STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135110	A. Building B. Wing	05/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karcher Post Acute	1127 Caldwell Blvd Nampa, ID 83651

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the FDA Food Code, policy review, and staff interviews, it was determined the facility failed to ensure 3 of 3 dumpsters and 1 of 1 garbage can were properly closed to prevent attracting pests and rodents into the facility. This deficient practice had the potential to affect all residents and staff in the facility. Findings include: The U.S. Food and Drug Administration 2022 Food Code, 5-501.115 (Outside Storage): Specifies that outside receptacles (like dumpsters) must be designed with tight-fitting lids, doors or covers that keep pests out and contain odors. The facility's policy titled, [NAME] Post Acute Trash and Dumpster Policy, undated, stated, all trash must be placed inside designated dumpsters. Do not leave trash on the ground. Close lids after use and do not overfill dumpsters. On 5/29/26 at 10:30 AM, three dumpsters and one outside garbage can were observed uncovered. [NAME] #1 stated, the dumpsters should be closed and the garbage can should be covered. On 5/29/26 at 11:03 AM, the Dietary Director stated, the dumpsters and garbage can should be closed.

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **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 ensure residents were provided respiratory services consistent with professional standards of practice. This was true for 5 of 16 residents (#16, #33, #37, #38, and #52) whose respiratory devices were not cleaned and stored properly and 2 of 16 residents (#22 and #38) reviewed for physician orders for oxygen therapy. This deficient practice created the potential for residents to develop infection and to receive too little or too much oxygen. Findings include: The facility's policy, titled Oxygen Administration, revised 10/2010, documented the purpose of the procedure is to provide guidelines for safe oxygen administration. Under the section titled, Preparation, 1. documented, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. 1. Resident #22 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease (COPD is a disease that causes airflow blockage and breathing related problems), respiratory failure, heart failure, and dementia. On 5/26/26 at 10:23 AM, Resident #22 was observed asleep in bed wearing a nasal cannula. Resident #22's oxygen concentrator had a humidification reservoir and was set to deliver 3.5 L of oxygen per minute. On 5/28/26 at 11:28 AM, Resident #22 was observed in their bedroom sitting in a wheelchair, Resident #22 was wearing a nasal cannula attached to a portable oxygen tank hanging on the back of the wheelchair. The portable E size oxygen tank was set to deliver 2 L of oxygen per minute. Resident #22's care plan, revised on 6/27/25, documented they required oxygen therapy, and directed staff to monitor for signs and symptoms of respiratory distress and provide oxygen via nasal cannula per physician orders. Resident #22's physician orders documented the following: -Change/Replace humidifier as needed, dated 6/16/25 -Clean oxygen concentrator/filter once per week, dated 6/16/25 -Monitor oxygen saturation prior to meals and ensure oxygen tank is full, dated 12/26/25 Resident #22's physician orders did not document how much oxygen Resident #22 should have been receiving. On 5/28/26 at 12:33 PM, the DON stated, Resident #22 did not have an oxygen order transcribed upon admission on [DATE]. The DON further stated, Resident #22 should not have been receiving oxygen without a physician order. 2. Resident #38 was readmitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure, pulmonary edema, and COPD. A physician order dated 3/9/26 documented, continuous oxygen at 3 Liters per minute (LPM) via (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nasal cannula every shift for oxygen use. Resident #38's Treatment Administration Record (TAR) documented Resident #38 was receiving 2 LPM of oxygen. On 5/28/26 at 11:50 AM, Resident #38 was observed sitting on the edge of his bed using 2 LPM of portable oxygen via nasal cannula. On 5/28/26 at 12:07 PM, RN #1 accompanied the surveyor to Resident #38's room and confirmed Resident #38's portable oxygen was set to 2 LPM. When asked about the physician order for Resident #38's oxygen, RN #1 confirmed Resident #38's portable oxygen tank should have been set at 3 LPM. The Facility's Administering Medications through a Small Volume Nebulizer Policy, dated October 2010, directed staff to: Rinse and disinfect the nebulizer equipment according to facility protocol, or: Wash pieces with warm, soapy water; Rinse with hot water; Place all pieces in a bowl and cover with isopropyl (rubbing) alcohol. Soak for five minutes; Allow to air dry on a paper towel. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 1. Resident #33 was readmitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure, congestive heart failure (CHF-a chronic condition where the heart muscle is too weak to pump blood efficiently), and pulmonary edema (a serious condition where excess fluid collects in the lungs' air sacs, making it difficult to breathe). On 5/26/26 at 10:04 AM and 5/27/26 at 2:49 PM, Resident #33's nebulizer face mask was observed sitting on the bedside tabletop without a barrier or a bag. On 5/28/26 at 8:59 AM, Resident #33's nebulizer face mask was observed sitting on top of her nebulizer machine without a barrier or a bag. 2.Resident #37 was admitted to the facility on [DATE], with multiple diagnoses including dementia, asthma, and sleep apnea. On 5/28/26 at 11:44 AM, Resident #37's nebulizer face mask was observed sitting upside down on top of the nebulizer machine. 