| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 115660 | A. Building<br>B. Wing | 02/18/2026 |

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| Roselane Health Center by Harborview | 613 Roselane Street<br>Marietta, GA 30060 |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff and resident interviews, record review, and review of the facility's policy titled Residents' Rights, the facility failed to allow choice of personal hygiene care, bathing, or showering of one of 33 sampled residents (R) (R112). This deficient practice had the potential to cause loss of dignity and sense of control over life's needs and contributed to depression and poor skin integrity. Findings included: During an observation and interview on 2/15/2026 at 2:30 pm, a malodorous smell was detected in R112's room. During the interview, R112 admitted that when he is offered a bath, it is always a bed bath because he requires a mechanical lift to get out of bed. He stated that he would prefer a shower instead of a bed bath. During a follow-up interview with R112 on 2/16/2026 at 1:30 pm, he stated that he would prefer a shower but said that it is too much work for the staff, so he doesn't push the issue. A review of the electronic medical record (EMR) revealed R112 was admitted to the facility on [DATE] with pertinent diagnoses, including but not limited to morbid obesity, systolic heart failure, atrophic disorder of skin, xerosis cutis, bipolar disorder, and major depressive disorder.A review of R112's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated R112 is cognitively intact. The functional status on the assessment revealed R112 required two staff members for care due to morbid obesity. He required a mechanical lift for transfers from bed to chair and back to bed. He is incontinent with his bowels and bladder. A review of R112's care plan dated February 2026 indicated a problem of alteration in elimination of bowel/bladder related to benign prostatic hypertrophy, medication use, decreased mobility, diagnosis of urinary retention, and incontinence. A review of December 2025 and January 2026 shower sheets revealed that there were only five shower sheets for R112 in December 2025 (all documented bed baths) and three shower sheets for January 2026 (all documented bed baths). There was no documentation for refusals, and no documentation that R112 was ever provided with assistance in taking a shower.During an interview on 2/16/2026 at 3:00 pm, Certified Nursing Assistant (CNA) AA revealed that R112 is very particular about who showers him, and this usually occurs during the second shift.During an interview on 2/16/2026 at 3:10 pm, Registered Nurse (RN) BB revealed that she had been working at this facility for three years and was unaware that R112 wanted showers rather than bed baths. She stated that if a resident refuses a bath or shower, the CNA is supposed to complete a shower sheet, document the refusal, and notify the charge nurse on the hall so she/he can ask the resident and confirm the refusal. All residents are to have a shower sheet completed on their shower day, indicating the type of bath or shower, or if they refuse, and the charge nurse signs the sheet.During an interview on 2/18/2026 at 10:26 am, the Director of Nursing (DON) confirmed that every resident should have two shower sheets per week, and that the type of bath, refusals, and any skin issues should be documented. She states that expectations for resident choice include honoring residents' choices and making accommodations for them. During<br><br>(continued on next page) |

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

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0561<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | an interview on 2/18/2026 at 11:02 am, the Administrator stated that the expectations are that the resident's baths be a personal choice and that accommodations be made to honor their choices.A review of the facility's policy titled Residents' Rights, with the last revision date of 2/1/2025, revealed the resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choices, including (a) The resident has the right to choose activities, schedules, and health care, and to make choices about aspects of his or her life in the facility that are significant to the resident. |

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| F 0600<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility policies titled Abuse, Neglect and Exploitation and Reporting Reasonable Suspicion of a Crime, the facility failed to protect two of 33 sampled residents (R)(R57 and R148) from abuse. Harm was identified to have occurred on 11/14/2025 when R57 sustained bruising and a skin tear after staff grabbed her arm. Findings included:1. A review of the electronic medical record (EMR) revealed resident R57 was admitted to the facility on [DATE] with a diagnosis of, but not limited to, the following: Acute embolism and thrombosis of the right femoral vein, history of pulmonary embolism, fibromyalgia, major depressive disorder, and dementia with agitation.A review of R57's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 10, which indicated R57 had moderate cognitive impairment; that R57 requires setup and cleanup and substantial assistance with toileting hygiene and showering; that R57 requires partial assistance from staff for upper body dressing; that R57 requires substantial assistance for lower body dressing and footwear on and off, and personal hygiene; and that R57 is dependent on the staff for transfer.The review of R57's care plan dated 9/3/2025 indicated a need for activities of daily living (ADL) assistance due to impaired mobility.A review of facility documents revealed that on 11/14/2025, R57 reported that she had asked to be assisted back to bed, and the Certified Nursing Assistant (CNA) AAA, told her she could