STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135014	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Caldwell Care of Cascadia	210 Cleveland Boulevard Caldwell, ID 83605

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interview, it was determined the facility failed to respect the right of residents when they did not provide written notification prior to moving a resident to a new room. This was true for 1 of 1 resident (Resident #13) who was moved prior to receiving written notification. This deficient practice created the potential for psychosocial harm if Resident #13 was not provided an opportunity to see the new location, meet a new roommate, or have questions answered related to the move. Findings include:The facility's Resident Room Changes & Roommate Rights Policy, revised 8/31/25, documented when a resident is being moved at the request of facility staff, the resident, family, and/or representative must receive an explanation in writing of why the move is required. The resident must be provided with the opportunity to see the new location, meet the new roommate, and ask questions.Resident #13 was re-admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a chronic mental condition combining schizophrenia symptoms with mania or depression), insomnia, anxiety, depression, and dementia.A Quarterly MDS assessment dated [DATE], documented Resident #13 was cognitively intact.A notice of Room-to-Room Transfer form, signed 11/13/25, documented the rational for Resident #13's transfer from room [ROOM NUMBER] to 219 as POA Notified. No further explanation was written.On 3/5/26 at 3:41 PM, the Social Services Manager stated the notification of room change was not filled out correctly and should have identified in writing why Resident #13 was moving from room [ROOM NUMBER] to 219.

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and staff interview, it was determined the facility failed to ensure resident rights were honored when past survey results were not posted in an area readily accessible to residents and their representatives. This failure created the potential for misinformation about the facility's prior 3 years of survey results and plans of correction. Findings include:On 3/2/26, 3/3/26, 3/4/26, and 3/5/26, a binder labeled State Survey Results was observed in a pocket folder on the wall of a corridor leading to the courtyard. The access to the binder was blocked by a stuffed chair with other large equipment stacked on top of it, two vitals signs towers, and an extra large padded specialized wheelchair. On 3/4/26 at 3:25 PM, during a Resident Council group discussion with surveyors, residents stated they were not aware of the facility's responsibility to make the past 3 years of survey results readily accessible or their right to review the results and plans of correction. The residents stated they did not know where the survey results were posted in the facility. On 3/5/26 at 2:23 PM, the Administrator confirmed the survey results were not accessible because they were blocked by stored equipment.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined resident rights were not honored. This was true for 1 of 16 residents (Resident #9) whose records were reviewed for physician notification. This failure placed Resident #9 at risk for harm when abnormal vital signs were not reported to her physician. Findings include: Resident #9 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a severe chronic mental health condition), depression, and anxiety. Resident #9's blood pressure record documented four elevated readings the past 90 days:3/1/26: 171/1042/1/26: 164/981/22/26: 171/991/20/26: 173/104Resident #9's record did not document the physician was notified of the elevated blood pressure readings. On 3/6/26 at 9:20 AM, the DON stated the nurses should have notified the physician of Resident #9's elevated blood pressures immediately. The DON was unable to provide documentation the physician was notified.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and resident and staff interview it was determined the facility failed to provide a homelike environment when resident's walls were left unrepaired and/or with visible patch work. This was true for 2 of 16 residents (#13 and #53) whose rooms were observed. This created the potential for psychosocial harm and embarrassment if residents did not have a homelike environment if their walls were not repaired and did not have consistent wall paint covering the white patchwork. Findings include: The facility's Homelike Environment policy, revised 9/17/25, documented the facility supports a residents rights to a safe, clean, comfortable, and homelike environment to promote dignity, independence, and quality of life.1. Resident #13 was re-admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a chronic mental condition combining schizophrenia symptoms with mania or depression), insomnia, anxiety, depression, and dementia.On 3/2/26 at 9:52 AM it was observed in Resident #13's room there was a jagged vertical damaged line on the wall from floor to ceiling exposing broken drywall. Other areas of the room walls were covered with white patches on top of colored paint. Resident #13 stated the white patches, and damaged wall had been there since she