3. Resident #52 was readmitted to the facility on [DATE], with multiple diagnoses including respiratory failure, COPD, and pulmonary edema. On 5/27/26 at 2:59 PM and 5/28/26 at 9:01 AM, Resident #52's nebulizer face mask was observed sitting on top of the nebulizer machine on top of Resident #52's dresser without a barrier or a bag. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Resident #38 was readmitted to the facility on [DATE], with multiple diagnoses including chronic respiratory failure, pulmonary edema, and COPD. The following nebulizer observations were made: -On 5/26/26 at 10:15 AM, Resident #38's nebulizer face mask was observed on top of the bedside table without a barrier or a bag. -On 5/28/26 at 11:37 AM, Resident #38's nebulizer face mask was observed hanging over the back end of the bedside table without a bag. 5. Resident #16 was admitted on [DATE], with multiple diagnoses including dependence on supplemental oxygen, chronic pain, and major depressive disorder. On 5/28/26 at 9:25 AM, Resident #16's nebulizer was observed on his nightstand with white particles on the mask and liquid in the nebulizer reservoir. The mask was observed to be touching the nightstand while the tubing was wrapped over the nebulizer machine. On 5/28/26 11:54 AM, the DON stated the nebulizers should be rinsed after each use and should be washed nightly. On 5/28/26 at 12:02 PM, RN #1 stated resident's nebulizers should be rinsed, air dried, and stored in a bag. 6. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses including anxiety, depression, and hypertension. On 5/28/26 at 11:31 AM, Resident #8 was observed sitting in her wheelchair next to her bed. Her nasal cannula was observed resting directly on her blankets. When asked how often she wears her nasal cannula Resident #8 stated she uses her oxygen at night and whenever she sleeps. On 5/28/26 at 11:50 AM, the DON observed the nasal cannula and disposed of it. The DON confirmed the nasal cannula should be placed in a bag when not in use.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, policy review, FDA Food Code review, resident and staff interviews, it was determined the facility failed to appropriately store, distribute and label foods. This deficient practice had the potential to affect all residents who received food prepared in the facility. This placed residents at risk for potential contamination and use of spoiled foods, and adverse health outcomes including food borne illnesses. Findings include: 1. The FDA Food Code, Section 3-501.19, titled, Time as a Public Health Control, stated, once a Time/Temperature Control for Safety (TCS) food is removed from temperature control (the kitchen steam table or refrigeration), it must be consumed or discarded within 4 hours. Leaving a tray in a residents room for hours violates professional standards for food safety and distribution. Resident #68 was admitted to the facility on [DATE], with multiple diagnoses including heart failure (a chronic condition where the heart muscle doesn't pump blood as effectively as it should) and hypertension. On 5/28/26 at 11:50AM, Resident #68's uncovered breakfast tray was observed still in her room. Resident #68 stated she ate breakfast at 7:30 AM this morning. On 5/28/26 at 11:55 AM, CNA #2 stated, the breakfast trays for Resident #68's hall are usually delivered around 7:30 AM. On 5/28/26 at 3:15 PM, ADON stated, meal trays should be picked up 30 minutes after they are finished. 2. The facility policy titled, Food Receiving and Storage, revised 11/2022, under Dry Food Storage section 3, stated dry foods and goods are handled and stored in a manner that maintain the integrity of the packaging until they are ready for use. In Foods and Snacks Kept on Nursing Units, section 2, stated, all foods belonging to residents are labeled with the resident's name, the item and the use by date. a. On 5/28/26 at 10:30 AM, during kitchen observation, a Quaker Oats container was observed on the shelf with a cracked lid. On 5/28/26 at 1:15 PM, the Dietary Director stated, the box should not be used and it was thrown out. b. On 5/29/26 at 1:10 PM, a Tillamook ice cream container was observed in the assisted dining room freezer which was opened and unlabeled. On 5/29/26 at 1:10 PM, RCM #1 stated the ice cream should be labeled and dated.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, and staff interview, it was determined the facility failed to ensure residents were treated with dignity and respect. This was true for 1 of 1 resident (Resident #16) reviewed for respect and dignity. This deficient practice placed residents at risk of embarrassment and diminished self-worth. Findings include: The facility's Dignity policy revised February 2021, documented staff were expected to promote dignity by helping residents to keep urinary bag covered.Resident #16 was admitted to the facility on [DATE] and readmitted on [DATE], with multiple diagnoses including neuromuscular dysfunction of the bladder and paraplegia (the partial or complete loss of motor and sensory function in the lower half of the body typically caused by spinal cord injury or disease).On 5/26/26 at 12:45 PM and 5/27/26 at 1:16 PM, Resident #16 was observed sitting in his wheelchair outside the Assisted Dining Room with his urinary bag containing urine uncovered.On 5/26/26 at 1:18 PM, the DON who was walking by was informed of Resident #16's urinary bag being uncovered. The DON stated that should be covered.

