

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135059	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/24/2026
NAME OF PROVIDER OR SUPPLIER Franklin County Transitional Care		STREET ADDRESS, CITY, STATE, ZIP CODE 44 North 1st East Preston, ID 83263	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews, it was determined the facility failed to ensure residents remained free from abuse and neglect. This was true for 3 of 6 residents (#2, #14, and #28) reviewed for abuse prevention practices. The facility's failure to prevent, identify, and respond to abuse and neglect created harm for Resident #2 and #14 when staff failed to respond in a timely manner to her complaint of pain, and when they forcibly removed a washcloth from Resident #2; and when Resident #28 experienced psychosocial harm, fear, and decreased self-esteem. Findings include: The facility's Freedom from Abuse, Neglect, and Exploitation policy revised 1/23/25 documented: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. [The facility] will actively prevent, identify and report any such situations. Resident #2 was admitted on [DATE], with multiple diagnoses including constipation, chronic pain, and adult failure to thrive. a. A review of the facility's grievance investigation dated 4/20/26, documented on 4/20/26, CNA #3 sent a text message to the DON alleging that Resident #2's needs were not met. CNA #3 was instructed to email the allegation to the DON and Administrator. A review of CNA #3's written statement dated 4/21/26, documented concerns regarding Resident #2's pain and lack of staff response. Following receipt of the statement, the facility requested statements from CNA #6 and LPN #1. On 4/21/26, the facility sent a message to all staff reminding them that residents have the right to receive safe and prompt treatment in a manner that meets their preferences. The investigation included a written statement from LPN #1, dated 4/22/26 at 5:11 PM, documenting: LPN #1 administered pain medication to Resident #2 prior to assisting CNA #7 with transferring Resident #2 to bed. LPN #1 documented Resident #2 required catheter replacement and instructed staff to notify her before putting Resident #2 in bed. After Resident #2 was transferred to bed, Resident #2 complained of right leg pain. (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 0600 Level of Harm - Actual harm Residents Affected - Few	LPN #1 documented she asked Resident #2 to describe the pain, and Resident #2 stated: It was really bad pain all over her leg and it felt like her leg was still broke. LPN #1 documented she assessed Resident #2 but did not identify abnormal findings and proceeded with the catheter change. The investigation did not include an interview with Resident #2 or other residents in proximity to the incident. On 7/23/26 at 10:45 AM, Resident #2 was asked about the incident but stated she did not recall the event. During a phone interview on 7/23/26 at 4:12 PM, CNA #3 stated, At approximately 5:25 PM on 4/20/26, she entered the dining room and observed Resident #2 experiencing significant leg pain. CNA #3 stated she approached the doorway and asked three CNAs at the nurses' station if they could assist Resident #2 to bed because Resident #2 was in a lot of pain. CNA #3 stated none of the staff responded. She stated LPN #1 was providing care to residents down the hall and she attempted to call her but was having issues with the radio system. CNA #3 stated she attempted to position Resident #2's leg and provide comfort while waiting for assistance. CNA #3 stated at approximately 5:55 PM, CNA #7 entered the facility, and CNA #3 asked her for help. CNA #7 and LPN #1 then assisted Resident #2 to bed. On 7/23/26 at 11:51 AM, the DON stated the facility did not identify abuse or neglect at the time of the incident and confirmed the facility should have. b. A review of the facility's abuse and neglect investigation dated 6/2/25, documented the facility received a text message from CNA #3 alleging abuse involving an interaction observed between Resident #2 and CNA #5. The text message documented CNA #3 was assisting Resident #2 with her night routine. CNA #3 handed Resident #2 a wet washcloth to wash her face. Resident #2 washed her face and handed the washcloth back. CNA #3 then handed Resident #2 a dry washcloth to dry her face. Resident #2 took the dry washcloth, and before she could dry her face, CNA #5 snatched the dry washcloth out of Resident #2's hand, hung it back on the rack, looked at Resident #2, and stated, We don't do that, do we? A statement from CNA #3 documented Resident #2 subsequently dried her face with her shirt. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	The investigation concluded CNA #5 displayed inappropriate behavior, and CNA #5 was terminated. The investigation did not include interviews with residents identified during the investigation process who may have witnessed or been in proximity to the incident. On 7/23/26 at 10:47 AM, Resident #2 was interviewed but did not recall the incident. On 7/23/26 at 11:49 AM, the DON stated the investigation confirmed the allegation of abuse. 2. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including an open wound on her right lower leg, polyneuropathy (a medical condition where multiple peripheral nerves throughout the body are damaged at the same time), chronic venous hypertension on right lower extremity (a condition where sustained, elevated blood pressure occurs in the veins of the right leg due to damaged vein valves or blockages), hypertension (high blood pressure, a common condition where blood pushes too hard against the artery walls), diabetes, and anxiety. On 7/21/26 at 3:17 PM, Resident #14 stated she had concerns about staff, but did not want to be specific as she felt her treatment might not be the same. A review of the facilities grievances documented on 7/6/26, Resident #14 had complained to her daughter about the leg wrappings being too tight. Resident #14's daughter called the DON to complain about her mother's pain and to notify the DON that RN #2 was abrupt with Resident #14. The grievance included a statement where RN #2 reported she was able to change Resident #14's leg wrapping sometime later that afternoon. A review of the LTC State Portal did not show a neglect report had been uploaded on 7/6/25 for Resident #14. On 7/24/26 at 9:52 AM, RN #2 stated Resident #14 woke up around 8:00 AM on 7/6/26, and wanted to have her leg wrapping changed from the original wrapping the night before. Due to having other residents to take care of, RN #2 told Resident #14 she could not change her dressings at that time. Around 9:00 AM, RN #2 stated she provided pain medication to Resident #14 along with her regular morning medications. RN #2 acknowledged she did not check in with Resident #14 to see if the pain medication had helped. RN #2 was unclear what time she changed Resident #14's leg wrapping but believed she had changed it around 10:30 AM or 11:00 AM. RN #2 stated, 2 &ndash; 2.5 hours was too long for a resident to be in pain. When asked about her nursing progress note indicating she had changed Resident #14's leg wrappings in the late afternoon, she did not respond. On 7/24/26 at 11:10 AM, the DON stated Resident #14's pain medication would take about 45 minutes to become effective, and RN #2 could have checked on Resident #14. The DON stated she did not believe this incident was a neglect case since both parties (Resident #14 and RN #2) had worked through the concern satisfactorily. She stated that this incident was not reported as neglect since the incident had been resolved, but looking at it now, it should have been reported. 3. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including visual loss (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	in both eyes, muscle weakness, diabetes, and depression. A review of an abuse/neglect report dated 6/13/25, submitted to the LTC Reporting System documented Resident #28 had an encounter with staff that left him fearful. The report documented the facility was notified on 6/14/26 that Resident #28 reported to staff he was fearful about comments made to him by CNA #8 during the night on 6/13/26. Resident #28 reported CNA #8 was in his room when she told him, I know where you live. Resident #28 stated he asked CNA #8 if she was stalking him, and Resident #28 reported hearing CNA #8 respond, That's something for me to know and you to find out. A nursing progress note dated 6/14/25 at 9:33 PM, documented staff checked on Resident #28 said he was worried about his family and about not being able to drive over and check on them. A nursing progress note dated 6/15/25 at 10:45 AM, documented the Administrator spoke to Resident #28 about the incident and informed the Administrator he had been CNA #8's Sunday school teacher, and he was confused if CNA #8's comment was made directly about him or the home of his ex-wife. The investigation concluded CNA #8 stated she had spoken before thinking, assuming Resident #28, who she knew personally, would understand her comments as a joke. The investigation documented Resident #28 did not interpret the statements that way, and staff were trained to avoid jest, sarcasm, or other forms of joking that may be perceived negatively by residents or others in the facility. The investigation documented CNA #8 had prior verbal and written warnings regarding her work ethic and following directions from her supervisors. The incident was identified as a last chance warning for CNA #8 to pay closer attention to her language before speaking and to avoid statements that may be interpreted as aggressive or unsafe. The investigation documented that, at Resident #28's request, CNA #8 was allowed to return to work after providing an apology to Resident #28, and informing him when she was in his room and why she was there. On 7/22/26 at 3:45 PM, the surveyor interviewed Resident #28 who did not recall the incident on 6/13/25. On 7/23/26 at 11:08 AM, the surveyor left a message with CNA #8. CNA #8 did not return the call. On 7/24/26 at 11:23 AM, the DON stated as written, Resident #28 experienced verbal abuse by CNA #8. Cross reference F609 and F610.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, Food Drug Administration (FDA) Food Code, and staff interview, it was determined the facility failed to ensure kitchen equipment was cleaned and sanitized. This deficient practice had the potential to affect the 33 residents who consumed food prepared by the facility. This placed residents at risk for potential foodborne illnesses and adverse health outcomes. Findings include: The FDA Code Section 4-602.12 Cooking and Baking Equipment documented food-contact surfaces of cooking equipment must be cleaned to prevent encrustation's that may impede heat transfer necessary to adequately cook food. Encrusted equipment may also serve as an insect attractant when not in use. On 7/24/26 at 2:37 PM, cooking saute pans and baking sheets were observed with a black encrusted residue which did not scrape off without effort. On 7/24/26 at 2:40 PM, the Dietitian stated the baking sheets, and saute pans should not have the black encrusted residue.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on policy review, record review, and staff interview, it was determined the facility failed to implement its antibiotic stewardship program as required. This was true for all residents residing in the facility. This failure created the potential for adverse events, including inappropriate antibiotic use and development of multi-drug resistant organisms. Findings include: A review of the facility's Antimicrobial Stewardship Protocol, revised 3/2/26, documented the facility must: -Assess residents for infection using standardized tools and criteria. -Use Lobes minimum criteria before initiating antibiotics. -Provide education to prescribing practitioners and nursing staff. -Require antibiotic orders to include indication, dose, and duration. A review of stewardship documents received 7/27/26 at 4:19 PM documented the following concerns identified by the facility on 4/16/26: -The facility lacked a defined diagnostic algorithm. -Point Click Care charting was not aligned with McGeer's or Lobes criteria. -Reflex urine cultures were being performed without indication. -UTI antibiotic courses were not consistently reassessed at 72 hours. A review of the facility's Healthcare Associated Infection LTC monitoring dated April 2026 - June 2026, documented the following: - on 4/1/26, Resident #29 reported increased fatigue. The provider ordered the following labs: complete blood count (CBC), comprehensive metabolic panel (CMP) and a urine analysis (UA). The IP conducted a review of the infection control protocol and determined Resident #29 did not meet McGeer's or the LOBES criteria at the time labs and UA were ordered. -On 6/30/26, Resident #16 displayed a change in mental status. Resident #16 was assessed, and no signs or symptoms of infection were identified. A UA was conducted, and Resident #16 was prescribed Cipro 500 mg twice daily for 7 days. The IP conducted a review and determined Resident #16 did not meet criteria. The report documented staff would contact the provider to discontinue the order as Resident #16 did not have urinary symptoms and altered mental status resolved prior to antibiotic therapy initiation. On 7/22/26 at 3:00 PM, IP confirmed infection control screening was not conducted for Resident #29 or Resident #16. When asked about the infection control protocol for screening residents IP stated, we don't really have a process in place, I came into the position, and the person prior was not doing very much. On 7/22/26 at 5:58 PM, IP stated, the expectation is that they will report the symptoms to the provider, send the culture, use McGeer's and LOBES to ensure they meet criteria, get culture results, then initiate antibiotics. She confirmed screening was not conducted for Resident #29 or Resident #16.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, policy review, and staff interview, it was determined the facility failed to ensure residents medical records were complete, accurately documented, readily accessible, and systemically organized. This was true for 4 of 6 residents (#2, #3, #4, and #14) reviewed for RNA services. This deficient practice created the potential for harm if resident's records did not show physician ordered services were being completed related to resident's rehabilitation programs. Findings include: The facility's Restorative Nursing Program, dated 5/18/20, documented maintenance and restorative services will be provided to residents designed to maintain or improve a resident's ability to the highest practicable level. Restorative aides will implement the plan and for a designated period, perform the activities, and document on the Restorative Aide Worksheet. 1. