STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115638	A. Building B. Wing	04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Manor, Incorporated	2455 Oak Grove Church Road Carrollton, GA 30117

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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 0600 Level of Harm - 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, interviews, and policy review, the facility failed to protect the residents' right to be free from physical and/or verbal abuse by two residents (R) (101 and R70) of the five of eleven residents R89, R102, R103, R57, and R90 reviewed for abuse. The facility's failure to ensure residents were protected from abuse resulted in actual physical harm to R89, R102, and R103, and created the potential for other residents in the facility to experience physical and/or psychological abuse. Findings include: 1. Review of R101's admission Record, located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease. R101 was discharged from the facility on a psychiatric hold on 04/06/26 and was not residing in the facility during the survey. A. Review of R101's Progress Notes, dated 07/03/25 and found in the EMR under the Notes tab, revealed, SSD [Social Services Director] was notified of an altercation between resident [R101] and another resident [R89] @ [at] approximate 11:50 am time of incident [sic]. One of our residents [R89] went into another resident [R101] room and the other resident [R101] slapped her [R89]. The altercation was immediately diffuse [sic] and no apparent bruise/broken part was noted. Resident that was slapped did have a small scratch in nose area but not sure if it happened at the altercation or not. Nurse did observe the scratch and no need for any further action. SSD notified APS [Adult Protective Services] and Ombudsman. Review of the facility's investigation related to the 07/03/25 altercation between R101 and R89 revealed substantiated physical abuse of R89 by R101 and indicated the injury to R89's face was received as a result of the incident. The Investigation Follow-Up Report indicated, As a result of the incident occurring the facility will attempt to monitor the victim more closely to minimize wandering into perpetrator's room or close interactions outside of perpetrator's room in an effort to avoid future incidents. The report did not indicate any planned interventions related to the perpetrator (R101). B. Review of R101's Progress Notes, dated 07/17/25 and found in the EMR under the Notes tab, revealed, Resident [R101] hit another resident [R102] in the eye, scratched her neck, arm, and broke her glasses. [R101] stated she [R102] walked in my room i thought she was going to grab me and so i grabbed her shirt and broke her glasses, hit her in her eye and scratched her arm and neck, i got her before she got me this is statement she made to police. Review of the facility's investigation related to the 07/17/25 altercation between R101 and R102 revealed substantiated physical abuse of R102 by R101. The investigation indicated that R102's glasses were broken, and her eye, neck, and arm were scratched as a result of the incident. The Investigation Follow-Up Report indicated, [R102], the presumed instigator, has since been transferred from the facility to receive more specific treatment for her condition. The facility is not aware of a (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	timeline for readmission at this time. If [R102] does return to the facility will seek to minimize interactions with other residents and look at modifying medications with the hope of medical director and psychiatrist. The report did not indicate any planned interventions related to the perpetrator (R101). C. Review of R101's Progress Notes, dated 10/09/25 and found in the EMR under the Notes tab, revealed, [R103] was returning to room with CNA [Certified Nurse Aide] and was moving past Resident [R101] who was heading toward the nurse's station. CNA reported that [R103] commented that [R101] looked lost. [R101] then slapped [R103] in the face, knocking [R103's] eye glasses off. CNA reports that [R103] said that hurt when resident was hit. CNA told [R101] that hitting someone was not acceptable and held hand out to keep resident from advancing toward [R103] again. CNA stated that [R101] continued to try to get to [R103] until other CNAs arrived and led [R101] away from the hall and to [her] room. DON [Director of Nursing] and MD notified. Report completed with [Police Officer. [R101] family notified. The facility's investigation of the 10/09/25 incident and physical abuse of R103 by R101 was substantiated. The Investigation Follow-Up Report indicated, This writer and the Administrator did review the facility's camera and did witness the alleged perpetrator [R101] make a hitting/shoving movement with semi-closed hand to the left temple area of the victim [R103]. The alleged perpetrator has and is being followed by the facility's contracted psychiatrist and he has changed her medications after this incident. The facility is awaiting to see if this change has been effective. Also, the facility did change the resident's room and this seems to have helped some. The alleged perpetrator is active and does ambulate within the facility with staff attempting to redirect and keep an eye on the resident. However, this incident happened as an employee was wheeling another resident [R103] passed [sic] her. The facility did conduct interviews of three residents on the alleged perpetrator's hall and there was no indication of any other resident to resident abuse. There was no documentation of ongoing interventions or monitoring of R101 related to the incident. Review of the facility's abuse investigation documentation revealed nothing to indicate an investigation had ever been done related to the 10/18/25 incident or any documented ongoing follow-up or monitoring of R101 on the part of the facility related to the incident. Review of R101's Behavior Care Plan, dated 01/19/26 and found in the EMR under the Care Plan tab, revealed the resident had behaviors related to grabbing, cursing, and threatening other residents as well as related to being physically aggressive towards other residents. Interventions included to give daily baths as resident allowed, notify police, remove from area and return to room, administer medication as needed to deescalate resident, anticipate and meet resident's needs, assist the resident to develop more appropriate methods of coping and interacting, encourage the resident to express feelings appropriately, and, if reasonable, discuss the resident's behavior, explain/reinforce why the behavior is inappropriate and/or unacceptable to the resident. Other interventions were to intervene as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to alternate location as needed, and praise any indication of the resident's progress/improvement in behavior. D. Review of R101's Progress Notes, dated 02/08/26 and found in the EMR under the Notes tab, revealed, At 1:10 [PM], writer was in nurse's med room with another nurse and the other nurse heard resident [R101] say I don't give a damn who you tell to [R89]. [R89] screamed. Writer and other nurse went to the door and saw the [R89] wheeling towards nurse's station. [R89] said she [R101] put her hands on my face and then demonstrated the action. Writer took resident [R101] to room (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	while [other nurse] took resident [R89] in the other direction . [R89] has a scratch on forehead above and in the middle of the brow. TC [Telephone Call] to DON and advised to contact the police. Review of the facility's investigation into the 02/08/26 incident of verbal/physical abuse of R89 by R101 revealed R89 received a scratch to her face related to the incident and indicated verbal/physical abuse of R89 by R101 was substantiated. The Investigation Follow-Up Report indicated, After review of the facility's camera footage the facility has concluded [R101] did strike [R89] on 02/08/26. This writer did interview with 3 residents throughout the building and all 3 stated they had no aggressive encounters with other residents at the time. This writer has reached out to the Ombudsman to schedule a meeting to explore options to include possible discharge from the facility. There was nothing in the record to indicate ongoing interventions/monitoring of R101 was implemented related to the 02/08/26 incident. E. Review of R101's Progress Notes, dated 02/14/26 and found in the EMR under the Notes tab, revealed, Staff notified writer of an incident in the dining room involving two residents. Staff immediately separated both residents. Resident [R101] grabbed the other resident's [R57's] left lower arm. DON notified. MD notified of the aggressive behavior. Orders received to increase Risperdal to 1 mg and initiate Ativan [an anti-anxiety medication] PRN. RP notified. Staff will monitor [R101] closely throughout the remainder of the shift. [R101] will eat meals in her room to help maintain a calm environment and reduce further agitation. No other concerns noted at this time. Call light within reach. The facility's investigation related to the 02/14/26 incident revealed substantiated physical abuse of R57 by R101. The Investigation Follow-Up Report indicated, This writer did review the facility's camera footage and [R101] did shove [R57] while [R57] was in the wheelchair. There was no injury noted after the exchange. Interview of 3 residents after the incidents indicated that none of the 3 knew of or had personal experience of any aggressiveness from any residents inside the facility. The perpetrator in this incident has had a medication change while the facility is in discussion regarding potential discharge from the facility as this resident [R101] has been involved in multiple similar incidents. There was nothing in the record to indicate ongoing interventions/monitoring of R101 was implemented related to the 02/14/26 incident. Review of R101's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/20/26 revealed a Brief Interview for Mental Status (BIMS) score of one out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident exhibited physical and verbal behaviors toward others (including hitting, kicking, pushing, scratching, grabbing, abusing others sexually, threatening others, screaming at others, and/or cursing at others) on one to three days of the assessment reference period. F. Review of R101's Progress Notes, dated 04/01/26 and found in the EMR under the Notes tab, revealed, Around 12:25 [PM] resident [R101] was observed on 500 hallway being physical with another [unidentified] resident. She grabbed the resident's arm and pushed her back. (Resident was sitting in wheelchair). Around 12:50 [PM] [R101] had another altercation in the dining room with the same resident. They were sitting at the dining room table and the other resident became very upset given the incident earlier and [R101] grabbed her arm again. [R101] was brought back to her room to finish her lunch. New PRN order received and staff frequently trying to intervene before anymore [sic] physical altercations. Will continue to monitor. Review of the facility's abuse investigation documentation revealed nothing to indicate that an (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	investigation had ever been conducted related to the 04/01/26 incident, or that the facility had documented ongoing follow-up or monitoring of R101 regarding the incident. G. Review of R101's Progress Notes, dated 04/06/26 and found in the EMR under the Notes tab, revealed, Nurse observed [R101] hit another resident [R89]. Residents were separated and [R101] asked why she hit [R89]. [R101] did not recall hitting [R89]. 911 was called and a deputy came out to speak to both residents. [RP] notified of incident and police coming out. He verbalized understanding and expressed thanks. Will continue to monitor. Review of the facility's investigation related to the 04/06/26 incident revealed substantiated physical abuse of R89 by R101. The Investigation Follow-Up Report indicated, This writer did review the facility's camera system and found the incident. [R101] did strike [R89] in what is best described as a harsh poke. This did result in a small skin tear to [R89's] right cheek which the wound care nurse tended to immediately with a small Band-Aid. This writer did interview residents, but none had any issues with other residents being aggressive or abusive toward them or other residents. The facility does have record of [R101] inciting other incidents within the facility and spoke with a doctor following her care and was able to 1013 [send resident out emergently for psychiatric reasons] to a facility for medication regimen review on the date of the incident [04/06/26]. During [R101's] stay at the other facility the son called the facility to give up her bed as he would be admitting her to a different long term care facility at the request of Carrolton Manor due to her numerous prior incidents. During an interview with the DON on 04/23/26 at 12:35 PM, he confirmed he was the facility's abuse coordinator and confirmed multiple allegations of alleged abuse of residents by R101 had been substantiated. The DON stated medication changes had been attempted for R101 related to the incidents and stated he asked facility staff to keep a closer eye on R101 related to the incidents. The DON confirmed ongoing monitoring of R101 had not been done or documented related to any of the incidents. During an interview with the DON and the Administrator on 04/23/26 at 4:27 PM, both indicated they were not aware of the incidents involving R101 on 09/20/25, 10/18/25, 01/19/26, or 04/01/26. The DON stated staff were expected to separate residents when an incident occurred and then the residents would be kept separated for the rest of the day. The DON stated he instructed staff to keep an extra eye on residents when incidents of potential abuse occurred but stated there were no specific parameters related to the increased monitoring, and monitoring of residents was not documented in any way. The DON stated resident's care plans were not updated related to incidents unless there was a specific need to do so (like if an incident was not isolated). The DON indicated interventions the facility might put into place after an incident of abuse included a change in medication or requesting staff keep an extra eye on the resident when the resident was in common areas of the facility. The DON stated every 15-minute checks or one-to-one monitoring for R101 or any other resident related to abusive behavior were not done. The DON stated he did not feel the incidents perpetrated by R101 toward other residents represented any kind of a pattern since R101 had never abused any resident more than one time in the same day. The Administrator stated all potential incidents of abuse, including verbal and physical abuse, were expected to be reported to himself and the DON, confirmed R101 had injured multiple residents during incidents of abuse, and confirmed his expectation was residents residing in the facility should remain free from abuse. 2. Review of R70's EMR Profile tab revealed R70 was admitted on [DATE] with diagnoses of major depressive disorder, unspecified dementia, intermittent explosive disorder, restlessness and agitation, vascular dementia, moderate agitation, and depression. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Review of the EMR quarterly MDS with an ARD of 01/30/26 revealed a BIMS score of 00 out of 15 indicating R70 had severe cognitive impairment. Review of the EMR Progress Notes tab, the nursing progress notes dated between 10/10/25 and 03/30/26 revealed multiple incidents where R70 displayed anger and agitation towards others while telling them to stay away from his wife. There was no documentation that any changes or interventions were made to R70's care. Review of the five-day follow-up report, dated 04/04/26, submitted to the SA (State Agency) as documented by the DON revealed that after further investigation, it was determined there was one additional incident that occurred that was not included in the initial reported incident. The report documented that there was an incident in the hallway where R70 hit R90 on the arm and told R90 to stay away from my [wife], and was considered resident-to- resident abuse with no injury. The DON documented in the report that he had spoken to three residents that lived on R70's hall, and they had no concerns regarding R70 being aggressive and that the DON would continue to monitor R70's behaviors and make changes to his care as needed. Review of the FRI (Facility Reported Incident) investigation, dated 04/04/26, revealed that there was no documentation that the alleged perpetrator was separated from other residents, or that he was monitored and supervised after the alleged abuse. There was no documentation that any changes were made to R70's care plan and no interventions were initiated or changes implemented to R70's care to prevent further resident-to-resident abuse. There was no documented evidence that staff members received training regarding resident-to-resident abuse. During an interview with the DON and the Administrator on 04/21/26 at 4:45 PM, the DON said the follow-up to an incident required the residents to be separated and, then the next day we just don't sit them next to each other in a group. He stated staff are supposed to separate the residents and take them back to their rooms. If they are ambulatory, then he tells staff to keep an eye on them. He said he tells the nurse to inform the other staff to keep an eye on the residents as well. During an interview with the DON on 04/23/26 at 11:46 AM, regarding the facility reported incident submitted to the SA on 03/30/26, he said he did not have any documentation of any resident being monitored after the incident. He said, we just tell staff to keep an eye on the residents and intervene if something starts to escalate. Review of the facility's policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, revised April 2021, indicated, 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.