STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135095	A. Building B. Wing	07/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cherry Ridge of Cascadia	501 West Idaho Boulevard Emmett, ID 83617

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on record review, review of the SOM, and staff interview, it was determined the facility failed to ensure the designated Culinary Manager met the required professional qualifications for overseeing food and nutrition services. This failure had the potential to impact all residents receiving meals and nutrition services. Findings include:The SOM, Appendix PP, revised 7/23/25, documented, if a qualified dietician or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. The director of food and nutrition services must at a minimum meet one of the following qualifications:-A certified dietary manager.-A certified food service manager, or-has similar national certification for food service management and safety from a national certifying body; or-Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or-Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving. The facility's Culinary Manager position description documented the following qualifications:License/Certification:-Food Handlers permit if required per state regulations-ServSafe Food Safety Certification required.-One or more of the following required:Certified Dietary Manager (CDM)Certified Food Protection Professional (CFPP) with the Dietary Manager's AssociationDietetic Technician, Registered, with the commission on Dietetic Registration of the American Dietetic Association; or,Certification with the American Culinary Federation On 7/7/26 at 8:42 AM, the Culinary Manager (CM) stated she had been working at the facility since August 2025 as the CM. The CM further stated she was overseen by the facility's Registered Dietician (RD) who worked at the facility one day per week.Documentation of the CM certification was requested and no certification for the CM was provided for the following dates and times:-7/7/26 at 9:00 AM-7/7/26 at 4:24 PM-7/9/26 at 3:48 PMOn 7/9/26 at 8:11 AM, when asked about her education and experience, the CM stated she had two years of experience as a cook and one year of experience as a kitchen manager at a boarding school. On 7/9/26 at 10:51 AM, the CEO confirmed the CM did not have qualifications and was in the process of getting certified.Cross Reference F804 and F812

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the FDA Food Code, review of the SOM, and staff interviews, it was determined the facility failed to ensure 1) the kitchen cooking hood was kept clean, 2) food items were free from mold, 3) personal staff beverages were stored in a manner to prevent contamination, 4) kitchen staff performed proper hand hygiene, 5) required food and refrigerator temperatures were recorded to ensure safe hot-holding and cold-holding of Time/Temperature Control for Safety (TCS) foods. These failures placed all residents who consumed meals prepared by the facility at risk for potential contamination of food and adverse health outcomes, including food-borne illnesses. Findings include:1.The FDA Food Code Section 6-501.14 (A) documented cleaning ventilation systems intake and exhaust air ducts shall be cleaned so they are not a source of contamination by dust, dirt, and other materials.On 7/10/26 at 9:43 AM, the gray kitchen cooking hood vent was observed with a layer of brown particles on the outside of the hood vent.On 7/10/26 at 9:45 AM, when asked about the kitchen cleaning schedule, the CM stated kitchen staff were to clean vents once per week. When asked about the cleaning of the cooking hood vent, the CM stated she didn't think the kitchen staff realize that is also considered a vent. 2. The FDA Food Code Section 3-501.17 Ready-to-Eat, TCS (time/temperature control for safety) food, date marking, states marking the date or day the original container is opened in a food establishment, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises, sold, or discarded.On 7/10/26 at 9:16 AM, a box labeled cantaloupe was observed to the lower wire rack shelf in the dry storage area. Three cantaloupes were observed in the box. One cantaloupe was observed to have a large oblong shape, white in color, fuzzy substance on the cantaloupe. The white fuzzy substance was observed to be in contact with the other two cantaloupes in the box.On 7/10/26 at 9:26 AM, the CM with the RD present was asked how often the facility receives fruit. The CM stated they receive fruit every two weeks. When asked how often fruit is inspected, the CM stated they inspect fruit anytime they go to use the fruit. When asked when the cantaloupe was last ordered, the CM spun the box around to see the front label on the box and stated the cantaloupe was last ordered on 6/25/26 and stated the cantaloupe was bad and removed the box from the dry storage area. When asked to describe the condition of the cantaloupe, the CM stated they were white and moldy. When asked how long fresh fruit is kept, the CM stated fruit is kept for three to five days and stated the cantaloupe should have been pulled on 6/30/26. 