relocated to the room in November 2025.2. Resident #53 was admitted to the facility on [DATE] with multiple diagnoses including schizophrenia (a chronic, severe mental disorder characterized by disruptions in thought processes, perceptions, emotional responsiveness, and social interactions) and COPD.On 3/2/26 at 2:35 PM it was observed in Resident #53's room various white patches on painted walls which were both small and large throughout the room. Resident #53 stated the white patches had been on the walls since she could remember.On 3/5/26 at 11:43 AM, the Maintenance Director stated Resident #13 and #53's room walls were patched and primed, ready to be painted; however, they had not been able to paint them yet. He further stated he was unaware Resident #13's room had any damaged walls that needed to be fixed.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, record and policy review, and resident and staff interview, it was determined the facility failed to ensure a grievance process was available for residents. This deficient practice created the potential for psychosocial harm if residents' concerns were not identified and addressed in a timely manner. Findings include:The facility's Grievance Process policy, revised 8/29/25, documented the Grievance program addresses the concerns of residents, family members, and visitors and the facility should make prompt efforts to resolve grievances.On 3/2/26 at 8:30 AM, the SA requested a copy of the facility's grievances from September 2025 through March 2026.The facility provided grievances from January 2026 through March 2026. No additional grievances were available.On 3/3/26 at 4:02 PM, the Administrator, with the CRN present, stated there were no grievances available prior to January 2026. The CRN confirmed the facility had identified their grievance process required a performance improvement plan.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to accurately report which resident was the victim and aggressor in an abuse investigation submitted to the Idaho BFS LTC Reporting System. This was true for 1 of 3 residents (Resident #13) reviewed for abuse. This deficient practice created the potential for psychosocial harm as Resident #13 was identified as the victim on the report and this was reported to Resident #13 and her family member, and to the State of Idaho, contradicting witness statements which identified Resident #13 as the aggressor. Findings include:The facility's Abuse - Reporting & Response: No Crime Suspected policy, dated 8/25/25, documented the report must include sufficient detail to describe the nature of the alleged violation, and new or revised information supplementing the initial report should be included in the follow-up submission to ensure completeness and accuracy.Resident #13 was re-admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a chronic mental condition combining schizophrenia symptoms with mania or depression), insomnia, anxiety, depression, and dementia.An abuse report, dated 11/13/25, documented Resident #13 was the victim in a resident-to-resident interaction when Resident #17 was heard banging on the restroom door while Resident #13 was using it. Resident #13 exited the bathroom on Resident #17's side, began yelling at her, and Resident #17 reacted by grabbing Resident #13's shirt, without making physical contact. Resident #13 reported she had a hurt arm, which was assessed, and no injury was found. Resident #13 was moved to a new room the same day as the facility believed Resident #13 should not share a bathroom with Resident #17 for their safety.The witness statement, dated 11/13/25, documented Resident #13 was the aggressor as she entering Resident #17's room and yelling at her. Resident #17 reacted to Resident #13 by grabbing her shirt.On 3/5/26 at 10:21 AM, the Administrator stated he filled the report out incorrectly as Resident #13 was the aggressor, not the victim as was documented on the investigation report.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined the facility failed to ensure required transfer and discharge documentation was included in the resident's medical record to support the communication of essential information to the receiving healthcare provider. This was true for 1 of 2 residents (Resident #1) reviewed for discharge processes. This failure created the potential to result in delayed or inappropriate treatment. Findings Include:Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including acute respiratory failure, pneumonia, and chronic obstructive pulmonary disease.Resident #1's care plan initiated 6/19/23, documented he had altered respiratory status and directed staff to monitor and report to physician if signs of compromised airway occurred.Resident #1's record included the following:A progress note dated 1/16/26, documented Resident #1 was not responding to an albuterol breathing treatment and continued to have declining oxygen saturation requiring a higher level of care.A Notice of Transfer or discharge date d 1/16/26, documented Resident #1 required immediate transfer due to urgent medical needs.A bed hold agreement signed 1/16/26.Resident #1's record did not include documentation the following required information was sent to the receiving healthcare provider at the time of transfer:Contact information of the practitioner responsible for the care of the resident.Resident representative information including contact information.Advance Directive information.All special instructions or precautions for ongoing care, as appropriate.Comprehensive care plan goals.On 3/5/26 at 9:14 AM, the DON and the CRN confirmed Resident #1's record did not include the required transfer and discharge documentation.