STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	135147	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meridian Meadows Transitional Care	2656 E Magic View Drive Meridian, ID 83642

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on resident interviews, representative interviews, staff interviews, observations, review of grievances, and review of the three-week nursing schedule, it was determined the facility failed to ensure sufficient staffing was available to meet resident needs according to their plan of care. This failure had the potential to affect all residents residing in the facility if staff were not available to ensure resident needs and safety measures were provided. Findings include: The National Academies of Sciences, Engineering, and Medicine (NASEM) website accessed on 4/8/26, article titled The National Imperative to Improve Nursing Home Quality (2022) documented, inadequate staffing contributes to delayed care, missed care tasks, and reduced resident safety. Staffing must be aligned with resident acuity, not just minimum numbers.A review of facility grievances dated 10/1/25 through 3/31/26, documented the following:-A Grievance Form dated 1/12/26, documented a resident reported not receiving incontinence care from 6:00 PM to 6:00 AM and was found wet the following morning. The Investigation outcome confirmed the allegation. The resident was not assisted overnight. Staff were reˆeducated on consistent overnight checks and timely incontinence assistance.-A Grievance Form dated 2/11/26, documented a family member reported concerns about staffing levels, long wait times for medications and showers, and delays in assistance with meals and transfers. The Investigation outcome confirmed the allegation. CNA mealˆsetup issues were identified and staff were educated. The investigation referenced a review of callˆlight response times and medication administration but did not document the outcome of those reviews.-A Grievance Form dated 3/5/26, documented a resident expressed concern about long callˆlight wait times and CNAs providing rushed care. The Investigation outcome confirmed the allegation. The resident was educated that call lights would be answered timely but not instantly. CNAs were instructed to answer call lights, provide a time estimate, and follow through.-A Grievance Form dated 3/14/26, documented a resident reported delayed care, stating his catheter bag reached 2,000 mL before a CNA arrived to empty it. The Investigation outcome confirmed the allegation. Staff were reminded to monitor and empty catheter bags during routine rounds.-A Grievance Form dated 3/22/26, documented a family member reported delayed care and concerns about the resident not getting out of bed in a timely manner. The Investigation outcome confirmed the allegation. The investigation identified call lights were answered timely, but care was delayed because the resident required twoˆperson assistance and staff were assisting others. Staff were reminded of the importance of timely followˆthrough once needs are identified.A review of the threeˆweek facility staffing schedule, dated 3/8/26 through 3/28/26, as follows:Week 1-3/8/26 (Sunday): Census 37 | Staffing hours 110.6-3/9/26 (Monday): Census 38 | Staffing hours 125.1-3/10/26 (Tuesday): Census 38 | Staffing hours 130.5-3/11/26 (Wednesday): Census 37 | Staffing hours 143.7-3/12/26 (Thursday): Census 37 | Staffing hours 148.6-3/13/26 (Friday): Census 38 | Staffing hours 139.8-3/14/26 (Saturday): Census 38 | Staffing hours 139.6Week 2-3/15/26 (Sunday): Census 38 | Staffing hours 116.8-3/16/26 (Monday): Census 39 | Staffing hours 151.5-3/17/26 (Tuesday): Census 41 | Staffing hours 153.9-3/18/26 (Wednesday): Census 41 | Staffing hours 154.6-3/19/26 (Thursday): Census 41 | Staffing hours 132.3-3/20/26 (Friday): Census 42 | Staffing hours 143.1-3/21/26 (Saturday): Census 41 | Staffing hours 105.9Week (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3-3/22/26 (Sunday): Census 41 | Staffing hours 119.3-3/23/26 (Monday): Census 40 | Staffing hours 138.5-3/24/26 (Tuesday): Census 40 | Staffing hours 131.1-3/25/26 (Wednesday): Census 41 | Staffing hours 141.7-3/26/26 (Thursday): Census 43 | Staffing hours 160.0-3/27/26 (Friday): Census 42 | Staffing hours 145.7-3/28/26 (Saturday): Census 42 | Staffing hours 108.0The three-week facility staffing schedule documented consistently lower staffing hours on weekends compared to weekdays. On 3/30/26 at 9:58 AM, Resident #5 stated she has had a low staffing concerns and has informed staff about it. She states a few weeks ago she submitted a grievance form with low staffing concerns but had not heard back.On 3/31/26 at 9:16 AM, Resident #40 stated that when the facility is shortˆstaffed, residents who normally eat in the independent dining room are required to eat in the assisted dining room due to lack of supervision. She stated this occurs primarily on weekends.On 3/31/26 at 10:32 AM, Resident #15 stated staff are not available to assist when needed throughout the day.On 3/30/26 at 11:55 AM, a family representative stated the facility has low staffing on the weekend and when she arrives to visit her mother, the room is often unorganized. She also stated she has made several attempts to coordinate with the facility staff to pick up her mother from the facility, but the resident is never ready on time.On 3/31/26 at 10:43 AM, a family representative stated the facility is shortˆstaffed on weekends and they are often unable to get assistance when needed.On 4/1/26 at 9:28 AM, the Resident Council meeting identified the following concerns:-Low weekend staffing has been repeatedly brought to administration without resolution.