3. The FDA Food Code Section 2-401.11 Eating, Drinking, or Using Tobacco Products states an employee shall eat, drink, or use any form of tobacco products only in designated areas where contamination of exposed food or other items needing protection can not result.On 7/7/26 at 8:22 AM, the surveyor observed a McDonald's cup in the kitchen freezer with a dark liquid filling the cup. When asked who the cup belonged to, [NAME] #1 stated It's mine.On 7/7/26 at 8:43 AM, when asked about personal staff drinks, the CM stated personal drinks should not be kept in the freezer.4. The FDA Food Code Section 2-301.12 Cleaning Procedure states food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink.On 7/9/26, [NAME] #2 was observed during tray line preparation washing his hands for four seconds at the following times:-7:12AM-7:14 AM-7:17 [NAME] 7/9/26 at 7:44 AM, [NAME] #2 was observed to have a cream, off-white colored substance stuck to the back or his right arm. [NAME] #2 was not observed to wash the substance from his arm prior to serving food.On 7/10/26 at 9:51 AM, the CM stated employees should be vigorously washing their hands for 20 seconds.5a. The SOM, Appendix PP, revised 7/23/25 states, temperatures are critical in preventing foodborne illness. Cooking food to the temperature and for the time specified below will either kill dangerous organisms or inactivate them sufficiently so that there is little risk to the resident if the food is eaten promptly after (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cooking.Monitoring the food's internal temperature is important and will help ensure microorganisms can no longer survive and food is safe for consumption. Foods should reach the following internal temperatures in these situations:-Poultry and stuffed foods, i.e., turkeys, pork chops, chickens, etc. - 165 degrees F;-Ground meat (e.g., ground beef, ground pork), ground fish, and eggs held for service - at least 155 degrees F;-Fish and other non-ground meats - 145 degrees F.On 7/9/26 at 9:41 AM, the CM was asked about puree food temperatures as it was left blank on the 7/9/26 breakfast Food Temperature Log. The CM stated puree food temperatures were recorded under minced and moist as the puree was an extension of minced and moist. The facility's Food Temperature Logs for May 2026-July 2026 were requested and reviewed which documented no food temperatures for the following days:-5/17/26-dinner-5/22/26-lunch-5/23/26-breakfast, lunch, & dinner-5/26/26-dinner-6/15/26-dinnerOn 7/10/26 at 10:01 AM when asked about the missing food temperatures, the CM stated she didn't catch that they weren't doing them.b. The SOM, Appendix PP, revised 7/23/25 states, PHF/TCS [Potentially Hazardous Foods/Time/Temperature Control for Safety] foods must be maintained at or below 41 degrees F, unless otherwise specified by law. Frozen foods must be maintained at a temperature to keep the food frozen solid. Refrigeration prevents food from becoming a hazard by significantly slowing the growth of most microorganisms. Inadequate temperature control during refrigeration can promote bacterial growth. Adequate circulation of air around refrigerated products is essential to maintain appropriate food temperatures. Foods in a walk-in unit should be stored off the floor. Practices to maintain safe refrigerated storage include:-Monitoring food temperatures and functioning of the refrigeration equipment daily and at routine intervals during all hours of operationi) On 7/7/26 at 9:30 AM, the facility's Refrigerator Temp. Log was observed in a transparent plastic sheet fixed to the front of a black refrigerator near the activities area. The Refrigerator Temp. Log was dated June 2026 with the location documented as activities. The Refrigerator Temp. Log indicated an area to record both refrigerator temperatures and freezer temperatures. The temperature log was observed to have six large X's crossing out the section to record freezer temperatures. The Refrigerator Temp. Log was also observed to be missing refrigerator temperatures for the following days:-6/27/26-6/28/26-6/29/26-6/30/26On 7/9/26 at 9:19 AM, the facility's Refrigerator Temp. Log was observed fixed to the front of the activities refrigerator that was dated July 2026. The temperature log was observed to be complete and current with refrigerator temperatures. Two large X's were observed crossing out part of the section to record freezer temperatures.On 7/9/26 at 10:07 AM, when asked how often refrigerator temperatures are taken, the Activities Director (AD) stated he checks the refrigerator temperatures daily. When asked if he checks the freezer temperatures, the AD stated he only checks the refrigerator temperatures because the refrigerator was only being used. The AD accompanied the surveyors to the activities refrigerator. When asked if there was anything in the freezer, the AD opened the freezer and stated there were blue ribbon orange cycle ice cream bars in the freezer. When asked if there was a thermometer in the freezer to monitor the temperature of the ice cream bars, the AD stated no, and further stated there should be a thermometer