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview, it was determined the facility failed to ensure Residents' Preadmission Screening and Resident Review (PASRR) accurately reflected the resident's primary diagnosis. This was true for 1 of 3 residents (Resident #34) reviewed for accuracy of PASRR's. This failure resulted in incorrect PASRR Level I determination. Findings include:Resident #34 was admitted to the facility on [DATE] with multiple diagnoses including major depressive disorder, anxiety disorder, and alcohol dependence.A review of Resident #34's medical diagnoses showed his primary diagnosis was recurrent major depressive disorder.Resident #34's PASRR Level I, dated 9/9/25, documented, Yes in Box 12, indicating the individual had a primary diagnosis of dementia or Alzheimer's disease.On 3/5/26 at 4:45 PM, the Social Worker confirmed Resident #34's PASRR Level I was inaccurately completed.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews it was determined the facility failed to provide quarterly care conferences for 8 of 8 residents (#5, #6, #7, #9, #13, #25, #38 and #47), and for 2 of 16 residents (#5 and #34) whose care plans were not revised. This deficient practice created the potential for harm when the care conferences were not conducted, and when their care plans were not revised. Findings include:The facility's Resident Care Plan Revisions policy, revised 9/3/25, documented care plans will be created, reviewed, and revised by an interdisciplinary team (IDT), with family related to the residents' status and care needs, with active involvement from the resident and their representative, when applicable, updates to the care plan will occur as needed based on the residents' response to interventions and changes in condition.1. The following residents records did not have documentation quarterly care conferences were conducted:a. Resident #25 was admitted to the facility on [DATE], and readmitted on [DATE], with multiple diagnoses including dementia, depression, anxiety, muscle weakness, and difficulty walking.Resident #25's record documented a quarterly care conference occurred on 7/9/25, attended by the Social Services Manager, the Resident Care Manager, the Culinary Manager, and Resident #25's representative. There was no record of additional quarterly care conferences in or around October 2025 or January 2026.b. Resident #13 was readmitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder (a chronic mental condition combining schizophrenia symptoms with mania or depression), insomnia, anxiety, depression, and dementia.A review of Resident #13's care plan documented a care conference on 8/5/25, attended by the Social Services Manager, the Assistant Chief Nursing Officer, and Resident #13's representative. There were no quarterly care conferences found in Resident #13's record related to care conferences for November 2025 or March 2026.c. Resident #5 was admitted to the facility on [DATE]with multiple diagnoses including paranoid schizophrenia, depression, anxiety, and difficulty walking.A review of Resident #5's care plan documented a care conference on 6/11/25, attended by the Social Services Manager, the Chief Nursing Officer, and the Culinary Manager, and Resident #5's representative. There were no quarterly care conferences recorded for September and December 2025, or documentation of March 2026's care conference being scheduled for Resident #5. d. Resident #9 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, depression, and anxiety.Resident #9's record documented a quarterly/annual care conference was completed on 9/10/25, attended by the resident, the Social Services Manager, the DON, a Resident Support Services Assistant and the Culinary Manager.Resident #9's record did not include documentation her quarterly care conference was conducted as required in December 2025. e. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, dysphagia (difficulty swallowing) and sleep apnea.Review of Resident #47's record documented a care conference was held on 9/3/25 attended by the Social Services Manager, the DON, the Culinary Manager and Resident #47's representative. There was no other care conference documented on Resident #47's record.f. Resident #38 was readmitted to the facility on [DATE] with multiple diagnoses including dementia, bipolar disorder, and anxiety disorderResident #38's record documented a quarterly care conference occurred on 10/8/25, attended by the Social Services Manager, the Resident Care Manager, the DON, and Resident #38's representative.Resident #38's record did not include documentation of a care conference being conducted after 10/8/25.g. Resident #6 was admitted to the facility on [DATE] with multiple diagnoses including dementia, bipolar disorder, and anxiety.Resident #6's record documented a 48 hour/admission care conference occurred