-Residents who normally eat in the independent dining room must eat in assisted dining room on weekends due to staffing shortages.-Staff are observed sitting at the nurses' station charting while call lights remain unanswered.On 4/1/26 at 11:34 AM, a whiteboard was observed in the kitchen stating the independent dining room is closed on Saturdays and Sundays, consistent with resident reports of low weekend staffing.Residents were observed eating in the independent dining room on the following dates and times:-3/30/26 (Monday) at 7:29 AM-3/30/26 (Monday) at 12:36 PM-4/1/26 (Wednesday) at 7:21 AM-4/1/26 (Wednesday) at 12:32 PM-4/2/26 (Thursday) at 7:20 AM-4/2/26 (Thursday) at 12:26 PMOn 4/2/26 at 5:27 AM, the night shift LN (Licensed Nurse) stated each wing has one CNA and one LN on duty. She stated the 6:00 PM-6:00 AM shift generally meets resident needs, but between 4:00 AM and 6:00 AM, residents may wait longer for assistance.On 4/2/26 at 5:35 AM, the second night shift LN stated that around 4:00 AM, residents begin calling for assistance and staff try to help each other out. She stated residents are understanding that they have to wait.On 4/2/26 at 6:19 AM, CNA #1 stated the facility is often lowˆstaffed on weekends and is not always appropriately staffed from 6:00 PM to 10:00 PM, resulting in longer wait times to meet resident needs.On 4/2/26 at 9:41 AM, the Staffing Coordinator stated staffing is based on census and confirmed the facility, does not have a lot of weekend staff. She stated she sometimes comes in to help cover shifts.

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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 that treatment. This was true for 1 of 6 residents (Resident #5) whose records were reviewed for informed consent. This failure created the potential for miscommunication and adverse effects when Resident #5 was not informed in advance of the risks and benefits of the ordered medication. Findings include:Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including palliative care encounter, congestive heart failure, and acute kidney disease.Resident #5's medical record included the following physician orders:-Lorazepam (a controlled substance anti-anxiety medication) Oral Concentrate 2 mg/mL: Give 0.5 mL by mouth every 8 hours as needed for anxiety.-Lorazepam Oral Concentrate 2 mg/mL: Give 0.5 mL by mouth every 8 hours as needed for terminal agitation for 180 days.A review of Resident #5's record showed no documentation that Resident #5 or her representative were informed of the risks and benefits or consent for the initiation of lorazepam use.On 4/2/26 at 12:08 PM, the CRN confirmed Resident #5 or their representative had not signed a consent documenting their understanding of the risks and benefits of lorazepam treatment prior to adding lorazepam as an active order for Resident #5.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, policy review, resident interview, and staff interviews, it was determined the facility failed to ensure an interdisciplinary team assessment, physician orders, or careˆplan documentation were in place for selfˆadministration of glucose tablets. This was true for 1 of 3 residents (Resident #15), whose record was reviewed for medication administration. This failure created the potential for harm when unsafe medication practices and unmonitored treatment of hypoglycemia were identified. Findings include:The facility's Resident Self-Administration of Medication policy reviewed 12/30/25, documented residents may only self-administer medications after the facility's interdisciplinary team (IDT) has determined which medications may be self-administered safely. The results of the IDT assessment are recorded on the Medication Self-Administration Safety Screen. The care plan must reflect resident self-administration and storage arrangements for such medications. A re-assessment of safety at minimum should be considered by the IDT for the following: a. a significant change in resident's status, b. quarterly, c. annually, or d. medication error.Resident #15 was admitted , 2/3/20, and readmitted to the facility on [DATE] with multiple diagnoses including type 1 diabetes, partial paralysis of left side, and ataxia (loss of full control of bodily movements) after a stroke.On 3/30/26 at 1:07 PM, it was observed Resident #15 had a bottle of glucose tablets on his desk. When asked why there were glucose tablets on his desk, Resident #15 stated he took glucose tablets whenever he felt his blood sugar going low.A Medication Self-Administration Safety Screen assessment dated [DATE], documented Resident #15 required supervision to take medication, and glucose tablets were not listed as a medication he could store and take independently. Resident #15's record did not include documentation of Medication Self-Administration Safety Screen assessments had been conducted since 2023. A physician's progress note dated 2/13/26, documented the physician had seen Resident #15 for low blood sugars, and referenced Resident #15 was taking glucose tablets whenever his blood sugar was in the 60's.On 4/2/26 at 9:10 AM, the CRN and DON confirmed there were no Medication Self-Administration Safety Screen assessments related to Resident #15 being able to self-administer glucose tablets. Cross reference F684.

