STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135053	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ironwood Rehabilitation and Care Center	2200 Ironwood Place Coeur D'Alene, ID 83814

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record review, SOM Appendix PP, and staff interview it was determined the facility failed to provide quality care for residents. This was true for 4 of 20 (#2, #4, #8, and #51) whose records were reviewed. This deficient practice created the potential for harm when Resident #2's bowel protocol was not followed, when staff did not follow physician's orders for Resident #4 and #8, and when Resident #51 did not have a skin assessments completed. Findings include:SOM Appendix PP updated 4/25/25 documented quality of care is a fundamental principle applying to all treatment and care provided to facility residents where the facility must ensure residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. 1. Resident #51 was readmitted to the facility on [DATE], with multiple diagnoses including obesity, Parkinson's disease, cognitive communication deficit, bipolar disorder, and borderline personality disorder. A physician's order dated 4/15/26, documented Resident #51 should receive weekly skin assessments every evening shift on Tuesday starting 4/21/26. A Skin assessment dated [DATE], documented Resident #51 had no skin issues. No skin assessment was completed on 4/28/26. A nursing progress note dated 4/29/26, documented Resident #51 did not have any change to his skin. On 4/29/26 at 10:35 PM, Resident #51 and his representative complained about a red rash that was spreading from under the left lower arm, down into the abdominal area and slowly going down into the groin area. Resident #51's representative stated he had been putting cream Nystatin powder on the rash to calm it down as the facility had not done anything about it even after multiple requests to care for it over the past three weeks. On 4/30/26 at 3:30 PM, Surveyor, with Resident #51's permission and his representative present, CNA #2, SA observed a rash under Resident #51's left arm, going down into the panna/apron (lower abdomen skinfold) area of the abdomen, around towards his back, and down into his groin area. The area under his arm and flank skin fold were bright red, shiny and appeared moist. Resident #51 stated the areas itched and were painful. A review of Resident #51's record did not document Nystatin was a current medication. On 4/30/36 at 4:00 PM, the DON and RN #1 stated there should have been a weekly skin assessment (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 4/28/26. They also verified residents are not provided with medication without a physician's order. 2. Resident #4 was readmitted to the facility on [DATE], with multiple diagnoses including dementia, cognitive communication deficit, PTSD, and depression. On 4/28/26 at 11:58 AM, Resident #4 ended the surveyor interview stating she was tired and needed to rest before lunch. She stated she is usually sleepy and needs to rest before activities. Resident #4's care plan, initiated on 5/30/25, directed staff to observe for signs and symptoms of mood change, changes in normal behavior, social isolation, and/or fatigue related to antidepressant medication use and to report to physicians any signs or symptoms of fatigue related to anemia. Physician's orders included the following: -Monitor antidepressant medication side effects using the following scale: 0=none; 1=sedation; 2=drowsiness; 3=headache; 4=decreased appetite; 5=less common s/e; 6=dry mouth; 7=blurred vision; and 8=urinary retention every shift, dated 1/12/26. -Monitor episodes of behaviors every shift, dated 1/12/26. - Sertraline (anti-depressant) HCL tablet 100 mg, give 100 mg by mouth in the morning for depression, dated 2/5/26. A review of Resident #4's MAR and TAR documented the following dates of behavior monitoring were not recorded as ordered: - January 2026: 15 of 50 opportunities - February 2026: 9 of 56 opportunities - March 2026: 16 of 62 opportunities - April 2026: 3 of 60 opportunities A review of Resident #4's MAR and TAR documented the following dates Sertraline was not given: - January 2026: 14 of 50 opportunities - February 2026: 4 of 56 opportunities - March 2026: 13 of 62 opportunities - April 2026: 2 of 60 opportunities On 4/30/26 at 2:44 PM, the CRN stated facility staff should have been monitoring and documenting the behaviors and medication administration at every shift. 3. Resident #8 was admitted to the facility on [DATE], with multiple diagnoses including cognitive communication deficit, bipolar disorder, dementia, and depression. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #8's care plan, initiated on 11/26/25, directed staff to observe for signs and symptoms of mood change, changes in normal behavior, social isolation, and/or fatigue related to antidepressant and antipsychotic medication use and to report to physicians any signs or symptoms. Physician's orders included the following: -Monitor antipsychotic medication side effects using the following scale: 0=none, 1=drowsiness, 2=dry mouth, 3=blurred vision, 4=constipation, 5=edema, 6=extra pyramidal symptoms, 7=urinary retention, 8=stiff or tight muscles, 9=restlessness, and 10=tardive dyskinesia every shift, dated 12/12/25. -Monitor antidepressant medication side effects using the following scale: 0=none; 1=sedation; 2=drowsiness; 3=headache; 4=decreased appetite; 5=less common s/e; 6=dry mouth; 7=blurred vision; and 8=urinary retention every shift, dated 4/27/26. -Monitor episodes of behaviors every shift, dated 4/10/26. Physician's orders included the following: - Aripiprazole (antidepressant) oral tablet 10 mg, give 1 tablet by mouth at bedtime for bipolar disorder, dated 4/2/26. - Trazadone (antidepressant) HCL oral tablet 50 mg, give 25 mg by mouth at bedtime for insomnia, dated 12/26/25. A review of Resident #4's MAR and TAR documented the following dates of behavior monitoring were not recorded as ordered: - January 2026: 14 of 62 opportunities - February 2026: 4 of 56 opportunities - March 2026: 13 of 62 opportunities - April 2026: 1 of 60 opportunities On 4/30/26 at 2:44 PM, the CRN stated facility staff should have been monitoring and documenting the behaviors and medication administration at every shift. 4. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses, including Parkinson's Disease without Dyskinesia (a movement disorder characterized by involuntary, erratic, and sometimes painful body movements) and diabetes. A physician's order documented Resident #2 was to receive the following bowel medications: -Polyethylene Glycol (laxative) 3350 powder give one scoop by mouth in the morning for constipation. Dissolve in 6-8 oz of liquid -Dulcolax 10 mg tablet, one tablet by mouth every 24 hours as needed for no bowel movement after (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	three days, ordered 9/23/25. -MOM (Milk of Magnesia - laxative), give 30 cc every 24 hours as needed for bowel care if no bowel movement after three days, ordered 9/23/25. -Dulcolax Suppository (Bisacodyl) insert 10 mg rectally every 24 hours as needed for bowel care if no results from MOM, ordered 9/23/25. -Fleet enema insert one unit rectally every 24 hours as needed for bowel care if no results from Dulcolax, ordered 9/23/25. A review of Resident #2's Bowel Record documented that she did not have bowel movement from 4/6/26 through 4/10/26 (5 days). A review of Resident #2's MAR did not document she receive her bowel medication when she did not have a bowel movement for three days. On 5/1/26 at 11:07 AM, the IP and CRN reviewed Resident #2's bowel record. The CRN stated Resident #2 did not have a bowel movement from 4/6/26 through 4/10/26 (5 days). The CRN stated they will review Resident #2's record and will get back to the surveyor. On 5/1/26 at 11:32 AM, the CRN stated Resident #2 did not receive her bowel medications as needed.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, resident interview, and staff interview, it was determined the facility failed to ensure residents were provided a safe, comfortable, and homelike environment. This was true for 2 of 2 residents (#13 and #30) whose rooms were observed with wear or damage and for residents living in 2 of 3 Halls (South and East Halls) who experienced uneven flooring. These deficient practices created the potential for the residents to experience accidents and psychosocial harm due to the conditions of the rooms and uneven flooring. Findings include:1. a. Resident #13 was admitted to the facility on [DATE] with multiple diagnoses including, atrial fibrillation (irregular heartbeat), and dementia (a progressive irreversible syndrome causing decline in memory, thinking, and daily functioning). On 4/27/26 at 12:48 PM, observed Resident #13's room, which had at least 7 holes in the wall over the bed and scattered areas of missing paint on the same wall. On the wall edge next to bed, a large area of chipped off drywall from the baseboard and up measuring approximately 36 inches, and missing paint. b. Resident #30 was admitted to the facility on [DATE] with multiple diagnoses including dementia, and stroke (when blood flow to part of the brain is interrupted or reduced, causing brain tissue to die due to lack of oxygen). On 4/27/26 at 1:12 PM, observed Resident #30's room with multiple areas of paint missing on walls by the window and the East wall. Large water stains were observed on the ceiling above the sink. On 4/30/26 at 9:49 AM, the Maintenance Supervisor confirmed the holes, missing paint and water stain in the residents rooms and stated, we have a lot of issues with the holes in residents' walls and need for paint. He stated he did not currently have a plan for the repairs and paint, but will make it a priority to be fixed. 2. On 4/27/26 at 10:45 AM, multiple divots were observed throughout the hallways on the East and South Halls. Drainage covers were observed to be discolored and flooring was chipped and cracked off around the drain covers, creating uneven divots. Multiple chipped flooring divots partially filled with shellac were observed throughout the floor near the nurses' station and in both East and South Hallways. On 4/27/26 at 3:38 PM, Resident #5 stated he had seen wheelchairs get stuck in the rut and not be able to move throughout the hallways. On 4/30/26 at 9:20 AM, the Maintenance Director confirmed the flooring was not flush with the drainage covers, and there were multiple divots throughout the East and South hallways.