put herself in bed. The resident further stated that the CNA twisted her arm during the interaction. The nursing supervisor removed the CNA from the floor immediately and did a head-to-toe assessment of R57. R57 had a skin tear to the right arm, where R57 said the CNA twisted her arm. On 11/15/2025, another skin assessment was performed on R57, and bruising in the pattern of fingerprints could be seen around the skin tear on R57's right arm. The responsible party and the police were notified. The CNA AAA immediately submitted a written resignation and left before the police got to the facility.During an observation on 2/15/2026 at 1:56 pm, R57 was observed lying in bed on her left side away from the door. The resident did not answer when questioned about the abuse incident.During an observation on 2/16/2026 at 4:00 pm, R57 was observed lying in bed. The resident would not answer questions related to the incident and asked the surveyor to leave her room.An interview was attempted with R57 on 2/18/2026 at 9:30 am, but the resident refused.2. A review of the EMR revealed that R148 was last admitted to the facility on [DATE] with diagnoses including, but not limited to, essential (primary) hypertension, gastro-esophageal reflux disease, asthma, hemiplegia, and hemiparesis following cerebral infarction affecting the right dominant side. During an interview at 2:30 pm on 2/15/2026 with Social Worker District Coordinator (SDC) revealed that she was told by the staff that CNA BBB verbally abused R148 by yelling at her to shut up, however, she was not present at the time the verbal abuse incident occurred. The SDC stated she spoke with R148 regarding the alleged verbal abuse incident, and that R148 confirmed the allegation of verbal abuse by nodding her head yes. SDC stated she notified the Administrator (ADM) of the alleged verbal abuse incident.During an interview on 2/16/2026 at 2:50 pm, the ADM revealed she was contacted by the SDC on 12/3/2025 regarding the verbal abuse allegation. The ADM stated she interviewed R148 regarding the alleged verbal abuse allegation. She stated R148 is nonverbal but confirmed the verbal abuse allegation by nodding her head up and down to confirm that it occurred. An interview with the Director of Nursing (DON) on 2/18/2026 at 10:30 am revealed that her expectations to prevent abuse are that no physical or verbal abuse is tolerated and will be dealt with swiftly.An interview with the ADM on 2/18/2026 at 3:05 pm revealed that she expects that abuse does not happen at all in the facility.A review of the facility policy titled Abuse,<br><br>(continued on next page) |

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| F 0600<br>Level of Harm - Actual harm<br>Residents Affected - Few | Neglect and Exploitation revised on 7/15/2025, under the section titled Policy, states it is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.section1a revealed that the policy will prohibit and prevent abuse, neglect, and exploitation of residents. Section 5a Analyzing the occurrence to determine why abuse occurred, and what changes are needed to prevent further occurrences.Further review of the facility policy titled Reporting Reasonable Suspicion of a Crime, revised on 8/1/2024, titled Policy, states it is the policy of this facility pursuant to Section 1150B of the Social Security Act, to report any reasonable suspicion of a crime committed against a resident of this facility. |

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| F 0638<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Assure that each resident’s assessment is updated at least once every 3 months.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled MDS 3.0 Completion, the facility failed to ensure quarterly Minimum Data Set (MDS) assessments were completed within the required regulatory timeframe for two of three sampled residents (R) (R33 and R104). This deficient practice had the potential to delay the development and implementation of an updated comprehensive care plan and impact regulatory compliance.Findings included:A review of the Electronic Health Record (EHR) revealed R33 was admitted on [DATE].A review of the R33's Minimum Data Set (MDS) assessments revealed the following Assessment Reference Dates (ARDs):12/21/2024 - Quarterly Assessment3/25/2025 - Quarterly Assessment3/29/2025 - Quarterly Assessment6/29/2025 - Quarterly Assessment9/21/2025 - Annual Assessment12/22/2025 - Quarterly AssessmentFurther review determined the interval between the 12/21/2024 Quarterly Assessment and the 3/25/2025 Quarterly Assessment was 94 days, exceeding the 92-day regulatory timeframe from the prior Omnibus Budget Reconciliation Act (OBRA) assessment.During an interview on 2/18/2026 at 11:56 am, the Registered Nurse-Vice President of Clinical Reimbursement (RNVPCR) VV, confirmed the assessments were late by two days (94 days between intervals). She stated she expects to monitor the assessment schedule to ensure dates are set according to Resident Assessment Instrument (RAI) guidelines.During an interview on 2/18/2026 at 1:25 pm, the Administrator and National Director of Risk Management (NDRM) WW revealed the expectation is that assessments are completed on time. They identified potential negative outcomes, including failure to meet regulatory requirements and inability to ensure appropriate care planning within required timeframes.A review of the facility policy titled MDS 3.0 Completion, revised on 1/1/2026, revealed that the facility conducts initially and periodically a comprehensive, accurate, and standardized assessment of each resident's functional capacity, using the RAI specified by the State. As stated under the section titled Types of OBRA Assessments. Annual Assessment - a comprehensive assessment completed using an ARD no >366 days from the most recent prior comprehensive assessment and no >92 days