected delivery this evening.Interview on [DATE] at 10:15 AM with Registered Nurse (RN) CC who was administering medications on the A-hall, revealed her cart did not contain Lidocaine patches for R113.Interview on [DATE] at 10:20 AM with Unit Manager RN AA revealed she was unaware that R113's Lidocaine patches were unavailable. Review of the MAR indicated documentation that the patch was administered on [DATE] at 10:54 AM, [DATE] at 10:26 PM, and [DATE] at 10:13 AM, suggesting no doses were missed. The Unit Manager met with LPN BB to address documentation reflecting administration when no patch was available. LPN BB stated she did not know how the documentation occurred and was instructed to correct the entry. Follow-up interview on [DATE] at 11:24 AM revealed RN AA contacted the evening nurse who stated she administered the patch the previous evening but did not realize she clicked on that.Interview on [DATE] at 3:05 PM with R113 revealed that she did not receive her Lidocaine patch at all the previous day and had not received one yet on the day of the interview. She reported requesting Tylenol for pain management until her Lidocaine patch became available.Interview on [DATE] at 12:52 PM, via telephone with Name of company Pharmacy revealed that the pharmacy representative confirmed receipt of a new order that day for a Lidocaine 4% patch for R113. She stated the previous order had expired on [DATE], which prevented processing a refill.Interview on [DATE] at 1:11 PM with RN CC stated that she was unfamiliar with the procedure for priming an insulin pen or holding the pen in place after it reached zero/clicks. She indicated she had not received training or been made aware of any facility policy regarding insulin pen administration. RN CC further explained that she did not administer the resident's morning insulin as ordered because the resident was not in his room at the scheduled time. She believed that since the insulin was long-acting, the timing would not adversely affect the resident.Interview on [DATE] at 9:46 AM with LPN BB stated that when reviewing R114's metoprolol order, she only considered the heart rate parameter and did not account for the blood pressure. She acknowledged that administering the medication outside the prescribed parameters, particularly with a low blood pressure, could cause dizziness or confusion. The LPN stated she would monitor the resident's blood pressure and watch for side effects, and if the BP fell below 100 mmHg, she would contact the NP for possible intervention.Interview on [DATE] at 9:45 AM with the Director of Nursing (DON) revealed that nurses were required to verify the MAR at least three times to ensure accuracy and prevent medications errors. She further emphasized that the facility's expectation was a zero-error rate for all medication administration. Nurses must never document a medication as given if it was not available. If a medication was unavailable in the cart or automated medication system, the nurse was expected to contact the pharmacy to obtain the medication, notify the physician of the missed dose, inform the responsible party, and document all actions taken in the MAR. For insulin pens, nurses must prime with 2 units and hold the pen in place for five seconds (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to ensure proper delivery, as failing to do so may result in administering air and improper absorption. If a medication was given outside the physician's parameters, nurses were expected to assess the resident, monitor blood pressure, notify the physician, and document all actions, since deviations could result in the resident's blood pressure dropping dangerously low.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interviews, record review and review of the facility's policies titled, Storage of Medications F 761 and reference guide by Omnicare pharmacy titled, Guidance for Using Insulin Products, the facility failed to ensure medications were properly stored by failing to remove expired medications from one of three medication rooms, and failing to properly date and discard expired insulin pens in one of five medication carts. This deficient practice had the potential to result in residents receiving ineffective or expired medications, placing them at increased risk for adverse health outcomes.Findings include:Review of the facility's policy titled Storage of Medications F761, revised 10/2024, revealed under Guidelines step 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed per state regulation. Review of the facility's reference guide by Omnicare pharmacy titled, Guidance for Using Insulin Products dated 2025 