in the freezer.On 7/9/26 at 10:13 AM, when asked if the activities refrigerator temperature logs were documented anywhere else, the AD stated he personally did not document temperature logs anywhere else other than the Refrigerator Temp. Log on the front of the refrigerator and further stated he had missed a few days of logging temperatures. When asked who takes the temperatures on the days the AD is not there, the AD stated he was the only staff member checking the temperatures on the weekdays and stated the temperatures are not checked on Saturdays and Sundays when he is out of the building. When asked how the temperature log is being completed for Saturday's and Sundays when he is out of the building, the AD stated he uses the temperature reading from Friday when he left and the temperature reading from Monday when he returns to fill in and complete the log.ii) On 7/9/26 at 9:16 AM, the facility's Activities refrigerator was observed to have condensation on the interior back wall of the refrigerator. The refrigerator was observed to have a large oblong shape and black in color build up noted to the lower shelf. The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature was noted above the safe line on the thermometer and read 51 degrees. The refrigerator was observed to have 2 bottles of hot sauce in the door and a jug of blue juice on one of the shelves.On 7/9/26 at 9:30 AM, the activities Refrigerator Temp. Log was reviewed for June-July 2026 and the temperature log was observed to have notations in the left side margin as follows:-On 6/18/26 adjusted temp controller to get it lower-On 6/25/26 adjusted even lower, maintenance notified-On 7/8/26 changed thermometer to checkOn 7/9/26 at 10:09 AM, the AD was asked what the temperature of the refrigerator was. The AD took the thermometer out of the refrigerator and confirmed the thermometer was reading above the safe line and stated the refrigerator was at 42 degrees. When asked what temperature the refrigerator should be, the AD stated 36 to 40 degrees were safe temperatures. The AD further stated it would not be appropriate to use anything in the refrigerator. When asked who oversaw the cleaning of the refrigerator, the AD stated he was in charge of cleaning the refrigerator. When asked what the black build up in the refrigerator was, the AD stated I don't know.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on the facility's Quality Assurance and Performance Improvement (QAPI) Committee policy, the facility's Quality Assurance Performance Improvement Plan, and staff interview, it was determined the facility failed to ensure goodˆfaith efforts were made to implement and monitor performance improvement activities related to skin assessments and food sanitation. This failure created the potential to affect all residents who reside in the facility and receive nursing services or consume food provided by the facility. Findings include:The facility's Quality Assurance and Performance Improvement Committee Policy, revised 9/1/25, documented that the committee identifies performance improvement opportunities through tracking and trending of data.The facility's Quality Assurance Performance Improvement Plan, dated 4/1/26, documented the organization will continue to monitor progress toward goals by comparing results to benchmarks and historical performances.On 7/10/26 at 3:47 PM, the CEO stated he had three performance improvement plans (PIPs). When asked about PIP #1, he stated it addressed incomplete skin assessments. He stated PIP #1 was initiated on 3/30/26 and completed the following week on 4/6/26. When asked why the PIP remained active, he stated, we didn't want to fall off track. When questioned regarding benchmark measurements, he stated he used percentages but confirmed PIP #1 did not include documented benchmark measurements.On 7/10/26 at 3:55 PM, the CEO stated PIP #2 was initiated on 5/2/26 when the QAPI committee identified issues with food labeling in the snack room. When asked about benchmark measurements, he stated, we did not do percentages on this one, and reported the benchmark measurement was documented as improved.On 7/10/26 at 3:57 PM, the CEO stated PIP #3 was complete and no longer in place. The CEO did not provide additional information on what was included on PIP #3. On 7/10/26 at 3:58 PM, the CEO stated, maybe we need to reˆwrite our benchmark measurements. He confirmed the current method used to measure performance improvement plans did not adequately track whether improvement had occurred since the date of implementation.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure residents were informed in advance of the care and treatment to be furnished, including the risks and benefits of treatment. This was true for 1 of 5 residents (Resident #23) whose records were reviewed for informed consent. This failure created the potential for miscommunication and adverse effects when Resident #23 was not informed in advance of the risks and benefits of his ordered medication. Findings include: Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD) anxiety, and post-traumatic stress disorder (PTSD). Resident #23's record included the following physician orders:-Seroquel (antipsychotic) Extended-Release 200 mg by mouth at bedtime for schizoaffective disorder and bipolar disorder, initiated on 3/11/26.