STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135105	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple View Transitional Care Center	660 South Second Street West Rexburg, ID 83440

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 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, review of the State Operations Manual, and staff interviews, the facility failed to treat residents who needed assistance with eating their meals with dignity and respect. This failed practice had the potential to negatively affect resident's self-esteem, decreased enjoyment of meals and mealtime, and may impact resident's food and fluid intake. Findings include:On 1/5/26 at 11:37 AM, RNA #1 was observed standing next to the dining room table, spoon feeding Resident #34 when he was seated at the table eating his lunch.On 1/5/26 at 11:40 AM, RNA #1 stated she always stands so she can move around the room to help other residents if they need it. On 1/5/26 at 11:50 AM, the DON and the Regional Nurse stated staff should not be standing while feeding residents.

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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	135105	A. Building B. Wing	01/09/2026

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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 policy review, record review, and staff interview, it was determined the facility failed to ensure a resident and their representative received assistance to exercise their right to formulate an advanced directive. This was true for 2 of 17 residents (Resident #35 and #41) whose records were reviewed for advanced directives. This deficient practice created the potential for harm or adverse outcomes if residents' wishes were not followed or documented regarding their advance care planning. Findings include:The facility's Nursing Administration – Advance Directive Documentation policy, revision date December 2019, documented the facility shall include documentation in the resident's health record that, at the time of admission, the residents have been provided with written information regarding the advanced directives and whether the resident has executed such a document. The following resident's records did not contain documentation of an advanced directive or that the resident or the resident's representative was offered assistance to formulate an advanced directive. Resident #35 was initially admitted to the facility 11/23/22 and readmitted [DATE], with multiple diagnoses including acute posthemorrhagic anemia (rapid blood loss leading to a sudden drop in red blood cells and oxygen delivery) and COPD (a group of lung diseases that block airflow and make it difficult to breath). A Social Services assessment, dated 2/20/25, documented Resident #35 had an advanced directive. On 1/7/26 at 9:02 AM, review of Resident #35's medical record documented a Durable Power of Attorney (DPOA). Her DPOA was for financial power not medical power. Resident #35's record did not include an advanced directive or documentation of information about an advanced directive was provided and discussed with her or resident representative. On 1/7/25 at 10:20 AM, the LSW stated Resident #35 did not have an advanced directive or documentation that she was offered to formulate one and should have. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including acute respiratory failure with hypercapnia (a lung condition that can cause confusion and severe shortness of breath), schizoaffective disorder (a serious mental illness), and AFib (an irregular heartbeat where episodes start and stop on their own). On 1/5/26 at 3:12 PM, a review of Resident #41's medical record did not contain documentation of an advance directive or an offer to formulate an advance directive. On 1/7/26 at 10:46 AM, the DON confirmed there was no advance directive in Resident #41's medical record and neither Resident #41 or his guardian was offered to formulate an advance directive.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were provided with a clean, safe, homelike environment. This was true for all residents who resided in the facility whose environment were observed. This deficient practice created the potential for harm if: a) residents were embarrassed by and/or felt the disrepair in the facility was unacceptable, disrespectful, or undignified or b) residents were injured due to unsafe areas in the facility. Findings include:The facility's Homelike Environment policy, undated, documented Temple View Transitional Care is committed to providing residents with a safe, clean, comfortable, and homelike environment that promotes dignity, independence, choice, and quality of life. This policy ensures compliance with federal regulations while supporting a person-centered care philosophy. The following areas were observed: a) On 1/5/26 at 8:12 AM, observed a fly strip covered with bugs in the middle of room [ROOM NUMBER]. Observed another fly strip by the window with several bugs on it. On 1/5/26 at 8:14 AM, Resident #8 stated the fly strips had been there since last summer and the maintenance man had placed them there. b) On 1/5/26 at 8:15 AM, observed in room [ROOM NUMBER]'s restroom, a metal bracket sticking out from the wall at eye level. On 1/5/26 at 8:16 AM, Resident #8 stated she did not know what metal bracket I was asking about because she cannot see very well. c) On 1/5/26 at 10:26 AM, observed in room [ROOM NUMBER]'s restroom the vent was covered with a gray fuzzy substance. d) On 1/5/26 at 11:22 AM, observed the vent in the ceiling, on the hallway outside the dining rooms covered with a thick black substance. The vents in the front lobby had a black substance on the vent and on the ceiling surrounding the vent. e) On 1/6/ 26 at 11:35 AM, observed the walls by Hall 100's nurse's station with large areas of the walls with gouges and missing paint in several different areas. The vent above the nurse's station was observed to have a black substance on the vent and on the ceiling around the edge. On 1/6/26 at 1:09 PM, review of the Housekeeping Weekly Cleaning Schedule did not document cleaning of the vents. On 1/6/26 at 11:45 AM, the Maintenance Supervisor stated the walls should have been repaired and the vents needed to be cleaned but he was not sure whose job it was to clean the vents. He also stated the fly strips, and the metal bar should not have been in room [ROOM NUMBER]. On 1/6/26 at 11:54 AM, the DON stated she did not know the fly strips were in room [ROOM NUMBER] and they should not have been there. (continued on next page)