revealed Upon opening, all vials/cartridges/pens should be dated.Observation and interview on 1/28/2026 at 1:50 pm during review of the medication room A/B/E-Hall, on the second floor, with Unit Manager Registered Nurse (RN) AA, revealed 5 floor stock of 50% Dextrose injection, usp 25G/50 mL, which were located inside a box under the counter, had expired on 07/2025. RN AA confirmed the expiration of the Dextrose injections, further stating that she was not aware that it was inside that box, and immediately removed them and discarded them. Observation and interview on 1/28/2026 at 2:15 pm during review of the B-Hall medication cart with Licensed Practical Nurse (LPN) BB revealed the following concerns: One insulin Aspart pen with an open date of 1/1/2026, and an expiration date of 1/31/2026, indicating the pen had been in use for more than 28 days and was expired as of 1/28/2026. One Lantus Solostar insulin pen with no documented open date or expiration date; the pen was observed open and in current use. One insulin Lispro (Humalog) KwikPen labeled with an open date of 1/28/2026 and an expiration date of 2/5/2026, reflecting a 7-day expiration rather than the manufacturer-recommended 28 days after opening.LPN BB confirmed the documented dates, or lack thereof, on the insulin pens and stated she did not open or label those pens, noting that multiple nurses utilize the medication carts as they are frequently reassigned. She stated that once insulin is removed from refrigeration, the expiration date should be calculated as 28 days from the date opened and clearly written on the pen or vial. She acknowledged that this process had not been followed for the identified insulin pens and stated that failure to properly date insulin could result in residents receiving ineffective medication. The expired and undated insulin pens were discarded at the time of observation. LPN BB further stated that nurses are expected to calculate the 28-day expiration timeframe; however, she was not aware of a specific written policy outlining this requirement. Interview on 1/30/2026 at 9:45 am with the Director of Nursing (DON) revealed that nurses are required to verify the Medication Administration Record (MAR) at least three times prior to medication administration to ensure that there are no errors before giving the medication. The DON stated that unit managers are responsible for conducting weekly checks of medication carts and daily checks of medication rooms to ensure all medications listed on the MAR are available and properly stored. Expired medications are to be identified and scanned back to the pharmacy promptly. Regarding insulin management, the DON stated that all insulin maintained in medication carts must be clearly labeled with the date opened and the calculated expiration date, which is 28 days from opening. The nurse who opens the insulin is responsible for labeling it appropriately. If an insulin vial or pen is found to be undated or expired, it must be discarded. The DON further stated that use of expired medications may be harmful to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents and potential side effects are unknown.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, staff and resident interviews, record review, and review of the facility's policies titled, Infection Prevention and Control Program F880, F880 Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP), and Wound Care Guidelines the facility failed to provide a Legionella water program, use aseptic technique during wound care, ensure proper use of Personal Protective Equipment (PPE) for residents who were under enhanced barrier precautions (EBP) during medication administration, identify and prevent the spread of C-Diff (clostridium difficile) colitis, and to clean and maintain respiratory equipment properly. This deficient practice had the potential to cause widespread infection, food-borne illness, and widespread C-Diff colitis and could affect all 129 residents who resided at the facility.Findings include: Review of the facility policy titled, F 880 Multidrug-Resistant Organisms (MDRO) and Enhanced Barrier Precautions (EBP) revised April 2025 revealed the facility's expectation Appropriate precautions will be taken when caring for individuals . requiring Enhanced Barrier Precautions. Further review of section Definition: Enhanced Barrier Precautions revealed that Nursing home residents with . indwelling medical devices are at especially high risk.The use of gown and gloves for high-contact resident care activities is indicated. Item 3. Indwelling Medical Devices are defined as (but not limited to): . c. Feeding tubes . Item 5. Application During Daily Life: . g. Indwelling medical device care (device care or use). Review of the facility policy titled, Wound Care Guidelines revised May 2021 revealed in section Steps in the Procedure . item 2. Establish a clean field on resident's overbed table ., . Item 5. Place disposable cloth next to resident (under the wound) to serve as a barrier to protect the bed linen and other body sites. Item 9. Use no-touch technique. Item 16. Be certain all clean items are on clean field. Item 21. Use disinfectant wipe to clean overbed table. Item 23. Wipe reuseable supplies with alcohol as indicated (i.e. outsides of containers that were touched by unclean hands .) Review of the facility's policy titled Infection Prevention and Control Program F800 revised January 2024, revealed there is no verbiage concerning Legionella testing or prevention. 1. Interview with the Maintenance Director on 01/30/2026 at 10:38 AM revealed when the water management program was requested from the Maintenance Director, he brought back an empty clipboard. He stated he had no idea what the water management program was, he had never heard of it. An interview on 01/30/2026 with the Director of Nursing (DON) revealed she had no idea that there was no water infection prevention program for the facility. An interview with the Administrator revealed that he had just become aware that there was no water infection program in place. He provided a report containing water testing from 2/13/2024, testing for Legionella, and none was detected. 2. Observation made on 01/28/2026 at 1:11 PM of medication administration by Registered Nurse (RN) CC to R50 revealed the medication observed was alprazolam tablet 1 mg (milligram) (controlled substance), ordered to be administered via gastrostomy tube (G-tube) three times daily for anxiety disorder. During the administration of the medication via the resident's G-tube (an indwelling medical device), RN CC donned (put on) gloves but did not don a gown prior to performing the high-contact resident care activity involving the indwelling medical device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 01/28/2026 at 1:39 PM with RN CC acknowledged that she should have worn appropriate PPE, including a gown, when providing care to R50. When asked about the EBP signage posted on the resident's door, RN CC stated she was not aware that PPE, including a gown, was required when administering medications via the resident's G-tube. Observation made on 01/30/2026 at 11:50 AM revealed Licensed Practical Nurse (LPN) Wound Skin Ostomy Care (WSOC) performing wound care for R6 with a Stage IV sacral wound. The LPN WSOC did not disinfect the treatment cart prior to placing paper barriers and wound care supplies on the surface. Clean supplies were placed on the resident's bedside table without sanitizing the table, and were later transferred to the resident's bare mattress, which was not disinfected. During wound cleansing, the LPN wiped the wound bed with gauze using gloved hands and did not remove gloves or perform hand hygiene prior to opening and applying CollaSorb powder and calcium alginate dressing. The same gloves used to cleanse the wound were used to handle clean supplies and apply treatment products. Following completion of the dressing, the LPN washed the wound cleanser bottle with soap and water while wearing gloves and later returned the bottle to the treatment cart. 3. Review of the electronic medical record (EMR) revealed R6 was admitted to the facility with pertinent diagnoses including but were not limited to Stage IV full-thickness sacral pressure wound, type 1 diabetes mellitus with neuropathy and other circulatory complications, chronic kidney disease stage 3A, cerebrovascular disease, and polyneuropathy. Review of R6's care plan dated 01/28/2026 indicated a problem of stage 4 sacral pressure wound and diabetic foot ulcers. Goals included, but not limited to, wound healing, preventing infection, and avoiding complications related to pressure and diabetes. Interventions included, but were not limited to, administering prescribed wound treatments and medications, monitoring and documenting wound size, depth, and condition, assessing for signs of infection, and reporting changes to the physician as needed. Review of the Physician's Orders for R6 included but was not limited to: Order dated 11/11/2025 for Treatment: Cleanse sacrum wound with wound cleanser or normal saline and blot dry. Apply collagen to wound bed and then calcium alginate. Skin prep periwound (around the wound). Apply a border gauze dressing. Change dressing 3x's (times per week) a week and prn (as