-Seroquel 100 mg by mouth once a day for bipolar disorder, initiated on 3/12/26.-Lorazepam (anti anxiety) 2 mg/mL give 0.5 mL by mouth every 4 hours as needed for palliative care related to chronic obstructive pulmonary disease, initiated on 6/29/26. A review of Resident #23's record showed no documentation that Resident #23 or his representative were informed of the risk and benefits or consents for the initiation of Seroquel and lorazepam. On 7/10/26 at 10:42 AM, the Clinical Resource Nurse (CRN) and Chief Nursing Officer (CNO) both confirmed Resident #23 did not have signed consents for Seroquel or lorazepam.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, it was determined the facility failed to ensure residents' call lights are within their reach. This was true for 1 of 1 resident (Resident #38) reviewed for residents' rights. This deficient practice created the potential for harm if the resident could not call for assistance when needed or experienced an adverse medical event that required attention. Findings include:Resident #38 was admitted to the facility on [DATE], with multiple diagnoses including acute cystitis (bladder infection) with hematuria (presence of red blood cells in the urine), diabetes, and cirrhosis (advance scarring of the liver caused by chronic diseases) of the liver.On 7/10/26 at 9:14 AM as three surveyors were passing by Resident #38's room, Resident #38 asked one of the surveyors to call a staff member. Resident #38 was sitting in the chair with the front wheel walker in front of her. When asked where her call light was, Resident #38 extended her arm toward her call light which was hanging on the wall and out of reach. Resident #38 stated she was assisted to her room by a staff member after her breakfast and had been sitting in the chair for a while.On 7/10/26 at 10:28 AM, RN #1 and CNA #1 entered Resident #38's room after being informed by the surveyor that Resident #38 needed assistance.On 7/10/26 at 10:40 AM, CNA #1 stated Resident #38 was unable to reach her call light which was on the other side of her bed. CNA #1 stated Resident #38's call light should be within her reach and it was not.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the State Operations Manual (SOM), record review, and staff interview, it was determined the facility failed to ensure a copy of a resident's advance directive was maintained in the medical record. This was true for 1 of 12 residents (Resident #32) whose records were reviewed for advanced directives. The absence of the advance directive created the potential for an adverse outcome if Resident #32 became unable to communicate treatment preferences and those preferences were not available to guide care. Findings include: The SOM, Appendix PP, defines an advance directive as a written instruction, such as a living will or durable power of attorney for health care, recognized under State law . relating to the provision of health care when the individual is incapacitated. The Manual further clarifies that a Physician Orders for Life^Sustaining Treatment (POLST) form is a portable medical order communicating a patient's treatment preferences during a medical emergency, based on the patient's current medical condition, and is not an advance directive.Resident #32 was admitted to the facility on [DATE] with multiple diagnoses including dementia, muscle weakness, and protein^calorie malnutrition.Resident #32's care plan, revised 5/12/22, documented: Provide Resident #32 and his appointed healthcare representative with education regarding advance directives as needed.Resident #32's care conference evaluation dated 6/26/26 documented, the resident had an advance directive in his record.On 7/8/26 at 10:13 AM, Resident #32's medical record was reviewed. A living will or a durable power of attorney for health care was not located.On 7/8/26 at 5:00 PM, the CNO confirmed Resident #32's record did not include an advance directive, and the facility did not have a living will on file.

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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 ensure medications were administered with an appropriate clinical indication. This was true for 1 of 5 residents (Resident #23) reviewed for unnecessary medications. The lack of an appropriate indication created the potential for chemical restraint use and improper medication administration. Findings include:Resident #23 was admitted to the facility on [DATE], with diagnoses including COPD, anxiety, and PTSD.Resident #23's care plan, revised 5/27/26, documented, give medications as ordered by physician.A review of Resident #23's physician orders documented, Lorazepam 2 mg/mL, 0.5 mL by mouth every 4 hours as needed, ordered for palliative care related to chronic obstructive pulmonary disease, initiated on 6/29/26.On 7/9/26 at 2:45 PM, the CNO reviewed the lorazepam order and stated the indication should be shortness of breath or anxiety.