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	135105	A. Building B. Wing	01/09/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/7/26 at 11:57 AM, the Administrator stated the vents should have been cleaned by maintenance but had not been cleaned for a year. On 1/6/26 at 12:02 PM, observed in the Medication Prep room on the 100 Hall, the sharps container filled past the full line and the wall mount enclosure was unlocked and the door ajar. On 1/6/26 at 12:45 PM, RN #2 stated the sharps container should have been changed when it was full, and the enclosure locked. On 1/7/26 at 11:08 AM, the DON stated the sharps containers should have been changed when full and the enclosure locked.

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	135105	A. Building B. Wing	01/09/2026

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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 observation, policy review, record review, and staff interview, it was determined the facility failed to develop and implement comprehensive resident-centered care plans. This was true for 2 of 17 residents (#35 and #41) whose care plans were reviewed. These failures placed residents at risk of negative outcomes if services were not provided or provided incorrectly due to lack of information in their care plan. Findings include:The facility's Comprehensive Person-Centered Care Planning policy, revised April 2025, documented the facility IDT will develop and implement a comprehensive person-centered, culturally competent, and trauma-informed care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include resident's needs identified in the comprehensive assessment, any specialized services as a result of PASARR recommendation, and resident's goals and desired outcomes, preferences for future discharge and discharge plan. The following was observed for care plan review: Resident #35 was initially admitted to the facility 11/23/22 and readmitted [DATE], with multiple diagnoses including acute posthemorrhagic anemia (rapid blood loss leading to a sudden drop in red blood cells and oxygen delivery) and COPD (a group of lung diseases that block airflow and make it difficult to breath). Resident #35's Physician order dated 12/19/25, documented apply oxygen via NC at 2 LPM continuous, every shift. Resident #35's care plan did not document her oxygen use. On 1/6/25 at 11:54 AM, the DON stated Resident #35's oxygen had not been care planned and it should have been. Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including acute respiratory failure with hypercapnia (a lung condition that can cause confusion and severe shortness of breath), schizoaffective disorder (a serious mental illness), and AFib (an irregular heartbeat where episodes start and stop on their own). On 1/5/26 at 10:21 AM, Resident #41 was observed with bilateral upper side rails on his bed. Resident #41's care plan did not document the use of side rails. On 1/6/26 at 1:38 PM, the DON stated Resident #41's care plan did not document the use of side rails and should have.

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	135105	A. Building B. Wing	01/09/2026