from the most recent quarterly assessment (counting ARD to ARD). Quarterly Assessment - completed using an ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to ensure that Activities of Daily Living (ADL) care was provided for three of 33 sampled residents (R) (R15, R46, and R125) related to showers and bed baths according to the schedule. Findings included:1. During the initial screening interview on 2/15/2026 at 2:07 pm, R15 shared that she had not had a shower since her admission. She mentioned that she received bed baths; however, she expressed a preference for showers and declined once, when a male provider proposed to assist her with the shower task.A review of the electronic medical record (EMR) for R15 revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to, orthopedic aftercare following surgical amputation, sepsis, gangrene, atheroembolism of unspecified lower extremity, abscess of left foot, and urinary tract infection.A review of the admission Minimum Data Set (MDS) assessment dated [DATE] revealed R15 presented with a Brief Interview for Mental Status (BIMS) score of 15, indicating no cognitive impairment, impairment on one side of the lower extremity, and dependent with shower/bathing.A review of the care plan initiated on 1/16/2026, and last revised on 2/17/2026, confirmed focus on ADL care assistance related to decreased/impaired mobility. Goals included that R15 would receive ADL care assistance as recommended through the next review. Interventions included that R15 required assistance of two staff with bath/shower, transfers, and toileting as needed until therapy screen is completed - prefers bed baths.An examination of the bath schedule for the [NAME] Wing indicated that R15's room was allocated a shower on Monday and Thursday from 3:00 pm to 11:00 pm. However, no bath sheet was supplied for the date of 2/2/2026. The records for February bath sheets showed that one shower was administered out of the four scheduled dates.An interview and observation conducted on 2/17/2026, at 10:38 am, with R15 disclosed that her new roommate was given the opportunity to take a shower on the first day; however, no one inquired whether she would like to take a shower.2. Interview and observation on 2/16/2026, at 5:53 pm, R46 was in bed; her hair appeared oily and styled in a single braid at the back. R46 was eating; oral inspection could not be performed; she indicated that she had not had a shower.A review of the clinical record for R46 revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to, hemiplegia, unspecified affecting the right dominant side, contracture, and right hand.A review of the quarterly MDS assessment dated [DATE] revealed that R46 presented with a BIMS score of 14, indicating no cognitive impairment, and that R46 was dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear.A review of the care plan initiated on 1/21/2025 revealed R46 had an ADL self-care performance deficit related to activity intolerance, impaired balance, and limited mobility related to right-sided hemiplegia. Goals included that R46 will maintain the current level of function in ADL care through the review date. Interventions included checking nail length and trimming and cleaning nails on bath day, to report any changes to the nurse, to provide a sponge bath when a full bath or shower cannot be tolerated, and that R46 requires the assistance of two staff with bathing/showering.An examination of the bath schedule for the East Wing indicated that R46's room was allocated a shower on Tuesday and Thursday from 7:00 am to 3:00 pm. The records for February 2026 bath sheets revealed dates 2/3/2026 and 2/5/2026, with no indication of what bathing was provided.During an interview on 2/15/2026 at 1:04 pm, the family representative for R46 indicated that the resident's hair seemed to have never been shampooed, her teeth appear to be caked with debris and not brushed, and all leadership, particularly the Director of Nursing (DON) and the Social Worker Director, has been informed.During an interview on 2/17/2026 at 3:51 pm, Licensed Practical Nurse (LPN) UU disclosed that there<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | were two shower sheets available for R46 but that a total of six should have been present. Upon examining the shower forms to verify if baths or showers were performed, LPN UU indicated that nothing was recorded. Additionally, LPN UU confirmed that if a resident refused care, it should be documented and confirmed that there have not been any recent reports of such refusals for R46.During an interview on 2/17/2026, at 1:32 pm, the DON indicated that all residents should be provided with a shower on scheduled days. In cases where a resident declines, a nurse's signature must be recorded on the shower sheet, as the nurse is required to return to the resident's room to ask again. If the task cannot be completed, a note should be added to the progress notes, and the care plan must be updated accordingly.3. A review of the EMR revealed resident R125 was admitted to the facility on [DATE] and pertinent diagnoses including but was not limited to rheumatoid arthritis of right shoulder with involvement of other organs, left and right above the knee amputation, diastolic heart failure, atherosclerotic heart disease of native coronary artery, morbid obesity, chronic kidney disease stage 3, pressure ulcer of sacral region unstageable, obstructive sleep apnea, and anxiety disorder.Review of R125's quarterly MDS assessment dated [DATE] revealed a BIMS of 15, which indicated R125 was cognitively intact, that R125 required setup and clean-up assistance for meals, and that R125 was dependent on staff for oral hygiene, toileting, showers, dressing, and personal hygiene.A review of R125's care plan dated 12/22/2025 indicated a behavior problem pertaining to excessive clutter in his room. Interventions