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and policy review, the facility failed to implement pressure ulcer prevention measures and timely treatment and interventions for one of four residents (Resident (R) 28) reviewed for pressure ulcers. This failure contributed to the development and subsequent decline of a potentially avoidable stage III pressure ulcer on R28's sacrum. Actual harm was identified to have occurred on 04/20/2026 when R28 was noted to have developed a Stage III pressure ulcer to the sacrum after interventions to prevent pressure ulcers were not implemented in a timely manner. Findings include:Review of R28's admission Record, located under the Profile tab of the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] with diagnoses including vascular dementia and anoxic brain damage. Review of R28's Clinical admission note dated 04/09/2026 and located under the Progress Notes tab of the EMR revealed, Skin: Poor skin tugor [sic]. Edema to bilateral feet, hands, arms, legs. Red and purplish discolorations to bilateral legs and bilateral arms. Bilateral heels red. Right side of buttocks dry skin and skin peeling to buttocks. Red areas to bilateral buttocks and bilateral heels. {sic} The admission skin note did not indicate any skin issues to the sacrum. Review of the R28's EMR revealed no Baseline Care Plan addressing pressure ulcer risk on admission. Review of R28's Skin/Wound Note dated 04/20/2026 and located under the Progress Notes tab of the EMR, revealed, Resident noted to have a Stage III pressure wound to sacrum. Area measures 3.6 cm [centimeters][long] x [by] 3.6 cm [wide] x 0.3 cm [deep]. Beefy red tissue. No undermining or tunneling. Moderate amount of drainage. No odor. Notified RP [Responsible Party] of area and treatment. Notified hospice of area. Treatment medi-honey as ordered. RP in agreement for the wound MD [physician] and NP [Nurse Practitioner] for wound to see resident. Review of R28's EMR under the Orders tab revealed the physician's order for wound treatment was not entered until 04/22/2026. It indicated to clean the sacral wound with wound cleanser, pat dry, apply skin prep peri wound, apply Medi-honey to the open area, and cover with a silicone dressing every day for a stage III pressure ulcer. Review of R28's Care Plan, dated 04/23/2026 and located under the Care Plan tab of the EMR, revealed, The resident has potential for pressure injury/ impairment to skin integrity of the [sic] r/t [related to] bowel and bladder incontinence, fragile skin, limited mobility, self-care deficit, and disease processes. Resident has pressure wound on sacrum. The interventions included: Clean wound on sacrum as ordered . Encourage good nutrition and hydration in order to promote healthier skin . skin assessment as ordered . [and] Use caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. Review of R28's Skin Issues note, dated 04/24/2026 and located under the Progress Notes tab of the EMR, revealed the size of the stage III sacral pressure ulcer increased to 5.32 cm long x 5.56 cm wide x 0.5 cm deep. During an observation on 04/21/2026 at 11:11 AM in R28's room, she was observed lying on her back in bed on a regular mattress. R28 was not responsive to questions or verbal/tactile stimuli. She was not observed to move on her own. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During observations on 04/22/2026 from 10:22 AM to 11:47 AM in R28's room, she was observed lying in bed on her back on a regular mattress, with no changes in her position. She was not responsive to verbal or tactile stimuli. During an observation on 04/23/2026 at 9:27 AM in R28's room, R28 was observed seated in a reclining wheelchair, lying on her back. She was periodically observed in this position until 11:55 AM, when she was transferred into bed, again lying on her back. During an observation on 04/24/2026 at 9:30 AM in R28's room, she was observed lying in bed on her back with an alternating air overlay mattress. During an interview on 04/24/2026 at 3:2026 PM, the Director of Nursing (DON) stated an air mattress was placed on R28's bed today and stated the wound physician would see R28 on 04/28/2026. During an interview on 04/25/2026 at 9:31 AM, Registered Nurse (RN) 1 stated she was one of the wound care nurses. She stated she only worked every other weekend and had not been aware of R28's sacral wound until yesterday. She stated R28's wound was a stage III facility-acquired pressure ulcer. During an interview on 04/25/2026 at 9:53 AM, Certified Nurse Aide (CNA) 19 stated R28 was totally dependent on staff for bed mobility and all activities of daily living. She stated that when R28 was first admitted , she did not have skin issues on her sacrum; however, she currently has a wound on her sacrum. CNA19 stated the interventions in place to prevent the development of pressure sores for R28 included using barrier cream after episodes of incontinence and rolling her in bed. CNA19 stated there was no documentation of repositioning while in bed. During an interview on 04/25/2026 at 10:06 AM, Licensed Practical Nurse (LPN) 2, who served as the Unit Manager, stated R28 used just a regular mattress that everybody has when she was admitted to the facility. She stated that an alternating air overlay was implemented by the wound care team when the resident developed a stage III pressure ulcer. LPN2 stated that, typically, an assessment of pressure ulcer risk was conducted upon admission; however, she was unable to find an assessment of R28's pressure ulcer risk. LPN2 stated a Baseline Care Plan should also be initiated on admission to address pressure ulcer risk, if present. LPN2 stated R28's prevention measures upon admission would have included using protective barrier cream after episodes of incontinence and turning/repositioning as needed. LPN2 stated there was no formal repositioning schedule or documentation of repositioning. During an interview on 04/25/2026 at 12:57 PM, LPN4, who served as the wound care coordinator, stated R28 was admitted on [DATE]; however, LPN4 was out of the facility until 04/15/2026, at which time R28's sacrum was clear, and she had no pressure ulcers. On 04/20/2026, the stage III pressure ulcer was noted on R28's sacrum. On 04/24/25, an alternating air overlay mattress was implemented. LPN4 stated that typically the specialty mattress overlay would be implemented the same day the pressure ulcer was noted; however, R28 had already been put back to bed on 04/20/2026, so it was not implemented then. LPN4 stated that prevention measures prior to the development of the pressure ulcer included turning the resident side to side and using barrier cream. She stated she typically did not implement any specialty mattress until skin problems had already developed. LPN4 stated there was nothing documented regarding the need to turn and reposition R28 and use barrier cream, and she had no way to ensure this was being done. She stated she had not done any education with staff on turning/repositioning or using barrier cream; however, staff received (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	education through a sign on the staff bathroom door that pictured a turning/repositioning clock as a visual reference. LPN4 stated she felt the pressure ulcer developed from skin maceration due to being moist and under pressure. LPN4 stated she did not speak with the CNAs or nursing staff to determine possible causes and investigate whether R28 was turned/repositioned appropriately. During a concurrent interview on 04/25/2026 at 3:47 PM, the Administrator stated the only intervention to prevent pressure sores upon admission was the use of heel boots; there were no interventions addressing areas other than her heels. The DON stated that an air mattress overlay was implemented on 04/24/2026. The Administrator stated, We started turning her at night on Tuesday [04/22/2026] . I don't think she was being turned when she first came in. it was not scheduled or monitored. The DON stated the staff started monitoring her turning/repositioning on 04/22/2026. The DON added that the pressure ulcer risk assessment should be completed upon admission, and he did not know why one was not done. He stated the skin assessment was done, which showed no pressure ulcers at the time of admission. The DON stated R28 was likely at risk for pressure ulcer development due to her health conditions, and the risk should have been addressed in a Baseline Care Plan. During a telephone interview on 04/25/2026 at 4:25 PM, the Medical Director, who was also R28's primary physician, stated he was not involved in directing wound care orders, as a wound care physician came to the facility weekly to manage wound care. The Medical Director stated R28 had not yet been seen by the wound care physician, but the Medical Director had seen R28 twice. The Medical Director stated R28 was unable to move voluntarily and was unable to follow commands or respond to staff. He stated she was prone to developing pressure ulcers because of her lack of mobility and because she was a larger woman, so it was harder to reposition her. The Medical Director stated the wound may have been avoidable and added, It sounds like more could have been done to try to prevent it, at least more than they were doing. Review of the policy titled, Pressure Injuries Overview dated March 2020 revealed, Avoidable means that the resident developed a pressure ulcer/injury and that one or more of thefollowing was not completed: Evaluation of the resident's clinical condition and risk factors; Definition or implementation of interventions that are consistent with resident needs, residentgoals, and professional standards of practice;Monitoring or evaluation of the impact of the interventions; or Revision of the interventions as appropriate .Stage 3 Pressure Injury: . Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff and family interviews, and facility policy review, the facility failed to ensure a written notice of transfer and/or a written bed hold notice was initiated on four of four residents (R) (R1, R9, R3, and R10) reviewed for facility-initiated emergent transfer to the hospital. This failure had the potential to contribute to the possibility for denial of re-admission and loss of the resident's home following hospitalization.Findings include:1. Review of R1's admission Record from the electronic medical record (EMR) Profile tab revealed an admission date of 08/09/2024, readmission on [DATE], with medical diagnoses that included paroxysmal atrial fibrillation, acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), type II diabetes, heart failure, Alzheimer's disease, chronic kidney disease (CKD), congestive heart failure (CHF), and pancreatitis. Review of R1's EMR Progress Notes tab revealed on 04/11/2026 at 7:12 PM, R1 had been experiencing multiple episodes of emesis, experienced decreased oxygen saturation levels; became lethargic and non-responsive to questions; Floor nurse made the decision to send resident out. MD [Physician] notified and POA [Power of Attorney, or Responsible party {RP}] notified. Additional review of R1's EMR Miscellaneous tab, Assessment tab, and Progress Notes did not reveal any documentation of a transfer / discharge notice or bed hold notice being provided to R1 or her RP. Review of the facility provided Memorandum of Understanding to Family Member (F) F4, dated 04/13/2026, regarding the facility bed hold policy; revealed the lower section of the form showed R1's name, room number, and the date admitted to the hospital (04/11/2026). The section to check the option to hold R1's bed or not and a Resident or RP signature was blank. There were no notations or documentation found on the provision of the form to the Resident or RP. During a telephone interview with F4 on 04/24/2026 at 3:58 PM, regarding receipt of a written notice of transfer and a bed hold at the time of R1's emergent transfer, F4 stated, I don't think I received one for that visit. I know it's a bed hold, but I don't think it includes anything about why or where she is going. They always, always call me and tell me where she is going and why she is going. F4 confirmed nothing had been provided in writing. 2. Review of R9's admission Record from the EMR Profile tab revealed a facility admission date of 07/30/2020, readmission on [DATE], with medical diagnoses that included severe protein calorie malnutrition, pneumonia, Alzheimer's disease, aortic valve disorder, hypertension, and dementia. Review of R9's EMR Progress Notes revealed a late entry on 03/27/2026 at 9:08 PM that the resident had a distended abdomen, a fever, and facial grimacing. The RP was contacted and desired for the physician to be contacted; the physician ordered for R9 to be sent to the hospital emergency room, and R9 was transferred at 1:35 PM where she was admitted . Review of the Memorandum of Understanding regarding the 03/27/2026 hospitalization revealed the notice was addressed to R9's RP, the date of transfer; R9's name, room number, and hospital admission date. There were no signatures, choices for bed hold, signatures, or notation of the date of provision of the form. No written evidence of the provision of a transfer / discharge was provided. During a telephone interview on 04/24/2026 at 2:50 PM regarding receipt of a written transfer / discharge notice and a written bed hold notice, F5 stated, They called and let me know she was going to the hospital but no paperwork. 3. Review of R3's admission Record, located in the EMR under the Profile tab revealed the resident (continued on next page)

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	115638	A. Building B. Wing	04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease and emphysema. The record indicated the resident's RP was his daughter. Review of R3's Progress Notes, dated 03/04/2026 and located in the EMR under the Notes tab, revealed, Resident c/o [complained of] chest pain. Administered nitro [medication used for treatment of chest pain] PRN [as needed] x3 [three times] with no relief. Contacted MD. MD to send resident to [Hospital] for evaluation. EMS [Emergency Medical Services] arrived at facility at 0641 [6:41 AM]. The record revealed R3 remained out of the facility at the hospital until 03/04/2026 at approximately 8:18 PM. Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/23/2026 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated severe cognitive impairment. Review of R3's comprehensive record revealed nothing to indicate a written notice was provided to R3's RP that indicated the reason for the transfer to the hospital. 4. Review of R10's admission Record, dated 04/25/2026 and located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes and chronic kidney disease. The record indicated the resident's RP was her son. Review of R10's Progress Notes, dated 01/14/2026 and located in the EMR under the Notes tab, revealed, Resident [R10] admitted to [hospital] with DX [diagnosis]: Septic Shock. The record revealed R10 remained out of the facility at the hospital until 01/19/2026. Review of R10's significant change MDS, with an ARD of 01/30/2026 and located in the EMR under the MDS tab, revealed a BIMS score of one out of 15, which indicated the resident was severely cognitively impaired. Review of R10's comprehensive record revealed nothing to indicate a written reason or bed hold notice was provided for R10's transfer to the hospital to the RP. During an interview on 04/23/2026 at 2:50 PM, the Director of Nursing (DON) stated that staff called the resident representatives when a resident went to the hospital, but he was not aware of anything being provided in writing. During an interview on 04/25/2026 at 1:48 PM, the Administrator stated he expected the resident and/or resident representative to be notified in writing of the emergent transfer and bed hold policies when residents transferred to the hospital and that the notices were documented. Review of the facility's policy titled, Transfer, Emergency Acute Care, revised March 2025, revealed: 2. When a resident is temporarily transferred to an acute care facility, a notice of transfer is provided to the resident and resident representative as soon as practicable before the transfer. 4. Notices will meet all requirements for content and timing of such notices at 483.15(c)(5). Review of the facility's policy titled, Bed-Holds and Returns, revised October 2022, revealed:1. All residents/representatives are provided with written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice:a. notice 1: well in advance of any transfer (e.g., in the admission packet); andb. notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours) .3. Multiple attempts to provide the resident representative with notice 2 should be documented in cases where staff were (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	unable to reach and notify the representative timely.4. The written bed-hold notices provided to the residents/representatives explain in detail:the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility;a. the reserve bed payment policy as indicated by the state plan (for Medicaid residents);b. the facility policy regarding bed-hold periods;c. the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed d. beyond the state bed-hold period (for Medicaid residents); ande. the facility return policy.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on document review, staff interviews, and policy review, the facility failed to ensure the menus were developed to meet residents' nutritional needs by failing to indicate portion sizes for all 86 facility residents and failing to indicate substitutions for omitted foods. This failure had the potential to lead to weight loss, malnutrition, or dissatisfaction with meals for all residents.Findings include: Review of the weekly menu, provided on paper by the Dietary Supervisor (DS), revealed it contained a mix of typed and handwritten entries for breakfast, lunch, and dinner, with instructions such as no bread for the soft/bite-sized diet and omit bacon/sausage for the NAS [no added salt] diet, with no substitutions listed of similar nutritive value. There were no portion sizes or serving instructions on the menu. During an interview on 04/21/26 at 9:30 AM, the DS stated she did not have a menu that included portion sizes or any documentation of how much of each food item to serve and adaptations for each mechanically altered texture or therapeutic diet. The DS stated she has never had a menu with portion sizes before. During a concurrent interview on 04/24/26 at 3:30 PM, the Administrator stated the facility did not have any recipes for the meals served, as most of the foods were pre-packaged, pre-made foods that the staff only heated and served. The DS confirmed there were no recipes for the meals served and no instructions for how to prepare foods in adequate quantities to meet residents' nutritional needs. During a telephone interview on 04/24/26 at 3:44 PM, the Registered Dietitian (RD) stated the kitchen staff should have a general guideline of portions to serve based on the food group, which was generally four ounces of meat, four ounces of vegetables, and four ounces of starch. The RD stated that generally, staff would serve six ounces of something like a casserole where different food groups were mixed together. She stated this was a general rule of thumb, and she would guess the menus were developed with these portion sizes in mind when their nutritive value was calculated; however, she had no way of knowing. The RD confirmed the staff would have no way of knowing how much to serve each food item to ensure the calculated nutritional value of the meal was met. The RD stated the facility did not have recipes for most food items, as they ordered a lot of pre-made packaged foods that they just heated up. The RD stated the staff would generally follow the instructions for portion size on pre-made packaged foods to know how much to serve. The RD stated there should be a recipe or instruction form for foods where the staff was adding seasonings, liquid, or doing any other type of preparation. The RD stated she was new to the position and had not yet focused on the menu or portion sizes from the kitchen. Review of the policy titled Menus, dated October 2017, revealed, Menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Sciences) . Menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the facility failed to ensure that food stored in the kitchen pantry, refrigerators, and freezer was appropriately labeled and dated, covered, and maintained at proper temperature. Additionally, the facility failed to ensure the vents above the stove, ceiling lights, air vents, and standing fans in the kitchen were clean. These failures had the potential to increase the risk of foodborne illness and infection among all 86 facility residents.Findings include: During initial observations of the kitchen on 04/21/2026 at 9:30 AM, along with the Dietary Supervisor (DS), the following was observed:1. In the juice cooler behind the tray line, three large boxes of thawed nutritional beverages were observed without a date indicating when they were thawed. The nutritional beverage cartons indicated the product should be used within 14 days of thawing. The DS confirmed there was no thaw date on the boxes of the nutritional beverages and stated she had never thought about it before, but the staff would not have a way of knowing how long the nutritional beverages had been thawed. 