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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 observation, resident and staff interview, and record review, it was determined the facility failed to ensure professional standards of practice were followed for 2 of 17 Residents (#2 and #46) reviewed for quality of care. Resident #2 and Resident #46 were at risk for adverse outcomes when physician orders were not written correctly and/or followed as ordered. This failed practice had the potential to adversely affect or harm residents whose care and services were not delivered according to accepted standards of clinical practices. Findings include:Resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including Left below knee amputation (BKA), Right above knee amputation (AKA) and diabetes.1. Resident #2's physician order documented Wound Vac to left BKA with continuous suction at 125mmHG Q shift. Order date 12.26.25Resident #2's Care Plan documented alterations in musculoskeletal status related to Left BKA and Right AKA. Date initiated 10.28.25On 1/5/26 at 10:30 AM, observed Resident #2 sitting on bed with wound vac attached to right above knee residual limb. On 1/5/26 at 3:00 PM, interviewed DON about Resident #2's physician's order for wound vac to left below knee residual limb. The DON stated she had transcribed the order incorrectly and would correct it in Resident #2's medical record.On 1/6/26 at 8:25 AM, observed Resident #2's wound vac order with revision date 1/5/26 at 3:30 PM, documented Wound Vac to Right BKA with continuous suction at 125mmHG Q shift. The wound vac order remained incorrect based on Resident #2's physical assessment.2. Resident #2's medical record included order for Biotene Dry Mouth/Throat Liquid Mouthwash - Give 1 application by mouth four times a day for dry mouth - Order date 10/27/25.On 1/6/26 at 1:47 PM, observed bottle of Biotene mouthwash at Resident #2's bedside. On 1/6/26 at 2:19 PM, Resident #2's Care plan reviewed and documented Self-administration of medication after nurse prepares. Date initiated 10/28/25.On 1/8/26 at 10:05 AM, the DON stated Resident #2's medical record should have included an order to have the Biotene at the bedside and did not. 3. Resident #46 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease caused by damage to the airways that limit airflow) and diabetes.Resident #46's physician orders for bowel care management were documented as: -Milk of Magnesia Suspension 400mg/5ml - Give 30 ml by mouth every 12 hours as needed for bowel care - Give on day 3 or day 4 with no bowel movement. Order date 5/30/25.-Prune Juice - Give 8 oz by mouth Q 12 hours prn every 12 hours as needed for bowel care - Give on day 3 or day 4 with no bowel movement. Order date 5/30/25.-Dulcolax Suppository 10 mg Insert 1 suppository rectally every 24 hours as needed for bowel care - Give on day 4 or day 5 with no bowel movement - Order Date 5/30/25.-Fleet Enema 7-19 Gm/118ml Insert 1 application rectally every 24 hours as needed for bowel care - Give on day 4 or day 5 with no bowel movement - Order Date 5/30/25.Resident #46 had a documented bowel movement on 12/28/25 at 9:13 AM and not again until 1/4/26 at 1:25 PM, over 168 hours with no documented bowel movement. No documentation of Resident #46 receiving the physician ordered medications for constipation management.On 1/8/26 at 10:12 AM, the DON stated Resident #46 should have received the ordered medications for bowel management and had not.

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	135105	A. Building B. Wing	01/09/2026

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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 observations, staff interview, and review of the facility policy, the facility failed to ensure residents were handled safely during transfers. This was true for 2 of 3 residents (Resident #35 and #68) reviewed for transfers. This failure had the potential to cause injury for residents requiring staff assistance with transfers. Findings include:The facility's Safe Resident Handling/Transfers policy, revision date 8/30/21, documented it is the policy of this facility that the residents will be transferred/handled safely. Use of gait belts or lifts may be used for residents as needed to provide safety for caregiver and patient during transfers. 1. Resident #35 was initially admitted to the facility 11/23/22 and readmitted [DATE], with multiple diagnoses including acute posthemorrhagic anemia (rapid blood loss leading to a sudden drop in red blood cells and oxygen delivery) and COPD (a group of lung diseases that block airflow and make it difficult to breath). On 1/5/26 at 8:12 AM, observed CNA #1 and CNA #2 transfer Resident #35 from her wheelchair to her bed. CNA #1 stood behind Resident #35's wheelchair and slid her arms under Resident #35's armpits while CNA #2 placed her arms under Resident #35's legs and they lifted her out of the wheelchair and transferred her to the bed. On 1/5/26 at 8:16 AM, when CNA #2 was asked if this is the way Resident #35 was supposed to be transferred, CNA #2 stated Resident #35 is care planned to be transferred this way. On 1/7/26 at 11:01 AM, the Director of Rehabilitation stated the Bear Hug transfer is used for a resident who can assist with a one-person transfer. A gait belt is placed around the resident's waist, and the staff use it to stand and pivot the resident to transfer. He also stated that grabbing the resident under the arms and legs to transfer was not appropriate. On 1/7/26 at 11:04 AM, the DON stated that the CNAs should not have transferred Resident #35 by grabbing her under the arms and legs. 2. Resident #68 was admitted to the facility on [DATE], with multiple diagnoses including pneumonia, UTI, and CHF (congestive heart failure). On 12/22/25, Resident #68's care plan documented 2 staff participation with transfers. On 12/23/25, a physical therapy evaluation of Resident #68 documented the following: - chair/bed-to-chair transfer - partial/moderate assist (meaning helper lifts, holds, or supports trunk or limbs but provides less than half the effort). On 12/26/25, Resident #68's MDS documents he is dependent with chair/bed-to-chair transfers (meaning resident does none of the effort to complete the activity or the assistance of 2 or more helpers is required for the resident to complete the activity). Per facility reported incident, on 12/27/25, Resident #68 was transferred to his bed from his (continued on next page)