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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, policy review, and staff interview it was determined the facility failed to assess a resident for safety related to bed rail use or informed consent was obtained prior to use of the bed rail. This was true for 1 of 1 resident (Resident #18) reviewed for restraint assessment. This deficient practice had the potential for physical and psychosocial harm if Resident #18 were injured, trapped, or felt she was being restrained unnecessarily. Findings include:The facility's Use of Assistive Devices policy, dated 12/29/25, documented the facility's process for the proper and consistent use of assistive devices for residents requiring equipment to maintain or improve function and/or dignity is based on the residents' comprehensive assessment, in accordance with the residents' plan of care. The facility's Restraint Free Environment policy, reviewed 12/31/25, defined the use of bed rails as one type of physical restraint.Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including leukemia, dementia, anxiety, and depression.On 3/30/26 at 10:52 AM, Resident #18 was observed in her bed with a transfer pole on the left side of her bed, and a 1/4 bed rail on the right side of her bed.A review of Resident #18's record did not document a restraint assessment or consent form had been completed for use of the 1/4 bed rail. On 4/3/26 at 10:27 AM, the CRN stated Resident #18 did not have any restraint assessments for the 1/4 bed rail and there should have been.Cross reference F656.

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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, record review, and staff interview, it was determined the facility failed to ensure resident care plans accurately reflected the use of assistive devices. This was true for 1 of 16 residents (Resident #18) reviewed for comprehensive person-centered care plans. This failure had the potential to result in unmet care needs and increased risk to resident safety. Findings include:Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including leukemia, dementia, anxiety, and depression.On 3/30/26 at 10:52 AM, Resident #18 was observed in her bed with a transfer pole on the left side of her bed, and a 1/4 bed rail on the right side of her bed.A review of Resident #18's care plan did not document the use of a transfer pole or 1/4 bed rail on her bed.On 4/3/26 at 10:28 AM, the CRN stated Resident #18 did not have a care plan implemented related to the 1/4 bed rail and transfer pole, and there should have been.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review 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 16 residents (Resident #4) reviewed for professional standards of practice. This failure created the potential for harm if Resident #4 were to receive oral medications despite having difficulty swallowing. Findings include:According to the National Council of State Boards of Nursing (NCSBN) website, accessed 4/6/26, nurses are professionally obligated to clarify and verify any order that is incomplete, inaccurate, unclear, or contraindicated before implementing it.Resident #4 was readmitted to the facility on [DATE] with multiple diagnoses including dysphagia, disease of the esophagus, and gastrostomy.Resident #4's nutritional care plan, revised 4/3/26, documented the resident was NPO (nothing by mouth).A review of Resident #4's physician orders showed the following medications were ordered to be administered by mouth:-Prednisone 5 mg: Give 1 tablet by mouth daily for renal insufficiency-Magnesium glycinate 100 mg: Give 1 capsule by mouth at bedtime for insomniaOn 4/2/26 at 11:32 AM, the DON and the CRN confirmed that Resident #4 does not take anything by mouth and stated the providers orders should have been clarified prior to implementation.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents who were dependent on staff for activities of daily living assistance received services for their fingernails. This was true for 1 of 1 residents (Resident #50) reviewed for nail care. This placed Resident #50 at risk of embarrassment which could affect him socially due to the appearance of his fingernails. Findings include: The facility's Nail Care policy, implemented 12/20/24 and revised 12/31/25 documented:The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health.Policy Explanation and Compliance Guidelines:Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible.Report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g., curling, color changes, separation from the nailbed, redness, bleeding, pain, odor, infection, etc.)Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke.Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.Principles of nail care:Nails should be kept smooth to avoid skin injury.Only licensed nurses shall trim or file fingernails of residents with diabetes.Residents without complicating disease processes, may have their toenails clipped by staff who have received education and training to provide this service within professional standards of practice and as per facility policy.Resident #50 was admitted to the facility on [DATE], with multiple diagnoses including muscle wasting and atrophy (the loss of muscle tissue, causing reduced strength and muscle thinning) and diabetes.Resident #50's ADL care plan, revised on 3/30/26, documented Resident #50 required partial to moderate assistance with ADLs.On 3/31/26 at 11:18 AM, Resident #50's fingernails were observed to be long, thick and yellow in color. When asked if Resident #50 preferred long fingernails, he stated he preferred his fingernails shorter. When asked if Resident #50 had asked the staff to cut his nails, Resident #50 stated he was unaware he could ask staff to cut his fingernails.On 4/1/26 at 11:45 AM, Resident #50's fingernails were observed to be long, thick and yellow in color. When asked if Resident #50 had asked staff to cut his nails, he stated he asked for his nails to be cut. On 4/2/26 at 1:37 PM, Resident #50's fingernails were observed with LPN #1. LPN #1 stated Resident #50's thumbnails were long and needed to be cut. LPN #1 further stated that the nails were yellow in color and were dirty and needed to be soaked. When asked who performs nailcare for Resident #50, LPN #1 stated nurses perform nail care. When asked how often nail care is performed, LPN #1 stated she would have to check Resident #50's order.On 4/2/26 at 1:45 PM, LPN #1 reviewed Resident #50's records and stated she didn't see an order for Resident #50's nail care. When asked if a physician order is needed for diabetic nail care, the ADON stated yes. When asked to show the surveyor Resident #50's order for diabetic nail care, the ADON stated when Resident #50 was admitted to the facility, the order would be in the physician notes. The ADON reviewed Resident #50's record and confirmed there was no order for Resident #50's diabetic nail care and would clarify with the provider.