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 1 of 3 residents (Resident #50) observed during cares. This deficient practice created the potential for psychosocial harm if Resident #50 experienced embarrassment or lack of self-esteem. Findings include: Resident #50 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses, including Down Syndrome and chronic respiratory failure with hypoxia (low levels of oxygen in the blood).On 4/30/26 at 1:23 PM, RN #2 assisted by CNA #1 performed wound care to Resident #50's bottom. RN #1 was also observed to clean Resident #50's penis. Resident #50's window curtain was not drawn to provide privacy. He was visible to the outside while receiving wound care.On 4/30/26 at 1:42 PM, RN #2 stated he did not notice Resident #50's curtain was not drawn while he was providing wound care. RN #2 stated the curtain should have been drawn to provide privacy to Resident #50.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interviews, it was determined the facility failed to provide self-administration of medication assessments. This was true for 1 of 3 residents (Resident #5) whose record was reviewed for self-administration of medications. This deficient practice created the potential for harm if Resident #5 took too much or too little of his inhaled medication, or suffered adverse effects, such as oral thrush, due to lack of assessment. Findings include:Resident #5 was readmitted to the facility on [DATE], with multiple diagnoses including quadriplegia (a medical condition involving paralysis of all four limbs and the torso, often caused by spinal cord injury, stroke, or disease), muscle weakness, stage 4 pressure ulcer of right buttock, anxiety, depression, emphysema (a chronic, progressive lung disease that makes it hard to breathe by destroying the delicate air sacs (alveoli) in the lungs), and sleep apnea (serious disorder where breathing repeatedly stops and starts during sleep, preventing restful, quality sleep).On 4/27/26 at 3:20 PM, it was observed Resident #5 had an inhaler on his bedside table.A physician's order dated 12/3/25 documented Proventil HFA (albuterol sulfate) Inhalation Aerosol Solution 108 mcg/act, 2 puffs inhale orally every 4 hours as needed for [shortness of breath], rinse mouth after use.A review of Resident #51's record did not document a self-administration of medication assessment.On 4/30/26 at 4:05 PM, the DON stated Resident #5 should not be self-administering medication without an assessment, and there should have been one.Cross Reference F761

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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 review of records and staff interviews it was determined the facility failed to ensure a bed-hold notice was provided to a resident and/or their representatives. This was true for 1 of 3 resident (Resident #50) whose records was reviewed. This failure created the potential for psychosocial distress if Resident #50 could not return to the facility following hospitalization. Findings include:The State Operation Manual Appendix PP, issued 7/23/25, documented At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy.Resident #50 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses, including Down Syndrome and chronic respiratory failure with hypoxia (low levels of oxygen in the blood).A Nursing Notes dated 3/30/26, documented Resident #50 was noted to have involuntary movement. Resident #50 had extreme labored breathing and oxygen was administered. EMS was called and Resident #50 was transferred to the hospital.A review of Resident #50's record did not document a bed-hold notice was provided to his representative when he was transferred to the hospital.On 5/1/26 at 1:23 PM, RN #1 stated she was unable to find documentation a bed-hold notice was provided to Resident #50 and/or his representatives when he was sent to the hospital.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility failed to develop and implement residents' comprehensive person-centered care plan. This was true for 1 of 20 residents (Resident #6) whose care plan was reviewed. This deficient practice placed Resident #6 at risk for their health and wellbeing with negative outcomes if services were not provided or provided incorrectly. Findings include: The facility's policy titled, Comprehensive Person-Centered Care Planning stated, 'It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. Resident #6 was admitted to the facility on [DATE], and readmitted [DATE], with multiple diagnoses including fracture of left tibia (break in the shin bone), stroke (the death of brain tissue caused by a sudden lack of oxygen due to obstructed blood flow), unsteadiness on feet, need for assistance with personal care, and muscle weakness (generalized). A physician's order dated 4/9/26 documented, OK to have 5 oz of wine daily prn every 24 hours as needed. Resident #6's comprehensive person-centered care had not documented the use of wine as written in the physician order.On 4/30/26 at 4:30 PM, the DON stated Resident #6 did not have wine use care planned, and she confirmed it should have been.