2. In the small refrigerator near the kitchen entrance, a tray containing beverages prepared for lunch was observed open, uncovered, and without dates. 3. The vents on the hood above the stove, where food was prepared, contained accumulated lint, dust, and debris. The DS stated maintenance staff was responsible for cleaning the vents, but was unsure how often this task was completed. When the vents were pointed out, the DS acknowledged the concern. 4. In the small refrigerator near the back of the kitchen, a five-gallon jug of pickles, approximately three-quarters used, was observed without an open date. The DS stated the jug had an expiration date but acknowledged the product is only safe for a limited time after opening, and staff would have no way of determining when it was opened. 5. In the walk-in freezer, a plastic bag of chicken patties was observed without a label or date. The DS stated the food should be labeled and dated, and needed to be thrown out. 6. In the milk refrigerator, no thermometer was present. The DS stated that there used to be a thermometer in the refrigerator, and it needed to be replaced. 7. In the pantry, an open bag of pasta was observed without an open date. 8. Ceiling lights and vents throughout the kitchen had dust and debris. A standing fan in the dish room, located near the food preparation area, was observed covered in dust and debris, and operating to circulate air. During a subsequent observation on 04/24/2026 at 11:24 AM, the following was observed:1. Fans near the food preparation area and dish room remained dirty and covered in dust and debris. The vents above the stove had been cleaned, but still contained some dust and debris. Ceiling lights and vents continued to have visible dust and debris. 2. In the walk-in refrigerator, an open, partially used container of Watergate salad was observed (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	without an open date. Additionally, three individually wrapped slices of pie were observed without dates. During an interview on 04/24/2026 at 4:31 PM, the DS stated she was unaware that the lights, ceiling vents, and fans were full of dust and debris, but now that she had noticed it, they would be cleaned. The DS stated she had tried to clean the vents above the stove; however, the dirt would not come off, and they needed to be removed and cleaned thoroughly by maintenance. The DS stated she had removed the undated Watergate salad and slices of pie from the walk-in refrigerator and needed to re-educate the staff on ensuring foods were dated when opened or thawed. During an interview on 04/25/2026 at 12:20 PM, the Maintenance Director stated the hood was cleaned regularly; however, the vents were done on an as-needed basis, and no routine cleaning schedule was in place. Review of the facility policy titled, Food Storage, dated 2017, revealed, All containers must be legible and accurately labeled and dated . Date marking to indicate the date or day by which a ready-to-eat, time/temperature control for safety food should be consumed, sold, or discarded will be visible on all high-risk food . Every refrigerator must be equipped with an internal thermometer . All foods should be covered, labeled and dated. All foods will be checked to assure that foods (including leftovers) will be consumed by their safe use by dates, or frozen (where applicable), or discarded. Review of the undated 2nd Shifts Daily Cleaning List, provided on paper by the DS, revealed, Monday: 1. Clean 'all' fans.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interviews, record review, and policy review, the facility failed to identify issues prior to their identification by the survey team and failed to implement and maintain an effective, ongoing Quality Assurance and Performance Improvement (QAPI) program that addressed identified concerns and ensured corrective actions were implemented and sustained. Specifically, the facility was unable to provide any Performance Improvement Plans (PIPs) completed in the last year and failed to address ongoing physical and verbal abuse by one resident toward other residents, allowing the abuse to continue.Findings include: Review of the facility documentation indicated QAPI meetings were held, but there was no data/trending, no root cause analysis for problems identified, no interventions started, no sustained improvements, and no meaningful action. Documentation was not provided for PIPs that included the systems and tools to identify, collect, and evaluate data from all departments to monitor performance indicators, including self-assessment tools, data collection tools, and feedback from staff, residents, and families. During an interview on 04/25/26 at 4:35 PM with the Administrator and the Director of Nursing (DON), the Administrator stated QAPI had a quarterly meeting that was attended by the Administrator, the DON, the Infection Preventionist, the Medical Director, and the manager of each facility department. The DON said the committee identified issues, usually through morning meetings, when staff were asked if they had any concerns. He said they were trying to get better with reports available in the electronic medical record system. He said they were not yet utilizing quality measures from their Minimum Data Set (MDS) assessments but were trying to get that started. The Administrator and the DON said that their method of soliciting input from the staff about concerns was on a personal level, and their doors were open for staff to come to them with their concerns. The Administrator said they had been working on a PIP and were building one right now to address the decline in attendance in the dining room for the evening meal. He said they were also building a PIP regarding urinary tract infections. He could not provide development or implementation of any action plans with measured success of any actions taken, and no performance tracking of at least one PIP in the past year. Review of the facility's policy titled, Quality Assurance and Performance Improvement (QAPI) Program, with a revision date of February 2020, documented The facility shall develop, implement, and maintain an ongoing, facility wide, data driven QAPI program that is focused on indicator of the outcomes of care and quality of life for our residents with the objectives of the QAPI program to 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life, 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators, 3. Reinforce and build upon effective systems and processes related to the delivery of quality care and services, and 4. Establish systems through which to monitor and evaluate corrective actions. Cross Reference F600.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, interviews, and facility policy review, the facility failed to develop a documented water management plan that included an assessment to identify where Legionella and other waterborne pathogens could grow and spread and what control measures were in place, and the facility failed to implement a program of enhanced barrier precautions (EBP) to assist in the prevention of cross contamination for residents with areas of risk. Specifically, appropriate personal protective equipment (PPE) was not worn for one resident (Resident (R) 3) during high contact care, hand hygiene was not performed during a tube feeding for R28, and signage on the door for R88 was not clear as to the procedures for contact isolation for visitors. These failures had the potential to affect all residents in the facility. Findings include: 1. During an interview on 04/23/26 at 8:55 AM, the Administrator advised that the facility did not have a Legionella water program. During an interview on 04/25/26 at 3:34 PM, the Maintenance Supervisor (MS) stated he had not been aware of the requirement for a Legionella water program. During an interview on 04/25/26 at 1:48 PM, the Administrator stated that an expectation was that the facility would be doing the water program. Review of the facility policy titled Legionella Water Management Program, revised September 2022, revealed: Policy Statement, Our facility is committed to the prevention, detection, and control of water-borne contaminants, including Legionella. Policy Interpretation and Implementation1. As part of the infection prevention and control program, our facility has a water management program, which is overseen by the water management team.2. The water management team consists of at least the following personnel:a. The infection preventionist;b. The administrator;c. The medical director (or designee);d. The director of maintenance; ande. The director of environmental services.3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease.4. The water management program used by our facility is based on the Centers for Disease Control and Prevention and ASHRAE recommendations for developing a Legionella water management program.5. The water management program includes the following elements:a. An interdisciplinary water management team (see above);b. A detailed description and diagram of the water system in the facility, including the following:(1) Receiving;(2) Cold water distribution;(3) Heating;(4) Hot water distribution; and(5) Waste.c. The identification of areas in the water system that could encourage the growth and spread ofLegionella or other waterborne bacteria, including the following:(1) Storage tanks;(2) Water heaters;(3) Filters;(4) Aerators;(5) Showerheads and hoses;(6) Misters, atomizers, air washers, and humidifiers;(7) Hot tubs;(8) Fountains; and(9) Medical devices such as CPAP machines, hydrotherapy equipment, etc.d. The identification of situations that can lead to Legionella growth, such as:(1) construction;(2) water main breaks;(3) changes in municipal water quality;(4) the presence of biofilm, stale, or sediment;(5) water temperature fluctuations;(6) water pressure changes;(7) water stagnation; and(8) inadequate disinfection.e. Specific measures used to control the introduction and/or spread of Legionella (e.g., temperature, disinfectants);f. The control limits or parameters that are acceptable and that are monitored;g. A diagram of where control (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	measures are applied;h. A system to monitor control limits and the effectiveness of control measures;i. A plan for when control limits are not met and/or control measures are not effective; andj. Documentation of the program.6. The water management program is reviewed at least once a year, or sooner if any of the following occur:a. The control limits are consistently not met;b. There is a major maintenance or water service change;c. There are any disease cases associated with the water system; ord. There are changes in laws, regulations, standards or guidelines. 2. Review of R3's admission Record, dated 04/25/26 and located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease, urinary obstruction, and emphysema. Review of R3's comprehensive care plan, dated 02/09/26 and found in the EMR under the Care Plan tab, revealed the resident had an indwelling urinary catheter in place, but did not address EBP related to the catheter. Review of R3's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/23/26 and found in the EMR under the MDS tab, revealed a Brief Interview for Mental Status (BIMS) score of three out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated R3 had an indwelling urinary catheter in place at the time of the assessment. Review of R3's Physician's Order Report, found in the EMR under the Orders tab, revealed an order dated 04/23/26 for the resident's use of an indwelling urinary catheter size 16 French with a 10 cubic centimeter (cc) bulb. There was no order in the record for R3 to be on EBP related to his catheter. During an observation on 04/24/26 at 9:12 AM, Certified Nurse Aide (CNA) 14 provided catheter-related care to R3 in his room. There was no signage on R3's door or in his room to indicate he was to be on EBPs, and no PPE, such as gowns, gloves, or masks, was in the area of R3's room. CNA14 wore gloves while providing direct care related to R3's catheter, including emptying urine from the catheter to discard in the resident's toilet. CNA14 did not wear a gown during the duration of the observation. During an interview with CNA14 on 04/24/26 at 9:20 AM, she stated she had not heard of EBP and did not know whether R3 was supposed to be on EBP or not. She stated she always wore gloves when providing catheter care to the resident, but never put on a gown while providing his care. During an interview with CNA16 on 04/24/26 at 9:24 AM, she confirmed she worked regularly with R3 and was aware of the resident's catheter. She incorrectly indicated residents in the facility on Transmission-Based Precautions (TBP) were on EBP and stated there was no one on the unit on which R3 lived who required EBPs. She stated she wore gloves while providing care to the residents on the unit, including R3, but did not wear a gown. During an interview with Housekeeper (HSK) 1 on 04/24/26 at 9:32 AM, she confirmed she did most of the cleaning on R3's hallway, including making beds, cleaning bathrooms, and general cleaning of high-touch areas. She stated she did not know what EBP was. She stated she always wore gloves while cleaning residents' rooms, and she changed the gloves each time she left a room; however, she did not wear a gown when cleaning any of the rooms in the hallway. During an interview with the Director of Nursing (DON) on 04/24/26 at 4:14 PM, he stated the facility had attempted to roll out EBP at some point last October or November, he thought, but that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	administration had become sidetracked with something else, and EBP had not been completely rolled out in the facility. He stated that signs were supposed to be placed on the doors of residents on EBP, and that a shelf was supposed to be in each room with PPE on it to indicate when a staff member was required to wear a gown or mask. The DON stated that facility staff should follow EBP, and the facility would work to roll out the process. 3. Review of R28's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including vascular dementia and anoxic brain damage. Review of R29's Care Plan dated 04/10/26 and located under the Care Plan tab of the EMR revealed, The resident requires tube feeding for nutrition/hydration. The approaches included providing tube feeding as ordered and checking the tube for placement and residual. Review of R28's EMR under the Orders tab revealed a physician's order, dated 04/21/26, for Diabetisource 1.2 tube feeding to be administered continuously for 20 hours at 60 milliliters per hour. During an observation on 04/23/26 at 10:27 AM in R28's room, Licensed Practical Nurse (LPN) 6 was observed as she initiated the tube feeding. She donned gloves upon entering the room, but did not don a gown. She then closed the door and pulled the curtain closed, uncovered R28's feeding tube, and repositioned R28, using the same gloved hands. She then touched her hair to brush it out of the way and began to turn on the feeding tube pump. Using the same gloved hands, she touched her hair to move it out of the way again and then used a syringe to inject air through the feeding tube and also to check the residual stomach contents. LPN6 then touched her hair again before she hooked up the feeding tube to the pump. She then doffed her gloves and used hand sanitizer. During an interview on 04/23/26 at 10:40 AM, LPN6 stated she did not notice that she had touched her hair while initiating the tube feeding and stated, I have to be careful; I can't go home and wash this hair. She added that she should have changed her gloves after touching her hair before providing resident care. She also stated she did not know what EBP was, but was never told to wear a gown when providing care for feeding tubes. During an interview on 04/25/26 at 10:17 AM, LPN2 stated staff should follow EBP and wear gowns and gloves when providing care for a feeding tube. During an interview on 04/25/26 at 6:01 PM, the Infection Preventionist (IP) stated nursing staff were expected to keep their hair back as part of the uniform. They should not touch their hair while providing care, but if they do, they should doff their gloves, sanitize their hands, and don a new pair of gloves. The IP stated LPN2 should have used a gown when initiating the tube feeding for R28. The facility's Enhanced Barrier Precautions Policy, revised December 2024, revealed, 1. Enhanced Barrier Precautions (EBPs) refer to infection prevention and control interventions designed to reduce transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities . apply when: b. A resident is NOT known to be infected or colonized with any MDRO, HAS a wound or indwelling medical devices, and DOES NOT have secretions that are unable to be covered or contained; and c. Contact precautions do not apply . Indwelling medical devices include central lines, urinary catheters, feeding tubes, and tracheostomies . EBPs imply targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply . Examples of high contact resident care activities requiring the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	use of gown and gloves for EBPs include: . g. changing linens h. prolonged high contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin i. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc and j. wound care (any open skin requiring a dressing. 4. Review of R88's admission MDS with an ARD of 03/23/26 located in the EMR revealed a facility admission date of 03/16/26 with medical diagnoses of atrial fibrillation, renal insufficiency, and respiratory failure. The resident was discharged from the facility on 04/22/26. Review of R88's EMR under the Miscellaneous tab revealed a positive urine culture on 04/01/26 and a subsequent positive Clostridium difficile (C. diff/bacterium causing severe, often antibiotic-associated diarrhea) culture on 04/14/26. During an observation on 04/21/26 at 10:58 AM, R88 was observed lying in bed with his door partially opened. There was a sign on the door indicating the resident was in isolation. There was no information to direct visitors on the precautions to take or to seek guidance from a staff member. During an interview on 04/25/26 at 12:34 PM regarding the lack of EBP for residents with risk, the IP responded, We ordered these caddies [for PPE], only had a certain number - put in room appropriate at the time for EBP, such as an IV [intravenous catheter], peg [gastrostomy] tube, foley [indwelling urinary catheter], urostomies, and wounds. If you're having to go in and change a draining wound, you should have on gowns/gloves. I've told the wound care nurses, Certified Nursing Assistant's (CNAs), and the nurses. Regarding residents on other isolation, such as contact isolation and how visitors would be advised of the need for personal protective equipment (PPE), the IP confirmed there is nothing for visitors to be directed to the nurse as the State had told us we couldn't have anything like that. When asked how visitors would know to wear PPE, the IP did not have an answer and confirmed if PPE were in a box in the room or hanging on the door and the door was open, a visitor would have no clue.