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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 and staff interviews, it was determined the facility failed to ensure an allegation of misappropriation was reported to the State Agency as required. This was true for 1 of 1 resident (Resident #23) reviewed for misappropriation. This failure created the potential for poor communication and continued misappropriation of resident funds. Findings include:Resident #23 was admitted to the facility on [DATE], with diagnoses including COPD, anxiety, and PTSD.On 7/7/26 at 10:39 AM, Resident #23 stated that approximately two months prior, he reported $1,600.00 missing to the Social Services Director (SSD). He stated he told the SSD he believed another resident had taken the money. Resident #23 stated the SSD asked, How long ago did it happen? and when Resident #23 responded about one and a half months ago, the SSD told him it had been too long ago to investigate.On 7/9/26 at 1:42 PM, a call was made to the SSD for interview, with no response.On 7/10/26 at 10:40 AM, the CNO stated she recalled a resident's family member mentioning Resident #23's missing funds but she did not ask any further questions. When asked why she did not inquire further or report the allegation, the CNO stated the allegation was never made directly to her or facility staff.On 7/10/26 at 12:16 PM, the CEO stated the allegation should have been reported to the State Agency.

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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 record review and staff interviews, it was determined the facility failed to ensure an allegation of misappropriation was investigated as required. This was true for 1 of 1 resident (Resident #23) reviewed for misappropriation. This failure created the potential for continued misappropriation of resident funds. Findings include: Resident #23 was admitted to the facility on [DATE], with diagnoses including COPD, anxiety, and PTSD.On 7/7/26 at 10:39 AM, Resident #23 stated that approximately two months prior, he reported $1,600.00 missing to the SSD. He stated he told the SSD he believed another resident had taken the money. Resident #23 stated the SSD asked, How long ago did it happen? and when Resident #23 responded about one and a half months ago, the SSD told him it had been too long ago to investigate.On 7/8/26 at 2:31 PM, the facility's grievance records dated February 2026 through June 2026 were reviewed. No allegations of misappropriation involving Resident #23 were documented.On 7/8/26 at 2:46 PM, the Longˆ Term Care Reporting Portal was reviewed. No reports of misappropriation involving Resident #23 were identified. On 7/9/26 at 1:42 PM, a call was made to the SSD for interview, with no response.On 7/10/26 at 10:40 AM, the CNO stated she recalled a resident's family member mentioning Resident #23's missing funds but she did not ask any further questions. When asked why she did not inquire further or report the allegation, the CNO stated the allegation was never made directly to her or facility staff.On 7/10/26 at 12:16 PM, the CEO stated the allegation should have been reported to him and investigated for potential misappropriation.

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Cherry Ridge of Cascadia	501 West Idaho Boulevard Emmett, ID 83617

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, policy review, and staff interviews, it was determined the facility failed to ensure that a written notice of discharge was provided to 1 of 3 residents (Resident #37) whose records were reviewed for discharges and transfers. This failure created the potential for Resident #37 to be without access to discharge information or appeal advocacy resources. Findings include: Review of the facility's Discharge or Transfer policy, revised 8/30/25 documented: Notice of Transfer or Discharge1. The facility must provide the resident, the resident's representative (if any), and the Office of the State Long-Term Care Ombudsman with a written notice at least 30 days before the resident is transferred or discharged , except when:a.The resident's safety or the safety of others would be endangered by remaining in the facility;b.The resident's health has improved sufficiently to allow a more immediate discharge;c.The resident's urgent medical needs require an immediate transfer; ord.The facility ceases to operate.2. The written notice must include:a.The reason for transfer or discharge;b.The effective date of transfer or discharge;c.The location to which the resident is being transferred or discharged ;d.The name, address, and telephone number of the State Long-Term Care Ombudsman; ande.For residents with developmental disabilities or mental disorders, the contact information for the relevant protection and advocacy agency. 3. A copy of the notice shall be maintained in the resident's clinical record.The facility's Notice of Discharge or Transfer form documented that, the facility must notify the resident and, if known, a resident advocate or legal representative of the resident of the transfer or discharge and the reason(s) for the move in writing and in a language and manner they understand.Resident #37 was admitted to the facility on [DATE] and discharged on 5/19/26 with multiple diagnoses that included; other chronic osteomyelitis, multiple sites (an autoinflammatory condition which is characterized by recurring episodes of inflammation, pain, and bone lesions in multiple skeletal areas), paraplegia (an impairment or loss of motor and sensory function in the lower half of the body), and chronic pain syndrome.An admission MDS assessment dated [DATE], documented Resident #37 to be cognitively intact.The Notice of Discharge or Transfer form dated 5/21/26 in Resident #37's record documented no signature from him under the Verification of Receipt of Notice section. Instead, the signature line stated, Resident #37 left the facility against medical advice (AMA) and included the initials of the SSD and CNO.On 7/10/26 at 9:00 AM, an interview was conducted with the CEO. The CEO stated the SSD was responsible for discharges and transfers from the building. The CEO further stated the facility did get a current address for Resident #37 but did not know if he received a written notice.A review of Resident #37's admission Record sheet documented an address on file.On 7/10/26 at 12:03 PM, a telephonic interview was conducted with the SSD. The SSD stated that it would be important for a discharging resident to receive the notice, however, since Resident #37 left AMA, it was different. The SSD further stated that Resident #37 did not receive a copy of his notice because he left the facility and did not return and there was no address to mail it to him.