on 8/22/25, attended by the Social Services Manager, the DON, and Resident (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#6's representative. There was no record of any quarterly care conferences for November 2025 or February 2026.h. Resident #7 was admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including dementia, major depressive disorder, and muscle weakness.Resident #7's record documented a quarterly care conference occurred on 6/24/25, attended the Social Services Manager, the DON, the Culinary Manager, and Resident #7's representative.There was no record of any quarterly care conferences for September 2025 or December 2025.On 3/4/2026 at 10:31 AM, the Administrator and CRN stated if the care conference is not in the residents [electronic health record] the care conference was not completed.2. The following residents did not have their care plans revised:a. Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including paranoid schizophrenia, depression, anxiety, and difficulty walking.Resident #5's care plan, dated 8/24/23, documented fall interventions directing staff to provide a variety of fall preventions including a low bed position at night, call light within reach, non-skid socks, and to re-evaluate quarterly and with change of condition or if a fall occurs.On 12/1/25, a fall investigation report documented Resident #5 fell while unattended in the dining room. The IDT directed staff to supervise Resident #5 always while in the dining room.There was no record of this fall intervention being added to Resident #5's care plan until 1/27/26.On 3/4/26 at 2:10 PM, the DON confirmed the care plan related to staff supervision for Resident #5 was not added to the care plan until 1/27/26 when it should have been added in December 2025.Cross reference F689.b. Resident #34 was admitted to the facility on [DATE] with multiple diagnoses including major depressive disorder, anxiety disorder, and alcohol dependence.A review of Resident #34's care plan, revised 4/6/22, documented the resident was independent with toileting, and staff were directed to provide one?person assistance for occasional nighttime incontinence.A review of the Quarterly Minimum Data Set (MDS) dated [DATE], documented Resident #34 was dependent on staff assistance for all toileting needs, which was inconsistent with the toileting status documented in the resident's care plan.On 3/5/26 at 8:40 AM, the DON confirmed Resident #34 was dependent in toileting and stated the care plan should have been revised to reflect the resident's current care needs.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure services provided met accepted professional standards of clinical practice This was true for 2 of 6 residents (#47 and #56) who were observed during medication administration and for 1 of 1 resident (Resident #3) who received hemodialysis services. These failures placed Resident's #47 and #56 at risk for harm when their medications were not administered appropriately, and placed Resident #3 at risk for harm when staff took his blood pressure on the arm with his hemodialysis access. Findings include: 1. Lippincott's Nursing 2026 webpage titled, Protecting a Hemodialysis Fistula; Clinical Do's and Don'ts, accessed 3/4/26, documented, do not take blood pressure readings on the access arm as it could contribute to clotting in the fistula, and do not put any excessive pressure on the access arm. Resident #3 was admitted to the facility on [DATE] with multiple diagnoses including end stage renal (kidney) disease and dementia. Resident #3's record documented he was dependent on hemodialysis (a treatment using a machine to replicate kidney function, removing waste from the bloodstream), and his dialysis access site was an AV fistula in his left forearm (an arteriovenous fistula is a surgical connection made between an artery and vein used for hemodialysis). Resident #3's care plan, dated 11/3/22, documented no blood pressures should be taken on the left arm due to his AV fistula dialysis access site. On 3/4/26 at 9:16 AM, Resident #3's vital signs records documented he had 18 blood pressure readings taken on the left arm in the past 90 days. On 3/6/26 at 8:34 AM, the DON confirmed Resident #3's record documented blood pressure readings were taken on his left arm. She added, it was likely the person measuring his blood pressure documented incorrectly as there had not been any adverse outcomes and the resident was aware blood pressures should not be taken on his left arm to protect his dialysis access. 