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	135105	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Temple View Transitional Care Center	660 South Second Street West Rexburg, ID 83440

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	wheelchair by CNA #3. CNA #3 provided a written statement documenting the following: - CNA #2 and CNA #3 entered Resident #68's room to assist with transferring him from his wheelchair to his bed. - On 12/27/25, CNA #3 transferred Resident #68 using a bear hug technique (when 1 caregiver wraps their arms around patient's chest and under armpits, lifting from chair, pivoting resident to sit in another location). - CNA #2 stood behind CNA #3 while he completed the bear hug transfer for Resident #68. - CNA #3 stated he did not remember using a gait belt. On 12/27/25, CNA #2 provided a written statement documenting Resident #68 had a gait belt on, but it was too loose. Resident #68 landed perpendicular on the bed after the bear hug transfer. On 1/8/25 at 2:36 PM, the DON stated CNA #3 used the bear hug technique to transfer Resident #68. She stated CNA #3 was hurrying and should have slowed down and waited for CNA #2 to assist with the transfer.

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	135105	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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, interviews, and record review, the facility failed to ensure resident received oxygen as prescribed by the provider. This was true for 2 of 17 residents (#9 and #30) reviewed for respiratory care. This failure created the potential for respiratory difficulties or impaired breathing. Findings include:Resident #9 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (disease caused by damage to the airways that limit airflow) and depression. Resident #9's medical record included physician orders for oxygen 1.5 liters per minute via nasal cannula continuously. Order start date of 11/6/25. On 1/5/26 at 11:35 AM, observed Resident #9 sitting in the dining room with oxygen administered at 2L/min via nasal cannula. On 1/6/26 at 11:20 AM, observed Resident #9 sitting in her room with oxygen administered at 2L/min via nasal cannula from bedside oxygen concentrator. The bedside oxygen concentrator was labeled to administer at 2L/min. Resident #9's portable oxygen concentrator on walker was labeled and set to administer at 2L/min. On 1/6/26 at 11:25 AM, RN #2 stated Resident #9's oxygen rate should have been at 1.5L/min via nasal cannula as ordered and had not been. Resident #30 was admitted to the facility on [DATE], with multiple diagnoses including orthopedic aftercare, Sjorgren's disease (chronic autoimmune disorder that affects the body's moisture-producing glands) and diabetes. On 1/5/26 at 9:30 AM, 1/6/26 at 11:12 AM, and 1/7/26 at 10:02 AM, observed Resident #30's oxygen humidifier dated 12/28/25. Resident #30's medical record included physician orders for oxygen tubing change weekly and humidifier bottle every night shift every Sunday. Order start date of 12/21/25. On 1/7/26 at 10:52 AM, the DON stated Resident #30's oxygen humidifier should have been changed on Sunday (1/4/26) and had not been.

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	135105	A. Building B. Wing	01/09/2026