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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, record review, resident interview, and staff interview, it was determined the facility failed to ensure residents had an active physician's order. This was true for 1 of 16 residents (Resident #15) whose record was reviewed for quality of care. This deficient practice created the potential for adverse outcomes when Resident #15 self-administered a medication not ordered by a physician. Findings include: Resident #15 was readmitted to the facility on [DATE] with multiple diagnoses including type 1 diabetes, partial paralysis of left side, and ataxia after a stroke.On 3/30/26 at 1:07 PM, it was observed Resident #15 had a bottle of glucose tablets on his desk. When asked why there were glucose tablets on his desk, Resident #15 stated he took glucose tablets whenever he felt his blood sugar going low.A physician's note dated 2/13/26, documented the physician had seen Resident #15 for low blood sugars, and referenced Resident #15 was taking glucose tablets whenever his blood sugar was in the 60's.A review of physician's orders, dated 3/1/26 through 4/1/26, did not include an order for glucose tablets.On 4/2/26 at 9:10 AM, the CRN and DON confirmed there were no current physician orders related to glucose tablets.Cross reference F554.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and staff interview, it was determined the facility failed to ensure wound care was provided according to physician orders and acceptable standards of practice. This was true for 1 of 1 residents (Resident #5) observed for wound treatment. This failure created the potential for delayed healing and wound deterioration. Findings include:a.Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including palliative care encounter, congestive heart failure, and acute kidney disease.A physician order directed staff to cleanse Resident #5's left heel with wound cleanser, apply normalˆsaline-moistened gauze, and cover with a dry dressing every shift.On 4/3/26 at 10:01 AM, RN #1 was observed performing wound care for Resident #5. RN #1 removed the soiled dressing, cleansed the wound with wound cleanser and gauze, patted the wound dry, applied skin prep, and applied a clean dry dressing.The treatment provided did not include the ordered normalˆsaline-moistened gauze.On 4/3/26 at 10:16 AM, RN #1 confirmed she performed the wrong treatment.On 4/3/26 at 10:46 AM, the ADON confirmed the wound care provided was not consistent with the physician's order.b.Resident #5's care plan, revised 3/30/26, documented she was at risk for skin impairment and pressure ulcers.A review of Resident #5's record documented the following physician order dated 3/27/26:-Discontinue wound vac (a negative pressure device) and apply wetˆtoˆdry dressing until further orders are received.A Nursing Progress Note dated 3/27/26 at 3:15 PM, documented the following woundˆcare orders had been discontinued:-Right lateral foot and left medial foot: Cleanse with wound cleanser and cover with Mepilex border or similar bandage once daily every Monday and Thursday.-Left heel: Check wound vac dressing and ensure pump is functioning every morning and at bedtime.-Charge wound vac at bedtime.-Wound vac procedure including cleansing, skin prep, black foam application, transparent dressing, and negative pressure at -125 mmHg continuously, changed twice weekly.-Instruction to remove wound vac and apply wetˆtoˆdry dressing if the device was nonfunctional for more than 2 hours and notify provider.The Nursing Progress Note did not include documentation that a new wound treatment was implemented following the discontinuation of the wound vac.A review of Resident #5's Treatment Administration Record showed that a new woundˆcare order for the left heel-cleanse with wound cleanser, apply normalˆsaline-moistened gauze, and cover with a dry dressing every shift-was not implemented until 3/31/26, four days after the wound vac was discontinued.On 4/3/26 at 10:46 AM, the ADON stated the facility had difficulty communicating with the hospice agency to clarify the woundˆcare order and acknowledged he did not think to obtain a temporary order from the facility's medical director.