STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145827	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
British Home, The	8700 West 31st Street Brookfield, IL 60513

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow therapeutic diet orders, failed to ensure nutritional supplements ordered by the Registered Dietician were provided during meals, and failed to monitor, assess, and document meal/nutritional intake of residents. This failure affected three residents (R1, R7, R28) in a sample of 20 residents reviewed for nutrition. These failures have the potential to affect 35 residents that receive oral intake at the facility. Findings include: 1.R7 is [AGE] years of age. Current diagnoses include but are not limited to Dementia, Weakness, History of Falling, Hypothyroidism, Chronic Obstructive Pulmonary Disease, Palliative Care, Gastro-esophageal Reflux Disease. R7's comprehensive assessment section C Cognitive Patterns, dated 05/11/2026, documents a BIMS (Brief Interview for Mental Status Score) of 13, which indicates R7 is cognitively intact. On 05/11/2026 at 11:17 am, R7 was asked about her meals. R7 said, When the food comes, they don't bring what I order even when I ask them for it, they never bring it back. On 05/12/2026 at 12:20 pm, R7 is alert and oriented, while in bed. R7 is in bed with the head of the bed elevated eating her lunch. R7 was served diced bite sized pieces of chicken, lo mein noodles, stir fry carrots and broccoli, chicken noodle soup, cranberry and apple juice. R7 ate approximately 10% of her lunch and drank all 6 ounces of cranberry juice. R7 said, I always ask for my ice cream and they never bring it. R7's diet ticket on her lunch tray has ice cream circled per her request. On 05/12/2026 at 12:57 pm, R7's physician orders document 04/07/2026 Magic cup with meals- 1 cup PO (by mouth) twice a day for nutritional supplement (provide with lunch and dinner). Frequency: BID (twice a day). R7's care plan documents- I am at nutritional risk for weight loss related to medications, medical conditions, varied po (by mouth) intakes, mechanically altered diet, and impaired mobility. H/O (History of) recent swallow and chewing issues/dental issues. Malnutrition per MNA (Mini Nutritional Assessment) signed by provider 1/14/26. A) Provide diet as prescribed: Regular, regular texture, thin liquids. Provide: Boost BID (twice a day) and Magic cup BID. Please honor my food preferences with diet regimen. Review of R7 weight loss documents the following: On 01/08/2026, the resident weighed 135 lbs. On 05/01/2026, the resident weighed 125 lbs (pounds) which is a -7.41% loss. On 05/12/2026 at 2:25 PM, V1 Administrator provided R7's MNA (Mini Nutritional Assessment), dated 1/14/26, which documents a screening score of 7, which indicates she is malnourished. (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	preferences.Policy Explanation and Compliance Guidelines2. Therapeutic diets, including mechanically altered diets where appropriate, will be based on the resident's individual needs as determined by the resident's assessment. Therapeutic diets may be considered in certain situations, such as, but not limited to:a. Inadequate nutritionb. Nutritional deficitsc. Weight lossd. Medical conditions such as diabetes, renal disease, or heart diseasee. Swallowing difficulty4. The reason for a therapeutic diet is to be documented in the medical record and/or indicated on the resident's comprehensive plan of care. All diet orders are to be communicated to the dietary department in accordance with facility procedures.5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed. 3.R1 was initially admitted to the facility on [DATE] and was readmitted on [DATE] after being hospitalized . R1's 4/6/2026 admission diagnoses included urinary tract infection, extended spectrum beta lactamase (ESBL) resistance, klebsiella pneumoniae, bacteremia, acute systolic congestive heart failure, hydronephrosis with renal and urethral calculous obstruction, muscle wasting and atrophy, atrial fibrillation, systolic congestive heart failure, toxic encephalopathy, dysphagia, difficulty walking, cognitive communication deficit, type two diabetes, chronic kidney disease stage two (mild), unsteadiness on feet, atherosclerotic heart disease, hyperlipidemia, gout, anemia, hypothyroidism, acute respiratory failure with hypoxia, essential tremor, urinary retention, essential hypertension, dysphagia, severe sepsis without septic shock, delirium due