included, but were not limited to, the staff assisting R125 in removing unwanted items. Problem-R125 is at risk for falls related to bilateral amputations, morbid obesity, and vertigo. Interventions: Assess that the wheelchair is the appropriate size; assess the need for footrests; assess the need to have the wheelchair locked for safety.A review of the paper shower sheets for December 2025, January 2026, and February 2026 revealed that there were only three bath sheets for December, four for January, and two for February.Observation and interview on 2/15/2026 at 2:26 pm with R125 revealed a very strong body odor upon this surveyor's entry into the resident's room. R125 and his roommate revealed that they do not get baths consistently, less than twice a week, per the facility procedure. R125 will only take bed baths because he stated he has orthostatic hypotension and does not feel comfortable sitting up in a shower or wheelchair. He stated that he does refuse on some occasions when he is not feeling well, but not very often, and now the staff has just quit offering baths altogether.An interview with R125, conducted on 2/1/2026 at 2:18 pm, revealed that he never gets out of bed and is scheduled for baths on Tuesdays and Thursdays.An interview with Certified Nursing Assistant (CNA) AA on 2/16/2026 at 2:40 pm revealed that R125 takes a complete bed bath when he wants to, and that all residents must have a shower sheet completed on their shower day, documenting the type of bath, any skin issues, and whether they refused. So, every resident should have at least two shower sheets documented each week, whether they refused their bath or not.An interview with LPN BB on 2/16/2026 at 3:00 pm revealed that R125 does not feel comfortable getting out of bed, due to being a double above-knee amputee. He feels off balance sitting in a chair, so he will only accept bed baths. She also confirmed that every resident should have a bath sheet for every day they are scheduled for a bath, and if they request an extra bath during the week. If the resident refuses, the bath sheet should reflect that, and the charge nurse must sign it. All residents are scheduled for two baths a week.An interview with the DON on 2/18/2026 at 10:26 am revealed that bath sheets are to be completed for every resident who is offered a bath or shower at least twice a week. If they refuse, that should be reflected on the bath sheet, and the charge nurse should be notified so they can follow up with the residents to ensure that they do not want a bath and if another time would be better. She stated that the expectation is that every resident be offered baths/showers at least twice<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | weekly, and a shower sheet be filled out to document the bath, their skin condition, and refusals. A review of the facility's policy titled Activities of Daily Living (ADLs), revised 7/15/2026, section Policy 1, revealed that care and services will be provided for the following activities of daily living: 1. Bathing, dressing, grooming, and oral care. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and review of the facility's policy titled Oxygen Administration, the facility failed to ensure the oxygen concentrator filter was free of debris for one of 30 residents (R) (R30) receiving oxygen therapy. This deficient practice created the potential for impaired oxygen delivery, inhalation of contaminants, and worsening respiratory symptoms.Findings included:A review of the Electronic Health Record (EHR) revealed R60 was admitted on [DATE] and readmitted on [DATE] with diagnoses including but not limited to chronic obstructive pulmonary disease (COPD), chronic respiratory failure with hypoxia, interstitial pulmonary disease, and paroxysmal atrial fibrillation.A review of the quarterly Minimum Data Set (MDS) dated [DATE] documented that the resident receives oxygen therapy.A review of physician orders dated 2/4/2026 revealed an order to Clean Oxygen (O2) Concentrator Filter once weekly and as needed.A review of the resident's care plan revealed the resident was care planned for COPD and oxygen therapy with interventions including oxygen as ordered and monitoring for signs and symptoms of acute respiratory insufficiency, including anxiety, confusion, restlessness, shortness of breath at rest, cyanosis, and somnolence.Observations conducted on 2/15/2026 at 2:09 pm, 2/16/2026 at 1:30 pm, and 2/16/2026 at 4:20 pm in revealed the oxygen concentrator filter contained gray, fuzzy debris.An interview and observation conducted on 2/17/2026 at 9:53 am with Certified Nursing Assistant (CNA) TT stated that another nurse specializes in oxygen concentrators and changes them, but she was unsure of the schedule. CNA TT confirmed the oxygen concentrator filter contained gray, fuzzy debris.An interview conducted on 2/17/2026 at 10:05 am with Licensed Practical Nurse-Unit Manager (LPN) UU stated that the facility recently transitioned from having a Respiratory Therapist (RT) who previously checked concentrators twice weekly. She stated nursing staff is now responsible for weekly cleaning. She reported checking concentrators on 1/30/2026, but acknowledged she did not turn the concentrator around to inspect the filter. She stated it had likely been over two weeks since the filter had been checked and identified potential negative outcomes, including the resident breathing in bacteria and becoming ill.An interview conducted on 2/18/2026 at 10:26 am with the Director of Nursing (DON) confirmed the facility currently does not have a Respiratory Therapist and that external filters are expected to be cleaned weekly. The DON stated that potential negative outcomes include respiratory symptoms related to a clogged or dirty filter.An interview conducted on 2/18/2026 at 1:25 PM with the Administrator revealed expectations that oxygen concentrators are cleaned weekly, monitored, and audited. She stated that a potential negative outcome could include compromised breathing.A review of the facility policy titled Oxygen Administration, revised on 10/1/2025, revealed under the section titled Policy, Oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences. As stated under the section titled Policy Explanation and Compliance Guidelines, Follow manufacturer recommendations for the frequency of cleaning equipment filters. Cleaning and care of equipment shall be in accordance with facility policies for such equipment. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident's drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled Antibiotic Stewardship Program, the facility failed to ensure antibiotic medications were not administered unnecessarily for two of five sampled residents (R) (R92 and R10) reviewed for unnecessary medications. This deficient practice had the potential to cause adverse drug reactions, medication interactions, and the development of multidrug-resistant organisms (MDROs).Findings included:1. A review of the Electronic Health Record (EHR) for R92 revealed she was admitted on [DATE] with a most recent readmission date of 4/7/2025 with diagnoses included, but not limited to, vascular dementia with psychotic disturbance, delirium due to a known physiological condition, urinary retention, cerebrovascular disease, metabolic encephalopathy, and major depressive disorder.A review of the Quarterly Minimum Data Set (MDS) assessment dated [DATE] documented that R92 presented with a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment; and documented active use of antidepressants, anticoagulants, antiplatelet, and anticonvulsant medications.A review of physician orders revealed a urinalysis with culture and sensitivity was ordered on 1/8/2026 due to increased confusion and hallucinations.A practitioner note dated 1/13/2026 documented that the urinalysis results were positive for a urinary tract infection (UTI). The practitioner ordered Nitrofurantoin 100 milligrams (mg) to be administered by mouth two times per day (BID) for seven days.A record review of the January 2026 Medication Administration Record (MAR) revealed R92 was administered Nitrofurantoin Macrocrystal (antibiotic medication) 100 mg by mouth twice daily for seven days from 1/13/2026 through 1/19/2026.A record review of the Antibiotic Stewardship Binder under the document titled Antibiotic Dispensed revealed that R92 was administered Nitrofurantoin Macrocrystal 100 mg BID for seven days with a start date of 1/13/2026. Documentation in the binder indicated R92 did not meet McGeer criteria for antibiotic initiation.A review of the revised McGeer Criteria for Infection Surveillance Checklist provided by the facility, dated 1/8/2026, revealed documentation of increased confusion and visual hallucinations for R92. The checklist indicated that UTI criteria were not met.2. A review of the EHR for R10 revealed he was admitted on [DATE] with diagnoses included, but not limited to, infection and inflammatory reaction due to an indwelling urethral catheter, neuromuscular dysfunction of the bladder, urinary retention, acute cystitis without hematuria, Type 2 diabetes mellitus with hyperglycemia, unspecified psychosis, and major depressive disorder, recurrent, moderate.A review of the Quarterly MDS assessment dated [DATE] documented that R10 presented with a BIMS score of 14, indicating that the resident was cognitively intact; that the resident had an indwelling catheter; and that he was ordered to receive antipsychotic, antidepressant, antibiotic, opioid, antiplatelet, hypoglycemic (including insulin), and anticonvulsant medications.A record review of R10's care plan revealed the resident had an indwelling catheter related to obstructive uropathy and urinary retention, and the care plan directed staff to observe and report signs and symptoms of a UTI, including but not limited to foul-smelling urine, cloudiness, altered mental status, and behavior changes.A record review of progress notes dated 1/13/2026 documented that R10's urine was cloudy with foul smell and sediments, and the practitioner was notified with a request for urine testing.A review of physician orders revealed Ciprofloxacin Hydrochloride 250 milligrams was ordered to be administered by mouth every 12 hours for five days for a UTI, with an order date of 1/20/2026.A review of the January 2026 MAR revealed that R10 was administered Ciprofloxacin HCl Tablet 250 MG every 12 hours for five days from 1/20/2026 through 1/26/2026 for urinary tract infection.A review of the revised McGeer Criteria for Infection Surveillance Checklist for R10, dated 1/13/2026, revealed documentation of foul smell, cloudy urine, and sediments. The checklist indicated<br><br>(continued on next page) |

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| | 115660 | A. Building<br>B. Wing | 02/18/2026 |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | urinary tract infection criteria were not met.A review of the Antibiotic Stewardship Binder under the document titled Antibiotic Dispensed revealed R10 was administered Ciprofloxacin Hydrochloride 250 milligrams every 12 hours for five days. Documentation in the binder indicated R10 did not meet McGeer criteria for antibiotic initiation.During an interview on 02/17/2026 at 12:49 pm, the Director of Nursing (DON) revealed that the facility had not been appropriately following antibiotic stewardship practices per their policy and with McGeer criteria. The DON further acknowledged that the facility had not been conducting antibiotic time-outs and that the data tracking tool for stewardship had not been properly implemented. She confirmed the antibiotic stewardship data had been inaccurate due to previous infection prevention oversight. The DON stated that R92 was treated due to