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, policy review, and staff interview, it was determined the facility failed to ensure residents received oxygen therapy per physician orders. This was true for 1 of 1 residents (Resident #1) reviewed for oxygen therapy. This deficient practice created the potential for adverse outcomes if residents' did not receive the proper amount of oxygen. Findings include:The facility's Oxygen Administration policy, implemented 12/30/25 documented, Oxygen is administered under orders of a physician, except in the case of an emergency.Resident #1 was admitted to the facility on [DATE] with multiple diagnoses including chronic respiratory failure with hypoxia and congestive heart failure.Resident #1's care plan revised on 3/7/26, documented Resident #1 used oxygen per physician order.A physician order dated 3/26/26, documented oxygen at 0-2 LPM via nasal cannula as needed to keep oxygen saturations equal to or greater than 88% and to check oxygen saturation every shift.Resident #1's March and April 2026 MAR/TAR documented Resident #1's oxygen saturations ranged from 90-95% and was occasionally receiving 3 LPM of oxygen as needed.On 3/30/26 at 1:00 PM, Resident #1 was observed resting in bed with the head of the bed elevated. His oxygen concentrator was running but he was not wearing his nasal cannula. Resident #1's oxygen concentrator was set at 2.5 LPM. When asked about the oxygen, Resident #1 stated he uses his oxygen at night and when he is napping.On 4/3/26 at 9:26 AM, Resident #1 was observed lying in bed with oxygen on via nasal cannula.On 4/3/26 at 10:43 AM, the DON accompanied the surveyor to Resident #1's room. Resident #1 was observed still lying in bed with oxygen on via nasal cannula. When asked what Resident #1's oxygen concentrator was set at, the DON stated the oxygen concentrator was set at 3 LPM.On 4/3/26 at 10:45 AM, the DON reviewed Resident #1's record and was asked to verify Resident #1's oxygen order. The DON stated Resident #1's oxygen order was for 0-2 LPM via nasal cannula. When asked what Resident #1's oxygen concentrator should have been set at, the DON reviewed Resident #1's record and stated she was looking for any changes in Resident #1's condition that would indicate a need for more oxygen. The DON confirmed that Resident #1's oxygen concentrator should have been set between 0-2 LPM.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and staff interview, the facility failed to ensure the presence of a registered professional nurse for at least 8 consecutive hours per day, as required. This failure had the potential to affect all residents in the facility who may require a higher level of nursing assessment or intervention. Findings include:Review of the facility's three-week nursing schedule, dated 3/8/26 through 3/28/26, documented the facility did not provide 8 consecutive hours of registered professional nursing coverage on the following dates:-3/14/26 - No consecutive 8 hours-3/15/26 - No consecutive 8 hours-3/28/26 - No consecutive 8 hoursOn 4/2/26 at 9:47 AM, the Staffing Coordinator stated she was unaware the registered professional nursing hours must be consecutive.

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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 residents were free from duplicate medication orders and side effect monitors were in place. This was true for 2 of 6 residents (#2 and #5) whose records were reviewed for unnecessary medications. This failure placed Resident #2 at risk for overmedication and Resident #5 at risk for their needs to go unmet when they were not monitored for side effects of their medications. Findings include: 1. According to the Food and Drug Administration (FDA) Ativan (lorazepam) prescribing information, accessed 4/7/26, patients receiving lorazepam must be monitored for the following potential adverse effects: -Sedation -Respiratory depression -Cognitive impairment -Paradoxical reactions (such as agitation or hyperactivity) -Dependence and withdrawal symptoms Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including palliative care encounter, congestive heart failure, and acute kidney disease. Resident #5's medical record included the following physician orders: -Lorazepam Oral Concentrate 2 mg/mL: Give 0.5 mL by mouth every 8 hours as needed for anxiety. -Lorazepam Oral Concentrate 2 mg/mL: Give 0.5 mL by mouth every 8 hours as needed for terminal agitation for 180 days. A review of Resident #5's care plan and physician orders showed no documentation of monitoring interventions for the use of lorazepam, including monitoring for sedation, respiratory status, cognitive changes, or other adverse effects identified in the FDA prescribing information. On 4/2/26 at 11:16 AM, the DON confirmed that Resident #5's record did not include monitoring parameters for lorazepam. 2. Resident #2 was admitted to the facility on [DATE] with multiple diagnoses including diabetes, congestive heart failure, and a mild cognitive impairment. Resident #2's physician orders documented the following: -Bisacodyl Suppository, Insert 10 mg rectally as needed for constipation If no results within 24 hours from bisacodyl tablet -Start Date- 12/2/2024 -Bisacodyl Rectal Suppository 10 mg, Insert 10 mg rectally every 24 hours as needed for, No BM [bowel movement] after prior bowel protocol regimen -Start Date- 11/29/2024 (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/26 at 12:13 PM, the CRN stated Resident #2 had two orders for bisacodyl suppositories in error.