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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 record review, resident observation, and staff interviews, it was determined the facility failed to implement a comprehensive, personˆcentered care plan as written. This was true for 1 of 12 residents (Resident #32) whose record was reviewed for care plan implementation. This failure created the potential for Resident #32 to develop pressure injuries and adverse outcomes when his heels were not offloaded as directed by his care plan. Findings include: Resident #32 was admitted to the facility on [DATE] with multiple diagnoses including dementia, muscle weakness, and proteinˆcalorie malnutrition.A review of Resident #32's care plan, revised 6/18/21, directed staff to offload Resident #32's heels or use Prevalon boots when in bed, as he allowed.On 7/9/26 at 11:22 AM, Resident #32 was observed in bed without Prevalon boots in place.On 7/9/26 at 11:23 AM, LPN #2 stated Resident #32 should have his boots on. LPN #2 lifted the blanket and observed Resident #32's legs resting on a pillow. When asked if Resident #32's heels were offloaded, LPN #2 stated, no and confirmed they should have been offloaded.

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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, policy review, record review, and staff interviews, it was determined the facility failed to ensure resident's medications were administered according to professional standards of practice. This was true for 1 of 1 resident (Resident #30) whose medication was reviewed and true for 1 of 3 residents (Resident #9) whose medication administration was observed. This failed practice created the potential for Resident #30 to receive improper treatment, skin irritation, allergic reaction, or other adverse outcomes and created the potential for Resident #9 to not receive the full dose of their prescribed eye drops. Findings include: 1. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including dementia, anxiety, and adult failure to thrive. On 7/7/26 at 10:58 AM, CNA #2 was observed assisting Resident #30 with activities of daily living (ADLs). CNA #2 stated Resident #30 had redness to her lower abdomen and under her breasts. CNA #2 stated she assisted Resident #30 with keeping the areas clean twice per day. Resident #30 declined to let the Surveyor observe treatment to the abdomen and breasts. A review of Resident #30's Skin Evaluation dated 7/6/26 documented, Resident #30 had redness to the abdominal folds and under the breasts with treatment in place. A review of Resident #30's physician orders and MAR/TAR documented no orders for skin treatment to the abdomen or breasts. On 7/8/26 at 3:56 PM, CNA #2 was asked about the treatment provided to Resident #30. CNA #2 stated she cleansed the affected areas with warm soapy water and patted the areas dry. CNA #2 further stated the nurse on duty then applied a powder to the affected areas. On 7/9/26 at 3:16 PM, LPN #2 was asked about the skin treatment for Resident #30. LPN #2 stated a Gold Bond powder was being applied to the affected areas. When asked if there was an order for Gold Bond powder application, LPN #2 stated there was no active order and she would text the physician. 2. The facility's Administration of Eye Drops policy revised 9/17/25 documented during post-administration of eye drops: a. Instruct the resident to close the eye gently (not squeeze). b. Encourage gentle eye movement to distribute the medication. c. Blot excess medication with a clean tissue. The American Family Physician webpage article titled Using Glaucoma (abnormally high pressure inside the eye) Eyedrops documented after you squeeze the drop of medicine into your eye, close your eye. Then press a finger between your eye and the top of your nose. Press for several minutes. This way, more of the medicine stays in your eye. Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including unspecified (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	glaucoma, hypertension, and prostate cancer. A physician order dated 7/29/26 documented, Resident #9 was to receive the following: -Brimonidine Tartrate (an eye drops to lower the elevated pressure in the eye) Ophthalmic Solution 0.2%, instill one drop in both eyes three times a day related to unspecified glaucoma. -Dorzolamide (an eye drops to lower the elevated pressure in the eye) HCL Ophthalmic Solution, instill one drop in both eyes two times a day related to unspecified glaucoma. On 7/9/26 at 7:05 AM, LPN #1 handed a tissue paper to Resident #9. LPN #1 then administered one drop of Brimonidine to both of Resident #9 eyes. Resident #9 was observed to rub both of his eyes with the tissue paper. LPN #1 told Resident #9 not to rub his eyes, but Resident #9 continued to rub his eyes. LPN #1 was not heard to instruct Resident #9 to press his finger between his eyes and the top of his nose after the administration of the eye drop. LPN #1 administered Resident #9 oral medications. When Resident #9 finished taking his oral medications, LPN #1 then administered one drop of Dorzolamide to both of his eyes. Resident #9 was observed to rub his eyes with the tissue paper. LPN #1 was not heard to educate Resident #9 regarding the rubbing of his eyes after the administration of his eye drops. On 7/9/26 at 10:00 AM, LPN #1 stated she told Resident #9 to dab his eyes and not to rub his eyes when she first administered his first eye drops. LPN #1 stated she did not educate Resident #9 on the importance of not rubbing his eyes after the eye drops administration.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident observation, and staff interviews, it was determined the facility failed to ensure podiatry treatment orders and careˆplan interventions were implemented as written. This was true for 1 of 1 resident (Resident #32) reviewed for podiatry services. This failure created the potential for untreated foot conditions, discomfort, and deterioration of skin integrity due to the lack of required podiatry services. Findings include:Resident #32 was admitted to the facility on [DATE], with multiple diagnoses including dementia, muscle weakness, and proteinˆcalorie malnutrition.A review of Resident #32's care plan, initiated 4/11/24, directed staff to provide podiatry evaluation and treatment as needed.On 7/9/26 at 11:25 AM, LPN #2 removed Resident #32's socks and stated his toenails needed to be trimmed. When describing the toenails, LPN #2 stated they were chunky, yellow, and irregular.On 7/9/26 at 11:34 AM, LPN #2 stated Resident #32 was on the podiatry list to be seen every three months.A review of Resident #32's podiatry visit dated 5/19/26 documented a physician order for:- Ammonium lactate 12% cream, apply to bilateral feet and callused skin as needed for 180 days.A review of Resident #32's physician orders from 05/01/26 through 07/09/26 documented no order for ammonium lactate.On 7/10/26 at 3:34 PM, the CNO stated that when the ammonium lactate order was received, Resident #32 was asked if he wanted the treatment implemented and he said no. The CNO stated the provider's notification of the refusal and the resident's refusal was not documented in the medical record.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident observation, and staff interview, it was determined the facility failed to ensure proper monitoring was conducted to identify potential catheterˆassociated urinary tract infections. This was true for 1 of 3 residents (Resident #32) reviewed for catheter care. This failure created the potential for undetected signs of infection if Resident #32 was not monitored for appropriate symptoms. Findings include:Resident #32 was admitted to the facility on [DATE] and was readmitted on [DATE], with multiple diagnoses including dementia, muscle weakness, and proteinˆcalorie malnutrition.A review of Resident #32's physician order, dated 2/14/25, directed staff to monitor, record, and report to the provider signs and symptoms of catheterˆassociated urinary tract infection, including: pain, burning, bloodˆtinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foulˆsmelling urine, fever, chills, altered mental status, changes in behavior, or changes in eating patterns.Resident #32 was observed with white, milky urine in his catheter tubing flowing into the catheter bag on the following dates:-7/7/26-7/8/26-7/9/26A review of Resident #32's MAR dated July 1-10, 2026, documented No for completion of the physician order initiated on 2/14/25 directing staff to monitor, record, and report signs and symptoms of catheterˆassociated urinary tract infection.On 7/10/26 at 10:29 AM, the CNO stated she would not document a change when Resident #32's urine appeared milky white because this was his baseline. The CNO stated the monitoring order was not appropriate for Resident #32 because cloudiness would be normal for him. The CNO confirmed Resident #32's record did not include documentation of physician notification regarding urine changes.