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a long-lasting disease where the body's immune system attacks the protective covering of nerve cells in the brain and spinal cord, leading to communication problems between the brain and the body), and anxiety disorders. Resident #3's care plan, revised 6/4/26, documented Resident #3 was to continue to work with Restorative to maintain her functional ability. A review of Resident #3's record, did not include a physician order for Restorative Nursing Program. Resident #3's record, dated May 2026 through July 2026, documented the following restorative programs: -Offer to assist her to ride the NUTSTEP 6 times a week for 10 minutes. -Offer active range of motion 6 days a week for 15 min per day. Include arm and leg exercises. A review of Resident #3's restorative nursing program, dated May 2026 through June 2026 did not document exercise or refusals for the following: NUTSTEP: -May 2026: 29 of 30 days -June 2026: 29 of 30 days. The facility provided three printed calendars dated May 2026 &ndash; July 2026 with Resident #3's first name written at the top. The calendars contained handwritten entries documenting restorative opportunities which did not match the restorative nursing documentation in the resident's clinical record. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the calendars documented Resident #3 was provided opportunities for only 1 of the 2 restorative programs, which did not match the restorative nursing documentation in the resident's clinical record. 2. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including anxiety, chronic pain syndrome, and a history of urinary tract infections. Resident #4's care plan, revised 7/2/26, documented Resident #4 was to continue to work with Restorative to maintain her functional ability. No physician's orders were located in Resident #4's record. Resident #4's record, dated May 2026 through July 2026, documented to offer to assist her to ride the NUTSTEP 6 times a week for 10 minutes. A review of Resident #4's restorative nursing program, dated May 2026 through June 2026 did not document exercise or refusals for the following: -May 2026: 6 of 31 days -June 2026: 20 of 30 days -July 2026: 17 of 21 days The facility provided three printed calendars dated May 2026 &ndash; July 2026 with Resident #4's first name written at the top. The calendars contained handwritten entries documenting restorative opportunities which did not match the restorative nursing documentation in the resident's clinical record 3. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including open wound on right lower leg, polyneuropathy, chronic venous hypertension on right lower extremity, hypertension, diabetes, and anxiety. Resident #14's care plan, revised 2/16/26, directed staff to encourage her to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as: group exercises and participate with the restorative program. A review of Resident #14's record documented no physician's orders for restorative services. Resident #14's record, dated May 2026 through July 2026, documented to offer to assist her to ride the NUTSTEP 6 times a week for 10 minutes. A review of Resident #14's restorative nursing program, dated May 2026 through June 2026 did not document exercise or refusals for the following: (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-May 2026: 12 of 31 days -June 2026: 23 of 30 days -July 2026: 16 of 24 days The facility provided three printed calendars dated May 2026 &ndash; July 2026 with Resident #14's first name written at the top. The calendars contained handwritten entries documenting restorative opportunities which did not match the restorative nursing documentation in the resident's clinical record On 7/24/26 at 9:21 AM, the RNA RN stated refusals are noted and usually recorded in the resident's medical record; however, the RNA Aides will usually keep an external hard copy calendar of the resident's refusals and activities which should then be input into the resident's medical record. The RNA RN stated documentation should be completed within 24-hours of the completed or refused activity. For Resident's #3, #4, and #14, the RNA RN stated there were no recorded services or refusals in the resident's medical record. 4. Resident #2 was admitted on [DATE] with multiple diagnoses including constipation, chronic pain, and adult failure to thrive. A review of Resident #2's care plan documented: Resident #2 will participate in restorative nursing service to continue to improve strength and mobility to return home. A review of Resident #2's physician orders did not include an order for restorative nursing services. A review of Resident #2's record dated May 1, 2026 &ndash; July 23, 2026, documented the following restorative programs: -Bed mobility: Assist for 15 minutes/day at least 6 days/week; include stretching the right leg with knee brace off while lying flat. -Eating: Offer assistance 6 days/week for at least 15 minutes/day. -Range of Motion (ROM): Offer ROM 6 days/week for at least 15 minutes/day. Resident #2's record documented missed opportunities on the following weeks: ROM: 5/4/26&ndash;5/10/26: 1 (continued on next page)		

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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, record review, policy review, and staff interview, it was determined the facility failed to ensure Enhanced Barrier Precautions (EBP) were implemented and maintained for 7 of 32 residents who resided in the facility. This failure created the potential for cross-contamination, increased risk of infection, and adverse events. Findings include: The CDC's website accessed [DATE] titled Considerations for Use of Enhanced Barrier Precautions in Skilled Nursing Facilities, documents that traditional Standard Precautions are insufficient to prevent MDRO (Multi-Drug Resistant Organisms) spread in nursing homes, where residents often have:-Chronic wounds-Indwelling medical devices-High levels of physical contact with staff-Long lengths of stay-Frequent MDRO colonizationThe CDC further states EBP must be used for residents who:-Have unhealed wounds or chronic skin breakdown.-Have indwelling medical devices such as catheters, feeding tubes, tracheostomies, ports, and PICC lines.-Are colonized or infected with CDC-targeted MDROs.The use of EBP requires gown and glove use during high-contact care activities such as:-Dressing-Bathing-Transferring-Providing hygiene-Changing linens-Toileting-Wound care-Device careA request for the facility's Enhanced Barrier Precautions policy was made; no policy was provided.The facility's Infection Control Plan revised [DATE], documented that the Infection Preventionist is responsible for overseeing the infection prevention and control program based on epidemiology principles, research, and consideration of resident demographics and disease trends.On [DATE], [DATE], [DATE], [DATE], and [DATE], the State Agency conducted observations throughout the facility and identified no use of Enhanced Barrier Precautions for residents who had chronic wounds or indwelling medical devices.On [DATE] at 3:42 PM, the IP stated the facility previously followed EBP practices but stopped in [DATE] after the Administrator and DON received an update that EBP was no longer necessary.On [DATE] at 5:27 PM, the DON provided documentation of the directive that the facility was following: CMS issued QSO-24-08-NH, dated [DATE], documented EBP recommendations now include use of EBP for residents with chronic wounds or indwelling medical devices during high-contact resident care activities regardless of their multidrug-resistant organism status. This guidance is incorporated into F880 Infection Prevention and Control. On [DATE] at 12:12 PM, upon reading QSO-24-05-NH to the DON she stated she misunderstood the memo and thought because the memo expired the facility no longer had to implement EBP.		