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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 review of the State Operations Manual (SOM), record review, and staff interview it was determined the facility failed to ensure residents exercised their right to formulate an Advanced Directive. This was true for 1 of 3 residents (Resident #33) whose records were reviewed. This failed practice created the potential for an adverse outcome if the resident's wishes were not followed. Findings include:The State Operation Manual (SOM), Appendix PP, defined an Advance Directive is a written instruction such as a living will or durable power of attorney for health care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Physician Orders for Life-sustaining Treatment (or POLST) paradigm form is a form designed to improve patient care by creating a portable medical order form that records patient's treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advanced directive.Resident #33 was readmitted to the facility on [DATE], with multiple diagnoses including congestive heart failure, pulmonary edema, and chronic respiratory failure.Resident #33's care plan, initiated on 5/4/26 and revised on 5/18/26, documented Resident #33 had an Advanced Directive on file and was up to date.An IDT Conference Note dated 5/12/26 documented, Resident #33's Advanced Directives were reviewed, accurate, and up to date.Resident #33's Advanced Directive was unable to be located in Resident #33's record.On 5/28/26 at 2:08 PM, when asked where Resident #33's Advanced Directive was located, the ADON stated she only saw Resident #33's POST form. When asked if a POST form is an Advanced Directive, the ADON stated, no, a POST form is different from an Advanced Directive. The ADON further stated she didn't believe Resident #33 ever gave the facility an Advanced Directive and confirmed there was not a copy of Resident #33's Advanced Directive on file.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, review of the facility grievances, and resident and staff interview, it was determined the facility failed to ensure grievances were investigated and prompt corrective action was taken to resolve them. This was true for 1 of 1 resident (Resident #6) reviewed for grievances. This failure created the potential for psychological harm if residents' grievances were not acted upon. Findings include:The facility's Grievance policy and procedure revised March 2019 documented concerns/grievances may be presented verbally or in writing. The policy also documented grievance should be completed with appropriate actions and follow-up. The Social Service Director/Designee should:-assist concerned resident(s), resident representative, other family members(s), or advocated that have issues or concerns to complete a Grievance/Concern Form. If the person with concern does not want to complete a Grievance Form, any format should be accepted.-log all concerns/grievances received onto the facility grievance log.-should keep a running log of concerns voiced and their resolution as well as copy of the completed grievance forms.-monitor trending of the issues noted, and report as needed to the facility's QA Committee as well as the designated Grievance Officer.Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including aftercare following surgery on the skin and subcutaneous tissue, Parkinson's Disease with dyskinesia (a movement disorders that causes involuntary, erratic and uncontrollable muscle movements).On 5/26/26 at 10:27 AM, Resident #6 stated he was unable to sleep due to his roommate's TV being so loud. Resident #6 also stated his roommate was turning the heater on and it was too hot in their room and was making it difficult to breathe. Resident #6 stated he reported his concerns to the Social Worker three times, the last one was this morning. He said the Social Worker spoke to his roommate, but nothing had changed.Review of the facility's Grievances' file did not include Resident #6's concerns regarding his roommate.On 5/26/26 at 2:19 PM, the LSW stated Resident #6 expressed his concerns regarding his roommate and spoke to his roommate. The LSW stated Resident #6's roommate denied turning the heater on. The LSW stated Resident #6's roommate was offered to use headphones, but he refused. The headphones then were offered to both residents, Resident #6 stated he would wear the headphones if his roommate was going to wear them too. The LSW stated Resident #6 spoke to her again this morning regarding his concerns with his roommate, that it was not resolved. The LSW stated she failed to complete a grievance form for Resident #6. LSW stated, Yes, it should have been completed. When asked if she had follow-up on Resident #6's concern, the LSW stated, No, I did not make a follow-up, and I should have.