to known physiological condition, myocardial infarction, acute kidney failure, need for assistance with personal care, cognitive communication deficit, generalized muscle weakness. R1's Minimum Data Set (MDS), dated [DATE], included a Brief Interview of Mental Status (BIMS) of 9, indicating moderate cognitive impairment. MDS also indicated R1 had difficulty or pain with swallowing and needed assistance with eating set up and clean up. R1 had two pressure injuries and a weight loss of greater than five percent in the last month. R1's care plan, dated 4/6/2026, stated, I (R1) am at nutritional risk for weight loss related to medications, medical conditions, varied po intake, therapeutic diet, advanced age, mechanically altered diet, weight loss, pressure injuries and impaired mobility, plus swallow deficits. Goal was to maintain current weight plus/minus five percent times thirty days. Interventions include monitoring oral intake of food and fluids. On 5/13/2026 at 2:47 pm, V1 R1's weight obtained on 5/13/2026 at 1:08 PM was 196.6 pounds. On 5/11/2026 at 10:54 am, R1 was in the dining room reading the newspaper. R1 stated, I've been losing weight. Don't ask me how much. I haven't been trying to lose weight. I was 201 pounds. I was 231 pounds and at some point, I was as high as 260 pounds. On 5/13/2026 at 9:12 am, V3 (Assistant Director of Nursing) described the process when a resident loses weight. V10 (Dietician) reviews weights, confirms the weight is accurate, looks at resident intake, and considers possible supplements. V3 stated R1's most recent dietician note is 4/9/2026 and (Nutritional supplements) were ordered. V3 could not locate in the EHR where the nurses were documenting meal consumption. On 5/13/2026 at 10 am, V2 (Director of Nursing/DON) stated, I don't see where the nurses are documenting the percentage of meals being eaten. I will check with the nurses to see if they are documenting it somewhere else that we are not aware of. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/13/2026 at 10:26 am, V10 (Dietician) stated, A significant weight loss is 5% at one month, 7.5% at three months, or 10% at six months. If a resident has significant weight loss. I assess the root cause. (R1's) weight decrease from 201 pounds to197.4 pounds is a concern. I monitor (R1's) intake by going through the nurses notes to figure out what (R1's) intake was. The nurses document dietary intake in the interdisciplinary notes or the nurses notes. V3 (Assistant DON) was present and stated there is no documentation of percentage of meal consumed in the EHR. V10 stated, The nurses document, for example, appetite 75%, which is how I know how much the resident has consumed. V10 was asked what appetite 75% means. V10 stated, I am looking at the 5/12/2026 nurses note. That means (R1) ate 75% of lunch. I do not know what (R1) ate for breakfast or dinner. The nurses usually document at least one of (R1's) meals consumption. V10 and V3 stated there was no note for breakfast or dinner on 5/12/2026 and there was no documentation of appetite or meal consumption every day by nursing. V10 stated the only way V10 knows what residents are eating, is when V10 is present and sees what residents are eating at mealtime. V10 stated, Otherwise, I don't know what residents are eating. V10 stated, (R1) is declining. (R1) is starting to decline in cognition, so (R1's) weight loss is concerning. The risk of decreasing weight is malnutrition and bed sores and I know (R1) already has a wound. We don't know if (R1) is getting enough protein or calories because I don't know what (R1) is eating. V10 affirmed meal consumption should be documented within the EHR and leaders need to review weights and weight loss. We will be working on a plan of correction now. On 5/13/2026 at 12:25 pm, V2 (Director of Nursing/DON) stated, Percentage of meal consumption by residents is occasionally documented in the interdisciplinary notes in the electronic health record (EHR), otherwise it is not documented anywhere else. The concern is the facility needs documentation and proof residents are eating enough to maintain heathy recovery and promote wound healing. Because meal consumption is not being documented, the risks are malnutrition without a direct plan of action and resident specific risks such as residents with diabetes who could experience hypoglycemia. The Certified Nursing Assistants (CNA) are not documenting meal consumption. On 5/12/2026, the nurse documented appetite 75%. That