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, observation, and staff interview, it was determined the facility failed to ensure that prior to the placement of bed rails, alternatives to bed rails were attempted and how the alternatives failed to meet the resident's assessed needs. This was true for 1 of 17 residents (Resident #41) reviewed for bed rails. This failure created the potential for harm due to the risk for injury, entrapment, and/or death. Findings include:The facility's Bed Rail Policy revised August 2017, documented It is the policy of the facility to attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails.The facility should maintain evidence that it has provided sufficient information so that the resident or resident representative could make an informed decision. Information that the facility must provide to the resident, or resident representative include, but are not limited to:What assessed medical needs would be addressed by the use of bed rails;The resident's benefits from the use of bed rails and the likelihood of these benefits;The resident's risks from the use of bed rails and how these risks will be mitigated; andAlternatives attempted that failed to meet the resident's needs and alternatives considered but not attempted because they were considered to be inappropriate.Resident #41 was admitted to the facility on [DATE], with multiple diagnoses including acute respiratory failure with hypercapnia (a lung condition that can cause confusion and severe shortness of breath), schizoaffective disorder (a serious mental illness), and AFib (an irregular heartbeat where episodes start and stop on their own).On 1/5/26 at 10:21 AM, Resident #41 was observed with bilateral upper side rails on his bed. Resident #41's medical record did not have documentation of the evaluation of the alternatives attempted or documentation of the purpose of the intended use of the side rails.On 1/6/26 at 1:38 PM, the DON stated Resident #41 did not have a side rail assessment completed and should have.

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	135105	A. Building B. Wing	01/09/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and staff interview, it was determined the facility failed to ensure controlled medications were tracked and kept secure from potential theft and/or diversion. This was true for 2 of 3 medication carts reviewed. This failure created the potential for undetected misuse and/or diversion of controlled medications and had the potential to affect all residents who received controlled medication in the facility. Findings include:On 1/7/26 at 4:40 PM, during the 200 Hall medication cart audit, observed the narcotic accountability sheet, dated 1/1/26 to 1/7/26, with 1 licensed nurse signature not documented. On 1/7/26 at 4:42 PM, CMA #1 stated two nurses should have signed the narcotic accountability sheet and she had not signed it when she accepted the medication cart today. On 1/7/26 at 4:45 PM, during the 100 Hall medication cart audit, observed the narcotic accountability sheet, dated 1/1/26 to 1/7/26, with 1 licensed nurse signature not documented. On 1/7/26 at 4:47 PM, LPN #2 stated two nurses should have signed the narcotic accountability sheet when they accepted the medication cart or released the medication cart. On 1/7/26 at 5:07 PM, the DON stated two nurses should have signed the narcotic accountability record when they accepted the medication cart or released the medication cart.

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	135105	A. Building B. Wing	01/09/2026

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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, policy review, and staff interview, it was determined the facility failed to ensure residents were assessed appropriately for adequate indications for the use of opioid pain medications. This was true for 1 of 17 residents (Resident #2) reviewed for unnecessary medications. This failure created the potential for residents to experience adverse consequences or increased risk of death. Findings include:The facility's Unnecessary Drugs policy, dated revision 5/2020, documented a resident's medication regime must be free from unnecessary drugs; in excessive dose, excessive duration, without adequate monitoring, without adequate indications for its use, or in the presence of adverse consequences or any combination of these reasons.Resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including right above knee amputation and diabetes.Resident #2's medical record included the following physician orders for pain medication:Acetaminophen Oral Tablet 325 Mg Give 1 tablet by mouth every 4 hours as needed for pain - Pain rated 1-5 - Order date 10/27/25.Percocet Oral Tablet 10-325 Mg (Oxycodone w/Acetaminophen) - Give 1 tablet by mouth every 4 hours as needed for Max of 4 a day for Pain rated 6-10 - Order date of 10/30/25.The following was documented on Resident #2's MAR for administration of Percocet 1 tablet:-11/7/25 at 9:35 PM for pain level of 5- 11/24/25 at 6:47 AM for pain level of 5-11/29/25 at 8:54 PM for pain level of 5-12/15/25 at 8:53 PM for pain level of 5-12/26/25 at 9:19 PM for pain level of 5-12/27/25 at 12:48 PM for pain level of 4-1/2/26 at 8:50 PM for pain level of 5-1/5/26 at 9:03 PM for pain level of 5On 1/7/26 at 10:40 AM, the DON stated the pain medication should have been administered as ordered according to the pain level and had not been.