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on facility document review, staff interview, and facility policy review, the facility failed to ensure an antibiotic stewardship program was developed and implemented. This failure had the potential to increase the risk of adverse events, including the development of antibiotic-resistant organisms (commonly called superbugs) from unnecessary or inappropriate antibiotic use for all 86 residents currently residing in the facility. Findings include: Review of the last three months of tracking/trending infections document provided by the facility revealed there was no documentation of whether an infection met any defined criteria for infection and antibiotic treatment, or if the antibiotic prescribed was effective for any identified organisms. During an interview on 04/25/26 at 11:42 AM, the Infection Preventionist (IP) stated he was in charge of the antibiotic stewardship program, but did not receive a monthly report of antibiotic use and just found out last week during a training that the facility should be using McGeers criteria (standardized surveillance definitions used to identify and track infections). The IP stated, Up until now, that I'm aware of, [determination of] infections were not based on any national criteria, just the nurse documenting [for example] saying foul smelling urine, confusion, and dysuria or frequency. When asked about if antibiotic stewardship program was being used, the IP responded, We do; when I see someone is being talked about with confusion, I ensure they are being changed every two hours. Again, I don't know; there is a specific place to document that the resident was on an appropriate antibiotic. Currently, there is no place on the tracking/trending that notes if the antibiotic was appropriate or if an infection did or did not meet a criteria for infection. During an interview on 04/25/26 at 1:48 PM, the Administrator stated an expectation is that the antibiotic stewardship program had been instituted. Review of the facility policy titled Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, revised December 2016, revealed:Policy StatementAntibiotic usage and outcome data will be collected and documented using a facility-approved antibiotic surveillance tracking form. The data will be used to guide decisions for improvement of individual resident antibiotic prescribing practices and facility-wide antibiotic stewardship.Policy Interpretation and Implementation1. As part of the facility antibiotic stewardship program, all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee.2. The IP, or designee, will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics.a. Therapy may require further review and possible changes if:(1) the organism is not susceptible to antibiotic chosen;(2) the organism is susceptible to narrower spectrum antibiotic;(3) therapy was ordered for prolonged surgical prophylaxis; or(4) therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics.3. At the conclusion of the review, the provider will be notified of the review findings.4. All resident antibiotic regimens will be documented on the facility-approved antibiotic surveillance tracking form. The information gathered will include:a. resident name and medical record number;b. unit and room number;c. date symptoms appeared;d. name of antibiotic (see approved surveillance list);e. start date of antibiotic;f. pathogen identified (see approved surveillance list);g. site of infection;h. date of culture;i. stop date;j. total days of therapy;k. outcome; andl. adverse events.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observations, staff interviews, review of Manufacturer's Instructions for Use (MIFU), and policy review, the facility failed to ensure bed frames, mattresses, and bed rails were inspected and maintained per the MIFU for six of six residents (Resident (R) 2, R5, R24, R28, R33, and R57) reviewed for bed rail use. This deficient practice has the potential for bed malfunction, failure, or entrapment, which could lead to resident injury.Findings include: 1. During observations on 04/21/26 at 12:18 PM and on 04/22/26 at 9:25 AM, it was revealed that R2 had bilateral upper (the head of the bed area) bed rails. 2. During an observation on 04/21/26 at 2:55 PM, it was revealed that R5 had bilateral upper bed rails. 3. During an observation on 04/21/26 at 3:08 PM, it was revealed that R24 had a rail in the middle section of the bed and one bed rail up towards the head of the bed. 4. During an observation on 04/21/26, at 11:11 AM in R28's room, she was observed lying in bed. R28 was unresponsive to questions or to verbal/tactile stimuli. She was not observed to move on her own. There were quarter-length bed rails, positioned on each side of the bed in the center of the bed, in the 'down' position, so that they both were used as a side rail. During an observation on 04/22/26 at 10:22 AM in R28's room, she was observed lying in bed with a quarter-length bed rail in the 'down' position on the left forming a side rail and in the 'up' position on the right forming a grab bar. During an interview on 04/23/26 at 1:11 PM, the Maintenance Supervisor (MS) stated he did not conduct bed and bed rail inspections or assessments unless a problem was brought to his attention, and did not have a bed assessment for R28's bed and bed rails. During an interview on 04/23/26 at 2:50 PM, the Administrator stated there was no assessment of R28's bed or fit of the rails on the bed. During an interview on 04/24/26 at 9:39 AM, LPN2 confirmed R28 had bilateral bed rails in place and stated every resident bed contained one side rail in the 'up' position and one side rail in the 'down' position per facility policy. She stated there was no assessment of the resident's bed, the fit of the rails on the bed, or the risk of entrapment within the rails. 5. Observations of R33 were conducted on 04/21/26 at 11:15 AM, on 04/22/26 at 3:19 PM, on 04/23/26 at 10:42 AM and 5:38 PM, and on 04/24/26 at 9:09 AM and 2:38 PM. The resident was lying in her bed with bilateral one-third-length side rails in the raised position during each of the observations. 6. Observations of R57 were conducted on 04/21/26 at 10:33 AM, on 04/22/26 at 3:21 PM, on 04/23/26 at 09:30 AM, and on 04/25/26 at 9:32 AM. R57 was in her room, either lying or sitting on her bed, or transferring from her wheelchair to her bed and back during each of the observations. One one-third-length bed rail and one quarter-length bed rail were observed in the raised position on the resident's bed during each of the observations. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility provided list regarding bedrails revealed that of the 89 residents in the facility, there was only one resident who did not use rails. During an interview on 04/23/26 at 1:10 PM regarding documentation for bed inspections/maintenance for the past year, the MS stated, I have nothing written down. I just wait until they tell me something. During an interview with the MS on 04/24/26 at 9:56 AM, he stated beds were not physically assessed for safety related to the use of bed rails for any resident in the facility, and stated he was not aware of the requirements for the safe installation of rails on beds. During an interview on 04/25/26 at 1:48 PM, the Administrator stated that an expectation would be that beds would be inspected and those inspections would be documented. Review of the facility provided owner's manual (manufacturer instructions for use) for a [name of bed] noted on page 20: Cleaning and Maintenance . Periodic Inspection and Maintenance . 2. Review Reducing the risk of entrapment listed in this manual. 3. Review and inspect for compliance to the Warnings listed in this manual. 4. Check casters to ensure they lock, if applicable, and roll properly. 5. Inspect all bed components for damage or excessive wear. 6. Visually examine all welds for cracks. 7. Inspect the deck components for bending or damage. 8. Check the motor actuator shaft and its connections for bending, damage, or excessive wear. 9. Check actuator ends and its mounting hardware for bending or excessive wear. 10. Inspect all bolts and fasteners (Do not overtighten bolts at pivot points). 11. Every 6 – 12 months or as needed due to squeaking or noise during travel, lubricate the pivot points with a clear or white silicone-based grease. See the Troubleshooting section of this manual for detailed instructions for safely lubricating pivot points. Review of the facility's policy titled, Bed Safety – Bed Rails, revised August 2022, revealed: .6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks. 7. The maintenance department provides a copy of inspections to the administrator and report results to the QAPI committee for appropriate action. Copies of the inspection results and QAPI committee recommendations are maintained by the administrator and/or safety committee. 8. Any worn or malfunctioning bed system components are repaired or replaced using components that meet manufacturer specifications.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interviews, record review, and policy review, the facility failed to ensure five of five Certified Nurse Aides (Certified Nurse Aide (CNA) 1, CNA2, CNA3, CNA4, and CNA5) reviewed for training received annual training to review the facility's Quality Assurance and Performance Improvement (QAPI) Program. This failure created a potential for staff to be unaware of their role in the facility's QAPI program and how to communicate their concerns, problems, or opportunities for improvement to the facility's QAPI committee.Findings include: 1. Review of CNA1's personnel file revealed a hire date of 03/16/23. Review of CNA1's User Learning transcript from 03/16/25 to 04/24/26 and provided on paper by the Director of Nursing (DON) revealed no training on the facility's QAPI program elements and goals, and the staff's role in QAPI. 2. Review of CNA2's personnel file revealed a hire date of 01/13/22. Review of CNA2's User Learning transcript dated 04/24/26 and provided on paper by the DON revealed no training on the facility's QAPI program elements and goals, and the staff's role in QAPI. 3. Review of CNA3's personnel file revealed a hire date of 03/19/20. Review of CNA3's User Learning transcript from 03/19/25 to 04/24/26 and provided on paper by the DON revealed no training on the facility's QAPI program elements and goals, and the staff's role in QAPI. 4. Review of CNA4's personnel file revealed a hire date of 06/17/98. Review of CNA4's User Learning transcript dated 04/24/26 and provided on paper by the DON revealed no training on the facility's QAPI program elements and goals, and the staff's role in QAPI. 5. Review of CNA5's personnel file revealed a hire date of 08/29/24. Review of CNA5's User Learning transcript dated from 08/29/24 to 04/24/26 and provided on paper by the DON revealed no training on the facility's QAPI program elements and goals, and the staff's role in QAPI. During an interview on 04/25/26 at 4:05 PM, the DON stated he thought training on the facility's QAPI program elements and goals and the staff's role in QAPI was provided in the annual computerized in-service training provided to CNAs; however, there was no training offered to staff on the topic. During an interview on 04/25/26 at 4:50 PM, CNA4 stated she completed the required computerized in-service training annually but was unsure whether training on QAPI was included. CNA4 then added, What is QAPI? When informed, she stated, I'm sure we've had training on that. What is that? but was unable to describe the QAPI program or her role. Review of the policy titled, In-Service Training, All Staff, dated 2001, revealed, All staff are required to participate in regular in-service education . Required topics include the following: . Elements and goals of the facility's QAPI program.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on document review and staff interview, the facility failed to complete an annual performance review for four of four Certified Nurse Aides (Certified Nurse Aide (CNA) 2, CNA3, CNA4, and CNA5) reviewed who were employed by the facility for more than one year. This failure had the potential for missed identification of performance problems, unsafe care, and missed training opportunities based on the evaluation.Findings include: 1. Review of CNA2's personnel file revealed a hire date of 01/13/22. Review of CNA2's personnel file provided by the DON did not have documentation of a performance review. 2. Review of CNA3's personnel file revealed a hire date of 03/19/20. Review of CNA3's personnel file provided by the DON did not have documentation of a performance review. 3. Review of CNA4's personnel file revealed a hire date of 06/17/98. Review of CNA4's personnel file provided by the DON did not have documentation of a performance review. 4. Review of CNA5's personnel file revealed a hire date of 08/29/24. Review of CNA5's personnel file provided by the DON did not have documentation of a performance review. During an interview on 04/24/26 at 2:32 PM, with the Administrator and the Director of Nursing (DON), the DON stated he was responsible for ensuring nurse aides were given performance reviews at least once every 12 months. He said he started some of the required training in Relias [online training] but had not monitored and administered their annual competency exams.

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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, record review, and policy review, the facility failed to ensure the dining experience was dignified for one resident (R) (R56) of 34 sampled residents. The deficient practice had the potential to contribute to depression, anxiety, decreased food intake, and dissatisfaction with meals for R56.Findings include:Review of R56's admission record, located under the Profile tab of her in the electronic medical record (EMR), revealed she was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, anxiety disorder, depression, and adjustment disorder. Review of R56's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/03/2026 and located under the MDS tab of the EMR revealed Brief Interview for Mental Status (BIMS) score of two, indicating severely impaired cognition. The assessment further revealed frequent wandering and physical behaviors directed toward others. R56 required partial to moderate assistance with eating. Review of R56's Care Plan, dated 03/18/2026, and located under the Care Plan tab of the EMR, revealed R56 required partial to moderate assistance with eating, and that her dementia impaired the resident's ability to consume meals consistently. During an observation on 04/21/2026 at 10:43 AM in the 400 Hall, R56 was observed in her wheelchair with an alarm and seat belt in place. R56 was unable to respond to questions. During an observation on 04/21/2026 from 12:40 PM to 12:57 PM, R56 was observed seated in her wheelchair, lined up in a line of wheelchairs, outside the dining room waiting for the assisted dining meal. At 12:57 PM, staff wheeled R56 into the dining room and was seated at a table. The resident's seatbelt remained buckled and was not released during the meal, though three to five staff members remained in the dining room throughout the meal. R56's meal tray was placed directly on the table, with her plate, cups, and utensils still on the tray. A clipboard located near the dining room entrance contained resident names and corresponding assistance needs. R56's name was visible with the notation Encourage. Behind R56's table, directly in her line of sight, staff were scraping off residents' plates into a large trash bin, pounding dishes on the side of the trash can, and putting the empty dishes in the window to the dish room. This activity was visible and audible from the dining area and within the resident's direct line of sight. During an additional dining observation conducted on 04/23/2026 at 1:20 PM, the clipboard containing resident names and assistance levels remained visible near the dining room entrance. R56's seatbelt remained buckled despite the continued presence of staff supervision in the dining room. The resident's tray, including plate, dessert, cups, and utensils, remained on the tray during the meal. During the observation, R56 spilled tea onto her tray and over her plate of food. She was not offered assistance to help clean up the spill or get a new plate of food, though a staff member was seated across from her at the table assisting another resident to eat. R56 began scooping her food off of her plate onto her tray and mixing it in the tea. There was no cuing or encouragement (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to begin to eat or assistance to clean up the spill. At 1:41 PM, Licensed Practical Nurse (LPN) 7 approached and assisted R56 with eating dessert while standing over the resident. LPN7 did not reposition to eye level or obtain a chair while assisting. The soiled tray containing the spilled tea and food mixture remained in front of the resident throughout the assistance. Staff did not replace the meal or beverage or clean the spill. Staff continued scraping dishes and discarding food into the trash container behind the residents during the meal service. During an interview on 04/23/2026 at 1:48 PM, Certified Nurse Aide (CNA) 13 stated the CNAs were required to dump all the trash and scrape all the food and liquid from dishes before passing to the kitchen. She stated at times, the staff got backed up waiting to scrape the dishes because all the residents finished at once, and the garbage can near the window to the dish room could get busy. During an interview on 04/23/2026 at 1:52 PM, LPN7 stated she expected the staff to be at residents' eye level when assisting them to eat; however, she was unable to sit and assist residents because she was supposed to be monitoring the room to ensure the safety of all residents. She stated, Technically, I'm not supposed to feed, but I'm not going to sit there while she doesn't eat. LPN7 stated R56 only wanted her dessert today and stated she did not notice that she had poured her tea on her tray or mixed her food into the tea on her tray. She stated the staff should get a new plate if something is spilled and should offer to assist in cleaning spills. During an interview on 04/25/2026 at 10:21 AM, LPN2, who served as the Unit Manager, stated residents were lined up outside the dining room prior to meals because supervision was required. LPN2 stated the clipboard displaying resident names and assistance needs contained protected health