2. The insulin aspart's pen Instruction for Use documented before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: Turn the dose selector to select 2 units. Hold the insulin pen pointing upwards, press the push-button all the way in. The dose selector returns to 0). A drop of insulin should appear at the needle tip. The Toujeo's insulin pen Instructions for Use documented select 3 units by turning the dose selector until the dose pointer is between 2 and 4. Then press the injection button all the way in. When insulin comes out of the needle tip, your pen is working correctly. Resident #56 was admitted to the facility on [DATE] with multiple diagnoses including diabetes and asthma. A physician's order documented Resident #56 was to receive the following medications: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Novolog Injection Solution 100 unit/ml (insulin aspart), inject 35 units subcutaneously three times a day related to diabetes, ordered 10/23/25. Toujeo SoloStar (insulin glargine) 100 unit/ml, inject 64 units subcutaneously two times a day related to diabetes, ordered 2/27/26. On 3/4/26 at 6:59 AM, RN #1 was observed sanitizing Resident #56's Novolog and Toujeo insulin pens and replaced their needles. RN #1 then dialed the Novolog insulin pen to 35 units and Toujeo insulin pen to 64 units. RN #1 was not observed to prime the insulin pens. RN #1 entered Resident #56's room and administered both insulin injections. On 3/4/26 at 7:30 AM, RN #1 stated she did not prime Resident #56's insulin pens. On 3/4/26 at 10:06 AM, the DON stated insulin pens should be primed before dialing the prescribed amount ordered by the physician. 3. The Drugs.com website accessed on 3/10/26, stated to take potassium chloride tablets with food or just after a meal to reduce the risk of stomach irritation. Follow with full glass of water. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, dysphagia (difficulty swallowing) and sleep apnea. A physician's order dated 9/19/24, documented Resident #47 was to receive potassium chloride 20 meq by mouth two times a day for diuretic use. On 3/3/26 at 3:27 PM, LPN #1 administered Resident #47's 20 meq potassium chloride which was dissolved in small amount of water and mixed it with pudding. Resident #47 answered, no when LPN #1 asked him if he would like to drink water after taking the medication. LPN #1 was not observed educating Resident #47 regarding the importance of drinking water after taking potassium chloride. On 3/3/26 at 3:30 PM, LPN #1 stated he offered Resident #47 water for his hydration. On 3/3/26 at 3:36 PM, the DON with the CRN present stated she would advise Resident #47 to drink a full cup of water after taking the potassium chloride. The CRN stated LPN #1 should have educated Resident #47 regarding drinking water after taking the potassium chloride.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, it was determined the facility failed to implement and follow resident?centered comprehensive care plan interventions and physician?ordered treatments for 3 of 16 residents (Residents #9, #47, and #64) reviewed for quality of care. The facility failed to apply physician?ordered interventions for Resident #47, failed to implement fall?prevention interventions for Resident #64, and failed to complete reassessment of blood pressures for Resident #9. These failures created the potential for harm when required care plan interventions, treatments, and reassessments were not carried out. Findings include:1. Resident #64 was readmitted to the facility on [DATE] with multiple diagnoses, including history of falling, adult failure to thrive, and a need for assistance with personal care. A review of Resident #64's care plan, revised 3/19/26, documented she required one?person assistance for ambulation and transfers. The care plan also directed staff to monitor Resident #64's position in bed and in her wheelchair for safety. A progress note dated 3/19/26 at 1:16 PM documented that CNA #1 was assisting Resident #64 with dressing. After completing the task, CNA #1 walked to the wardrobe closet to put away clothing. CNA #1 looked back and observed Resident #64 fall forward from the bed and strike her face on the floor. Nursing staff were notified, assessed the resident, and assisted her to stand. The note documented no injuries. During an interview on 3/5/26 at 11:15 AM, CNA #1 stated Resident #64 had been sitting on the edge of the bed when she stepped away to put the resident's shoes in the closet. CNA #1 stated she saw Resident #64 stand up and fall forward and attempted to stop her but was unable to reach her in time. A progress note dated 3/21/25 at 12:17 PM documented the Interdisciplinary Team determined that, due to the fall, an appropriate intervention would be to monitor Resident #64 for orthostatic blood pressures. On 3/5/26 at 3:40 PM, a request was made for documentation of orthostatic blood pressures, and none was provided. On 3/5/26 at 4:12 PM, the Director of Nursing (DON) confirmed the facility did not have records of any orthostatic blood pressures being obtained for Resident #64. 2. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses, including muscle weakness, dementia, and protein?calorie malnutrition. A review of Resident #2's care plan, revised 1/7/25, directed staff to apply pressure?relieving boots bilaterally at all times. A physician order dated 5/2/25 documented: Pressure relief/reducing boots to bilateral feet when in bed and up in wheelchair. Resident #2 was observed in the common area watching television without his pressure?relieving boots on the following dates and times: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/2/26 at 1:58 PM 3/3/26 at 9:35 AM 3/3/26 at 11:20 AM 3/4/26 at 7:25 AM 3/6/26 at 9:16 AM During both observations, the boots were seen in his room on the bedside nightstand, not on the resident. During an interview on 3/6/26 at 9:17 AM, LPN #1 confirmed Resident #2 was not wearing his boots and stated he only wears them when he's in bed. During an interview on 3/6/26 at 9:32 AM, the DON confirmed Resident #2 should have the boots on at all times. 