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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. Based on observation, policy review, staff interview, and record review, the facility failed to ensure care was provided in a manner that supported and promoted dignity and respect. This was true for 1 of 1 resident (Resident #17) observed during a restorative nursing activity. This failure created the potential for embarrassment, social discomfort, and reduced willingness to participate in the restorative nursing program. Findings include: The facility's Resident Rights Policy (revised 9/22/22) stated, Each resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. On 7/22/26 at 9:29 AM, Resident #17 was observed ambulating in the hallway with a CNA as part of his restorative nursing ambulation program. During this observation, the resident's urinary catheter drainage bag was hanging from his waistband, fully visible, containing approximately 100 mL of bright yellow urine. On 7/22/26 at 9:30 AM, CNA #4 stated Resident #17 participates in his restorative nursing ambulation program six times per week. When asked about the uncovered catheter bag, CNA #4 stated that placing the drainage bag in a privacy cover was too bulky. She acknowledged that the catheter bag should have been covered to maintain the resident's dignity and privacy during ambulation.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff interview, it was determined the facility failed to prevent harm without adequately monitoring the side effects of psychotropic drug medications. This was true for 5 of 5 residents (#4, #6, #9, #19, and #29) whose medication side effect monitoring were reviewed. This deficient practice created the potential for harm for Resident #4 when her psychotropic medication was not monitored and when Residents #6, #9, #19, and #29 were not monitored for signs and symptoms related to psychotropic medication use. Findings include: A policy for psychotropic use was requested and not provided. 1. Resident #19 was admitted to the facility on [DATE], with multiple diagnoses including anxiety, chronic pain syndrome, and a history of urinary tract infections. Drugs.com, accessed on 7/31/26, documented side effects of Clonazepam (an antidepressant) causes drowsiness, poor coordination and dizziness, along with memory disturbances, fatigue, and decreased appetite. An antidepressant care plan, initiated 5/26/26, directed staff to monitor and document side effects and effectiveness. No specific side effects were listed. An anti-anxiety care plan, initiated 5/26/26, directed staff to monitor, document, and report prn adverse reactions to anti-anxiety therapy, including: -Drowsiness, Lack of energy, Clumsiness -Slurred speech, Confusion and disorientation, Depression -Dizziness, Lightheadedness -Impaired thinking and judgment, Aggressive or impulsive behaviors A review of Resident #19's record documented the following physician orders: -Clonazepam oral tablet, 1 mg, 1 tablet daily at bedtime due to anxiety, initiated 5/26/26. -Clonazepam oral tablet, 0.5 mg, give 1 tablet in the morning due to anxiety, initiated 5/27/26. A review of Resident #19's care plan, initiated 6/24/26, documented the following: -6-24-26 unwitnessed fall, no apparent injury -6-25-26 unwitnessed fall, no injury noted (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-7-7-26 unwitnessed fall, no injury -7-10-26 unwitnessed fall, injury, (head laceration with three staples.) -7-12-26 unwitnessed fall, injury, (fell and hit head.) -7-17-26 unwitnessed fall, minor injury, (fell and hit head.) A review of Resident #19's record documented a 17.8-pound weight loss. On 7/23/26 at 3:03 PM, the DON stated the facility does not monitor side effects of antipsychotic medications. On 7/23/26 at 3:46 PM, the Dietitian stated Resident #19's 14% weight loss had not been identified prior to the interview. She stated staff had not notified her of Resident #19's reduction in appetite. Cross reference F689 and F692. 2. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including dementia and anxiety. The care plan, initiated 6/17/25, directed staff to monitor, document, and report prn adverse reactions of psychotropic medication, including, but not limited to: -Unsteady gait -Tardive dyskinesia, Extrapyramidal Symptoms (shuffling gait, rigid muscles, shaking), Frequent falls -Refusal to eat, Difficulty swallowing -Depression, Suicidal ideations, Social isolations -Blurred vision -Loss of appetite, Weight loss -Behavior symptoms not usual to the person A review of Resident #4's record documented the following active physician orders: -Brexiprazole oral tablet, 0.5 mg, give 1 tablet per day for dementia, initiated 3/19/26. On 7/23/26 at 3:07 PM, the DON stated the facility did not have side effect monitoring of Resident #4's dementia medications. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #29 was admitted to the facility on [DATE], with multiple diagnoses including dementia, anxiety, insomnia, and opioid dependence. The care plan, initiated 9/17/25, and updated on 6/6/26, directed staff to monitor every day and prn, psychotropic medications. No specific signs and symptoms were identified, nor were staff directed to record psychotropic medication effects. A review of Resident #29's record documented the following active physician orders: -Escitalopram tablet, 20 mg, daily for anxiety, initiated 9/11/25. -Clonazepam tablet, 0.5 mg daily for insomnia, initiated 11/14/25. -Clonazepam tablet, 0.5 mg daily for anxiety and agitation, initiated 12/5/25. -Trazodone HCl tablet, 50 mg at bedtime for insomnia, initiated 4/16/26. -Brexiprazole, 2 mg at bedtime for dementia, initiated on 7/10/26. Resident #29's record did not include monitoring documentation for anti-anxiety and antidepressant (psychotropic) medication side effects. On 7/23/26 at 3:07 PM, the DON stated the facility did not have side effect monitoring of Resident #29's antianxiety and antidepressant medications. 4. Resident #6 was readmitted on [DATE], with multiple diagnoses including depression, anxiety, and dementia. Resident #6's care plan, initiated 7/9/25, directed staff to monitor, document, and report PRN adverse reactions to antidepressant therapy, including: -Changes in behavior, mood, cognition -Hallucinations, delusions, social isolation, suicidal thoughts -Decline in ADLs, continence, or voiding -Constipation, diarrhea, fecal impaction -Gait changes, rigid muscles, tremors, movement problems -Falls, dizziness, vertigo -Fatigue, insomnia (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Appetite loss, weight loss, nausea/vomiting -Dry mouth, dry eyes A review of Resident #6's physician orders documented an active order for: -Sertraline (antidepressant) HCl 100 mg, one tablet daily for depression, initiated 11/15/25. A review of Resident #6's record documented no use of antidepressant side effect monitoring as required by the care plan. On 7/23/26 at 3:03 PM, the DON confirmed no side effect monitoring was present in Resident #6's record. 5. Resident #9 was admitted on [DATE], with multiple diagnoses including dementia, anxiety, and chronic pain. The care plan, initiated 3/6/24, directed staff to monitor, document, and report PRN adverse reactions to antianxiety therapy, including: -Drowsiness, lack of energy, clumsiness -Slow reflexes, slurred speech -Confusion, disorientation, depression -Dizziness, lightheadedness -Impaired thinking/judgment -Memory loss, forgetfulness -Nausea, stomach upset -Blurred/double vision -Unexpected reactions: mania, hostility, rage, aggressive/impulsive behavior, hallucinations A review of Resident #9's record documented the following active physician orders: -Lorazepam (antianxiety) 1 mg, twice daily for anxiety disorder, initiated 7/11/25. -Escitalopram (antianxiety) 10 mg, at bedtime for anxiety, initiated 6/13/25. Resident #9's record did not include monitoring documentation for antianxiety medication side effects. (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/26 at 11:55 AM, the DON stated the facility did not have official documentation of required side effect monitoring for Resident #9's antianxiety medications.