increased confusion and hallucinations and positive urine culture with 50-100,000 colony count of Escherichia coli (bacteria), but confirmed treatment was initiated without meeting McGeer criteria. She identified potential negative outcomes, including adverse drug reactions, increased risk of Clostridioides difficile infection, and antibiotic resistance, stating the issue is multifactorial. She stated R92 and R10 did not meet McGeer criteria and confirmed they were administered unnecessary medication.During an interview conducted on 2/18/2026 at 9:12 am, Nurse Practitioner (NP) II revealed she prescribes antibiotics based on the clinical picture and not solely lab results. She stated potential negative outcomes of unnecessary antibiotics include the development of MDROs. She confirmed that inappropriate prescribing can contribute to resistant organisms.During an interview conducted on 2/18/2026 at 1:25 pm, the Administrator and National Director of Risk Management revealed expectations that providers follow McGeer criteria. They stated that if prescribing patterns do not meet protocol, physician privileges can be addressed. They identified potential negative outcomes of unnecessary antibiotics, including MDRO development, inappropriate treatment of organisms, medication interactions, adverse reactions, and potential escalation of the resident's condition requiring a higher level of care.A review of the facility policy titled Antibiotic Stewardship Program reviewed on 6/1/2025 revealed, the facility uses the CDC's (Centers for Disease Control and Prevention) NHSN (National Healthcare Safety Network) Surveillance Definitions and updated McGeer criteria to define infections and determine whether to treat an infection with antibiotics. Under the section titled Monitoring antibiotic use, the policy states, random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness, and that antibiotic use will be monitored and tracked. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observations, record review, and a review of the facility's policies titled Medication Administration, the facility failed to be free of a medication error rate of 5 percent or less for six of 25 observations (24 percent medication error rate). This deficient practice had the potential to cause serious medication side effects and health issues.Findings included:During an observation of medication administration on 2/17/2026 at 9:12 am, R22 was observed to have a gastrostomy tube (GT) through which all medications were to be administered. Licensed Practical Nurse (LPN) FF crushed R22 medication together in the same envelope, mixed them in water, and administered it through the GT. Per professional standards, the medications should be crushed separately and given separately through the GT. There was also an omission of a Coreg 6/25mg, which was not available on the cart. LPN FF did not call the pharmacy nor check the emergency stock for the medication. A review of the electronic medical record (EMR) revealed that multiple residents had missing documentation in their medication administration records (MARs) on February 9th and 10th. R11 is missing documentation for enoxaparin Sodium Solution 40mg/0.4ml subcutaneously at bedtime dated 2/9, diazepam 10mg 1 po every 12 hours, missing documentation for the 2100 dose 2/9, Micatin Cream 2% 1700 2/10, and albuterol inhalation solution at 0000 and 0600 doses Oxycodone HCL tablet 20mg 1 tab by mouth every 4 hours routine missing documentation at 0000, and 1400 on 2/10/2026. Multiple missing documentations for R22 as follows, 2/10 9:00 am missing blood pressure and amlodipine besylate 10mg tab, change feeding syringe every night shift 2/10, clonidine transdermal patch weekly 0.2mg/24hours 2/10 0900am, MiraLax oral powder 17gm 2/10 9:00 am, Nexium oral packet 40mg 2/10 0600 am, vitamin B1 100mg 2/10 0900 am, Amantadine HCL oral capsule 100mg 2/10 at 0900 am, Coreg oral tab 6.25mg missing blood pressure and medication documentation 2/10 at 0900 am and 1700 pm. Enteral feeding2/10 at 0600 am and 1600 pm. Multiple missing documentations in MAR for R86 for 2/10 @ 0600am Protonix 40mg, 2/10 0600 am Methocarbamol 750mg, 2/10 0600 am acetaminophen 325mg 2 tabs. , 2/10 0400 oxycodone HCl 1 tab by mouth every 4 hours.The average medication error rate is 24%. 25 medications observed, 2 residents had the medication errors. The major cause of the medication errors was that the medications were crushed together and given together in a gastrostomy tube for one of the residents with a gastrostomy tube. An interview with Licensed Practical Nurse (LPN) FF on 2/17/2026 at 9:30 am revealed that she had not handled GT medication administration much, and that she was shown how to administer medication through a GT by another LPN. She confirmed that she was unaware of the proper way to administer medications through a GT and that she is unaware of the potential harm the deficient practice could cause.An interview with the Director of Nursing (DON) on 2/18/2026 at 10:30 am confirmed that mixing medications when crushing and mixing down a GT was a deficient practice, and that she would provide education to the nursing staff. She also confirmed the missing documentation in the MARs of the three residents sampled. She stated her expectations for medication administration were zero errors and to document the medications when given. An interview with the Administrator on 2/18/2026 at 11:10 am States expectations are for medication administration, that medications should be given per the policy and professional standards. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, staff interviews, and a review of facility policy titled Puree Food Preparation, it was determined that the facility failed to follow puree preparation guidelines to ensure puree food was prepared in a manner to conserve the nutritive value/appearance, and palatable for eight of eight residents who are on a puree or mechanical diet. This deficient practice places residents at risk for swallowing and choking hazards. Findings included: A review of the facility's policy titled Puree Food Preparation, dated 3/1/2022 and revised 6/1/2024, revealed, It is the policy of this facility to provide puree food that has been prepared in a manner to conserve nutritive value, palatable flavor, and attractive appearance.A review of the Puree Food Preparation Guideline per Serving revealed (more or less may be used depending on the consistency of the cooked food): Meats: Add 1 teaspoon beef broth or beef gravyPoultry: Add 1 teaspoon chicken broth or chicken gravyFish: Add 1 teaspoon of mayonnaiseNoodles: Add 1 teaspoon of margarineVegetables (leaf, stem, or flower) Add 2 teaspoons mashed potato flakesVegetables (root tuber): Add 1 teaspoon of margarineFruits (EXCEPT grapes, oranges, grapefruit, bananas, plums): Remove peels, skins, cores, pits, and or seeds. Add 1 tablespoon of food thickener (most watery fruits require a food thickener).On 2/16/2026 at 10:49 am, [NAME] OO was observed for puree food preparation. [NAME] OO stated that he had worked at the facility for five months and had been a cook for five years. The Food Service Director (FSD) was present during the Puree preparation and confirmed that there were eight residents currently receiving a pureed diet. Three (3) puree items were prepared, including pulled pork, carrots, and baked beans. [NAME] OO did not have all the supplies available before initiating the puree preparation. He stopped production to retrieve beef base and failed to use proper hand hygiene before resuming food preparation; failed to use a recipe and failed to use proper hand hygiene between preparation of each pureed item, observed to use a sink to rinse utensils; and failed to measure ingredients to ensure appropriate consistency for resident consumption. When asked to describe the expected consistency of each puree item, [NAME] OO stated, a peanut butter consistency. He did not follow a puree recipe and acknowledged that he did not know where the recipes were located. The FSD clarified that recipe books were on a shelving unit adjacent to the puree prep area.During an interview with the Administrator on 2/18/2026 at 1:58 pm, it was revealed that pureed foods should be prepared in accordance with recipes to present food integrity and nutritive value. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observations, interviews, and record review, the facility failed to ensure that kitchen staff wore appropriate beard nets. This deficient practice had the potential to contaminate food and cause food-borne illnesses. The facility had a census of 127.Findings included: During an observation on 2/15/2026 at 11:39 am, during the initial kitchen tour, the [NAME] (Cook NN) and the Food Service Director (FSD) were observed to have facial hair with no beard nets. On 2/16/2026 at 10:49 am, during the comprehensive kitchen tour, the [NAME] (Cook OO) and the FSD were observed to have facial hair with no beard nets. On 2/16/2026 at 12:05 pm, during the food temperature observation, [NAME] OO, [NAME] NN, and FSD were observed not to be wearing beard restraints. [NAME] OO took temperature readings for fifteen items. While testing the temperature of the food items, he had to lean over the steam table. His beard came into proximity to hot foods. On 2/16/2026 12:30 pm, the FSD confirmed beard restraints were on order for Dietary staff, and individuals with facial hair should wear restraints to prevent hair coming in contact with food. A review of facility policy titled Dietary Employee Personal Hygiene, dated 3/1/2022 and revised 9/1/2025, revealed that employees should never use bare hand contact with any foods, ready to eat or otherwise, and that all dietary staff must wear hair restraints (e.g., hairnet, hat, and/or beard restraint) to prevent hair from contacting food. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and review of the facility's policy titled Antibiotic Stewardship Program, the facility failed to implement an effective Antibiotic Stewardship Program to ensure antibiotics were initiated in accordance with nationally recognized infection surveillance criteria, specifically the McGeer criteria, for two of five sampled residents (R) (R92 and R10) reviewed. The facility initiated antibiotic therapy for residents who did not meet established McGeer criteria for urinary tract infection. This deficient practice had the potential to result in unnecessary antibiotic exposure, adverse drug reactions, development of multidrug-resistant organisms (MDROs).Findings included:1. A review of the Electronic Health Record (EHR) for R92 revealed she was admitted on [DATE] with a most recent readmission date of 4/7/2025. Diagnoses include but are not limited to vascular dementia with psychotic disturbance, delirium due to a known physiological condition, urinary retention, cerebrovascular disease, metabolic encephalopathy, and major depressive disorder.A record review of the Quarterly Minimum Data Set (MDS) dated [DATE] documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Section N (Medications) documented active use of antidepressants, anticoagulants, antiplatelet, and anticonvulsant medications.A record review of physician orders revealed a urinalysis with culture and sensitivity was ordered on 1/08/2026 due to increased confusion and hallucinations.A record review of practitioners note dated 1/13/2026 documented that Urinalysis results were positive for a urinary tract infection. The practitioner ordered Nitrofurantoin 100 milligrams to be administered by mouth two times per day for seven days, UA +UTI, will start nitrofurantoin 100 mg BID x 7 days.A record review of the January 2026 Medication Administration Record (MAR) revealed R92 