3. Resident #9 was admitted to the facility on [DATE] with multiple diagnoses including schizoaffective disorder, depression, and anxiety. Resident #9's vital signs records documented a blood pressure reading on 3/1/26 of 171/104. Resident #9's record did not include documentation her blood pressure was reassessed on 3/1/26, or she was assessed for other symptoms related to the elevated blood pressure. On 3/6/26 at 9:20 AM, the DON stated, the nurses should have notified the provider of the elevated blood pressure and re-assessed the resident. The DON was unable to provide documentation the nurses reassessed Resident #9's blood pressure. 4. Resident #47 was admitted to the facility on [DATE], with multiple diagnoses including heart failure, dysphagia (difficulty swallowing) and sleep apnea. Resident #47's Skin Evaluation dated 3/2/26, documented he had pressure areas to his palm but no open areas. A physician's order dated 2/2/26, directed staff to apply a carrot splint to Resident #47's right hand as tolerated and monitor him for skin alteration two times a day. Resident #47 was observed with both his hands closed in a fist on 3/2/26 at 10:26 AM, 3/3/26 at 10:05 AM and 10:29 AM, and 3/4/26 at 9:30 AM, with no carrot splint to his right hand. On 3/4/26 at 9:34 AM RNA #1 helped Resident #47 to open his right hand. Resident #47's right hand was noted to have pressure marks from his fingertips, with no open areas on his right palm. On 3/4/26 at 9:54 AM, the DON reviewed Resident #47's care plan and physician's order, and stated the carrot splint should be applied to his right hand. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/4/26 at 3:07 PM, the Director of Rehabilitation stated Resident #47 was on PT/OT/RNA program for his upper extremities and the carrot splint was ordered as skin intervention for his right hand.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to prevent a fall when a fall intervention was not updated in the resident's care plan. This was true for 1 of 5 residents (Resident #5) reviewed for accident prevention. This deficient practice created the potential for harm when Resident #5 fell from her wheelchair when she was left unsupervised in the dining room. Findings include:Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including paranoid schizophrenia, depression, anxiety, and difficulty walking.On 12/1/25, a fall investigation report documented Resident #5 fell from her wheelchair while unattended in the dining room. The IDT investigation documented, to avoid future falls, Resident #5 was always to be supervised while in the dining room.On 1/26/26, a fall investigation report documented Resident #5 fell from her wheelchair on 1/23/26 when a staff member left her in the dining room unsupervised.A review of Resident #5's care plan, revised 1/27/26, documented Resident #5 should have constant supervision while in the dining room.There was no record of Resident #5's care plan being updated on 12/1/25 when the intervention was first identified as a fall prevention measure by the IDT.On 3/4/26 at 2:10 PM, the DON confirmed the care plan related to staff supervision for Resident #5 was not added to the care plan until 1/27/26 when it should have been added in December 2025. When asked if the fall on 1/23/26 could have been prevented if Resident #5's care plan had been updated in December 2025, the DON declined to answer.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, pharmacy review, and staff interview, it was determined the facility failed to ensure recommended monitoring for adverse effects of antipsychotic medication was completed for 1 of 5 residents (Resident #38) reviewed for psychoactive?medication monitoring. This created the potential for side effects to go undetected when the facility did not complete a current AIMS (an abnormal involuntary movement scale) or DISCUS (dyskinesia identification system condensed user scale) assessment as recommended by the consulting pharmacist. Findings include:Resident #38 was readmitted to the facility on [DATE] with multiple diagnoses, including bipolar disorder, anxiety disorder, and traumatic brain injury.Resident #38's care plan directed staff to monitor and report side effects and adverse reactions related to psychoactive medications.A physician order dated 7/22/25 documented:Seroquel (an antipsychotic medication) 300 mg by mouth once daily for traumatic brain injury.A pharmacy review dated 1/26/26 documented antipsychotic medications have the capacity to cause tardive dyskinesia and other movement disorders, and recommended that a movement?disorder assessment, such as an AIMS or DISCUS test, be completed at least every six months while the resident remained on antipsychotic therapy.A review of Resident #38's medical record showed the last AIMS assessment was completed on 8/18/25, more than six months prior to the pharmacy recommendation and outside the recommended monitoring interval.On 3/4/26 at 9:55 AM, the DON confirmed the pharmacy recommendation had not been acted upon and Resident #38's record did not contain a current AIMS assessment.