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, policy and record review, it was determined the facility failed to ensure a seatbelt was assessed as potential restraints and a consent from the residents and/or their representatives was obtained. This was true for 1 of 1 resident (Resident #6) reviewed for potential restraint. This deficient practice had the potential for harm if the seatbelt were improperly used. Findings include: The facility's Use of Restraints policy revised April 2017, documented prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. The assessment shall be used to determine possible underlying causes of the problematic medical symptoms and to determine if there are less restrictive interventions that may improve the symptoms. The policy also stated restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative.Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including aftercare following surgery on the skin and subcutaneous tissue, Parkinson's Disease with dyskinesia.On 5/26/26 at 10:27 AM and 5/27/26 at 10:30 AM, Resident #6 was observed sitting in his power chair with a seatbelt on.Resident #6's record did not include documentation he was assessed prior to him using the seatbelt as a potential restraint.On 5/28/26 at 2:49 PM, the ADON stated the resident should be assessed and obtained consent from the resident and/or their representative before initiating the use of seat belt. The ADON stated she was unable to find documentation Resident #6 was assessed prior to initiating the use of the seatbelt.

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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 residents were appropriately monitored for side effects of antiˆanxiety medication. This was true for 1 of 5 residents (Resident #9) reviewed for unnecessary medications. This failure created the potential for inappropriate pharmacological interventions and adverse outcomes, including oversedation. Findings include:Resident #9 was admitted on [DATE] with multiple diagnoses including dementia with behavioral disturbances, history of falls, and anxiety.A review of Resident #9's care plan showed no documentation of monitoring for antiˆanxiety medication side effects, despite the resident's diagnosis of anxiety and use of antiˆanxiety medication.A physician order dated 3/16/26 documented: Antiˆanxiety medication: monitor for drowsiness, slurred speech, dizziness, nausea, aggressive/impulsive behavior.A review of Resident #9's TAR for antiˆanxiety sideˆeffect monitoring from 3/16/26 through 5/26/26 documented only a check mark for each monitoring entry.The TAR did not indicate whether any side effects were present or absent, nor did it provide descriptive information required to evaluate the resident's response to treatment.On 5/29/26 at 10:30 AM, the DON stated the record reflected that Resident #9 was monitored for side effects and that if side effects were present, the nurse would enter a progress note.When asked how the facility evaluates the resident's ongoing need for antiˆanxiety medication based on the monitoring entries, the DON stated she would change the order to require documentation of Y for yes and N for no to indicate whether side effects were present.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, it was determined the facility failed to ensure the required discharge process was followed when residents were transferred to a higher level of care. This was true for 2 of 2 residents (#6 and #16) reviewed for hospital discharge process. This failure created the potential for incomplete information of transfers, delay in care, and lack of required notifications. Findings include: 1.Resident #16 was admitted to the facility on [DATE], with multiple diagnoses including dependence on supplemental oxygen, chronic pain, and major depressive disorder. a. A nursing progress note dated 4/18/26 at 10:42 PM documented, Resident #16 was found unresponsive to verbal and physical stimulation. The LN documented Resident #6's oxygen saturation at 70% (normal 95–100%) and noted respiratory distress with snoring and gasping respirations. The LN called 911, and Resident #6 was transported to a higher level of care. A review of Resident #16's record showed no documentation that the State Longˆ Term Care Ombudsman was notified of Resident #16's transfer to the hospital. On 5/28/26 at 2:45 PM, the ADON stated the facility does not notify the State Ombudsman of hospital discharges. b. A review of Resident #16's medical record showed no documentation of what discharge information, such as medical records, medication lists, or clinical summaries, was provided to the receiving healthcare institution. On 5/29/26 at 9:26 AM, RCM #2 stated Resident #16's record did not include documentation of what information was sent with the resident at the time of transfer. 2. Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including aftercare following surgery on the skin and subcutaneous tissue, Parkinson's Disease with dyskinesia. A physician assistant progress notes dated 2/17/26, documented Resident #6 was discharged to the hospital for flap surgery. There was no documentation the Ombudsman was notified of Resident #6's discharge to the hospital. On 5/28/26 at 2:24 PM, the ADON stated Resident #6 went to the hospital for his scheduled flap surgery and they did not notify the Ombudsman of his discharge. The ADON stated the Ombudsman was being notified when the residents were discharged to the community or to their home.