was administered Nitrofurantoin Macrocrystal (antibiotic medication) 100 mg by mouth twice daily for seven days from 1/13/2026 through 1/19/2026.A record review of the Antibiotic Stewardship Binder under the document titled Antibiotic Dispensed revealed Nitrofurantoin Macrocrystal 100 mg BID x 7 days with a start date of 1/13/2026. Documentation in the binder indicated R92 did not meet McGeer criteria for antibiotic initiation.A record review of the Revised McGeer Criteria for Infection Surveillance Checklist dated 1/8/2026 revealed documentation of increased confusion and visual hallucinations. The checklist indicated that UTI criteria were not met.2. A record review of the EHR for R10 revealed he was admitted on [DATE]. Diagnoses include, but are not limited to, infection and inflammatory reaction due to an indwelling urethral catheter, neuromuscular dysfunction of the bladder, urinary retention, acute cystitis without hematuria, Type 2 diabetes mellitus with hyperglycemia, unspecified psychosis, and major depressive disorder, recurrent, moderate.A record review of the Quarterly MDS dated [DATE] documented in Section C (Cognitive Patterns) a Brief Interview for Mental Status score of 14. The Minimum Data Set documented in Section H (Bladder and Bowel), the resident had an indwelling catheter. As documented in Section N (Medications), the resident received antipsychotic, antidepressant, antibiotic, opioid, antiplatelet, hypoglycemic (including insulin), and anticonvulsant medications.A record review of R10's care plan revealed the resident had an indwelling catheter related to obstructive uropathy and urinary retention, and the care plan directed staff to observe and report signs and symptoms of a urinary tract infection, including but not limited to foul-smelling urine, cloudiness, altered mental status, and behavior changes.A record review of progress notes dated 1/13/2026 documented that the resident's urine was cloudy with foul smell and sediments, and the practitioner was notified with a request for urine testing.A record review of physician orders revealed Ciprofloxacin Hydrochloride 250 milligrams was ordered to be administered by mouth every 12 hours for five days for a urinary tract infection, with an order date of 1/20/2026.A record<br><br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | review of the January 2026 Medication Administration Record (MAR) revealed R10 was administered Ciprofloxacin HCl Tablet 250 MG every 12 hours for five days from 1/20/2026 through 1/15/2026 for urinary tract infection.A record review of the Revised McGeer Criteria for Infection Surveillance Checklist dated 1/13/2026 revealed documentation of foul smell, cloudy urine, and sediments. The checklist indicated urinary tract infection criteria were not met.A record review of the Antibiotic Stewardship Binder under the document titled Antibiotic Dispensed revealed R10 was administered Ciprofloxacin Hydrochloride 250 milligrams every 12 hours for five days. Documentation in the binder indicated R10 did not meet McGeer criteria for antibiotic initiation.An interview conducted on 2/17/2026 at 12:49 pm with the Director of Nursing (DON) revealed the facility had not been appropriately following antibiotic stewardship practices per their policy and had implemented a Performance Improvement Plan (PIP) after identifying noncompliance with McGeer criteria. The DON further acknowledged that the facility had not been conducting antibiotic time-outs and that the data tracking tool for stewardship had not been properly implemented. She confirmed the antibiotic stewardship data had been inaccurate due to previous infection prevention oversight. The DON stated that R92 was treated due to increased confusion and hallucinations and positive urine culture with 50-100,000 colony count of Escherichia coli (bacteria), but confirmed treatment was initiated without meeting McGeer criteria. She identified potential negative outcomes, including adverse drug reactions, increased risk of Clostridioides difficile infection, and antibiotic resistance, stating the issue is multifactorial. She stated R92 and R10 did not meet McGeer criteria and confirmed they were administered unnecessary medication.An interview conducted on 2/18/2026 at 9:12 am with Nurse Practitioner (NP) II revealed that she prescribes antibiotics based on clinical picture and not solely lab results. She stated potential negative outcomes of unnecessary antibiotics include the development of MDROs. She confirmed that inappropriate prescribing can contribute to resistant organisms.An interview conducted on 2/18/2026 at 1:25 pm with the Administrator and National Director of Risk Management revealed expectations that providers follow McGeer criteria. They stated that if prescribing patterns do not meet protocol, physician privileges can be addressed. They identified potential negative outcomes of unnecessary antibiotics, including MDRO development, inappropriate treatment of organisms, medication interactions, adverse reactions, and potential escalation of the resident's condition requiring a higher level of care.A review of the facility policy titled Antibiotic Stewardship Program reviewed on 6/1/2025 revealed, under the section titled Antibiotic use protocols, the policy states the facility uses the CDC's NHSN Surveillance Definitions and updated McGeer criteria to define infections and determine whether to treat an infection with antibiotics. Under the section titled Monitoring antibiotic use, the policy states, random audits of antibiotic prescriptions shall be performed to verify completeness and appropriateness, and that antibiotic use will be monitored and tracked. Also requires monitoring antibiotic use, reviewing laboratory results, conducting antibiotic time-outs within 48-72 hours of initiation, and verifying appropriateness of antibiotic prescriptions. |