information and should remain private. LPN2 further stated staff should assist residents at eye level and should replace spilled food and beverages. LPN2 confirmed nursing staff were required to scrape dishes and discard liquids into the trash container before returning trays to the kitchen. During an interview on 04/24/2026 at 4:31 PM, the Dietary Supervisor (DS) stated she did not know why the nursing staff were required to scrape the dishes into the trash can prior to returning them to the kitchen. She stated she had always thought it would be better for the trays to be dumped in the kitchen away from residents who were eating. She stated she felt the dining experience did not enhance residents' dignity and would like to implement changes to improve the experience. She stated she had thought about making changes but had not yet implemented anything. During an interview on 04/25/2026 at 4:05 PM, the Director of Nursing (DON) stated the clipboard had since been repositioned so resident information was not visible. The DON acknowledged tray scraping and trash disposal should not occur next to residents during meals and stated staff ideally should be seated while assisting residents to eat. The DON further stated spills should be cleaned promptly and meals replaced when necessary. The DON acknowledged the facility had discussed improving the dining experience to create a more dignified environment but had not implemented changes. Review of the policy titled, Dignity, dated October 2025, revealed, Each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem . When assisting with care, residents are supported in exercising their rights . Staff protect confidential clinical information . practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, and policy review, the facility failed to provide evidence that residents and/or their representatives were informed of the risks, benefits, and available treatment options before restraints were initiated for two of seven residents reviewed for restraints (Resident (R) 21 and R56) and before psychotropic medications were initiated for four of five residents reviewed for unnecessary medication (R33, R12, R38, and R70) from a total sample of 34 residents. This deficient practice could result in residents being restrained or receiving medications without clinical necessity. Findings include: 1. Review of R21's admission Record, located under the Profile tab of her electronic medical record (EMR), revealed she was admitted to the facility on [DATE] and had diagnoses of Alzheimer's disease with behavioral disturbance, restlessness, and agitation. Review of R21's admission Packet dated 11/12/24 and provided on paper by the Director of nursing (DON) revealed a Physical Restraints Record of Informed Consent form that documented, I have been fully informed about the use of restraints and the possible negative outcomes of their use and have been provided with a copy of the facility's policies and procedures governing the use of restraints. I understand that I have the right to be free from any physical restraint for the purposes of discipline or convenience and not required to treat my medical condition or symptoms. I fully understand that should the use of a restraint be necessary, it will only be considered to treat a medical condition or symptom that endangers my physical safety or the safety of other residents and will: 1. Only be used as a last resort measure after a trial period where less restrictive measures have been taken and proven to be unsuccessful; 2. Only be used upon the written order of my attending physician; 3. Only be used upon my written consent or the written consent of my representative . 4. Only be used when the benefits of a restraint outweigh the risks of not using the restraint. R21's representative consented to the general use of restraints. Review of R21's Care Plan dated 11/16/24 and located under the Care Plan tab of the EMR, revealed an approach to use a push-button seatbelt in R21's wheelchair for safety. Review of R21's Restraint-Physical (Initial Evaluation) dated 01/24/25 and located under the Assessments tab of the EMR revealed R21's reasons for use of a restraint included agitated behavior, frequent falls, and attempts to self-transfer. Nothing had worked in the past to control/limit the behavior/issue prompting the need for restraint, and alternatives that had been tried included scheduled rest times, one-to-one activities, medication review, and anticipating hunger, pain, heat, or cold. The assessment documented, She has periods of agitation, restlessness, decreased safety awareness secondary to advanced dementia. She is at risk for injuries without restraint. The assessment documented that R21's representative was notified, but did not include information related to consent or discussion of risks versus benefits. Review of R21's EMR under the Orders tab revealed a physician's order, dated 01/24/25, for an alarming seatbelt restraint to her wheelchair. Review of R21's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/22/26 and located under the MDS tab of the EMR revealed a score of zero out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. She used a trunk restraint in her wheelchair. (continued on next page)

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	115638	A. Building B. Wing	04/25/2026

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R21's Restraint-Physical (Quarterly/Annual Evaluation dated 01/22/26 and located under the Assessments tab of the EMR revealed the assessment documented R21's representative was notified, but did not include information related to consent or discussion of risks versus benefits. During an observation on the 500 Hallway on 04/21/26 at 11:05 PM, R21 was in her wheelchair wandering through the halls. She had an alarmed seatbelt on as well as a tab alarm on her wheelchair and had slid down in the chair, so her bottom was getting closer to the front edge of the seat. R21 was unable to respond to questioning and did not respond when asked to open her seatbelt. During an interview on 04/25/26 at 3:53 PM, the DON stated R21's representative signed a general consent for restraint use upon admission; however, there was no additional documentation of a review of the actual type of restraint being used, the medical symptoms the restraint was used for, and the specific risks and benefits of the restraint. 2. Review of R56's admission Record, located under the Profile tab of her EMR, revealed she was admitted to the facility on [DATE] and had diagnoses including Alzheimer's disease, anxiety disorder, history of falling, depression, adjustment disorder, and stroke. Review of R56's admission Packet, dated 08/25/25, revealed a Physical Restraints Record of Informed Consent form that documented, I have been fully informed about the use of restraints and the possible negative outcomes of their use and have been provided with a copy of the facility's policies and procedures governing the use of restraints. I understand that I have the right to be free from any physical restraint for the purposes of discipline or convenience and not required to treat my medical condition or symptoms. I fully understand that should the use of a restraint be necessary, it will only be considered to treat a medical condition or symptom that endangers my physical safety or the safety of other residents and will: 1. Only be used as a last resort measure after a trial period where less restrictive measures have been taken and proven to be unsuccessful; 2. Only be used upon the written order of my attending physician; 3. Only be used upon my written consent or the written consent of my representative .; 4. Only be used when the benefits of a restraint outweigh the risks of not using the restraint. R56's representative consented to the general use of restraints. Review of R56's Care Plan dated 09/01/25 and located under the Care Plan tab of the EMR revealed an approach to use a Velcro seatbelt in her wheelchair to prevent falls. Review of R56's EMR under the Orders tab revealed a physician's order, dated 09/01/25, for bed and chair alarms for safety and a physician's order, dated 09/22/25, for a Velcro alarming seatbelt. Review of R56's quarterly MDS with an ARD of 03/03/26 and located under the MDS tab of the EMR revealed a score of two out of 15 on the BIMS, indicating severely impaired cognition. She exhibited wandering and physical behaviors toward others frequently. She was dependent on staff with transfers and used an alarm in her wheelchair. R56 was not assessed as using a restraint. Review of R56's Restraint-Physical (Quarterly/Annual Evaluation) dated 03/03/26 and located under the Assessments tab of the EMR revealed the restraint was required due to attempts to self-transfer and documented, She forgets she can't walk & puts her at risk for falls. The alternatives tried were one-to-one activities and alarms. The assessment documented R56's representative was notified but did not include information related to consent or discussion of risks versus benefits. During an observation on 04/21/26 at 10:43 AM in the 400 Hall, R56 was observed in her wheelchair (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with an alarm and seatbelt in place. R56 was unable to respond to questioning and did not respond when asked to open her seatbelt. During an interview on 04/25/26 at 3:53 PM, the DON stated R21's representative signed a general consent for restraint use upon admission; however, there was no additional documentation of a review of the actual type of restraint being used, the medical symptoms the restraint was used for, and the specific risks and benefits of the restraint. 3. Review of R33's admission Record, dated 04/25/26 and located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included vascular dementia, insomnia, anxiety, and major depression. Review of R33's significant change MDS, with an ARD of 02/09/26 and found in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident was receiving antidepressant, antianxiety, and antipsychotic medications. Review of R33's Physician's Order Report, dated 04/25/26 and found in the EMR under the Orders tab, revealed an order with an initial order date of 06/20/25 for the resident to receive Abilify (an antipsychotic medication) five milligrams (mg) daily for depression, an order with an original order date of 06/20/25 for the resident to receive Celexa (an antidepressant medication) 20 mg once daily for depression, an order with an original order date of 02/19/26 for the resident to receive trazodone (an antidepressant medication) 50 mg each night at bedtime for insomnia, an order with an original order date of 02/19/25 for the resident to receive temazepam (an anti-anxiety medication) 15 mg each night at bedtime for anxiety/insomnia, and an order with an original order date of 02/20/25 for the resident to receive desvenlafaxine (an antidepressant medication) 50 mg daily for depression. Review of R33's Medication and Treatment Administration Records (MARs/TARS), dated 04/01/26 through 04/25/26 and found in the EMR under the Orders tab, revealed the resident was receiving her psychotropic medications per the physician's orders. Review of R33's comprehensive record revealed nothing to indicate informed consent had been obtained for the administration of any of the resident's psychotropic medications. During an interview with the DON on 04/24/26 at 4:14 PM, he stated he was unaware that informed consent needed to be obtained for the administration of psychotropic medications. 4. Review of R12's EMR Profile tab revealed R12 was admitted on [DATE] with diagnoses of Parkinson's disease, schizoaffective disorder, dementia, delusional disorders, and major depressive disorder. Review of the EMR quarterly MDS with an ARD of 04/08/26 revealed a BIMS score of 00 out of 15, indicating R12 had severe cognitive impairment. The MDS also revealed that R12 was taking antidepressant and antipsychotic medications. Review of the EMR Orders tab revealed current physician orders for multiple psychotropic medications, ordered 07/08/25, including Cymbalta (an antidepressant medication) for depression, haloperidol (an antipsychotic medication) for psychosis and aggression, and escitalopram (an antidepressant medication) for depression. Review of the EMR Medication Administration Record (MAR), dated April 2026, revealed that the (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	psychotropic and antipsychotic medications were administered to R12 as ordered for her. Review of R12's comprehensive record revealed nothing to indicate informed consent had been obtained for the administration of any of the resident's psychotropic medications. 5. Review of R38's EMR Profile tab revealed R38 was admitted on [DATE] with diagnoses of generalized anxiety disorder, Alzheimer's disease, unspecified dementia with agitation, and adjustment disorder with depressed mood. Review of the EMR quarterly MDS with an ARD of 01/30/26 revealed a BIMS score of 00 out of 15, indicating R38 had severe cognitive impairment. The MDS also revealed that R38 was taking an antipsychotic medication. Review of the EMR Orders tab revealed a current physician order, with an order date of 11/19/25, for Risperdal (an antipsychotic medication) for delusions in dementia. Review of the EMR MAR for April 2026 revealed the antipsychotic medication for R38 was administered to her as ordered. Review of R38's comprehensive record revealed nothing to indicate informed consent had been obtained for the administration of any of the resident's psychotropic medications. 6. Review of R70's EMR Profile tab revealed R70 was admitted on [DATE] with diagnoses of major depressive disorder, unspecified dementia, intermittent explosive disorder, restlessness and agitation, vascular dementia, moderate with agitation, and depression. Review of the EMR quarterly MDS with an ARD of 01/30/26 revealed a BIMS score of 00 out of 15 indicating R70 had severe cognitive impairment. The MDS also revealed that R70 was taking an antipsychotic medication. Review of the EMR Orders tab revealed a current physician order, dated 11/19/25, for Risperdal for Delusions in Dementia. Review of the EMR MAR for April 2026, revealed the antipsychotic medication was administered to R70 as ordered. Review of R70's comprehensive record revealed nothing to indicate informed consent had been obtained for the administration of any of the resident's psychotropic medications. During an interview on 04/24/26 at 9:19 AM, Licensed Practical Nurse (LPN) 2), who served as the Unit Manager, stated she had never heard of an informed consent for psychotropic medications. She said she was the only one responsible for receiving/processing physician orders. She stated that when a resident received a new medication order, she entered the order in the EMR, sent the order to the pharmacy, and the nurses take it from there, they complete the assessments, and they might do the consents, but I'm not sure. During an interview with the DON and the Administrator on 04/24/26 at 9:28 AM, the DON stated, I do not know anything about getting an informed consent for psychotropic medications, but I can start doing it. The Administrator said he would expect the facility staff to follow the legal guidelines and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility policy for informed consents for psychotropic medication. Review of the facility's policy titled, Psychotropic Medication Use, with a revision date of February 2025, revealed a paragraph for Informed Consent or Refusal that Prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician will review the following with the resident/representative prior to obtaining documented consent or refusal: a. non-pharmacological alternatives; b. the indications and rationale for the recommendation; c. the potential risks and benefits (including possible side effects, adverse consequences, and black box warnings); and d. the resident's/representative's right to accept or decline the treatment.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, document review, staff interviews, policy review, and Centers for Medicare and Medicaid (CMS) guidance review, the facility failed to ensure two of three residents (R) (R24 and R90) who were reviewed for Beneficiary Notices received a CMS-10055 Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN). This deficient practice had the potential for residents and/or their representatives not to be fully informed of the out-of-pocket costs associated with continuing to receive therapy after a Medicare Part A service ended. Findings Include:1. Review of R24's admission Record from the facility electronic medical record (EMR) Profile tab revealed a facility admission date of 09/17/2024, and readmission on [DATE], with medical diagnoses that included spinal stenosis, peripheral vascular disease (PVD), low back pain, altered mental status, acute pulmonary edema, and acute respiratory failure. Review of the facility provided Notice of Medicare Non-Coverage (NOMNC) revealed the residents' Medicare Part A benefit started 10/06/2025 with a last covered day of 12/03/2025. R24 signed the NOMNC and SNF ABN on 12/01/2025. However, SNF ABN did not include the estimated cost of continued therapy services to support an informed financial decision regarding continuation of services. 2. Review of R90's admission Record in the facility EMR Profile tab revealed a facility admission date of 11/29/2023 with medical diagnoses that included hearing loss, dementia, and cerebrovascular disease. Review of the facility provided NOMNC revealed a Medicare Part A benefit beginning on 12/31/2025 with a last covered date of 02/11/2026. The NOMNC was unsigned but had a handwritten note, Spoke with [spouse and name] states understand. The unsigned SNF ABN revealed speech therapy services beginning on 02/12/2026; However, the form did not include the estimated cost the resident would incur if services continued. During an interview on 04/24/2026 at 11:30 AM, the Business Office Manager (BOM) confirmed that she does not enter any amount on the SNF ABN notices. During an interview on 04/25/2026 at 1:48 PM, the Administrator stated the expectation was for the SNF ABN to be completed correctly, including the estimated cost of continued services. Review of the facility policy titled Medicare Advance Beneficiary and Medicare Non-Coverage Notices, revised September 2024, revealed: .Skilled Nursing Facility Advance Beneficiary Notice (CMS form 10055) .2. The SNF ABN provides information to the resident so that he or she can decide whether to get the care that may not be paid for by Medicare and assume financial responsibility. Review of the Form Instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) Form CMS-10055 (2024) located at https://www.cms.gov/medicare/medicare-general-information/bni/downloads/snfabn-instructionsv508_clean-11 revealed Medicare requires Skilled Nursing Facilities (SNFs) to issue the SNF ABN to Original Medicare . patients prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNF ABN provides information to the patient so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility . the SNF ANB, CMS-10055, (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	is only issued if the beneficiary intends to continue services and the SNF believes the services may not be covered under Medicare .