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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 staff administered and disposed of medications according to professional standards. This was true for 1 of 4 residents (Resident #79) observed during medication administration, and 1 of 6 residents (Resident #11) whose medication regimen were reviewed. These failures created the risk for harm when Resident #79's medication was not disposed of appropriately and when the nurse did not follow the physician's order for two medications, and a risk for harm to Resident #11 when two of their medication orders were written to administer by the wrong route. Findings include: -The National Library of Medicine web page titled Nursing Rights of Medication Administration, accessed 5/5/26, documented the five traditional rights for medication administration are, Right Patient, Right Drug, Right Route, Right Time, Right Dose. -PharmcareUSA - Medication Disposal in Longˆ Term Care, accessed 5/5/26, documented, When medications are not disposed of properly, they may increase the risk of diversion, accidental exposure, or unintended use. Improper handling can also create avoidable safety concerns for residents, staff, and visitors. 1. Resident #79 was admitted to the facility on [DATE] with multiple diagnoses including multiple fractures to their right ribs, chronic obstructive pulmonary disease (COPD is a disease that causes airflow blockage and breathing related problems), and hypertension (high blood pressure). a. Resident #79's record documented a physician order: Cozaar Tablet 25 MG (Losartan Potassium) Give 1 tablet by mouth in the morning for hypertension, hold for [systolic blood pressure less than] 100, ordered 4/29/26. On 4/30/26 at 9:26 AM, LPN #1 was observed measuring Resident #79's blood pressure, with a result of systolic/diastolic of 108/70. LPN #1 was observed explaining to Resident #79 that their blood pressure was too low to administer the blood pressure medication. On 4/30/26 at 10:10 AM, the DON and RN #1 stated LPN #1 did not follow the physician's order and held Resident #79's losartan in error. b. On 4/30/26 at 9:30 AM, LPN #1 was observed holding a medication cup with one tablet in it over the garbage can in Resident #79's room, turning the cup over, the tablet fell into the garbage can, then she dropped the medication cup into the garbage can. On 4/30/26 at 9:46 AM, LPN #1 stated when prepared medications are not administered they are disposed of in a pharmacy provided box for medication returns or a Drug Buster (a bottle with chemicals to make the medication useless and non-retrievable). LPN #1 stated, she should not have thrown a tablet away in the garbage can in the resident's room. c. Resident #79's record documented a physician's' order for Breyna Inhalation Aerosol 160-4.5 mcg/act (Budesonide Formoterol Fumarate Dihydrate) 2 puff inhale orally two times a day for [shortness of breath] rinse mouth after use, ordered 4/29/26.On 4/30/26 at 9:38 AM, LPN #1 was observed assisting Resident #79 to use his Breyna Inhaler. She placed the mouthpiece in his mouth and instructed him to take a breath when she pressed the inhaler to dispense the dose, she repeated the administration as ordered. LPN #1 then gathered her supplies and left Resident #79's room. LPN #1 was not observed asking Resident #79 to rinse his mouth after the use of the inhaler or providing education to why rinsing the mouth after the use of an inhaler was recommended. On 4/30/26 at 4:53 PM, the DON stated LPN #1 should always follow the physician's' order thoroughly and should have instructed Resident #79 to rinse his mouth after using an inhaler. 