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews, the facility failed to ensure allegations of abuse and neglect were reported to the State Agency (SA) as required. This was true for 3 of 6 residents (Resident #2, #14, and #28) reviewed for allegations of abuse and neglect. The failure to report allegations in accordance with federal timeframes created the potential for unaddressed harm and lack of external oversight. Findings include: The facility's Freedom from Abuse, Neglect, and Exploitation policy (revised 1/23/25) documented: The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. [The facility] will actively prevent, identify and report any such situations. 1. Resident #2 was admitted on [DATE] with diagnoses including constipation, chronic pain, and adult failure to thrive. a.A review of the facility's abuse investigation dated 6/2/25 documented the facility received a text message from CNA #3 alleging abuse involving CNA #5 and Resident #2. The allegation involved CNA #5 forcibly removing a washcloth from Resident #2's hand and speaking to her in a demeaning manner. A review of the Long-Term-Care Reporting Portal documentation showed the allegation was not reported to the State Agency within the required timeframe. On 7/23/26 at 11:49 AM, the DON stated she was unsure of when the allegation should have been reported to the portal. b.On 4/20/26, CNA #2 sent a text message alleging Resident #2's needs were not met, indicating possible neglect. The allegation was forwarded internally to the DON and Administrator. Staff statements were collected on 4/21/26 and 4/22/26. A review of the Long-Term Care Reporting Portal documented the facility did not report the allegation of neglect. On 7/23/26 at 11:51 AM, the DON stated the facility did not identify the incident as abuse or neglect at the time and confirmed the facility did not report the allegation 2. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including open wound on right lower leg, polyneuropathy, chronic venous hypertension on right lower extremity, hypertension, diabetes, and anxiety. On 7/21/26 at 3:17 PM, she told the surveyor she had concerns about staff but did not want to (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide details because she feared her care might change. A grievance dated 7/6/26 showed Resident #14 told her daughter her leg wrapping was too tight, and her daughter reported to the DON that Resident #14 was in pain and that RN #2 had been abrupt with her. RN #2 changed the leg wrapping later in the afternoon. A review of the Long-Term Care Reporting Portal showed no neglect report was submitted on 7/6/26. On 7/24/26 At 9:52 AM, RN #2 stated Resident #14 asked for her leg wrapping to be changed around 8:00 AM, but RN #2 delayed due to other duties. RN #2 gave pain medication around 9:00 AM, and RN #2 did not check whether it relieved the pain. RN #2 believed she changed the wrapping around 10:30&ndash;11:00 AM. RN #2 confirmed that 2&ndash;2.5 hours was too long for a resident to remain in pain. On 7/24/26 at 11:10 AM, the DON stated the pain medication would take about 45 minutes to work and staff could have checked on Resident #14. She also stated she did not consider this incident neglect because the concern resolved, and therefore it was addressed as a grievance rather than reported as neglect. 3. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including visual loss in both eyes, muscle weakness, diabetes, and depression. A review of an abuse/neglect report dated 6/13/25, submitted to the LTC Reporting System documented Resident #28 had an encounter with staff that left him fearful. The report documented the facility was notified on 6/14/26 that Resident #28 reported to staff he was fearful about comments made to him by CNA #8 during the night on 6/13/26. Resident #28 reported CNA #8 was in his room when she told him,I know where you live. Resident #28 stated he asked CNA #8 if she was stalking him, and Resident #28 reported hearing CNA #8 respond,That's something for me to know and you to find out. A nursing progress note dated 6/14/25 at 9:33 PM, documented staff checked on Resident #28 said he was worried about his family and about not being able to drive over and check on them. A nursing progress note dated 6/15/25 at 10:45 AM, documented the Administrator spoke to Resident #28 about the incident and informed the Administrator he had been CNA #8's Sunday school teacher, and he was confused if CNA #8's comment was made directly about him or the home of his ex-wife. The investigation concluded CNA #8 stated she had spoken before thinking, assuming Resident #28, who she knew personally, would understand her comments as a joke. The investigation documented Resident #28 did not interpret the statements that way, and staff were trained to avoid jest, sarcasm, or other forms of joking that may be perceived negatively by residents or others in the facility. The investigation documented CNA #8 had prior verbal and written warnings regarding her work ethic (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and following directions from her supervisors. The incident was identified as a last chance warning for CNA #8 to pay closer attention to her language before speaking and to avoid statements that may be interpreted as aggressive or unsafe. The investigation documented that, at Resident #28's request, CNA #8 was allowed to return to work after providing an apology to Resident #28, and informing him when she was in his room and why she was there. On 7/22/26 at 3:45 PM, the surveyor interviewed Resident #28 who did not recall the incident on 6/13/25. On 7/23/26 at 11:08 AM, the surveyor left a message with CNA #8. CNA #8 did not return the call. On 7/24/26 at 11:25 AM, the DON stated that abuse and neglect reports should be reported within the first 2 to 24 hours, depending upon the severity of the abuse or neglect. According to the incident report, dated 6/14/25, which included a comment on 6/16/25 at 8:00 AM, Resident #28's verbal abuse was not reported within the appropriate time. Cross reference F600 and F610.		

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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, policy review, record review, and staff interview, it was determined the facility failed to provide an accurate and thorough report to the Long-Term Care Reporting Portal. This was true for 3 of 6 residents (#2, #14, and #28) reviewed for abuse and neglect. This deficient practice created the potential for psychosocial harm if reports of resident verbal abuse or neglect were not thoroughly investigated to ensure resident safety. Findings include: A review of the facility's Freedom from Abuse, Neglect, and Exploitation policy (revised 1/23/25) documented the facility will actively prevent, identify and report any such situations. 1. Resident #14 was admitted to the facility on [DATE], with multiple diagnoses including an open wound on her right lower leg, polyneuropathy (a medical condition where multiple peripheral nerves throughout the body are damaged at the same time), chronic venous hypertension on right lower extremity (a condition where sustained, elevated blood pressure occurs in the veins of the right leg due to damaged vein valves or blockages), hypertension (high blood pressure, a common condition where blood pushes too hard against the artery walls), diabetes, and anxiety. On 7/21/26 at 3:17 PM, Resident #14 stated she had concerns about staff, but did not want to be specific as she felt her treatment might not be the same. A review of the facilities grievances documented on 7/6/26, Resident #14 had complained to her daughter about the leg wrappings being too tight. Resident #14's daughter called the DON to complain about her mother's pain and to notify the DON that RN #2 was abrupt with Resident #14. The grievance included a statement where RN #2 reported she was able to change Resident #14's leg wrapping sometime later that afternoon. A review of the LTC State Portal did not show a neglect report had been uploaded on 