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure incidents of potential resident-to-resident abuse were identified, reported, and investigated per the facility's policy for three of 11 residents (R75, R19, R101) reviewed for abuse. These failures placed the residents at risk for physical and/or psychosocial harm related to continued abuse. Cross Reference F600, F609, and F865.Findings include:1A. Review of R75's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted on [DATE] and had a diagnosis of dementia with psychotic disturbance. Review of R75's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/19/26 and located under the MDS tab of the EMR revealed a score of three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. Review of R75's EMR under the Progress Note tab revealed a General Nurses Note dated 03/04/26 that documented, Spoke with [R75's representative] about incident that occurred yesterday evening between resident and another resident from a different hall. Nurse was alerted that this resident and the other were caught making out, but were separated. Staff talked to this resident and resident was not aware that it was a female she kissed and became very upset. The incident was mutual between both residents. [R75] was taken down to her room to calm down. [R75's representative] verbalized understanding and expressed thanks for the update. Will continue to monitor. B. Review of R19's admission Record located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. Review of R19's quarterly MDS with an ARD of 04/01/26 and located under the MDS tab of the EMR revealed a score of three out of 15 on the BIMS, indicating severely impaired cognition. She exhibited no symptoms of depression and wandered frequently. Review of R19's EMR revealed no documentation of the incident with R75, or any follow up by the facility. C. During an interview on 04/23/26 at 4:02 PM, the Director of Nursing (DON), who served as the facility's abuse coordinator, stated there was no documented incident report and no investigation of the incident on 03/04/26. He stated he did not know one was needed in this instance. During an interview on 04/23/26 at 4:10 PM, Licensed Practical Nurse (LPN) 3 stated she was working on 03/04/26, and the Certified Nurse Aide (CNA) working that day had reported the incident to her. LPN3 stated she reported the incident to the DON, who directed her to notify R75's representative the following day. She reported R75 stated she thought she was kissing a man, and she began crying when told she was kissing R19. LPN3 stated this was a mutual act because they were both consenting to the activity at the time, while R75 was under the impression she was kissing a man. During an interview on 04/23/26 at 4:28 PM, the DON stated he was alerted to the incident on 03/04/26, but he was told it was a mutual act between both residents; therefore, the incident was not reported or investigated. The DON stated even though R75 thought she was kissing a man, she was involved in the act consensually. The DON stated the facility had not assessed either residents' capacity to consent or to understand their actions and was unable to explain how this was determined to be a consensual interaction. During a review of the security camera footage on 04/23/26 at 6:03 PM with the Administrator, R19 (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was seated in the hallway when R75 approached her, and they embraced and began kissing. The Administrator stated he was not aware of this incident and had not reviewed the footage or investigated until now. The Administrator stated if he were aware of the incident, he would have reviewed the footage and investigated to rule out any type of sexual abuse. During a telephone interview on 04/24/26 at 9:15 AM, Physical Therapist (PT) stated she witnessed R75 and R19 kissing and asked R75 if she knew what she was doing and who she was kissing and reminded her she was kissing a female but did not recall R75's reaction. The PT stated she did not intervene in the interaction, but she notified CNA18 and LPN3. During an interview on 04/24/26 at 9:32 AM, CNA18 stated she did not witness the interaction between R75 and R19; they were already separated when she saw them. She stated R75 said, 'She kissed me' and kept repeating this, getting agitated. She stated R19 denied kissing R75, stating, 'I don't kiss women.' CNA18 stated LPN3 was aware of the interaction. 2. Review of R101's admission Record, located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease. R101 was discharged from the facility on a psychiatric hold on 04/06/26 and was not residing in the facility during the survey. A. Review of R101's Progress Notes, dated 09/20/25 and found in the EMR under the Notes tab, revealed, Resident [R101] started arguing with her [unidentified] roommate. She was walking towards her roommate voicing violate threats B**** I will kill you; I will knock you out of your w/c [wheelchair]. Writer redirected resident. Called MD [Medical Doctor], he ordered Risperdal [an antipsychotic medication] 0.5mg [milligrams] PRN [as needed] for agitation. Writer administered PRN RISPERDAL 0.5mg. Moved resident to another room [room number removed] for the safety of herself & her roommate's safety. Educated and advised staff to monitor resident for any behaviors. No other concerns noted at this time. All safety measures implemented. RP [Resident Representative] notified. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the State Agency (SA) or that an investigation had been done related to the 09/20/25 incident. B. Review of R101's Progress Notes, dated 10/18/25 and found in the EMR under the Notes tab, revealed, last evening while in the dining room resident [R101] began to argue with another [unidentified resident] and stated to her if you say one more thing im going to kill you. seperated [sic] the two. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the State Agency (SA) or that an investigation had been done related to the 10/18/25 incident. C. Review of R101's Progress Notes, dated 01/19/26 and found in the EMR under the Notes tab, revealed, At 11:46 [AM] this morning resident [R101] was in another [unidentified] resident's face yelling at her and attempting to be physical. Nurse separated both residents. Around 12:15 [PM] charge nurse witnessed resident grab the same residents hand from this morning and put it to her face threatening her. Both residents were separated and [R101] was given her prn Depakote. DON was notified and had staff review the cameras. At first resident seemed to have calmed down but around 2:50 [PM] she asked another [unidentified] resident from another hall, What the hell are you looking at? This resident was not doing anything, but peeping around the corner. Charge nurse (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed [R101] that resident was not looking at her, he was just peeping around in general. [R101] made a smart remark. The resident from the previous incident this morning came strolling by and [R101] began cussing her out and telling her you better not f**king come over here. Ill whoop your ass. Shortly after [R101] had all five of her fingers in residents face and pressed them. Wound nurse was able to separate them and DON was notified again. DON requested that resident try to be separated as much as possible. [Physician] was called due to prn medication not being effective. He ordered for the Depakote to be discontinued and start Haldol [an antipsychotic medication] 2.5mg q6h [every six hours] as needed for a week and then he would reevaluate her next week. Resident has been very pleasant thus far. [RP] was notified and expressed thanks for the update. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the State Agency (SA) or that an investigation had been done related to the 01/19/26 incident. D. Review of R101's Progress Notes, dated 04/01/26 and found in the EMR under the Notes tab, revealed, Around 12:25 [PM] resident [R101] was observed on 500 hallway being physical with another [unidentified] resident. She grabbed the resident's arm and pushed her back. (Resident was sitting in wheelchair). Around 12:50 [PM] [R101] had another altercation in the dining room with the same resident. They were sitting at the dining room table and the other resident became very upset given the incident earlier and [R101] grabbed her arm again. [R101] was brought back to her room to finish her lunch. New PRN order received and staff frequently trying to intervene before anymore [sic] physical altercations. Will continue to monitor. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the State Agency (SA) or that an investigation had been done related to the 04/02/26 incident. During an interview with the DON and the Administrator on 04/23/26 at 4:27 PM, both indicated they were not aware of the incidents involving R101 on 09/20/25, 10/18/25, 01/19/26, or 04/01/26 and so the incidents were never reported or investigated. The Administrator stated all potential incidents of abuse, including verbal and physical abuse, were expected to be reported to himself and the DON. Review of the policy titled, Identifying Types of Abuse dated September 2022 revealed, As part of the abuse prevention strategy, volunteers, employees, and contractors hired by this facility are expected to be able to identify the different types of abuse that may occur against residents . Abuse toward a resident can occur as: resident-to-resident abuse . Physical Abuse includes but is not limited to hitting, slapping, biting, punching or kicking . Mental abuse is the use of verbal or non-verbal conduct which causes (or has the potential to cause) the resident to experience humiliation, intimidation, fear, shame, agitation or degradation . Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of verbal, written, or gestured communication, or sounds, to residents within hearing distance, regardless of age,ability to comprehend, or disability . Sexual Abuse is non-consensual sexual conduct of any type with a resident . Generally, sexual contact is nonconsensual if . the resident appears to want the contact to occur but lacks the cognitive ability to consent . Residents have the right to engage in consensual sexual activity. However, anytime there is reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility will take steps to ensure that the resident is protected from abuse, including evaluating whether the resident has the capacity to consent to sexual activity.

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	115638	A. Building B. Wing	04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Manor, Incorporated	2455 Oak Grove Church Road Carrollton, GA 30117

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of record review, document review, interviews, and policy review, the facility failed to ensure timely reporting of allegations of abuse related to three Residents (Resident (R) 101, R75, and R19) out of eleven residents reviewed for abuse. The facility's failure to ensure potential abuse was reported timely created the potential for ongoing abuse of residents in the facility. A total of 34 residents were reviewed in the sample. Cross reference F600 Findings include:1. Review of R101's admission Record, located in the electronic medical record (EMR) under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included Alzheimer's disease. R101 was discharged from the facility on a psychiatric hold on 04/06/26 and was not residing in the facility at the time of the survey. A. Review of R101's Progress Notes, dated 09/20/25 and found in the EMR under the Notes tab, revealed, Resident [R101] started arguing with her [unidentified] roommate. She was walking towards her roommate voicing violent threats B**** I will kill you; I will knock you out of your w/c [wheelchair]. Writer redirected resident. Called MD [Medical Doctor], he ordered Risperdal [an antipsychotic medication] 0.5mg [milligrams] PRN [as needed] for agitation. Writer administered PRN RISPERDAL 0.5mg. Moved resident to another room [number omitted] for the safety of herself & her roommate's safety. Educated and advised staff to monitor resident for any behaviors. No other concerns noted at this time. All safety measures implemented. RP [Resident Representative] notified. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the State Agency (SA) or the local Ombudsman. B. Review of R101's Progress Notes, dated 10/18/25 and found in the EMR under the Notes tab, revealed, last evening while in the dining room resident [R101] began to argue with another [unidentified resident] and stated to her if you say one more thing im [sic] going to kill you. seperated [sic] the two. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the SA or the local Ombudsman. C. Review of R101's Progress Notes, dated 01/19/26 and found in the EMR under the Notes tab, revealed, At 11:46 [AM] this morning resident [R101] was in another residents face yelling at her and attempting to be physical. Nurse separated both residents. Around 12:15 [PM] charge nurse witnessed resident grab the same residents hand from this morning and put it to her face threatening her. Both residents were separated and [R101] was given her prn Depakote. DON [Director of Nursing] was notified and had staff review the cameras. At first resident seemed to have calmed down but around 2:50 [PM] she asked another resident from another hall, What the hell are you looking at? This resident was not doing anything but peeping around the corner. Charge nurse informed [R101] that resident was not looking at her, he was just peeping around in general. [R101] made a smart remark. The resident from the previous incident this morning came strolling by and [R101] began cussing her out and telling her you better not f**king come over here. Ill whoop your ass. Shortly after [R101] had all five of her fingers in residents face and pressed them. Wound nurse was able to separate them and DON was notified again. DON requested that resident try to be separated as much as possible. [Physician] was called due to prn medication not being effective. He (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered for the Depakote to be discontinued and start Haldol [an antipsychotic medication] 2.5mg q6h [every six hours] as needed for a week and then he would reevaluate her next week. Resident has been very pleasant thus far. [RP] was notified and expressed thanks for the update. Review of the facility's documentation revealed the DON was notified of the incident; however, the facility was not able to provide any documentation to show the potential abuse was reported to the SA or the local Ombudsman. D. Review of R101's Progress Notes, dated 04/01/26 and found in the EMR under the Notes tab, revealed, Around 12:25 [PM] resident [R101] was observed on 500 hallway being physical with another [unidentified] resident. She grabbed the resident's arm and pushed her back. (Resident was sitting in wheelchair). Around 12:50 [PM] [R101] had another altercation in the dining room with the same resident. They were sitting at the dining room table and the other resident became very upset given the incident earlier and [R101] grabbed her arm again. [R101] was brought back to her room to finish her lunch. New PRN order received and staff frequently trying to intervene before anymore [sic] physical altercations. Will continue to monitor. Review of the facility's documentation revealed nothing to indicate the allegation of potential abuse was reported timely to facility administration or to the SA or the local Ombudsman. During an interview with the DON and the Administrator on 04/23/26 at 4:27 PM, both indicated they were not aware of the incidents involving R101 on 09/20/25, 10/18/25, 01/19/26, or 04/01/26. The DON stated the incidents should have been reported to himself and/or the Administrator and should have been reported timely to the SA and Local Ombudsman. 2A. Review of R75's admission Record, located under the Profile tab of the EMR revealed she was admitted on [DATE] and had a diagnosis of dementia with psychotic disturbance. Review of R75's annual MDS with an ARD of 01/19/26 and located under the MDS tab of the EMR revealed a score of three out of 15 on the BIMS, indicating severely impaired cognition. Review of R75's EMR under the Progress Note tab revealed a General Nurses Note dated 03/04/26 that documented, Spoke with [R75's representative] about incident that occurred yesterday evening between resident and another resident from a different hall. Nurse was alerted that this resident and the other were caught making out but were separated. Staff talked to this resident and resident was not aware that it was a female she kissed and became very upset. The incident was mutual between both residents. [R75] was taken down to her room to calm down. [R75's representative] verbalized understanding and expressed thanks for the update. Will continue to monitor. 3B. Review of R19's admission Record located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. Review of R19's quarterly MDS with an ARD of 04/01/26 and located under the MDS tab of the EMR revealed a score of three out of 15 on the BIMS, indicating severely impaired cognition. She exhibited no symptoms of depression and wandered frequently. Review of R19's EMR revealed no documentation of the incident with R75, or any follow up by the facility. C. During an interview on 04/23/26 at 4:02 PM, the DON, who served as the facility's abuse coordinator, stated there was no documented incident report and no report to the SA of the incident on (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/04/26. He stated he did not know one was needed in this instance. During an interview on 04/23/26 at 4:28 PM, the DON stated any allegation involving abuse should be reported to him immediately and reported to the SA within two hours. The DON stated he was alerted to the incident on 03/04/26, but he was told it was a mutual act between both residents; therefore, the incident was not reported. The DON stated the facility had not assessed either residents' capacity to consent or to understand their actions and was unable to explain how this was determined to be a consensual interaction. During a review of the security camera footage on 04/23/26 at 6:03 PM with the Administrator, R19 was seated in the hallway when R75 approached her, and they embraced and began kissing. However, the residents were viewed from behind, and R75's arm was blocking the view of the residents' faces. R75 began to touch R19's face and arm. The Administrator stated he thought it looked like a kiss on the cheek and hugging and back rub rather than any sexual contact. The Administrator stated he was not aware of this incident and had not reviewed the footage or investigated until now. The Administrator stated the incident should have been reported to him and to the SA so that adequate follow-up could be done. Review of the facility's Abuse, Neglect, Exploitation or Misappropriation – Reporting and Investigating Policy, dated most recently revised 09/2022 indicated, All reports of resident abuse (including injuries of unknown origin), neglect, exploitation, or theft/misappropriation of resident property are reported to local, state and federal agencies (as required by current regulations) and thoroughly investigated by facility management; and 1. If resident abuse, neglect, exploitation, misappropriation of property or injury of unknown source is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law; and Immediately is defined as: a. within two hours of an allegation involving abuse or resulting in serious bodily injury; or within 24 hours of an allegation that does not involve abuse or result in serious bodily injury.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement care plans for four residents (Resident (R)2, R5, R24, and R70) of 34 sampled residents. Specifically, care plans were not developed for residents' use of bed rails or oxygen, and resident-to-resident abuse interventions were not included in their comprehensive care plan. This failure had the potential to affect the accuracy and complexity of resident care. Findings include:1. Review of R2's admission Record from the facility's electronic medical record (EMR) Profile tab revealed a facility admission date of 10/10/2025 with medical diagnoses that included pneumonia, asthma, protein-calorie malnutrition, chronic respiratory failure, and chronic kidney disease (CKD). During an observation on 04/21/2026 at 12:18 PM, R2's bed had bilateral upper bed rails (towards the head of the bed). During an observation on 04/22/2026 at 9:25 AM, R2 was in bed with bilateral upper rails. Review of R2's EMR Care Plan tab revealed limitations in physical functioning and mobility, with a focus on intervention for bed mobility of: Resident is dependent on staff for all bed mobility. Nothing regarding the use of bed rails was found in the care plan. 2. Review of R5's EMR Profile tab admission Record revealed a facility admission date of 10/22/2022 with medical diagnoses that included cerebral infarction, dementia, hearing loss, and peripheral vascular disease. Review of R5's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/06/2026 showed a Brief Interview for Mental Status score of 12 out of a possible 15, indicative of moderate cognitive impairment. During an interview and observation on 04/21/2026 at 2:55 PM, R5 was observed with bilateral upper bed rails and stated she does not use them. Review of R5's EMR Care Plan tab revealed a self-care performance focus related to hemiplegia, hemiparesis, and a history of stroke, with an intervention for bed mobility of: The resident is dependent on staff for bed mobility. The resident will often refuse to turn and reposition and prefers to lie on her back despite education. Nothing regarding the use of bed rails was found in the care plan. 3. Review of R24's admission Record from the facility's EMR Profile tab revealed a facility admission date of 09/17/2024, readmission on [DATE], with medical diagnoses that included spinal stenosis, peripheral vascular disease (PVD), low back pain, altered mental status, acute pulmonary edema, and acute respiratory failure. Review of R24's quarterly MDS with an ARD of 06/18/2025 (R24 has been hospitalized frequently and has not had a full MDS since then) revealed a BIMS score of 14 out of a possible 15, indicative of being cognitively intact. During an interview on 04/21/2026 at 3:08 PM, R24 was noted to have one bed rail in the middle section of the bed on the interior side of the room and a bed rail on the upper section of the bed on the window side of the room. R24 was also noted to be using three liters per minute (LPM) of oxygen via (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nasal canula from an oxygen concentrator. R24 noted that three LPM were normal, but sometimes he would use four LPM. Review of R24's EMR Care Plan tab revealed a focus for bed mobility with an intervention of [R24's name] needs set up to supervision for bed mobility. Nothing regarding the use of bed rails or oxygen was found in the care plan. During an interview on 04/25/2026 at 1:48 PM, the Administrator stated that the expectation was that the care plans would include oxygen use and mobility assistance. 4. Review of R70's EMR Profile tab revealed R70 was admitted on [DATE] with diagnoses of major depressive disorder, unspecified dementia, intermittent explosive disorder, restlessness and agitation, vascular dementia moderate with agitation, and depression. Review of the EMR quarterly MDS with an ARD of 01/30/2026 revealed a BIMS score of 00 out of 15, indicating R70 had severe cognitive impairment. The assessment also revealed R70 exhibited verbal behavioral symptoms toward others by threatening others, screaming at others, and cursing at others. Review of the EMR Progress Notes tab revealed that the nursing progress notes dated between 10/10/2025 and 03/30/2026 indicated multiple observations that R70 appeared agitated towards other residents while telling them to stay away from his wife. Review of the EMR Care Plan tab revealed R70's care plan was not updated after confirmed occurrences of resident agitation or a reported incident of resident-to-resident abuse. The care plan documentation failed to initiate interventions that could prevent further resident-to-resident abuse. Care plan interventions initiated on 11/19/2025 included allowing the resident to make decisions about his treatment regime; educate resident/family/caregivers of the possible outcome of not complying with his treatment or care; encourage participation/interaction by the resident as possible during care activities; give clear explanation of all care activities prior to and as they occur during each contact; if resident resists with ADL's, reassure resident, leave and return at a later time; R70 may be seen by Care Now Psychiatrist Services; praise the resident when behavior is appropriate to provide consistency in care to promote comfort with ADL's. The care plan had no initiated interventions after 11/19/2025. Review of the investigation file for the reported allegations of abuse that occurred on 03/30/2026 revealed that no measures were implemented to protect other residents from the potential of R70's abusive behavior and to ensure a safe environment. During an interview on 04/21/2026 at 4:45 PM with the Director of Nursing (DON) and the Administrator, the DON stated that, typically, an incident is reported to him immediately after it occurs. He said he would not update the care plan at that time unless it was more than an isolated event. He said for interventions after an incident, We may change medications, monitor the residents to prevent further escalation by keeping an eye on them, but we do not usually document new interventions in the care plan. He said they have no targeted staff training or in- service after an incident occurs. Review of the facility policy titled, Care Plans, Comprehensive Person-Centered, revised March 2022, revealed: Policy Statement; A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	developed and implemented for each resident. Policy Interpretation and Implementation.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, include: . e.11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change. 12. The interdisciplinary team reviews and updates the care plan .