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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, resident and staff interviews it was determined the facility failed to ensure an oxygen concentrator was removed from the resident's room after the physician discontinued the resident's oxygen order. This was true for 1 of 1 resident (Resident #12) whose oxygen concentrator was observed. This deficient practice created the potential for harm if the resident attempted to use the oxygen equipment without a valid physician order. Findings include:The facility's Oxygen Administration, Safety, Storage & Maintenance policy revised 10/10/25, documented the facility would administer, store, and maintain supplemental oxygen safely in accordance with current standards of practice and licensed practitioner orders. If oxygen therapy was discontinued, discard all disposable components, replace filters as specified by the manufacturer, and disinfect the exterior surfaces of the oxygen equipment in accordance with the Instructions for Use.Resident #12 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including morbid (severe) obesity with alveolar hypoventilation (occurs when breathing is too slow or too shallow to meet the body's metabolic needs), and diabetes.On 7/7/26 at 12:23 PM, Resident #12 was observed in his room sitting in his power chair. An oxygen concentrator was observed at his bedside. When asked how often he used his oxygen, Resident #12 stated he only used oxygen when he needed it.Review of Resident #12's physician orders did not include an order for oxygen.On 7/8/26 at 3:03 PM, the CNO stated Resident #12's oxygen concentrator should not be in his room because he no longer used the oxygen, it was discontinued on 6/17/26.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure medications were administered with an appropriate clinical indication. This was true for 1 of 5 residents (Resident #23) reviewed for unnecessary medications. The lack of an appropriate indication created the potential for improper medication administration and use of medication without a clearly defined clinical need. Findings include:Resident #23 was admitted to the facility on [DATE], with multiple diagnoses including COPD, anxiety, and PTSD.Resident #23's care plan, revised 3/2/26, documented: give medications as ordered by physician.A review of Resident #23's physician orders documented the following order:- Morphine Sulfate 20 mg/mL, give 0.25 mL by mouth every 6 hours as needed for severe pain related to chronic obstructive pulmonary disease, initiated on 7/7/26.On 7/9/26 at 2:45 PM, the CNO stated she did not know what the appropriate indication for the morphine order should be.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and record review, it was determined the facility failed to ensure food was served at palatable temperatures as required. This was true for 1 of 1 resident (Resident #31) reviewed for food quality. This failure created the potential for reduced enjoyment of meals and decreased dietary intake when food was not served at acceptable temperatures. Findings include: Resident #31 was admitted to the facility on [DATE] with multiple diagnoses including diabetes, gastroˆesophageal reflux, and chronic kidney disease.On 7/7/26 at 3:16 PM, Resident #31 stated the hot food is always cold. She stated she generally eats in the dining room and that most of the time it is a problem. Resident #31 stated she normally does not ask for her food to be reheated because cold food is normal in the facility.On 7/9/26 at 7:46 AM, a request for a breakfast tray was made to the kitchen.On 7/9/26 at 8:12 AM, the tray was delivered by the CM. Food temperatures were taken and documented as follows:-French toast: 84 F- Eggs: 93 F- Sausage: 79 F-Apple juice: 51 [NAME] 7/9/26 at 8:15 AM, upon review of the temperatures, the CM stated she was not sure what an acceptable food temperature should be upon delivery.

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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 interviews, it was determined the facility failed to ensure a physician order was clarified regarding its clinical indication and medication dosage. This was true for 2 of 2 residents (#1 and #12) whose records were reviewed. This deficient practice resulted in inaccurate documentation within the resident's medical record. Findings include: The facility's Documentation of Resident Health Status Needs & Services, revised 9/1/25, documented that the resident's medical record should be accurate, objective and clinically relevant. 1. Resident #12 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including morbid (severe) obesity with alveolar hypoventilation, and diabetes. A physician order dated 6/4/26 documented Resident #12 was to receive the following medications: -Toujeo SoloStar Subcutaneous Solution Pen-Injector 300 units/ml (insulin glargine), inject 120 units subcutaneously one time a day related to morbid obesity with alveolar hypoventilation. - Toujeo SoloStar Subcutaneous Solution Pen-Injector 300 units/ml (insulin glargine), inject 120 units subcutaneously at bedtime related to type 2 diabetes. On 7/9/26 at 4:20 PM, the CRN reviewed Resident #12's physician order and stated the evening dose of insulin glargine was indicated for diabetes and the morning dose was indicated for obesity. The CRN stated insulin glargine was for diabetes and I don't know why the indication was changed to obesity. On 7/10/26 at 10:16 AM, during a follow-up interview, the CRN stated Resident #12's insulin glargine order should have been for diabetes and not for obesity, and that it had been mistyped by the nurse. 2. Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including quadriplegia (paralysis affecting all four limbs and the torso), depression, and anxiety disorder. Resident #1's MAR documented a medication order dated 6/22/26 for hydroxyzine HCl (antihistamine) Give 1 tablet by mouth every 8 hours as needed for anxiety. The order did not include a dose. On 7/10/26 at 12:47 PM, the CNO confirmed there was not a dose listed on the order and should have been. The CNO further stated Resident #1 was previously getting hydroxyzine 25mg tablets and whoever put in the order did not catch the 25mg.