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	135105	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review and staff interviews it was determined the facility failed to ensure medications were properly stored and not expired. This was true for the facility. This failure created the potential for residents to receive expired medications with decreased efficacy. Findings include:The following was observed during the medication cart audits. On 1/6/26 at 10:52 AM, the 200 Hall medication cart was audited with RN #1 present. Observed the following: - one bottle of Gas Relief with an expiration date of 7/25 printed on the bottle On 1/6/26 at 10:56 AM, RN #1 stated, the bottle of Gas Relief should have been discarded and had not been. On 1/6/26 at 2:25 PM, the DON stated the expired medications should have been removed from the medication cart and had not been.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of the State Operations Manual, interview, and record review, it was determined the facility failed to employ a qualified Director of Food and Nutrition Services. This deficient practice had the potential to affect all residents who received meals prepared in the facility's kitchen. Findings include:On 1/5/26 at 7:40 AM, during the initial tour of the kitchen, the Dietary Supervisor stated he is not a Certified Dietary Manager or qualified Director of Food and Nutrition Services but was enrolled in a Certified Dietary Managers course.On 1/5/26 at 7:41 AM, the Assistant Dietary Supervisor stated she is not Certified Dietary Manager, or Qualified Director of Food and Nutrition services but she took the Certified Dietary Manager course in 2023. She stated she did not attend the required 3-day in person training that was required to complete the course and had to take the course over.On 1/7/26 at 2:10 PM, the Administrator stated the Dietary Supervisor and Assistant Dietary Supervisor are not qualified Directors of Food and Nutrition services but are enrolled in an online Certified Dietary Managers course and should be certified by the end of this year.

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	135105	A. Building B. Wing	01/09/2026

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure accurate medical records were maintained for each resident. This was true for 2 of 17 residents (#2 and #4) whose records were reviewed for pain management. This deficient practice resulted in inaccurate documentation and created the potential for harm if inappropriate care and/or treatments were provided to the resident. Findings include: Resident #2 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including right above knee amputation and diabetes. On 1/7/26 at 10:10 AM, during record review Resident #2's November 2025 medication administration record documented Percocet Oral Tablet 10-325 Mg (Oxycodone w/Acetaminophen) had been administered by CNA #4 on 11/1/25 at 8:34 PM, 11/7/25 at 4:33 PM, and 11/29/25 at 1:10 PM. On 1/7/26 at 10:30 AM, review of the Active Employee List had CNA #4 listed as a registered nurse and an initial hire date of 7/9/13 with a termination date of 12/21/23 and a rehire date of 6/27/25. On 1/7/26 at 11:14 AM, the DON stated CNA #4 was currently working as a registered nurse and the facility had been unable to change her credentials in the electronic medical record system. Resident #4 was initially admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including above the knee amputation, multiple sclerosis (a disease where the immune system attacks the protective sheath around nerve fibers in the brain, spinal cord, and optic nerves), and chronic pain syndrome. Resident #4's physician's order dated 10/8/25, documented Fentanyl Patch 72 Hour 75 mcg/hr (micrograms per hour). Apply 1 patch transdermally one time a day every 3 day(s) for pain. Resident #4's December 2025 MAR documented the administration and site of the Fentanyl Patch 72 Hour 75 mcg/hr as follows: 12/10/25 11:53 AM - Shoulder - rear (right) 12/13/25 1:19 PM - Shoulder - rear (left)12/16/25 11:55 AM - Shoulder - front (right)12/19/25 11:51 AM - Shoulder - rear (left)12/22/25 10:22 AM - Shoulder - rear (right)12/25/25 10:58 AM - Shoulder - rear (left)12/28/25 11:45 AM - Shoulder - front (right)12/31/25 12:31 PM - Shoulder - front (left) Resident #4's physician order dated 10/3/25, includes instructions to document site of Fentanyl 75 mcg patch Q shift. Resident #4's December 2025 MAR documented the site of the Fentanyl 75 mcg patch as follows: 12/10/25 – left shoulder (day shift) 12/10/25 – left shoulder (NOC shift) 12/11/25 – left shoulder (day shift) (continued on next page)

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	135105	A. Building B. Wing	01/09/2026