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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. **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 expired medications were not available for administration to residents and failed to securely store medications. This was true for 1 of 3 medication carts (West Wing Cart) inspected for expired medications and true for 1 of 1 residents (Resident #4) reviewed for storage of self-administered medications. These failures created the potential for residents to receive expired medications with decreased efficacy and created the potential for harm to residents if they were to obtain medications which were left unsecured. Findings include:The facility's Medication Storage policy, implemented 12/29/25 documented all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.1. Resident #4 was readmitted to the facility on [DATE] with multiple diagnoses including dysphagia, disease of the esophagus, and gastrostomy. A review of Resident #4's care plan, revised 1/27/26, documented that he required supervision for self^administration of nutrition and was able to self^administer his medications. A review of Resident #4's Self^Administration of Medication Assessment, dated 2/13/26, documented that he required assistance to store medications in a secure location. On 4/1/26 at 11:01 AM, Resident #4 was observed sitting at his desk in his room. During the observation, two cups were noted on his nightstand. One cup contained white powdered residue, and the second cup—labeled 7 PM—was approximately one^quarter filled with white powder residue. Also on the nightstand were six containers of Jevity nutritional supplement. On 4/1/26 at 11:32 AM, Resident #4 stated that sometimes the licensed nurse brings his medications to his room and places them on the nightstand for him to take when he is ready. He further stated that at times he must go into the hallway at 4:00 AM to obtain his medications for the day. Resident #4 confirmed he placed the medications on his nightstand until he chooses to take them and stated the facility had not instructed him to store them elsewhere. Resident #4 also stated he self^administers his nutritional supplements without staff assistance and confirmed that facility staff provide him with a case of Jevity to self-administer. On 4/2/26 at 11:28 AM, the CRN stated she had not been informed that medications were being left on Resident #4's bedside table. 2. On 4/1/26 at 3:55 PM, 19 packets of Bacitracin ointment was observed in a clear plastic cup in the bottom drawer of the medication cart on the [NAME] Wing with an expiration date of 02/2025. When asked what the expiration date was on the medication, LPN #2 confirmed the bacitracin ointment was expired. When asked about the process when expired medications were found, LPN #2 stated expired medication should be disposed of. On 4/3/26 at 10:43 AM, when asked how often nurses are supposed to check medication carts for expired medications, the DON stated there was not a designated schedule and further added nurses should be watching during medication pass for expired medications.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, SOM Appendix PP, and staff interview, it was determined the facility failed to keep complete hospice records on file at the facility for residents receiving hospice services. This was true for 1 of 3 residents (Resident #18) whose record was reviewed for accuracy and completeness. This deficient practice created the potential for harm if hospice paperwork did not confirm Resident #18 agreed to receive hospice services. Findings include:SOM Appendix PP: Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.A. The designated interdisciplinary team member is responsible for the following:Obtaining the following information from the hospice: a. The most recent hospice plan of care specific to each patient. b. Hospice election form. c. Physician certification and recertification of the terminal illness specific to each patient. d. Names and contact information for hospice personnel involved in hospice care of each patient. e. Instructions on how to access the hospice's 24-hour on-call system. f. Hospice medication information specific to each patient. g. Hospice physician and attending physician (if any) orders specific to each patient.2. Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. The facility's Hospice Services Facility Agreement, dated 12/2/25, documented the facility would provide or arrange for hospice services which includes a designated facility member who would obtain information relating to the residents' hospice coordination of care and physician certification, and other documentation to include, but is not limited to, the Hospice Election Form. Resident #18 was admitted to the facility on [DATE] with multiple diagnoses including leukemia, dementia, anxiety, and depression.A review of Resident #18's medical record and hospice documentation did not include a Hospice Election form.On 4/2/26 at 11:46 AM, the CRN stated Resident #18's Hospice Election form was not on record at the facility prior to requesting a copy from the Hospice company earlier that morning.On 4/6/26 at 2:15 PM, the CRN clarified via email she did not believe the election form needed to be included in the Hospice documentation kept at the facility level.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a plan that describes the process for conducting QAPI and QAA activities. Based on record and policy review, and staff interview, it was determined the facility failed to implement a performance improvement plan (PIP) for a systemic concern related to staffing. This deficient practice created the potential for harm if residents received substandard quality of care if staffing concerns were not identified and responded to accordingly. Findings include:The facility's QAPI Facility Plan, dated January 2026, documented the QAPI plan for the facility was to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility. Objectives of the QAPI plan include:-Establish a facility-wide process to identify opportunities for improvement through continuous attention to quality of care, quality of life and resident safety.