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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 the State Operations Manual (SOM), record review, and staff interview, it was determined the facility failed to ensure a Pre-admission Screening and Resident Review (PASRR) was completed when new mental health diagnoses were identified for 1 or 4 residents (Resident #4), whose records were reviewed for PASRR screenings. This failure created the potential for harm if the resident required but did not receive specialized services for mental health while residing in the facility. Findings include:Appendix PP of the State Operations Manual, revised 7/23/25, documented any resident with newly evident or possible serious mental disorder, intellectual disability, or a related condition must be referred by the facility to the appropriate state-designated mental health or intellectual disability authority for review. Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including aphasia (inability to communicate verbally), hemiplegia and hemiparesis (paralysis and weakness on one side of the body), and stimulant abuse.Resident #4's medical record documented on 2/25/25, he received two new mental health diagnoses, bipolar II disorder and anxiety disorder.On 5/28/26 at 2:40 PM, the ADON stated Resident #4 should have had a new PASRR Level I conducted when he was diagnosed with bipolar II disorder and anxiety.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Karcher Post Acute	1127 Caldwell Blvd Nampa, ID 83651

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **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 PASRR screening for serious mental illness, intellectual disability, or related conditions were completed accurately. This was true for 2 of 4 residents (#22 and #44) whose PASRR records were reviewed. This failure placed Resident #22 at risk for harm if their needs went unmet when a diagnosis of serious mental illness was omitted from their PASRR level 1, and placed Resident #44 at risk for harm when a new PASRR level 1 was not completed. Findings include: 1. Resident #22 was admitted to the facility on [DATE] with multiple diagnoses including bipolar disorder, depression, and chronic respiratory failure. Resident #22's record documented a PASRR level 1 dated 5/14/26. The PASRR level 1 documented Resident #22 did not have any major mental illnesses, such as bipolar disorder. On 5/28/26 at 2:22 PM, the ADON stated Resident #22's PASRR level 1 from 5/14/26 was not accurate and should have been corrected upon her admission. 2. Resident #44 was readmitted to the facility on [DATE], with multiple diagnoses including bipolar disorder and depression. Resident #44's record was reviewed for PASRR level 1 screening for serious mental illness or intellectual disability. There was no documentation in Resident #44's record indicating a PASRR level 1 had been completed when Resident #44 readmitted to the facility on [DATE]. On 5/28/26 at 2:40 PM, the ADON and the LSW confirmed Resident #44's PASRR should have been completed when Resident #44 readmitted to the facility.