2. Resident #11 was admitted to the facility on [DATE] with multiple diagnoses including emphysema, muscle weakness, a need for assistance with personal care, and had a colostomy (a surgical opening from the intestine through the abdominal wall to bypass the rectum). Resident #11's record documented the following physicians orders:-Dulcolax Suppository (Bisacodyl) Insert 10 mg rectally every 24 hours as needed for bowel care if no results from [milk of magnesia], ordered 2/3/26 -Fleet Enema, Insert 1 unit rectally every 24 hours as needed for bowel care if no results from [suppository], ordered 2/3/26 On 4/30/26 at 4:56 PM, RN #1 stated Resident #11 had a colostomy and could not use any medications rectally and the route on the physicians' order is wrong for the bisacodyl suppository and fleet enema.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of records and interviews, it was determined the facility failed to ensure residents who were dependent on staff for activities of daily living (ADLs) received bath/shower assistance. This was true for 1 of 1 resident (Resident #20) whose ADL record was reviewed. This deficient practice created the potential for Resident #20 to experience diminished self-worth, embarrassment, and an increased risk for developing skin conditions. Findings include: Resident #20 was admitted to the facility on [DATE] with multiple diagnoses, including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following a stroke, diabetes, dysphagia (difficulty swallowing), and dysarthria (slurred, slow, or difficult to understand speech).An MDS Comprehensive assessment dated [DATE], documented Resident #20 was cognitively intact.On 4/29/26 at 3:44 PM, Resident #20 stated she was to be showered two times a week every Sunday and Thursday, but she only receives one shower a week. Resident #20 stated she did not refuse when she was offered a shower/bath.An ADL care plan initiated 5/29/25, documented Resident #20 required help in part of bathing activity. The care plan documented Resident #20 preferred to have two showers weekly in the morning.Resident #20's Bathing Flowsheets documented she received a shower on 4/2/26 and received her next shower on 4/16/26, 14 days later.Review of nursing notes did not document Resident #20 refused showers.On 4/30/26 at 2:35 PM, Resident #20's shower's flowsheet was reviewed with the DON. The DON confirmed Resident #20 did not have a shower on 4/5/26, 4/9/26 and 4/12/26. The DON also reviewed the PRN shower flowsheet and stated there was no PRN shower provided to Resident #20.

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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 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 observation, SOM Appendix PP, and resident and staff interview, it was determined the facility failed to assess the safety of a resident electing to smoke. This was true for 1 of 3 residents (Resident #80) whose record was reviewed for safe smoking assessments. This deficient practice created the potential for harm if a resident was not appropriately assessed for safety related to smoking. Findings include:SOM Appendix PP, updated 7/23/25, documented assessment of the resident's capabilities and deficits determines if supervision while smoking is necessary.Resident #80 was admitted to the facility on [DATE], and re-admitted on [DATE], with multiple diagnoses including COPD, chronic bronchitis, nicotine dependence, depression, anxiety, and mood disorder.On 4/27/26 at 3:51 PM, Resident #80 asked the surveyor to unlock the nursing cart so she could get her cigarettes.On 4/27/26 at 5:06 PM, the facility identified Resident #80 as one of the facility's resident's who chose to smoke. A Smoking Assessment, dated 4/23/26, documented Resident #80 was a non-smoker.Resident #80's care plan, dated 4/27/26, documented Resident #80 was safe to smoke independently.There was no additional smoking assessment found in Resident #80's record.On 4/30/26, the DON and RN #1, stated there were no additional smoking assessments after 4/23/26, and there should have been one after her re-admission on [DATE].