7/6/25 for Resident #14. On 7/24/26 at 9:52 AM, RN #2 stated Resident #14 woke up around 8:00 AM on 7/6/26, and wanted to have her leg wrapping changed from the original wrapping the night before. Due to having other residents to take care of, RN #2 told Resident #14 she could not change her dressings at that time. Around 9:00 AM, RN #2 stated she provided pain medication to Resident #14 along with her regular morning medications. RN #2 acknowledged she did not check in with Resident #14 to see if the pain medication had helped. RN #2 was unclear what time she changed Resident #14's leg wrapping but believed she had changed it around 10:30 AM or 11:00 AM. RN #2 stated, 2 &ndash; 2.5 hours was too long for a resident to be in pain. When asked about her nursing progress note indicating she had changed Resident #14's leg wrappings in the late afternoon, she did not respond. On 7/24/26 at 11:10 AM, the DON stated Resident #14's pain medication would take about 45 minutes to become effective, and RN #2 could have checked on Resident #14. The DON stated she did not believe this incident was a neglect case since both parties (Resident #14 and RN #2) had worked through the concern satisfactorily. She stated that this incident was not reported as neglect since the incident had been resolved, but looking at it now, it should have been reported. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including visual loss in both eyes, muscle weakness, diabetes, and depression. A review of an abuse/neglect report dated 6/13/25, submitted to the LTC Reporting System documented Resident #28 had an encounter with staff that left him fearful. The report documented the facility was notified on 6/14/26 that Resident #28 reported to staff he was fearful about comments made to him by CNA #8 during the night on 6/13/26. Resident #28 reported CNA #8 was in his room when she told him, I know where you live. Resident #28 stated he asked CNA #8 if she was stalking him, and Resident #28 reported hearing CNA #8 respond, That's something for me to know and you to find out. A nursing progress note dated 6/14/25 at 9:33 PM, documented staff checked on Resident #28 said he was worried about his family and about not being able to drive over and check on them. A nursing progress note dated 6/15/25 at 10:45 AM, documented the Administrator spoke to Resident #28 about the incident and informed the Administrator he had been CNA #8's Sunday school teacher, and he was confused if CNA #8's comment was made directly about him or the home of his ex-wife. The investigation concluded CNA #8 stated she had spoken before thinking, assuming Resident #28, who she knew personally, would understand her comments as a joke. The investigation documented Resident #28 did not interpret the statements that way, and staff were trained to avoid jest, sarcasm, or other forms of joking that may be perceived negatively by residents or others in the facility. The investigation documented CNA #8 had prior verbal and written warnings regarding her work ethic and following directions from her supervisors. The incident was identified as a last chance warning for CNA #8 to pay closer attention to her language before speaking and to avoid statements that may be interpreted as aggressive or unsafe. The investigation documented that, at Resident #28's request, CNA #8 was allowed to return to work after providing an apology to Resident #28, and informing him when she was in his room and why she was there. On 7/22/26 at 3:45 PM, the surveyor interviewed Resident #28 who did not recall the incident on 6/13/25. On 7/23/26 at 11:08 AM, the surveyor left a message with CNA #8. CNA #8 did not return the call. On 7/24/26 at 11:23 AM, the DON stated as written, Resident #28 experienced verbal abuse by CNA #8. Cross reference F600 and F609. 3. Resident #2 was admitted on [DATE], with diagnoses including constipation, chronic pain, and (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adult failure to thrive. A review of the facility's abuse investigation dated 6/2/25, documented the facility received a text message from CNA #3 alleging abuse involving CNA #5 and Resident #2. The allegation involved CNA #5 forcibly removing a washcloth from Resident #2's hand and speaking to her in a demeaning manner. The investigation concluded CNA #5 displayed inappropriate behavior and was terminated. However, the investigation did not include an interview with other residents or witnesses identified during the investigation process. On 7/23/26 at 10:47 AM, Resident #2 was asked about the incident but stated she did not recall it. On 7/23/26 at 11:51 AM, the DON confirmed the investigation did not include statements from residents in proximity to the incident and stated the facility should have interviewed them as part of the investigation.		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure residents were provided required written bed hold notification upon transfer out of the facility. This was true for 1 of 1 resident (Resident #8) whose record was reviewed for the discharge process. This failure created the potential for misunderstanding regarding the resident's right to return and the facility's obligation to maintain his bed during hospitalization or therapeutic leave. Findings include: A review of the facility's Transfer and Discharge Notification policy (revised 9/21/22) showed no documentation describing when the bed hold notice must be issued to residents upon transfer. Resident #8 was readmitted on [DATE], with multiple diagnoses including thyroid cancer, dysphagia, and weakness. A record review documented a debulking (a procedure to remove as much as possible of a widespread cancer or tumor) was scheduled for 5/28/26. A Progress Note dated 5/28/26 at 10:55 AM, documented that Resident #8 left the facility at 10:00 AM with his representative in a private vehicle. Resident #8's record included documentation of the facility's discharge process, including: -Practitioners contact information. -Resident representative information. -Physician Orders for Scope of Treatment (POST). However, the record did not include documentation that a bed hold notice was provided to Resident #8 at the time of transfer. On 7/23/26 at 3:08 PM, the DON stated the facility did not provide a bed hold notice to Resident #8. She stated she expected him to return but acknowledged the facility did not formally issue the required bed hold 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, policy review, and staff interviews it was determined the facility failed to provide a Preadmission Screening and Resident Review (PASRR) level II to the designated state agency. This was true for 1 of 1 residents (Resident #3) whose record was reviewed for PASRR documentation. This deficient practice created the potential for harm if Resident #3's coordination of care was not completed between the facility and the designated state agency. Findings include: The facility's policy PASRR for Long Term Care, dated 12/20/24, documented the Social Services Director shall be responsible for keeping track of each resident's assessment, care planning, and transitions of care. Any resident exhibiting a newly evident or possible serious mental disorder will be referred to the state mental health authority for a level II resident review. Resident #3 was admitted to the facility on [DATE], with multiple diagnoses including multiple sclerosis (a long-lasting disease where the body's immune system attacks the protective covering of nerve cells in the brain and spinal cord, leading to communication problems between the brain and the body), and anxiety disorder. On 5/7/25 Resident #3 was diagnosed with Major Depression (MDD). On 7/24/25 Resident #3 was diagnosed with Post-Traumatic Stress Disorder (PTSD). A review of Resident #3's record did not document a PASRR level II was sent to the state mental health authority on either 5/7/25 or 7/24/25. On 7/23/26 at 9:21 AM, the Social Services Director stated a new PASSR should have been completed and submitted for Resident #3 with the new diagnoses of MDD on 5/7/25 and PTSD on 7/24/25, and it was not.		