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents receiving anticonvulsant medications were monitored for potential side effects as required by their comprehensive person-centered care plans. This was true for 2 of 5 residents (#34 and #41) whose records were reviewed for unnecessary medications. This failure created the potential for harm if side effects were undetected. Findings include:1. Resident #34 was admitted on [DATE] with multiple diagnoses including major depressive disorder, anxiety disorder, and alcohol dependence.Resident #34's record included a physician order for Depakote (an anticonvulsant) sprinkles delayed release capsule 250 mg by mouth three times a day for alcohol dependence.Resident #34's care plan revised 8/6/25, directed staff to monitor, notify the provider and document side effects for anticonvulsants such as:Over-sedation or lethargyRestless agitationIncreased confusion or poor concentrationMental status changeVisual disturbanceChange in gaitBehavioral changesWeight changeResident #34's record did not include documentation the facility staff were monitoring for side effects of anticonvulsants.2. Resident #41 was admitted to the facility on [DATE] with multiple diagnosis including borderline personality disorder, Alzheimer's disease, and suicidal ideations.Resident #41's record included a physician order for Depakote sprinkles delayed release capsule 750 mg by mouth two times a day for borderline personality disorder.Resident #41's care plan revised 10/14/24, directed staff to monitor, notify the provider and document side effects for anticonvulsant such as:Over-sedation or lethargyRestless agitationIncreased confusion/poor concentrationMental status changeVisual disturbanceChange in gaitBehavioral changesWeight changeResident #41's record did not include documentation that facility staff were monitoring for side effects of anticonvulsants.On 3/5/26 at 8:32 AM, The DON confirmed Resident #34 and #41's record did not include monitors for anticonvulsants.

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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 observation and interview, it was determined the facility failed to ensure expired medications were removed from the medication storage room and not available for administration to residents. This was true for 1 of 1 medication room observed. This failed practice created the potential for adverse effects if residents received expired medications with decreased efficacy. Findings include:On 3/4/26 at 1:14 PM, during the inspection of the Medication Storage Room with the ADON, five acetaminophen suppositories which expired on 10/2025 were found inside the refrigerator. The ADON stated the acetaminophen suppositories were expired and should not be kept in the refrigerator.

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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 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 observation, review of FDA Food Code, and staff interview, it was determined the facility failed to ensure employees were not wearing jewelry during food preparation and service, and cutting boards were not cleaned properly. These deficiencies had the potential to affect the 59 residents who consumed food prepared by the facility. This placed residents at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include:1. The FDA Food Code Section 2-303.11 documented items of jewelry such as rings, bracelets, and watches may collect soil, and the construction of the jewelry may hinder routine cleaning. As a result, jewelry may act as a reservoir of pathogenic (disease causing) organisms transmissible through food.On 3/4/26 from 6:30 AM to 7:35 AM, [NAME] #1 and [NAME] Trainee #1 were observed preparing and serving food while wearing rings on their fingers, [NAME] Trainee #1 had additional bracelets on her right and left wrist. Hand hygiene was performed with the jewelry on.On 3/4/26 at 7:40 AM, the Dietary Manager stated jewelry should not be worn while preparing or serving food, and if the jewelry was permanent gloves should be worn to cover.2. The FDA Food Code Section 4-501.12 Cutting Surfaces documented cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.On 3/5/26 at 2:35 PM, it was observed the cutting boards in the kitchen had dark colored stains within the grains of the plastic.On 3/5/26 at 2:37 PM, the Culinary Manager stated the cutting boards should be replaced when they are not able to get clean or have the stains removed.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and American Health Care Association (AHCA)/National Center for Assisted Living (NCAL) and CDC guidance, the facility failed to ensure an infection control prevention and practices were implemented during medication administration and cleaning of a urine spill. These deficient practices created the potential for the spread of infectious diseases which could harm the residents in the facility. Findings include:1. The American Health Care Association website accessed on 3/10/26, stated to place a clean and dry paper towel under blood glucose meter before placing on resident's table or on top of medication cart. Resident #56 was admitted to the facility on [DATE] with multiple diagnoses including diabetes and asthma. On 3/4/26 at 6:59 AM, RN #1 entered Resident #56's room with the glucometer with the test strip inserted into it, two insulin