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	135053	A. Building B. Wing	05/01/2026

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and resident and staff interview, it was determined the facility failed to provide respiratory care as ordered by the physician. This was true for 1 of 3 residents (Resident #5) whose record was reviewed for oxygen therapy. This deficient practice created the potential for harm if resident's oxygen therapy did not follow physician's orders. Findings include: Resident #5 was readmitted to the facility on [DATE], with multiple diagnoses including quadriplegia, muscle weakness, stage 4 pressure ulcer of right buttock, anxiety, depression, emphysema, and sleep apnea.a. A physician's order dated 12/3/25 documented Resident #5 to receive oxygen at 0-4 LPM, as needed for SOB related to respiratory failure with hypoxia.On 4/27/26 at 3:38 PM, Resident #5's nasal cannula was observed hanging over the oxygen condenser without any covering on it.On 4/27/26 at 3:40 PM, Resident #5 stated he had used his nasal cannula the night before.On 4/28/26 at 9:43 AM, LPN #2 was asked to verify if the nasal cannula was properly stored. LPN #2 stated, No, the nasal cannula should be stored in clear bag on the oxygen condenser.The facility was unable to provide an Oxygen Equipment or Respiratory Therapy policy relating to the proper storage of a nasal cannula. On 5/1/26 at 9:01 AM, the CRN stated the facility did not have any Oxygen Therapy policies and staff are instructed to follow physician's orders related to the care and treatment of any oxygen services. When asked to clarify if a physician's orders were needed to store the nasal cannula in a separate bag, the CRN stated, Yes.b. A physician's order dated 12/3/25 documented to change tubing, clean filter and change oxygen water bottle every night shift every Sunday.On 4/27/26 at 3:38 PM, it was observed the oxygen tubing for Resident #5 did not have a date of change on the tubing.On 4/28/26 at 9:42 AM, LPN #2 confirmed there was no date located on Resident #5's oxygen tubing.A review of the MAR for April 2026 documented Resident #5 received an oxygen tubing change on 4/26/26.On 4/28/26 at 9:45 AM, LPN #2 stated the tubing should have been dated when it was changed out, and it was not.

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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, record review and staff interview, it was determined the facility failed to ensure medications were stored securely. This was true for 1 of 3 medication carts observed (North Hall Med Cart). This failure created the potential for harm related to unmonitored use of medications. Findings include: On 4/30/26 at 8:59 AM, the medication cart on the North Hall was observed to be unlocked and unattended. On 4/30/26 at 9:03 AM, LPN #1 returned to the medication cart. LPN #1 stated the cart was locked and attempted to demonstrate by pulling on a drawer handle, the drawer opened. LPN #1 stated the cart locked on a timer and she thought the cart was locked when she stepped away. LPN #1 stated she did not know how long the timer on the cart took to lock when left unattended and added she should have double checked it. On 4/30/26 at 9:59 AM, the CRN stated medication carts must be locked when the staff leave it unattended.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **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 a residents medical record was complete and accurately documented. This was true for 1 of 6 residents (Resident #11) whose medication regimen were reviewed. This failure created the potential for poor continuity of care and medication error when Resident #11's medication administration record (MAR) did not record their medications were not administered due to a hospitalization. Findings include: Resident #11 was admitted to the facility on [DATE] with multiple diagnoses including emphysema, muscle weakness, and a need for assistance with personal care. Resident #11's MAR documented, on 4/16/26, their midday and bedtime medications were not administered and on 4/17/26, their early morning medications were not administered. Resident #11's MAR did not include documentation of a code recording why the medications were not administered and the spaces for documentation were left blank. On 4/30/26 at 4:52 PM, the DON stated Resident #11 was at the hospital on 4/16 and 4/17 and the nurses administering medications should have recorded that on the MAR. The DON added, there should never be blanks on the MAR.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of CDC guidance, and interviews, it was determined the facility failed to ensure an infection control program was implemented. This was true for 1 of 1 resident (Resident #37) whose intravenous site was observed, and 1 of 1 staff (RN #2) who was observed while providing wound care to Resident #50. This deficient practice created the potential for Resident #37 to develop an infection to his IV site and the spread of infection due to cross contamination when RN #2 did not perform hand hygiene when changing gloves. Findings include: The CDC webpage titled Clinical Safety: Hand Hygiene for Healthcare Workers was accessed on 5/5/26, documented gloves were not a substitute for hand hygiene. The CDC recommended the following:-Perform hand hygiene before donning gloves and touching the patient or the patient's surroundings.