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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 policy review, record review, and staff interview, it was determined the facility failed to ensure bowel management was implemented according to the facility's bowel protocol and the resident's individualized plan of care. This was true for 2 of 12 residents (Resident #1 and #2) whose bowel records demonstrated repeated deviations from the required bowel protocol steps. Improper administration created the potential for unmanaged constipation, discomfort, bowel obstruction, and unnecessary use of PRN medications. Findings Include: The facility's Bowel Care policy, revised 3/4/25, requires the night nurse to: -Review every resident's chart nightly-Identify residents with >24 hours without a BM (bowel movement), or small BM in 48 hours-Identify residents with loose stools-Add residents to the Laxative List accordinglyThe facility's bowel protocol directs staff to administer interventions in a stepwise sequence:Day 1: Increase fluids + provide apple/apricot/prune juiceDay 2: Juice + oral medication (AM/PM)Day 3: Juice + oral medication (AM) + suppository if no BMDay 4: Notify the provider 1. Resident #2 was admitted on [DATE] with multiple diagnoses including constipation, chronic pain, and adult failure to thrive. Resident #2's record documented the following bowel physician orders: - Senokot S Oral Tablet 8.6-50 mg; Give 1 tablet by mouth two times a day related to constipation, initiated on 9/21/23. - Apricot juice, Prune, Juice or Apple juice 4-8 oz the first day without a bowel movement as needed for no bowel movement times one day, initiated 9/20/23. - Bisacodyl Suppository 10 mg; Insert 1 suppository rectally as needed for constipation daily if no results for milk of magnesia, initiated 9/30/24. - Bisacodyl Tablet Delayed Release; give 1 tablet by mouth as needed for constipation may have 1-2 tablets as needed to treat constipation once daily, initiated 9/20/23. - Enemeez Plus Enema 20-283 mg; Insert 1 dose rectally as needed for constipation may have one enema as needed for difficult evacuation, initiated 9/20/23. - Milk of Magnesia Concentrate Suspension; give 30 ml by mouth as needed for constipation may have once daily as needed, initiated 9/20/23. - MiraLax Powder Give 17 gram by mouth as needed for constipation may give in 8 oz of water or juice daily once or twice a day, initiated 9/20/23. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Senokot S Tablet 8.6-50 MG Give 1 tablet by mouth as needed for constipation may have 1-4 tabs by mouth daily, initiated 5/30/24. Resident #2's bowel record documented multiple dates where the bowel protocol was not followed, including incorrect sequencing, premature use of PRN medications, and skipped steps: 3/24&ndash;3/27/26: MiraLax given before Day 1; Bisacodyl tablets given on Days 3 and 4 4/17&ndash;4/19/26: MiraLax given on Day 1 5/18&ndash;5/21/26: Juice given on Day 3 (should be Day 1) 6/3&ndash;6/6/26: MiraLax given for 5 consecutive days 6/16&ndash;6/18/26: MiraLax given on Day 4 6/25&ndash;6/28/26: MiraLax given on Day 3 7/10&ndash;7/12/26: Bisacodyl tablets given on Days 3 and 4 On 7/24/26 at 12:08 PM, the DON confirmed Resident #2's record showed improper administration and documentation of the bowel protocol. 2. Resident #1 was admitted to the facility on [DATE], with multiple diagnoses including dementia, diabetes, and anxiety. Resident #1's physician's bowel protocol orders included the following: - Apricot juice, prune juice, or apple juice 4-8 oz the first day without a BM every 24 hours as needed for no bowel movement x 1 day, initiated 9/4/24. -Bisacodyl tablet delayed release, give 1 tablet by mouth every 24-hours as needed for constipation. May have 1-2 tables as needed to treat constipation once daily, initiated 9/4/24. -Enemeez plus enema 20-283 mg, insert 1 dose rectally every 24-hours as needed for constipation, may have one Enemeez as needed for difficult evacuation, initiated 9/4/24. -Milk of Magnesia Concentrated Suspension, give 30 ml by mouth every 24 hours as needed for constipation, may have once daily as needed, initiated 9/4/24. -MiraLax Powder, give 17 grams by mouth every 24 hours as needed for constipation, may give in 8 oz of water or juice daily once or twice a day, initiated 9/4/24. -Senokot tablet, 8.6-50 mg, give 1 tablet by mouth every 24 hours as needed for constipation, may have 1-4 tabs by mouth daily, initiated 9/4/24. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #1's care plan, initiated 9/4/24, did not include bowel management protocol. A review of Resident #1's medication administration record (MAR) documented the following: April 2026 No BM on 4/7, 4/8, 4/9 and 4/10. - Prune juice administered on 4/16. - Bisacodyl administered on 4/11. - Senokot administered on 4/9, 4/10, 4/18, 4/19, 4/22, and 4/24. Medication was not administered on 4/8 and 4/9. May 2026 No BM on 5/12, 5/13, 5/14 -Bisacodyl administered on 5/27 and 5/30. -Senokot tablet was administered on 5/14 and 5/21. Enemeez was not administered. Medication was not administered on 5/13. June 2026 No BM 6/8, 6/9, 6/10, 6/11, 6/12, 6/23, 6/24, 6/25, 6/27, 6/28, 6/29, and 6/30. -Apricot juice administered on 6/18, 6/29, and 6/30. -Bisacodyl tablet administered on 6/12, 6/13, 6/18, 6/24, and 6/30. -Senokot tablet administered on 6/11, 6/13, 6/15, 6/22, 6/25, 6/26, and 6/29. Enemeez was not administered. Medication was not administered on 6/9 and 6/28. July 2026 No BM 7/7, 7/8, 7/9, 7/16, 7/17, and 7/18. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Bisacodyl tablet was administered on 7/11, 7/18, and 7/19. -Senokot tablet was administered on 7/1, 7/3, 7/8, and 7/18. Apricot juice was not administered. Enemeez was not administered. No medication was administered on 7/9 and 7/17. On 7/24/26 at 12:08 PM, the DON stated, It appears we are not following the protocol as there are blanks [in the MAR] indicating we are not offering medication appropriately. She continued, The bowel protocol would not be included in the care plan unless it had been assessed and identified as a concern. The DON clarified that Day #1 of Bowel management begins 24 hours after a resident does not have a bowel movement.		

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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 accidents. This was true for 2 of 4 residents (Resident #5 and #28) whose records were reviewed for accident prevention. This deficient practice created a potential for harm when Resident #5 fell while wearing a pressure-relieving boot, and when Resident #28's room items were moved to new locations creating environmental hazards. Findings include: The facility's Risk Assessment for Accidents, Falls, and Care Planning revised 2/24/25, documented the resident environment is to remain as free of accident hazards as is possible, and to provide each resident adequate supervision and assistive devices to prevent accidents including: Identifying hazard(s) and risk(s); Evaluating and analyzing hazard(s) and risk(s); Implementing interventions to reduce hazard(s) and risk(s); and Monitoring for effectiveness and modifying interventions when necessary. 1. Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including visual loss in both eyes, muscle weakness, diabetes, and depression. Resident #28's care plan, initiated 5/30/25, directed staff about his limited mobility due to blindness; and to keep a safe environment with even floors free from spills and/or clutter. The facility's I&A report, dated 4/20/26, documented Resident #28 was found on the floor at 6:15 AM trying to get into his recliner. The report documented that Resident #28 was blind and that his garbage can and recliner had been moved and he was trying to put his garbage can back into the correct location, and when he went to sit on his recliner he fell to floor. He had slight redness to the right side of his back. On 7/24/26, the DON stated Resident #28's care plan should have directed housekeeping and nursing staff not to move his room furniture as it could have prevented his fall. 2. Resident #5 was admitted to the facility on [DATE], with multiple diagnoses including history of falling, muscle weakness, dizziness and giddiness. The Facility Fall Report dated 4/22/26, documented Resident #5 fell while attempting to self-transfer from his recliner to the restroom without assistance. The report documented Resident #5 was wearing a protective boot on his right foot and a non-skid sock on his left foot. Resident #5's care plan, revised 5/12/26, directed staff to implement the following fall prevention interventions: -Invite Resident #5 to sit in a recliner by the nurse's desk for increased observation during confusion/anxiety. -Labs and x-ray ordered. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Provide education about A^fib and symptoms. -Staff to round earlier in the morning and ask if he needs to use the restroom. -Ensure hearing aids are charging correctly when removed. -Ensure multiple walkers and clutter are removed from his room. Resident #5's care plan, revised 3/10/26, directed staff to implement the following interventions for suspected deep tissue injury: -Pressure^relieving boot on right foot only when in bed. -Float heels and remove shoes when he is in his recliner or bed. On 7/24/26 at 11:59 AM, the DON confirmed Resident #5 should not have been wearing his boot while in the recliner and agreed it may have contributed to his fall.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to monitor weight. This was true for 1 of 2 residents (Resident #19) whose record was reviewed for significant weight loss. This created the potential harm for Resident #19 when her 17.8 pound or 14.1% significant weight loss was not identified. Findings include: Based on record review and staff interview, it was determined the facility failed to monitor weight for a resident taking psychotropic medications. This was true for 1 of 2 residents (Resident #19) whose record was reviewed for significant weight loss. This created harm for Resident #19 when her 17.8 pound or 14.1% significant weight loss was not identified. Findings include: CDC's Healthy Weight and Growth resources accessed on 7/30/26, documented an unintended weight loss is a red flag for underlying health issues and should be evaluated promptly in chronic illness using the following clinical practice:-1 week: 2% weight loss-1 month: 5% weight loss-3 months: 7.5% weight loss-6 months: 10% weight lossResident #19 was admitted to the facility on [DATE], with multiple diagnoses including anxiety, chronic pain syndrome, and a history of urinary tract infections.Resident #19's care plan, initiated 6/15/26, directed staff to complete weekly weights, provide Ensure Plus 8 oz twice per day with meals, and notified staff Resident #19 did not want to have a bedtime snack.A review of Resident #19's record documented the following physician orders:-Clonazepam (antianxiety) oral tablet, 1 mg, 1 tablet daily at bedtime due to anxiety, initiated 5/26/26.-Clonazepam oral tablet, 0.5 mg, give 1 tablet in the morning due to anxiety, initiated 5/27/26.-Fluoxetine (antidepressant) HCl oral tablet, 10 mg, give 1 tablet in the morning for depression, initiated 5/27/26.-Regular diet, Ensure clear, 8 oz twice per day with one-ounce LiquaCel (nutritional supplement to boost protein and calories) added, initiated 5/26/26.A review of Resident #19's record documented the following weights:-126.4 pounds (wheelchair) on 6/27/26.-108.6 pounds (standing) on 7/20/26.Resident #19's vital record documented a 14.1% weight loss (-17.8 pounds) on 7/20/26.No weights were recorded between 5/29/26 through 6/26/26, or between 6/28/26 and 7/19/26.Resident #19's record did not document psychotropic medication monitoring for weight loss or appetite changes.A nursing progress note, dated 6/14/26 at 1:53 PM, documented Resident #19 ate 50% or less for 2 or more meals in the day. Resident was encouraged to eat and at this time her weight is stable.A Long-Term Care Evaluation, dated 6/17/26, at 2:40 PM, documented Resident #19 routinely [ate] an apple or berry ensure, and frequently has snacks between meals. No changes in nutritional status noted. A Physician Communication note, dated 6/25/26 at 8:43 AM, documented the DON spoke with [the physician] about [Resident #19's] increased confusion including a recent fall and attempting to use a piece of paper as a remote for the television. [The physician] attribute[d] this to her age and did not want to do anything at that time. Staff continue to encourage oral intake and encourage regular sleeping pattern to see if that helps.A nursing progress note, dated 7/15/26 at 11:05 AM, documented [Resident #19] was sleeping most of the day on 7/14/26. [Resident #19] had requested a Tylenol 3 for a headache. Resident's pupils were PERRL. Resident was alert to person, place, and time but when asked why she was [at the facility] stated, to go get a job. Resident did not eat much either. Resident #19's Nutrition - Amount Eaten Task Report documented Resident #19 percent food consumption:5/26/26 to 5/31/26:-0-25%: 1 of 16 opportunities-26 - 50%: 6 of 16 opportunities-51 - 75%: 7 of 16 opportunities-76 - 100%: 1 of 16 opportunities-Refused: 1 of 16 opportunities6/1/26 to 6/30/26:-0-25%: 10 of 90 opportunities-26 - 50%: 28 of 90 opportunities-51 - 75%: 28 of 90 opportunities-76 - 100%: 19 of 90 opportunities-Refused: 5 of 90 opportunities7/1/26 to 7/23/26:-0-25%: 7 of 69 opportunities-26 - 50%: 22 of 69 opportunities-51 - 75%: 23 of 69 (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opportunities-76 - 100%: 6 of 69 opportunities-Refused: 6 of 69 opportunities-Unavailable: 2 of 69 opportunitiesResident #19's Nutrition Supplement Record (Ensure) documented the following:-May: Refused 7 of 11 opportunities-June: Refused 40 of 60 opportunities-July: Refused 31 of 46 opportunitiesOn 7/23/26 at 3:46 PM, the Dietitian stated Resident #19's significant weight loss of 14% had not been identified prior to 7/23/26. She stated staff had not notified her of Resident #19's reduction in appetite.On 7/24/26 at 10:05 AM, the Dietitian stated residents are normally weighed weekly, and Resident #19 was care planned for weekly weights. She stated CNA's take weights on resident shower days and will re-weigh if there is a 5-pound increase/decrease, which was not done for Resident #19. The dietitian stated if a psychotropic monitoring system had been in place someone might have seen the weight loss pattern earlier. She could not answer why weekly weights had not been completed between 5/29/26 and 6/27/26 or between 6/27/26 and 7/20/26.Cross reference F605.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident interview, and staff interview, it was determined the facility failed to ensure residents received insulin administration, at the physician ordered time. This was true for 1 of 1 resident (Resident #28) reviewed for medication administration. This deficient practice created the potential for harm if time sensitive medication was not offered as ordered by the physician. Findings include:Resident #28 was admitted to the facility on [DATE], with multiple diagnoses including visual loss in both eyes, muscle weakness, diabetes, and depression.On 7/21/26 at 2:29 PM, Resident #28 stated he had missed an insulin dose but didn't recall which day it was.A physician's order, dated 2/10/26, documented to give Resident #28 insulin glargine, 100 unit/ml, inject 15 unit subcutaneously one time a day related diabetes, at 8:00 AM.Resident #28's care plan, initiated 5/30/25, directed staff to provide diabetes medication as ordered by the provider. An Incident and Accident report, dated 2/28/26, documented staff were preparing to give Resident #28 his evening medication and found his morning medication still in the drawer. Resident #28 had not received his morning medication. The incident report documented Resident #28, the physician, and DON were notified.A review of the Medication Administration Record (MAR) dated February 2026, documented all of Resident #28's morning medications were administered.A review of Resident #28's MAR, dated March 2026 through July 2026, did not document any missed insulin doses.On 7/24/26 at 12:42 AM, the DON stated that the nurse responsible for administering medication to Resident #28 on 4/20/28 documented the medication as administered before entering the resident's room. The DON reported that when the nurse entered the room, Resident #28 was in the bathroom, and the nurse subsequently returned the medication to the cart without correcting the MAR.The DON stated that best practice is to document medication as completed only after the resident has actually received the medication, and confirmed the nurse did not follow this required process.		