-Address gaps in the systems or processes.-Ensure adequate provision of staffing time, equipment and technical training resources.-Establish clear expectations around safety, quality, rights, choices and respect.-Continually improve the quality of care and services provided to [the] residents.The facility's self-reported [NAME] PBJ Staff Data Report for the first quarter of 2026 documented the facility had concerns with low weekend staffing.On 3/30/26 at 1:07 PM, Resident #15 stated he was concerned with the low weekend and night staffing and at resident council had complained about it with the other residents. He stated the residents stopped complaining about staffing around December 2025 when the facility had failed to respond to their earlier concerns.Resident Council Meeting Minutes were reviewed for staffing related concerns from October 2025 through March 2026 with the following results:-November 2025: Residents were concerned that the facility is often short staffed on the weekends.-December 2025: Residents were concerned about staffing on the weekends as they were not receiving their medications until 9:30 AM to 10:00 AM. Staffing concerns were noted as being in progress for a resolution.-January 2026: Residents were informed new staff have been trained and were working regularly, and residents stated the short staffing had significantly improved. The concerns were noted as resolved.-March 2026: Residents were concerned about not getting their snacks when the facility is short staffed.On 3/30/26 at 9:00 AM, the SA team met with facility residents who voiced concerns about low weekend staffing and poor staff response time during the night shift. The facility residents who were independent diners complained they could not eat in the independent dining hall when there were not enough staff on the weekend.On 4/3/26 at 12:20 PM, the Administrator confirmed independent dining had to be closed when there were not enough staff, so residents could safely dine with the available staff in the dependent dining hall.The Administrator provided two open performance plans which included: 1. Consistently offering snacks (opened December 2025); and 2. Tracking falls (opened 2/19/26).He stated there had been a staffing PIP opened in October 2025, but it closed in December 2025 when the residents stopped complaining about staffing. The Administrator did not identify any specific gaps in the staff systems or metrics related to how staffing was evaluated for effectiveness prior to closing the concern.Cross Reference F725, F727

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and staff interview, it was determined the facility failed to ensure infection control and prevention practices were maintained to provide a safe and sanitary environment when staff did not perform proper hand hygiene during medication administration or wound care, did not follow proper wound care protocol, and did not sanitize reusable medical equipment. This was true for 2 of 5 residents (#10 and #27) observed for medication administration and for 1 of 1 residents (Resident #5) observed for wound care. These failures had the potential to impact all residents in the facility by placing them at risk for cross contamination and infection. Findings include: 1. On 4/1/26 at 7:38 AM: LPN #2 was observed for morning medication pass. LPN #2 prepared medications for Resident #27, poured water into a clear plastic cup, locked the medication cart and went to Resident #27's room. LPN #2 knocked and entered Resident #27's room and handed resident #27 a medication cup and a cup of water. No hand hygiene was performed upon entering resident #27's room or prior to administering her medications. Resident #27 took her medications, LPN #2 performed hand hygiene upon exit of Resident #27's room and returned to the medication cart. On 4/1/26 at 7:48 AM: LPN #2 prepared medications for Resident #10, locked the medication cart and went to Resident #10's room. LPN #2 knocked and entered Resident #10's room. No hand hygiene was performed upon entering Resident #10's room. LPN #2 administered medications to Resident #10 with a spoon and applesauce. LPN #2 performed hand hygiene, exited Resident #10's room and returned to the medication cart. On 4/1/26 at 8:07 AM, when asked when hand hygiene is performed, LPN #2 stated hand hygiene is performed before entering and exiting resident's rooms. On 4/3/26 at 10:34 AM, observations were discussed with the DON and CRN. When asked if staff should perform hand hygiene before entering resident rooms, the DON confirmed staff should be performing hand hygiene upon entering resident's rooms. 2. Resident #5 was admitted to the facility on [DATE] with multiple diagnoses including palliative care encounter, congestive heart failure, and acute kidney disease. Resident #5's care plan, revised 3/30/26, documented she was at risk for developing a multidrugˆresistant organism (MDRO) through silent transmission related to her medical condition, chronic wounds, and history of MDRO to her left heel. A review of Resident #5's physician order dated 2/6/26 directed staff to maintain Enhanced Barrier Precautions every shift due to her wounds. An Enhanced Barrier Precautions sign was posted outside Resident #5's room directed all individuals to sanitize hands before entering and after leaving the room, and directed healthˆcare providers to wear gloves and gowns when performing highˆcontact residentˆcare activities, including: -Dressing/bathing -Transferring (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Changing linens -Providing hygiene assistance -Changing briefs or assisting with toileting -Device care or use (central line, urinary catheter, feeding tube, tracheostomy) -Wound-care (any skin opening requiring a dressing) On 4/3/26 at 10:01 AM, RN #1 was observed performing wound care for Resident #5. The following infectionˆcontrol concerns were observed: -Upon entering the room, RN #1 performed hand hygiene and applied gloves; however, no gown was worn, as required under Enhanced Barrier Precautions for wound care. -RN #1 placed a barrier cover on the bed and placed supplies on top of it, then grabbed the bed remote and adjusted the bed while wearing the same gloves, contaminating them. -RN #1 removed Resident #5's sock and placed her foot on the barrier while her wound-care supplies were directly placed on Resident #5's bed. -RN #1 reached into her pocket, removed a pair of scissors, and used them to cut the dressing without sanitizing the scissors. -After removing the soiled dressing, RN #1 removed her gloves, performed hand hygiene, and applied clean gloves. She then placed her gloved hand on the footboard of the bed while reaching across the bed to obtain wound cleanser. -After completing the treatment, RN #1 disposed of contaminated supplies, removed her gloves, and reapplied gloves without performing hand hygiene. On 4/3/26 at 10:14 AM, RN #1 confirmed she should have applied proper PPE, sanitized her scissors before use, and performed appropriate hand hygiene.