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, and policy review, the facility failed to ensure an ongoing program of activities was provided for one of five residents reviewed for activities (Resident (R) 28), who was bedbound. This failure placed R28 at risk for isolation or lack of sensory stimulation.Findings include:Review of R28's admission Record, located under the Profile tab of the EMR, revealed she was admitted to the facility on [DATE] with diagnoses including vascular dementia and anoxic brain damage. During an observation on 04/21/26 at 11:11 AM in R28's room, she was observed lying in bed. R28 was not responsive to questions or verbal/tactile stimuli. R28's eyes remained closed and she was not observed to move on her own. There was no radio in her room, and the TV was not on. During an observation on 04/22/26 from 10:22 AM to 11:47 AM in R28's room, she was lying in bed with her eyes closed and was unresponsive to verbal or tactile stimuli. The TV was on; however, there was no volume. During an observation on 04/22/26 at 2:25 PM in R28's room, she was lying in bed with her eyes closed and was unresponsive to verbal or tactile stimuli. The TV was on; however, there was no volume. Review of R28's Care Plan, dated 04/22/26 and located under the Care Plan tab of the EMR revealed, The resident is dependent on staff for meeting emotional, intellectual, physical, and social needs r/t [related to] cognitive deficits. The approaches included: All staff to converse with resident while providing care . The resident needs 1:1 [one-to-one] bedside/in-room visits and activities if unable to attend out of room events . [and] The resident needs assistance/escort to activity functions. During an observation on 04/23/26 at 10:27 AM in R28's room, she was observed seated in a reclining wheelchair with her eyes closed. There was no music or TV on in the room. Review of R28's activity participation calendar dated April 2026 and provided on paper by the Activity Director (AD) revealed she received room visits on 04/10/26, 04/14/26, 04/16/26, 04/20/26, and 04/23/26. There was no other activity participation documented. During an interview on 04/24/26 at 3:05 PM, the AD stated R28 was unable to respond to staff or participate in any activities. She stated the resident was bedbound and would need room visits where the staff would play music, talk to her, or provide some sort of auditory or tactile stimulation. The AD stated the resident did not have a radio in her room but would benefit from music or having the TV on to listen to throughout the day between staff visits. Review of the Activity Programs policy, dated June 2018, revealed, Activities offered are based on the comprehensive resident-centered assessment and the preferences ofeach resident . Our activity programs are designed to encourage maximum individual participation and are geared to the individual resident's needs . Our activity programs consist of individual, small group, and large group activities that are designed to meet the needs and interests of each resident . Activities are not necessarily limited to formal activities being provided only by activities staff. Other facility staff, volunteers, visitors, residents and family members may also provide the activities.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, staff interviews, review of the Food and Drug Administration (FDA) guidance, and facility policy review, the facility failed to ensure assessments, including alternatives to rail usage, were attempted prior to the installation and use of bed rails for six 34 sampled residents (Resident (R) 2, R5, R24, R28, R33, and R57). This failure had the potential to increase accidental entrapment or injury.Findings include:1. Review of R2's admission Record from the facility electronic medical record (EMR) Profile tab revealed a facility admission date of 10/10/25 with medical diagnoses that included pneumonia, asthma, protein calorie malnutrition, chronic respiratory failure, and chronic kidney disease (CKD). During an observation on 04/21/26 at 12:18 PM, R2's bed had bilateral upper (towards the head of the bed) bed rails. During an observation on 04/22/26 at 9:25 AM, R2 was in bed with bilateral upper rails. Review of R2's EMR Assessment tab, Progress Notes tab, and Miscellaneous tab did not reveal a bed rail assessment or evaluation, or informed consent with advisement of the risks/benefits of rails. Review of R2's EMR Care Plan tab revealed for limitations in physical functioning and mobility focus an intervention for bed mobility of: Resident is dependent on staff for all bed mobility. 2. Review of R5's EMR Profile tab admission Record revealed a facility admission date of 10/22/22 with medical diagnoses that included cerebral infarction, dementia, hearing loss, and peripheral vascular disease. Review of R5's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/06/26 and located in the MDS tab, showed a Brief Interview for Mental Status score of 12 out of a possible 15, indicative of moderate cognitive impairment. Review of R5's EMR Assessment tab, Progress Notes tab, and Miscellaneous tab did not reveal a bed rail assessment or evaluation, or informed consent with advisement of the risks/benefits of rails. Review of R5's EMR Care Plan tab revealed a self-care performance focus related to hemiplegia, hemiparesis, and history of stroke with an intervention for bed mobility of The resident is dependent on staff for bed mobility. The resident will often refuse to turn and reposition and prefers to lie on her back despite education. During an observation and interview on 04/21/26 at 2:55 PM, R5 was noted to have bilateral upper bed rails and stated she does not use them. When asked if the facility had reviewed the risks/benefits of bed rails with her, R5 responded, They didn't mention anything. 3. Review of R24's admission Record from the facility electronic medical record (EMR) Profile tab revealed a facility admission date of 09/17/24, readmission on [DATE], with medical diagnoses that included spinal stenosis, peripheral vascular disease (PVD), low back pain, altered mental status, acute pulmonary edema, and acute respiratory failure. Review of R24's quarterly MDS with an ARD of 06/18/25 (R24 has been hospitalized frequently and has not had a full MDS since then) revealed a BIMS score of 14 out of a possible 15, indicative of being cognitively intact. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R24's EMR Assessment tab, Progress Notes tab, and Miscellaneous tab did not reveal a bed rail assessment or evaluation, or informed consent with advisement of the risks/benefits of rails. Review of R24's EMR Care Plan tab revealed a focus for bed mobility with an intervention of [R24's name] needs set up to supervision for bed mobility. During an interview on 04/21/26 at 3:08 PM, R24 was noted to have one bed rail in the middle section of the bed on the interior side of the room and a bed rail on the upper section of the bed on the window side of the room. R24 stated he used the rail for positioning and has rolled out of bed a couple of times. When asked if the facility had advised him of the risks and/or benefits of the bed rails, R24 responded, Nobody told me the risks or if they did, I don't remember. During an interview on 04/23/26 at 2:50 PM the Director of Nursing (DON) revealed there were no bed rail assessments or evaluations for R2, R5, and R24. 4. Review of R28's admission Record, located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] with diagnoses including vascular dementia and anoxic brain damage. During an observation on 04/21/26 at 11:11 AM in R28's room, she was observed lying in bed. R28 was not responsive to questions or verbal/tactile stimuli. She was not observed to move on her own. There were 1/4 bed rails, positioned on each side of the bed in the center of the bed, in the 'down' position so that they both were used as a side rail. During an observation on 04/22/26 at 10:22 AM in R28's room, she was observed lying in bed with a quarter-length bed rail in the 'down' position on the left forming a side rail and in the 'up' position on the right forming a grab bar. Review of R28's EMR revealed no assessment for the use of bed rails, no order for the use of bed rails, and no indication of the reason for use of bed rails. Review of R28's Care Plan dated 04/23/26 and located under the Care Plan tab of the EMR revealed she was totally dependent on staff for bed mobility, transfers, and all activities of daily living. She was bedfast all or most of the time. The Care Plan did not address the use of bed rails. During an interview on 04/23/26 at 2:50 PM, the Administrator stated there was no assessment of R28's need for, or ability to use, the bed rails. During an observation on 04/24/26 at 9:30 AM in R28's room, she was observed lying in bed with a quarter-length bed rail in the 'down' position on the left forming a side rail and in the 'up' position on the right forming a grab bar. During an interview on 04/24/26 at 9:39 AM, Licensed Practical Nurse (LPN) 2 confirmed R28 had bilateral bed rails in place and stated every resident bed contained one side rail in the 'up' position and one side rail in the 'down' position per facility policy. She stated there were no orders, Care Plans, or assessments for the use of bed rails unless they were being used as a restraint. LPN2 stated R28 was unable to move on her own and did not roll in bed or use the bed rails for positioning/mobility. LPN2 stated there was no method to communicate to staff who required bed rails and which ones should be in the 'up' position versus the 'down' position. She stated the CNAs would make their own judgment if bed rails were needed and if they should be 'up' or 'down.' (continued on next page)

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	115638	A. Building B. Wing	04/25/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5. Review of R33's admission Record, dated 04/25/26 and located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included vascular dementia and type 2 diabetes. Review of R33's significant change MDS, with an ARD of 02/09/26 and found in the EMR under the MDS tab, revealed a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. The assessment indicated the resident required substantial to maximal assistance from staff to roll left to right in her bed and was dependent upon staff to transfer in and out of her bed. Review of R33's comprehensive care plan, dated 02/09/26 and found in the EMR under the Care Plan tab, revealed no care plan related to the resident's use of bed rails. Review of R33's Physician's Order Report, dated 04/25/26 and found in the EMR under the Orders tab, revealed no orders for the resident's use of bed rails. Review of R33's comprehensive medical record revealed nothing to indicate an assessment had ever been done related to the resident's use of bed rails. Review of R33's comprehensive medical record revealed nothing to indicate informed consent had ever been obtained for the resident's use of bed rails. Observations of R33 were conducted on 04/21/26 at 11:15 AM; on 04/22/26 at 3:19 PM; on 04/23/26 at 10:42 AM and 5:38 PM; and on 04/24/26 at 9:09 AM and 2:38 PM. The resident was laying in her bed with bilateral one-third length side rails in the raised position on her bed during each of the observations. R33 was observed along with LPN2 on 04/24/26 at 10:00 AM. LPN2 confirmed the resident's bed rails were raised on both sides of her bed and stated the rails were probably raised because R33 requested them. R33 stated she thought the rails were useful when turning in bed but did not remember requesting the rails or giving informed consent for the use of the rails. 6. Review of R57's admission Record, located in the EMR under the Profile tab revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included adult failure to thrive. Review of R57's comprehensive care plan, dated 02/09/26 and found in the EMR under the Care Plan tab, revealed no care plan related to the resident's use of bed rails. Review of R57's significant change MDS, with an ARD of 03/19/26 and found in the EMR under the MDS tab, revealed a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired. The assessment indicated the resident was independent with rolling left to right in her bed as well as with transfers in and out of her bed. Review of R57's Physician's Order Report, dated 04/25/26 and found in the EMR under the Orders tab, revealed no orders for the resident's use of bed rails. Review of R57's comprehensive medical record revealed nothing to indicate an assessment had ever been done related to the resident's use of bed rails. Review of R57's comprehensive medical record revealed nothing to indicate informed consent had ever been obtained for the resident's use of bed rails. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations of R57 were conducted on 04/21/26 at 10:33 AM, on 04/22/26 at 3:21 PM, on 04/23/26 at 09:30 AM, and on 04/25/26 at 9:32 AM. R57 was in her room either laying or sitting on her bed or transferring from her wheelchair to her bed and back during each of the observations. One one-third length bed rail and one quarter-length bed rail were observed in the raised position on the resident's bed during each of the observations. R57 was observed along with LPN2 on 04/24/26 at 9:39 AM. LPN2 confirmed the resident's bed rails were raised on both sides of her bed and stated she interpreted the rails as being up on one side and not up on the other side of the bed. LPN2 stated the quarter-length rail was not considered to be in the raised position and stated orders, consent, and a care plan were only obtained for the use of bed rails if rails were raised on both sides of a resident's bed. The UM stated she was not aware of any assessment conducted for any resident's use of bed rails. During an interview with the DON on 04/24/26 at 4:14 PM, he stated all of the beds in the facility with bed rails already had the rails on them when the beds were delivered to the facility. He confirmed no assessment was done related to residents' use of bed rails and confirmed physician's orders, a care plan, and informed consent for the use of rails were not obtained for the use of bed rails, either. During an interview on 04/25/26 1:48 PM the Administrator stated an expectation was that residents would be assessed for the need for bed mobility rails. Review of the FDA guidance located at https://www.fda.gov/regulatory-information/search-fda-guidance-documents/hospital-bed-system-dimens.) revealed recommendations for rail entrapment revealed, .Potential Zones of Entrapment, This guidance describes seven zones in the hospital bed system where there is a potential for patient entrapment. Entrapment may occur in flat or articulated bed positions, with the rails fully raised or in intermediate positions. Descriptions of the seven entrapment zones appear on pages 15-21 in this guidance.The seven areas in the bed system where there is a potential for entrapment are identified in the drawing below: Zone 1: Within the Rail, Zone 2: Under the Rail, Between the Rail Supports or Next to a Single Rail Support, Zone 3: Between the Rail and the Mattress, Zone 4: Under the Rail, at the Ends of the Rail, Zone 5: Between Split Bed Rails, Zone 6: Between the End of the Rail and the Side Edge of the Head or Foot Board, Zone 7: Between the Head or Foot Board and the Mattress End.Dimensional Limits for Identified Entrapment Zones 1-4, FDA is recommending dimensional limits for zones 1 through 4 at this time because we believe the majority of the entrapments reported to FDA have occurred in these zones. We based these recommended limits upon the body parts entrapped in these individual zones identified through adverse event reports and entrapment scenarios described in the reports. Review of the facility's policy titled, Bed Safety and Bed Rails, revised August 2022, revealed: The use of bed rails is prohibited unless the criteria for use of bed rails have been met . 1. The resident's sleeping environment is evaluated by the interdisciplinary team. 2. Consideration is given to the resident's safety, medical conditions, comfort, and freedom of movement, as well as input from the resident and family regarding previous sleeping habits and bed environment. 3. Bed frames, mattresses, and bed rails are checked for compatibility and size prior to use . 6. Maintenance staff routinely inspects all beds and related equipment to identify risks and problems including potential entrapment risks . Bed Rails . are prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. 4. Prior to the installation or use of a side or bed rail, alternatives to the use of side or bed rails are attempted . 