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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 policy review, record review, and staff interviews, it was determined the facility failed to ensure residents were provided with a comprehensive, personˆcentered care plan as required. This was true for 2 of 17 residents (Residents #5 and #6) reviewed for care plans. Comprehensive, personˆcentered care plans are essential for identifying resident needs, directing staff actions, and ensuring coordinated care. This deficient practice created the potential for unidentified or unmet care needs. Findings include:The facility's policy titled Care Plans, Comprehensive PersonˆCentered, revised 3/22, documented: The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. 1. Resident #5 was admitted on [DATE], with diagnoses including unspecified psychosis, depression, and insomnia. A Comprehensive MDS assessment dated [DATE] documented, under Section I (Active Diagnoses) that Resident #5 had depression and a psychotic disorder. A physician progress note dated 4/30/26 at 8:00 AM, documented an active diagnosis of generalized anxiety disorder. A review of physician orders documented Duloxetine 20 mg at bedtime for anxiety. A review of Resident #5's care plan showed no documentation of anxiety, related needs, or interventions. On 5/29/26 at 11:20 AM, the DON confirmed Resident #5's care plan did not reflect the anxiety diagnosis or associated interventions, stating it should have been included. 2. Resident #6 was admitted to the facility on [DATE] and readmitted [DATE], with multiple diagnoses including aftercare following surgery on the skin and subcutaneous tissue, Parkinson's Disease with dyskinesia. a. On 5/26/26 at 10:20 AM, Resident #6 stated he had a colostomy (a surgical procedure that creates an opening, called ostoma, in the abdominal wall) done a few months ago. Resident #6's care plan did not document he had a colostomy. On 5/27/26 at 1:43 PM, the DON stated Resident colostomy was not in the care plan. The DON stated, Yes, it should be in the care plan. b. On 5/26/26 at 10:27 AM and 5/27/26 at 10:30 AM, Resident #6 was observed sitting in his power chair with a seatbelt on. Resident #6's care plan did not document he was using a seatbelt. On 5/28/26 at 2:49 PM, the ADON stated Resident #6's seatbelt was not documented in his care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The ADON stated, Yes, it should be in the care plan. c. Resident #6's TAR documented he was being monitored for the following behaviors: verbal aggression, vulgar/sexual remarks, tearfulness, and isolation, started on 3/14/26. Resident #6's care plan documented he was being monitored for the following behaviors: voiced sadness due to recent loss of ex-wife, frustration with current medical circumstance, rejection of care/medicines, and yelling/lashing out. On 5/27/26 at 2:02 PM, the LSW reviewed Resident #6's care plan. The LSW stated Resident #6's target behavior was not in the care plan. The LSW stated, Yes, the target behavior should be the one documented in the care plan. On 5/27/26 at 2:28 PM, the DON stated Resident #6's behaviors that was being monitored were not in the care plan and it should be in the care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, the National Council of State Boards of Nursing (NCSBN) website, and staff interview, it was determined the facility failed to ensure physician orders were clarified to verify the correct route of medication administration. This was true for 1 of 2 residents (Resident #2) whose physician orders were reviewed. This deficient practice created the potential for harm if residents were to receive oral medications when they were ordered to receive nothing by mouth. Findings include:According to the NCSBN website, accessed 6/4/26, nurses are professionally obligated to clarify and verify any order that is incomplete, inaccurate, unclear, or contraindicated before implementing it. The facility's policy, titled Administering Medications, stated, medications are administered in a safe and timely manner, and as prescribed. Section 10 stated, the individual administering medications checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including Cerebral Palsy (a neurological disorder that affects muscle control, balance, and posture) and dysphagia (difficulty swallowing).Resident # 2 had a PEG-tube (a percutaneous endoscopic gastrostomy tube surgically placed directly into the stomach through the abdominal wall for medication, nutrition, and hydration).On 5/27/26 at 12:10 PM, RN #1 was observed administering a probiotic via PEG-tube.Resident #2's physician's order included the following:- NPO to texture, diet and consistency dated 8/29/25.-Probiotic Oral Capsule, Give 1 capsule by mouth in the morning for gut health, dated 12/17/25.- Milk of Magnesia Oral Suspension 400 mg/5ml, give 30 ml by mouth as needed for bowel care as needed for no BM in 3 day, dated 12/17/25On 5/29/26 at 2:37 PM, the DON stated Resident #2 was NPO and should have nothing by mouth.