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record and policy review, SOM Appendix PP, and staff interview, it was determined the facility failed to educate residents on the risks and benefits of pneumococcal and influenza immunizations. This was true for 3 of 5 residents (#4, #8, and #36) whose records were reviewed for current immunizations. This deficient practice created the potential for harm if residents were not educated about the risk and benefits of receiving or declining the pneumococcal and influenza immunizations. Findings include:The facility's Pneumococcal Vaccine and Influenza Immunization policies, reviewed 12/22/25 documented:-Prior to administration of the influenza or pneumococcal vaccine, the person receiving the immunization, or his/her legal representative, will be provided with a copy of the CDC's current vaccine information statement relative to the vaccinations.-The vaccine information statements will be supplemented with visual presentations or oral explanations to assist vaccine recipients in understanding the benefits and potential side effects of the influenza or pneumococcal vaccines.-Individuals receiving the influenza or pneumococcal vaccine, or their legal representative, will be required to sign a consent form prior to the administration of the vaccine. The completed, signed, and dated record will be filed in the individual's medical record.-The resident's medical record will include documentation that the resident and/or the resident's representative were provided education regarding the benefits and potential side-effects of immunization, and that the resident received or did not receive the immunization due to medical contraindication or refusal.1. Resident #4 was readmitted to the facility on [DATE] with multiple diagnoses including muscle wasting and osteonecrosis (the death of bone tissue due to a temporary or permanent loss of blood supply, often leading to bone collapse and severe arthritis).A review of Resident #4's record did not document whether he was offered the opportunity to decline or accept the pneumococcal immunization based on education from staff discussing the risks and benefits.On 4/1/26 at 11:03 AM, the CRN stated there were no records on file related to educating Resident #4 on the risks or benefits of receiving the pneumococcal immunization.2. Resident #36 was admitted to the facility on [DATE] with multiple diagnoses including cancer and coronary artery disease (a heart condition caused by plaque buildup in the arteries that supply blood to the heart, restricting blood flow).A review of Resident #36?s record did not document whether he was offered the opportunity to decline or accept the pneumococcal immunization based on education from staff discussing the risks and benefits.On 4/1/26 at 11:04 AM, the CRN stated there were no records on file related to educating Resident #36 on the risks or benefits of receiving the pneumococcal immunization.3. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses including osteoarthritis (the most common chronic joint disease, characterized by the breakdown of cartilage, bone changes, and inflammation), protein-calorie malnutrition, and dementia.A review of Resident #8's record did not document she or her representative was offered the opportunity to decline or accept the influenza and pneumococcal immunizations based on education from staff discussing the risks and benefits.On 4/1/26 at 11:05 AM, the CRN stated there were no records on file related to educating Resident #8 on the risks or benefits of receiving the influenza and pneumococcal immunizations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record and policy review, and staff interview, it was determined the facility failed to document if the COVID-19 vaccine was offered to residents. This was true for 2 of 5 residents (#4 and #8) reviewed for COVID-19 vaccination. This deficient practice created the potential for harm when residents were not offered education related to the risks and benefits of receiving the COVID-19 vaccination. Findings include:The facility's COVID-19 Vaccination policy dated 12/11/25, documented the resident's medical record will include documentation of the following:-Education to the resident or resident representative regarding the risks, benefits, and potential side effects of the COVID-19 vaccine.-Each dose of the vaccine administered to the resident, or,-If the resident did not receive the COVID-19 vaccine due to medical contraindication or refusal.1. Resident #4 was readmitted to the facility on [DATE] with multiple diagnoses including muscle wasting and osteonecrosis.A review of Resident #4's record did not document if he was offered the opportunity to decline or accept the COVID-19 vaccination.On 4/1/26 at 11:07 AM, the CRN stated there were no records on file related to educating or offering the COVID-19 vaccine for Resident #4. 2. Resident #8 was admitted to the facility on [DATE] with multiple diagnoses including osteoarthritis, protein-calorie malnutrition, and dementia.A review of Resident #8's record did not document if she was offered the opportunity to decline or accept the COVID-19 vaccination.On 4/1/26 at 11:08 AM, the CRN stated there were no records on file related to educating or offering the COVID-19 vaccine for Resident #8.