5. If attempted alternatives do not adequately meet the resident's needs the resident may be evaluated for the use of bed rails. This interdisciplinary evaluation includes: an (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review, the facility failed to provide medically-related social services to address potential psychosocial concerns and evaluate the ability to consent in sexual activities for two of three residents (Resident (R) 75 and R19) reviewed for behavioral and emotional needs. These failures had the potential to contribute to ongoing psychosocial distress following an incident of potential sexual abuse.Findings include:1. Review of R75's admission Record located under the Profile tab of the electronic medical record (EMR) revealed she was admitted on [DATE] and had a diagnosis of dementia with psychotic disturbance. Review of R75's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/19/26 and located under the MDS tab of the EMR revealed a score of three out of 15 on the Brief Interview for Mental Status (BIMS), indicating severely impaired cognition. Review of R75's EMR under the Progress Note tab revealed a General Nurses Note dated 03/04/26 that documented, Spoke with [R75's representative] about incident that occurred yesterday evening between resident and another resident from a different hall. Nurse was alerted that this resident and the other were caught making out but were separated. Staff talked to this resident and resident was not aware that it was a female she kissed and became very upset. The incident was mutual between both residents. [R75] was taken down to her room to calm down. [R75's representative] verbalized understanding and expressed thanks for the update. Will continue to monitor. Review of R75's EMR under the Care Plan tab revealed her Care Plan was last revised on 02/10/26 and was not updated with new information following this incident. 2. Review of R19's admission Record located under the Profile tab of the EMR revealed she was admitted to the facility on [DATE] and had a diagnosis of Alzheimer's disease. Review of R19's quarterly MDS with an ARD of 04/01/26 and located under the MDS tab of the EMR revealed a score of three out of 15 on the BIMS, indicating severely impaired cognition. She exhibited no symptoms of depression and wandered frequently. Review of R19's EMR revealed no documentation of the incident with R75, or any follow up by the facility. Review of R19's EMR under the Care Plan tab revealed her Care Plan, revised on 04/16/26, was not updated with new information following this incident. During an interview on 04/23/26 at 4:02 PM, the Director of Nursing (DON), who served as the facility's abuse coordinator, stated there was no documented incident report and no investigation of the incident on 03/04/26. He stated he did not know one was needed in this instance. During an interview on 04/23/26 at 4:10 PM, Licensed Practical Nurse (LPN) 3 stated she was working on 03/04/26 during the incident; however, she did not witness the incident directly. She stated the Certified Nurse Aide (CNA) working that day had reported the incident to her. LPN3 stated she reported the incident to the DON, who directed her to notify R75's representative the following day. She stated the CNA reported to her that R75 was kissing R19 with tongue but there was no groping or other sexual contact. She stated R75 stated she thought she was kissing a man, and she began crying (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	when told she was kissing R19. LPN3 stated this was a mutual act because they were both consenting to the activity at the time, while R75 was under the impression she was kissing a man. During an interview on 04/23/26 at 4:28 PM, the DON stated he was alerted to the incident on 03/04/26, but he was told it was a mutual act between both residents; therefore, the incident was not reported or investigated. The DON stated the facility had not assessed either residents' capacity to consent or to understand their actions and was unable to explain how this was determined to be a consensual interaction. During a review of the security camera footage on 04/23/26 at 6:03 PM with the Administrator, R19 was seated in the hallway when R75 approached her, and they embraced and began kissing. However, the residents are viewed from behind, and R75's arm is blocking the view of the residents' faces. R75 began to touch R19's face and hair. A staff member walked past the two residents during this interaction and stopped to watch as they continued to embrace. The Administrator was unable to identify the staff member. The staff member then approached CNA18, and both staff went to speak with the residents, who had already separated. At this time, R75 began crying, and staff were consoling her. The Administrator stated he thought it looked like a kiss on the cheek and hugging and back rub rather than any sexual contact. The Administrator stated he was not aware of this incident and had not reviewed the footage or investigated it until now. The Administrator stated if he were aware of the incident, he would have reviewed the footage and investigated to rule out any type of sexual abuse. During an interview on 04/24/26 at 8:46 AM, the Administrator stated the unidentified staff witness was the Physical Therapist (PT). During a telephone interview on 04/24/26 at 9:15 AM, the PT stated both R75 and R19 had significant cognitive deficits due to dementia. She stated R75 approached R19 and leaned forward to give her a kiss on the lips. The PT stated, this caught me off guard because they have both have been married to men. The PT stated she asked R75 if she knew what she was doing and who she was kissing and reminded her she was kissing a female but did not recall R75's reaction. The PT stated she did not intervene in the interaction, but she notified CNA18 and LPN3. The PT added, It puzzled me because I knew both of them before . in normal life they would be appalled by this. I didn't want to let them do something to make them feel bad about themselves . It was just concerning because it was not normal behavior. During an interview on 04/24/26 at 9:32 AM, CNA18 stated she did not witness the interaction between R75 and R19; they were already separated when she saw them. She stated R75 said, 'She kissed me' and kept repeating this, getting agitated. She stated R19 denied kissing R75, stating, 'I don't kiss women.' CNA18 stated LPN3 was aware of the interaction. CNA18 stated R75 did not bring up the incident again later in the day. During an interview on 04/24/26 at 5:01 PM, the Social Services (SS) staff stated she was unaware of the incident between R75 and R19. The SS stated, I don't know how it could be mutual because their cognition is low. She stated both residents had very low BIMS scores and were likely unable to understand the consequences of their actions or formulate consent. The SS stated she would have expected to be notified of this incident right away so she could follow up with both residents to ensure they were ok and there were no negative psychosocial effects of the incident. The SS added she would talk with the residents and their responsible parties to assess their ability to consent. The SS added she would have referred both residents to counseling after the incident. Review of the policy titled, Identifying Types of Abuse, dated September 2022, revealed, Sexual Abuse is non-consensual sexual conduct of any type with a resident . Generally, sexual contact is nonconsensual if . the resident appears to want the contact to occur but lacks the cognitive ability to consent . Residents have the right to engage in consensual sexual activity. However, anytime there is (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility will take steps to ensure that the resident is protected from abuse, including evaluating whether the resident has the capacity to consent to sexual activity. Review of the policy titled, Social Services, dated September 2021, revealed, Medically-related social services are provided to maintain or improve each resident's ability to controleveryday physical needs (e.g., appropriate adaptive equipment for eating, ambulation, etc.); and mental and psychosocial needs (e.g., sense of identity, coping abilities, and sense of meaningfulness or purpose) . The facility staff is able to identify and address factors that have a potentially negative effect on psychosocial functioning of a resident, for example: . situations that impede the resident's dignity and sense of control; . difficulty with personal interactions or social skills, and/or resident to resident altercations; . abuse of any kind; . [or] behavioral problems.

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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, and staff interviews, the facility failed to ensure a medication error rate was less than five percent during medication administration review. Five errors were identified from 31 opportunities involving three residents (R) (R39, R46, and R49), resulting in a 16.13 percent medication error rate. The deficient practice placed residents at risk for inaccurate dosing and adverse clinical outcomes. Findings include:1. Review of R39's admission Record, dated [DATE] and located in the electronic medical record (EMR) under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included hypertension. Review of R39's Physician's Order Report, dated [DATE] and located in the EMR under the Orders Tab, revealed an order dated [DATE] for the resident to receive ferrous sulfate (iron supplement) 325 milligrams (mg) one time per day and an order dated [DATE] for the resident to receive amlodipine (a blood pressure reducing medication) 2.5 mg one time a day for high blood pressure. The order indicated the amlodipine was to be held if the resident's systolic blood pressure was less than 110 or his diastolic blood pressure was less than 60. Licensed Practical Nurse (LPN) 6 was observed administering R39's medication on [DATE] at 9:39 AM. The expiration date on the resident's Feosol (ferrous sulfate) was rubbed out, so the expiration date could not be determined; however, LPN6 poured the medication for administration anyway. R39's blood pressure reading was obtained prior to administration of the medications and revealed a blood pressure of 146/48, which indicated the resident's diastolic blood pressure was below the parameter requiring the resident's amlodipine to be held. LPN6 poured the resident's amlodipine and administered the medication to the resident, even though the resident's physician's orders indicated the medication was to be held. During an interview with LPN6 on [DATE] at 9:54 AM, she stated she was not sure what to do if a medication had expired or she was not able to see the expiration date on a medication container clearly. She stated, I just started being a nurse. LPN6 stated she gave R39 her amlodipine rather than holding it because the resident's systolic blood pressure was above the ordered parameter, and so she used her nursing judgment and administered the medication. 2. Review of R46's admission Record, dated [DATE] and located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included osteoarthritis. Review of R46's Physician's Order Report, dated [DATE] and located in the EMR under the Orders tab, revealed orders dated [DATE] for the resident to receive guaifenesin extended release (an expectorant) 600 mg every 12 hours for congestion and gabapentin (an anticonvulsant medication used for nerve pain) 600 mg three times daily to control pain related to osteoarthritis. LPN1 was observed administering R46's medication on [DATE] at 10:01 AM. LPN1 could not locate the resident's gabapentin or guaifenesin in the medication cart and therefore did not administer either medication to R46. During an interview with LPN1 on [DATE] at 10:17 AM, she confirmed she could not administer R46's gabapentin or guaifenesin because neither of the medications was available. She stated she would order the medications so R46 would be able to receive her medication later in the day. She stated, If I (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order (the medication) now, they will probably be here (delivered to the facility) by 4:00 PM or so. 3. Review of R49's admission Record, dated [DATE] and located in the EMR under the Profile tab, revealed the resident was admitted to the facility on [DATE]. The resident's diagnoses included type 2 diabetes. Review of R49's Physician's Order Report, dated [DATE] and located in the EMR under the Orders tab, revealed an order with an original order date of [DATE] for the resident's blood sugar (BS) to be obtained three times daily prior to meals and for the resident to receive insulin aspart (short-acting insulin) 10 units before meals routinely. There were no ordered hold parameters related to the resident's insulin. LPN3 was observed administering R49's medication on [DATE] at 10:51 AM. LPN3 obtained R49's blood sugar and recorded a blood sugar result of 174. LPN3 then stated she was going to hold the resident's insulin since the resident's blood sugar was less than 200. LPN3 did not administer R49's regularly scheduled insulin. During an interview with LPN3 on [DATE] at 11:00 AM, she stated she held R49's insulin based on nursing judgment and that she always held insulin for the resident if her blood sugar reading was less than 200. During an interview with the Director of Nursing (DON) on [DATE] at 4:40 PM, he confirmed that he expected ordered medications to be available for administration, that medications were not to be administered if expired, and that medication was not to be held unless nursing staff obtained a physician's order to do so. The facility's policy titled, Administering of Medication Policy, dated [DATE], indicated, Medications are administered in a safe and timely manner, and as prescribed; and 4. Medications are administered in accordance with prescriber orders, including any required time frame; and 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified, for example, before and after meal orders; and 8. If a dosage is believed to be inappropriate or excessive for a resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns; and The expiration/beyond use date on the medication label is checked prior to administering.

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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 record review, observation, staff interviews, and policy review, the facility failed to ensure proper storage of refrigerated medications in one of two medication storage rooms in the facility. The facility's failure to ensure medication was appropriately stored created the potential for residents to receive inactive/ineffective medication. Findings include:On 04/25/2026 at 12:00 PM, the facility's main medication storage room was observed with Licensed Practical Nurse (LPN) 2, who served as Unit Manager. The refrigerator in the medication room was used to store multiple residents' medications, including insulin, suppositories, eye drops, and vaccine vials. The facility's temperature monitoring form dated 04/01/2026 through 04/25/2026 was in a book next to the refrigerator; however, temperature entries were missing over multiple days. At the time of observation, the refrigerator temperature was 34 degrees Fahrenheit, cooler than indicated by the facility's policy. Review of the facility's Medication Refrigerator Temperature Log for the refrigerator in the main medication storage room revealed missing temperature entries on 04/01/2026, 04/03/2026, 04/05/2026, 04/08/2026, 04/13/2026, 04/14/2026, 04/18/2026, 04/19/2026, 04/21/2026, 04/22/2026, and 04/24/2026. During an interview with LPN2 on 04/25/2026 at 12:15 PM, she stated the refrigerator temperature was to be monitored at least daily on the evening shift, and the temperatures were to be recorded in the facility's Medication Refrigerator Temperature Log. She confirmed the refrigerator temperatures had not been monitored consistently as required. During an interview with the Director of Nursing (DON) on 04/24/2026 at 4:40 PM, he confirmed he expected at least daily monitoring and recording of temperatures for any refrigerator in the facility containing resident medications or immunizations. Review of the facility's Storage of Medications and Biologicals Policy, revised in September 2001, indicated, Medications requiring refrigeration of Temperatures between 2 degrees Celsius (36 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit) are kept in a refrigerator with a thermometer to allow temperature monitoring.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	115638	A. Building B. Wing	04/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carrollton Manor, Incorporated	2455 Oak Grove Church Road Carrollton, GA 30117

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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on documentation review and interview, the facility failed to post daily nurse staffing data that included the total number of licensed and unlicensed staff working each shift responsible for resident care. This deficient practice has the potential to affect all residents and visitors by not informing them of the available nursing staff to care for the residents.Findings include:Review of the facility's posted daily nurse staffing data revealed the form included the facility's name, date, census, and the actual hours worked per shift for licensed and unlicensed staff responsible for resident care but did not contain the total number of licensed and unlicensed staff members who were on duty for each shift. During an interview on 04/24/26 at 2:32 PM with the Administrator and the Director of Nursing (DON), the DON stated he was responsible for calculating and posting the daily nurse staffing and all the required components of the posting. He stated he was unaware that the total number of staff members needed to be included in the posted report. He stated he would ensure the total number of staff members would be posted on the daily nurse staffing posted. A policy related to daily nurse staffing reports was not provided during the survey.