may mean 75% of breakfast and lunch were consumed, but there is no identification of whether the nurse is documenting for breakfast or lunch. The morning nurse documents on the even numbered rooms. The evening nurse documents on the odd numbered rooms. (V3, Assistant DON) spoke to the CNAs. There was a change in the computer system some time ago and CNAs can no longer document meal consumption. It is important to know what residents are consuming nutritionally. On 5/13/2026 at 12:37 pm, V3 (Assistant Director of Nursing) stated, Certified Nursing Assistants (CNA) do not document meal consumption on any resident. It is not part of their charting. V3 stated, (V18, CNA) stated it is standardized that the CNAs cannot document meal consumption for any resident. It has been months that the CNAs have not been able to chart meal consumption for the residents. On 5/13/2026 at 12:42 am, V18 (Certified Nursing Assistant) stated, CNAs do not document meal consumption. Maybe a year ago the facility changed the documentation and removed that ability. The nurses ask at the end of the shift what each resident ate. They will say how much did they eat. I will say 50% for example. I assume that they mean lunch. On 5/13/2026 at 1:26 pm, V6 (Medical Director) stated, If meals are not eaten, it is noticed, but not a rule of thumb that it is documented. If we note plates have leftovers on them, the staff would document that. Other facilities document the percentage of meals eaten. This facility makes it more homelike. If a resident is not eating, the Certified Nursing Assistants (CNAs) should be documenting that. If the CNAs are not documenting, it is the nurses' responsibility. If nursing is not documenting (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the percentage of meals consumed, I would be concerned and if the meal is less than 50% eaten. If the amount of meal eaten is not documented, the weight loss becomes the guide that a resident is not eating. If you don't have nurses that are documenting, leadership needs guidelines that documentation should be done. The immediate indicator a resident is not eating could be dehydration, change in vital signs, decreased blood pressure or delirium. Review of R1's progress notes include on 5/13/2026 at 2:06 PM V19 (Nurse documented Appetite: 100% of breakfast, lunch. 1 bottle of ensure On 5/13/2026 at 7:18 PM V10 (Dietician) documented current body weight 196.6 pounds on 5/13/2026. Weight history: in 2 weeks, R1 had a 2.2% weight loss. In one month, R1 has been stable. In two months, R1 had a 7.8% weight loss. R1 is consuming about 75% of most meals per nursing notes. On 5/13/2026 at 7:21 PM V32 (Physician) documented in the plan daily weights. On 5/12/2026 at 2 PM V33 (nurse documented Appetite: 75%. On 5/11/2026 at 6:31PM V34 (physician) assessment and plan included daily weights. On 5/11/2026 at 4;06 PM V19 (Nurse) documented Appetite: 75%. On 5/11/2026 at 4;45 PM V34 (physician) assessment and plan included daily weights. On 5/10/2026 at 2:26 PM V35 documented Appetite: 75%. On 5/10/2026 at 6;31 PM V34 (physician) assessment and plan included daily weights. On 5/9/2026 at 3:08 PM v36 (Nurse) documented Appetite 100%. On 5/8/2026 at 2:44 PM V19 (Nurse) documented Appetite 75%. On 5/8/2025 at 11:42 PM V37 (Nurse Practitioner) assessment and plan included daily weights. On 5/7/2026 at 2:39 PM V19 (Nurse) documented Appetite 75%. There was no documentation provided by the facility which included the percentage of all three meals consumed on any given day. Facility Weight Monitoring policy (revised 2/11/2026) stated meal consumption information should be recorded.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure portion sizes were adequate, failed to ensure portion sizes were served according to the recipe, and failed to weigh food products to ensure correct serving sizes prior to serving in accordance with professional standards. These failures affect all 35 residents that consume food from the kitchen. Findings include: Facility census (5/11/2026) documents 37 residents reside in the facility. Facility nothing by mouth (NPO) list (undated) documents 2 residents do not consume oral nutrition. Facility menu (5/11/2026) documents the lunch meal is chicken noodle soup, Italian beef sandwich, roasted potato wedges, marinated mushrooms and peppers, and a peanut butter cookie. Recipe for the Italian beef sandwich (5/11/2026) documents, Serve 3 oz (ounce) slice of beef with a Side Cup of Hot Beef