pens, lancet and alcohol wipes. RN #1 placed the glucometer and insulin pens on the foot of Resident #56's bed, performed hand hygiene and donned gloves. RN #1 then took the glucometer and placed it above the pillow where Resident #56's arm was resting and checked her blood glucose. RN #1 was not observed to place a barrier when she placed the glucometer and insulin pens on two different surfaces on Resident #56's bed. On 3/4/26 at 10:06 AM, the DON stated insulin pens and glucometer should be placed on top of a paper towel before placing them on any surface in residents' room. 2. The CDC web page titled Environmental Cleaning Procedures accessed on 3/12/26, under This is the general processes for cleaning of spills of blood or body fluids: Wear appropriate PPE. Confine the spill and wipe it up immediately with absorbent (paper) towels, cloths, or absorbent granules (if available) that are spread over the spill to solidify the blood or body fluid (all should then be disposed as infectious waste). Clean thoroughly, using neutral detergent and warm water solution. Disinfect by using a facility-approved intermediate-level disinfectant. Immediately send all reusable supplies and equipment (e.g., cleaning cloths, mops) for reprocessing (i.e., cleaning and disinfection) after the spill is cleaned up. On 3/4/26 at 9:57 AM, CNA #2 was observed assisting CNA #3 with a urine spill from a leaking urinary catheter collection bag in the [NAME] Wing common area. CNA #2 was observed placing a dry white towel over top of a small puddle of urine. CNA #2 donned gloves and wiped the urine spill with the dry white towel and left the [NAME] Wing common area. On 3/4/26 at 2:25 PM, when asked what the process was for cleaning soiled areas, CNA #2 stated the process was to wear gloves, wipe up the soiled area, and to use alcohol wipes or disinfectant wipes on the soiled area. When asked if CNA #2 used any alcohol wipes or disinfectants on the urine spill she cleaned that morning, CNA #2 stated she did not use any disinfectant and stated she should have (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sanitized the area and notified housekeeping of the spill.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interview, it was determined the facility failed to ensure its Antibiotic Stewardship practices were followed by initiating antibiotic therapy without obtaining culture and sensitivity results to guide appropriate treatment. This was true for 1 of 1 residents (Resident #64) reviewed for antibiotic stewardship. This failure created the potential for inappropriate antibiotic use and development of antibiotic?resistant organisms. Findings include:The facility's Antibiotic Stewardship Policy, revised 8/10/25, documented the facility focuses on improving antibiotic use through an Antibiotic Stewardship Program to ensure appropriate antibiotic usage, promote therapeutic and cost?effective care, and reduce the likelihood of developing multi?drug?resistant organisms. The policy also documented the facility utilizes McGeer's Criteria to validate infections and routinely reviews culture and sensitivity reports as part of infection surveillance.The Revised McGeer's Criteria for urinary tract infection (UTI) without an indwelling catheter requires both of the following be present:1. At least one clinical sign or symptom, such as:Fever, rigors, or new?onset hypotension (low blood pressure) with no alternate site of infectionAcute change in mental status or functional decline with leukocytosis (extremely high white blood cell counts)New?onset suprapubic pain or costovertebral angle tenderness (pain at the angle formed by the 12th rib and spine)Purulent discharge or acute pain/swelling of the testes, epididymis (inflammation of the coiled tube at the back of the testicle that stores and carries sperm) or prostate.AND:2. At least one microbiologic criteria, such as:? 10? cfu/mL of no more than two organisms in a voided urine sample? 10^2 cfu/mL of any organism in a catheterized specimenResident #64 was readmitted to the facility on [DATE] with multiple diagnoses, including history of falling, adult failure to thrive, and a need for assistance with personal care.Resident #64's care plan revised 3/27/25, directed staff to encourage fluids and monitor for the following symptoms:[urinary] frequency malaisefoul smelling urinedysuria (pain when urinating)fevernauseavomitingflank painsupra-pubic painhematuriacloudy urinealtered mental statusloss of appetitebehavioral changesA progress note dated 3/27/25 at 4:43 PM, documented Resident #64 was observed to be increasingly lethargic with decreased muscle function. As a result, the provider was notified, and the following new orders were given:CBC (complete blood count lab test)CMP (comprehensive metabolic panel blood test)Urine analysis with culture and sensitivityCefdinir (an antibiotic) 300mg by mouth twice daily for 5 days for a diagnosis of urinary tract infection.A review of Resident #64's lab results documented the urine specimen was collected on 3/27/25 at 1:45 PM and the culture and sensitivity were completed on 3/29/25 at 7:54 AM, 3 days after antibiotics were started.On 3/5/26 at 4:12 PM, the DON confirmed Resident #64 did not meet McGeer's criteria for antibiotics for a urinary tract infection.