-Always clean your hands after removing gloves.The facility's Infection Control policy revised 1/26, documented hand hygiene should be performed before donning sterile gloves and after removing gloves.1. Resident #50 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses, including Down Syndrome and chronic respiratory failure with hypoxia (low levels of oxygen in the blood).A care plan revised 4/17/26 documented Resident #50 had moisture associated skin disorder to his buttocks and staff were directed to administer treatments as ordered.On 4/30/26 at 1:23 PM, RN #2 assisted by CNA #1 performed wound care to Resident #50. RN #2 wiped Resident #50's bottom and applied a new incontinence brief. RN #2 removed his gloves and put on new pair of gloves without performing hand hygiene. RN #2 then was observed to put on another pair of gloves to his already gloved hands. RN #2 proceeded to apply the Triamcinolone cream to Resident #50's bottom, removed the first pair gloves to expose another pair of gloves and then cleaned Resident #50's penis. RN #2 then applied Triamcinolone cream to Resident #50's penis, removed his gloves and put on a new gloves without performing hand hygiene. RN #2 then secure Resident #50's incontinence brief.On 4/30/26 at 1:42 PM, RN #2 stated he put on two gloves on both hands, applied the Triamcinolone cream to Resident #50's bottom and then cleaned his penis. RN #2 stated he then removed the gloves and proceeded to apply the Triamcinolone cream to his penis with his gloved hand. RN #2 stated he did not perform hand hygiene when he changed his gloves.On 5/1/26 at 9:30 AM, the IP stated wearing double gloves was not allowed in the facility and hand hygiene should be performed before and after donning gloves.2. Resident #37 was admitted to the facility on [DATE] and readmitted [DATE] with multiple diagnoses including, hemiplegia (paralysis on side of the body) and hemiparesis (weakness on one side of the body) following a stroke, dysphagia (difficulty swallowing) and muscle weakness.A Quarterly MDS assessment dated [DATE], documented Resident #37 was cognitively intact.The CDC MMWR (Morbidity and Mortality Weekly Report) webpage accessed on 5/6/26, stated Replace gauze dressing every 2 days and transparent dressing every 7 days on short term catheters. Replace the dressing when the catheter is replaced, or when the dressing becomes damp, loosened, or soiled, or when inspection of the site is necessary.On 4/27/26 at 3:13 PM, Resident #37 was awake in bed. He was observed to have an intravenous (IV) access site to his right wrist which was covered with a transparent dressing. A black looking material was noted on top of the insertion site. Resident #37 stated it was dried blood and had been there for a while. Resident #37 stated the IV was used for his antibiotic, and it was completed few days ago. When asked if the IV site was hurting, Resident #37 stated No.A review of Resident #37's April 2026 MAR, documented he received 2 grams ceftriaxone sodium solution reconstituted intravenously once a day for infection/appendicitis, ordered for 11 days which was completed on 4/24/26.On 4/27/26 at 3:20 PM, RN #3 checked Resident #37's IV site and asked him if it was hurting, Resident #37 stated it was not hurting.On 4/27/26 at 3:29 PM, the IP stated they received an order to remove Resident #37's IV access site. The IP and RN #3 donned gown and gloves and entered Resident #37's room to remove his IV tubing from his right wrist. RN #3 was asked to measure the dried blood, and it was 5 cm long by 2 cm wide. RN #3 then gently lifted the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	edges of the transparent dressing and removed it slowly. As RN #3 was lifting the clear dressing, the dried blood was noted to stick to the clear dressing. A wet and gel like dark brown looking material (blood) was observed above the insertion site. RN #3 then pull the catheter and cleaned the site.On 4/27/26 at 3:36 PM, the IP stated if the dressing on the IV site was soiled, it must be changed. When asked if Resident #37's dressing to his IV site was soiled, the IP stated Yes, if it's soiled with blood, then it has to be changed.On 4/27/26 at 4:12 PM, DON #2 stated the expectation was for the nurse to change the dressing if blood was noted on the IV insertion site.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **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 were provided with the pneumococcal vaccine when requested. This was true for 1 of 5 residents (Resident #6) whose medical records were reviewed for pneumococcal immunization. This failure created the potential for Resident #6 to have an increased risk of pneumococcal pneumonia (a serious bacterial lung infection) and the potential for severe illness or death. Findings include: The facility's policy, titled Immunizations-Residents, dated 1/26 documented, It is the policy of this facility to offer and administer influenza, pneumococcal, and COVID-19 immunization to eligible residents after providing education on the risks and potential side effects of the vaccine(s) and obtaining consent. Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including fracture of left tibia, stroke, unsteadiness on feet, need for assistance with personal care, and muscle weakness (generalized). A review of Resident #6's medical record showed on 9/27/25, she consented to receive the pneumococcal vaccine as per CDC guidance. The record did not include documentation the vaccine had been given. On 5/1/26 at 9:30 AM, the IP stated she misunderstood the information and thought Resident #6 was up to date on her pneumococcal vaccine and was mistaken. The IP stated she will offer the vaccine to Resident #6 when she returns to the facility.