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/11/25 – left shoulder (NOC shift) 12/12/25 – left shoulder (day shift) 12/12/25 – right shoulder (NOC shift) 12/13/25 - right shoulder (day shift) 12/13/25 - right shoulder (NOC shift) 12/14/25 - left shoulder (day shift) 12/14/25 - left shoulder (NOC shift) 12/15/25 - left shoulder (day shift) 12/15/25 - left shoulder (NOC shift) 12/19/25 - right shoulder (day shift) 12/19/25 - right shoulder (NOC shift) 12/20/25 - right shoulder (day shift) 12/20/25 - left shoulder (day shift) 12/20/25 - left shoulder (NOC shift) 12/25/25 – right shoulder (day shift) 12/25/25 – right shoulder (NOC Shift) 12/26/25 – right shoulder (day shift) 12/26/25 – right shoulder (NOC Shift) 12/27/25 – right shoulder (day shift) 12/27/25 – right shoulder (NOC Shift) 12/28/25 – left shoulder (day shift) 12/28/25 – left shoulder (NOC Shift) 12/29/25 – left shoulder (day shift) 12/29/25 – left shoulder (NOC Shift) 12/30/25 – left shoulder (day shift) (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	12/30/25 – right shoulder (NOC Shift) 12/31/25 – right shoulder (day shift) 12/31/25 – left shoulder (NOC Shift) On 1/8/26, A review of Resident #4's MAR identified a discrepancy in the documented administration and site compared to the documentation of the Q shift site observation of the Fentanyl 75 mcg patch. On 01/8/26 at 9:30 AM, the DON stated the nurses should have been documenting on the MAR the correct site of the Fentanyl 75 mcg patch and had not.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, policy review, and staff interview, it was determined the facility failed to ensure infection control prevention practices were maintained to provide a safe and sanitary environment. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: The facility's Infection Control Prevention and Control Program - Hand Hygiene Policy Updated 1/1/22, documented wash hands with soap and water for the following reasons: a. Before eating or after using the restroom b. When hands are visibly soiled; and c. After contact with a resident with infectious diarrhea including but not limited to infections caused by norovirus and C. difficile. The following was observed for hand hygiene: a) On 1/5/26 at 7:48 AM, observed LPN #1 serve Resident #23 his meal tray in his room. Resident #23 was not offered or encouraged to perform hand hygiene before eating. On 1/5/26 at 7:50 AM, observed LPN #1 serve Resident #8 her meal tray in her room. Resident #8 was not offered or encouraged to perform hand hygiene before eating. On 1/5/26 at 7:51 AM, LPN #1 stated she should have offered the residents hand hygiene with meals. b) On 1/5/26 at 10:47 AM, LPN #1 changed Resident #22's wound vac (a non-surgical treatment using a sealed dressing, foam, and a portable suction pump to remove fluid, reduce swelling, and draw edges together and promote faster healing). The following was observed: LPN #1 washed her hands in the restroom using soap and water. She then donned a gown and gloves. She removed Resident #22's socks, Ace bandage, Kerlix (gauze roll), and old dressing. She then removed her gloves and applied a new pair of gloves. LPN #1 did not wash her hands between glove changes after cleaning Resident #22's wound. She cleaned the wound with normal saline. She then removed her gloves and applied a new pair of gloves. LPN #1 did not wash her hands between gloves changes after cleaning the wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LPN #1 applied skin prep around the wound bed as a barrier. She then applied Adaptic (a non-adherent wound dressing) over the wound bed. LPN #1 applied black foam over the Adaptic and then covered the suction device with a barrier dressing. LPN #1 removed her gloves and then washed her hands in the restroom with soap and water. On 1/5/26 at 11:03 AM, LPN #1 stated she should have washed her hand between glove changes and thought she had. The following was observed for enhanced barrier precautions: On 1/5/26 at 8:16 AM, observed Enhanced Barrier Precaution signage on Resident #35's door. On 1/5/26 at 8:17 AM, observed CNA #1 and CNA #2 enter Resident #35's room and had transferred her from the wheelchair to the bed. CNA #1 and CNA #2 had not donned proper PPE before transferring Resident #35. On 1/5/26 at 8:23 AM, CNA #2 stated they should have used donned PPE before transferring Resident #35. The following was observed for hall trays: On 1/5/26 at 12:10 PM, observed RN #2 communicating to two other staff present that there was one undelivered tray remaining in the food cart, RN #2 then removed a dirty food cover and meal tray from the food cart. On 1/5/26 at 12:18 PM, RN #2 stated the dirty food cover and meal tray should not have been put in the meal cart when there were undelivered lunch trays in the cart.