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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, policy review, and staff interview it was determined the facility failed to ensure professional standards of practice were followed for 1 of 2 residents (Resident #2) reviewed for enteral feeding. This failure created the potential for adverse outcomes when Resident #2's physician orders were not followed for enteral flush and medication administration. Findings include: The facility's policy titled Enteral Feeding Tubes, reviewed 4/2022 stated, it is the policy of this center that residents receiving enteral tube feedings receive appropriate treatment and services to prevent complications. It further stated under Water Flush/Administration, the licensed nurse administers water flushes per physician order using lukewarm or room temperature water. If physicians orders are not specified, the recommendations are as follows:A. 15-30 cc pre/post medication administration.B. 5-10 mL prior to individual medication administration. Resident #2 was admitted to the facility on [DATE], with multiple diagnoses including Cerebral Palsy and dysphagia. On5/27/27 at 9:45 AM, Resident #2 was observed with a PEG-tube. Resident #2's physician order included the following: -Enteral Feed Order: every shift Enteral Water flushes; a. 15-30cc pre/post medication administration when multiple medications are administered together.b. 5-10cc prior to individual medication administration.c. 15-30cc pre/post tube feeding administration/discontinuation. -Enteral Feed Order four times a day for nutrition needs Vital AF 1.2- 250 ml bolus feeds QID to provide 1000 ml, 1200 kcal, 75 g protein, 75 ml flush pre/post bolus. On 5/27/26, Resident #2's feeding bag was observed to be empty between 9:45 AM to 11:50 AM. On 5/27/26 at 11:55 AM, RN #1 was observed to prepare Resident #2's medications and placed them crushed into 13 individual medication cups. On 5/27/26 at 12:10 PM, RN #1 entered Resident #2's room to administer his medications. Resident #2's empty feeding bag was observed still connected to his PEG tube, with enteral feeding still in the tubing. RN #2 was observed to put 240 ml of water into the feeding bag as a bolus. RN #1 then mixed each of Resident #2's medications with water and administer them one at a time via his PEG tube using a large syringe. RN #1 flushed Resident #2's PEG tube with more than 30 ml of water between each medication administration. RN #1 was observed returning to the sink three times to obtain approximately 250 ml of water each time during Resident #2's medication administration. On 5/27/26 at 12:40 PM, when asked RN #1 how much water he used, he stated, I have no idea. When asked what time he started Resident #2's enteral feeding, he stated, about 9:00 AM and it should have finished about 9:30 AM. On 5/27/26 at 4:04 PM, when asked when a feeding tube should be flushed after completion, RN #1 stated Resident #2's PEG tube should be flushed with water after the enteral feeding was finished, but he did not flush it until before he administered medication. On 5/27/26 at 4:19 PM, the DON stated when an enteral feeding was done, it should be checked for residual and then flushed within minutes of completion. On 5/29/26 at 2:37 PM, the DON stated RN #1 did not follow the physician's orders regarding flushing Resident #2's PEG tube.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and staff interview, it was determined the facility failed to ensure Certified Nursing Assistants (CNAs) received the required 12 hours of annual in-service training and performance reviews. This was true for 1 of 3 CNAs reviewed for skills and qualifications. This failure created the potential to affect resident safety by limiting staff competency in providing care. Findings include:On 5/29/26 at 12:57 PM, a request was made for CNA education records and performance reviews.On 5/29/26 at 1:50 PM, the Administrator stated that 1 of 3 CNAs did not have documentation of the required 12 hours of annual training or a performance review.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interview, it was determined the facility failed to ensure resident records accurately reflected active medical diagnoses. This was true for 1 of 17 residents (Resident #5) reviewed for accuracy of records. This failure created the potential for miscommunication and unmet or unidentified care needs. Findings include:Resident #5 was admitted on [DATE], with multiple diagnoses, including unspecified psychosis, depression, and insomnia.A physician progress note dated 4/30/26 at 8:00 AM documented, Resident #5 had an active diagnosis of generalized anxiety disorder.A review of Resident #5's record showed generalized anxiety disorder was not listed as an active diagnosis in the resident's medical record.On 5/29/26 at 10:03 AM, the ADON stated Resident #5's record did not include generalized anxiety disorder as an active diagnosis and confirmed the record would be updated to reflect the physician's documented diagnosis.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on policy review, record review, and staff interview, it was determined the facility failed to ensure immunizations were offered and/or provided as indicated. This was true for 1 of 5 residents (Resident #4) reviewed for pneumococcal immunization. This deficient practice placed residents at risk of developing pneumococcal pneumonia and developing serious, potentially life-threatening complications. Findings include:The CDC webpage titled, Pneumococcal Vaccination accessed on 6/1/26, documented there are two types of pneumococcal vaccines. They are Pneumococcal conjugated vaccines (PCV) and Pneumococcal polysaccharide vaccine. The CDC recommended pneumococcal vaccination for:-All adults 50 years or older.-Adults 10 through [AGE] years old with certain risk conditions.Resident #4 was admitted to the facility on [DATE], with multiple diagnoses including aphasia, hemiplegia, and hemiparesis affecting right dominant side following a stroke.Resident #4's Immunization Information, documented he refused to receive the pneumococcal vaccine on 10/21/24.There was no documentation in Resident #4's record he/and or his representatives was offered and educated regarding the risk and benefits of having pneumococcal vaccines.On 5/26/26 at 2:52 PM, the MDS Nurse (previous IP) stated pneumococcal vaccine was being offered to residents upon their admission to the facility. The MDS Nurse stated she was unable to find documentation Resident #4 was offered or educated of the risks and benefits of the pneumococcal vaccination.