needed). Interview on 01/30/2026 at 12:20 PM with LPN WSOC regarding the wound care procedure. The LPN reported no observed breaches in infection control during the procedure. She stated that she believed all her actions were appropriate and that, if she used disposable paper barriers, the procedure complied with infection-control standards. She further stated that hand hygiene was required only twice, after removing the old dressing and upon completion of wound care. Additionally, she reported that washing the wound cleanser bottle with soap and water was considered sufficient. Interview on 01/30/2026 at 3:10 PM with the Director of Nursing (DON) revealed that LPN WSOC reported directly to her. She stated that facility expectations for wound care included disinfecting the treatment cart prior to set-up and after completion of the procedure, disinfecting bedside tables and bed surfaces before placing supplies, changing gloves and performing hand hygiene after wound cleansing and prior to application of treatment products, and disinfecting reusable wound care bottles with alcohol or other approved disinfectant wipes. The DON confirmed that cleaning the wound cleanser bottle with soap and water alone did not meet facility infection-control standards. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. During observation with R18 on 1/27/2026 at 1:06 PM, it was revealed that R18 was on 3 liters of oxygen (O2). The O2 machine had fuzzy, thick, and dry gray particles on the filter on the back of machine. R18 also stated that the tubing for the O2 machine got changed once a week and she hadn't seen a Respiratory Therapist (RT). Observation on 01/28/2026 at 1:24 PM revealed that R18 had just finished ADL (activities of daily living) care and was lying in bed with a night gown on. The air filter on the back of the O2 machine was covered with fuzzy, thick, and dry gray particles. Observation on 01/30/2026 at 8:19 AM revealed R18 was sitting up in bed eating breakfast and watching television. The air filter on the back of the O2 machine was covered with fuzzy, thick, and dry gray particles. Interview with Certified Nursing Assistant (CNA) NN on 01/27/2026 at 02:16 PM revealed that the nurses handled O2 machines. Interview with RN CC on 01/28/2026 at 2:24 PM revealed that tubing for O2 machines was replaced on the night shift and that she was not sure how often the tubes were replaced. RN CC also stated that RT was supposed to clean filters every day and was last here Monday, 01/26/2026 and Tuesday, 01/27/2026. Interview with Unit Manager AA on 01/30/2026 at 8:39 AM revealed she didn't know who was supposed to clean the O2 machine filters, ensure that a resident had a filter, or how often the filters were to be cleaned. Interview with DON on 01/30/2026 at 9:28 AM revealed that the RT was supposed to follow up on all residents that were on O2.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations and staff interviews, the facility failed to provide a safe, functional, sanitary environment for residents, staff, and the public by not cleaning the Packaged Terminal Air Conditioner (PTAC) filter in six rooms (Room D-16, Room D-12, Room D-15, Room E-52, Room D-15, and Room E41) on five of five halls sampled. This deficient practice had the potential to cause respiratory irritation and exacerbation of conditions in residents with chronic obstructive pulmonary disease and other related lung diseases.Findings include:Observation on 01/27/2026 at 11:45 AM in room D16 revealed that the PTAC unit had two filters, and both filters observed to have a grey fuzzy substance approximately 1/8 inch thick, covering the filter.Observation on 01/27/2026 at 12:00 PM of resident rooms D12 and D15 revealed that both PTAC units in these rooms had 2 filters, and both filters in each unit were covered with a grey fuzzy substance that made the filters opaque.Observation on 01/27/2026 at 12:17 PM of resident room E52 revealed that both filters in the PTAC unit were covered with a grey fuzzy substance that made the filters opaque.Observation on 01/27/2026 at 02:06 PM revealed that room D15's PTSC filters still had a fuzzy grey substance on the two filters.Observation on 01/27/2026 at 02:10 PM revealed the PTAC filters in room E41 had a grey fuzzy substance on both filters.Observation on 01/28/2026 at 02:24 PM revealed that the PTAC filters in rooms D16, D12, D15, and E41 had a grey fuzzy substance on them that made the filter opaque. Observation and interview on 01/28/2026 at 05:00 PM during a walk-through with the Maintenance Director revealed that all PTAC units in the building, including B, C, E, A, and D halls, required cleaning.