Broth for dipping. Portion according to serving size. A picture of the sandwich is on the recipe and appears like a beef sandwich on a long sub roll that occupies approximately half of the plate. There were several portions of beef that fill the roll to the degree which would not allow the roll to close. On 5/11/2026 at 11:21 am, V11 (Cook) and V13 (Cook) began to plate meals from the steamtable for the skilled rehab residents. Observed uniform pieces of sliced beef in the steam table in a beef broth. V11 and V13 were putting one to three slices of beef on a small roll. The roll appeared approximately 4 inches in length. V11 was unsure of the portion size of beef and explained the staff used to have the recipe available but V11 did not have the recipe for the beef. V11 showed surveyor the dietary spreadsheet which indicated the portion of beef was 0.5 each. V11 was unsure what was meant by the 0.5 each and referred surveyor to speak with V9 (Dietary Director). V13 prepared an Italian beef sandwich and placed one slice of beef on the roll. V13 was unsure the exact portion size that was to be used. V13 explained servings of meat are generally between two and four ounces of meat. V13 explained, The portion of meat every resident gets, yes, it varies by the resident. We sometimes don't put as much because then they will get scared and not eat as much. A lot of times they will ask for half orders. V11 and V13 affirmed the beef came pre-sliced in portions. V11 and V13 denied the cooks in the facility never weigh meat prior to serving. On 5/11/2026 at 11:34 am, V9 affirmed the cooks did not have access to the recipes because they hadn't been printed yet. V9 obtained the kitchen's scale from the Dietary Manager's office. A test plate was prepared by V13. 3 slices of beef were placed on the roll. V9 explained the beef was pre-packaged and each slice was about 1 ounce of beef. Observed V9 calibrate (zero) the scale. V9 removed the portion of beef and placed it on the scale. The scale read 1.9 ounces. Confirmed observation with V9. V9 affirmed the portion size should have been around three ounces and the amount served was not enough beef. V9 instructed V13, (V13) you need to be putting more (beef) on there (the sandwich). You need like double the amount of meat. V13 and V11 continued plating and did not weigh any of the meat portions during plating. V9, V11, and V13 did not replate or reweigh any of the food already prepared to ensure the correct portion of beef was served. On 5/11/2026 at 11:41 am, V10 (Registered Dietician) affirmed V10 is the consultant Dietician for the facility. V10 explained, Beef is the protein component of the lunch served. Protein is an essential nutrition as it helps with muscle healing and wound healing. If residents no not receive enough protein, they can experience muscle wasting or retention of fluids. V10 affirmed 1.9 ounces of beef served is way less than it is supposed to be. V10 affirmed the Dietary staff should be weighing meat products prior to serving to ensure the correct portion size is served. V10 observed V13 plating food for the residents in the skilled nursing facility. V13 was putting 3 slices of beef on the sandwiches and was not weighing the meat prior to making the sandwich. Confirmed observed with V10. V10 affirmed, Yes, (V13) should be weighing the meat and (V13) isn't. V10 reviewed the picture of the sandwich on the recipe, and affirmed the sandwiches being served have less beef and the roll is smaller than the picture. V10 described the picture on the recipe of the sandwich as taking up a lot of the plate, like at least a third. V10 confirmed the facility's sandwich did not look like the sandwich on (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the recipe. Facility policy titled, MEAL/TRAY ASSEMBLY PROCEDURES (Revised 1/2025), documents, Meal service is prompt and accurate to ensure temperatures and nutrient content of food is preserved. PROCEDURES: Ensures current diet extension is available and followed at each meal period . Checks meals for accuracy .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to label/store food items in accordance with professional standards, failed to discard expired or undated food products, failed to clean non-food surfaces to prevent the build-up of grease, failed to repair walls of the kitchen to ensure the wall was able to be cleaned in accordance with professional standards, and failed to complete regular quality assurance monitoring of sanitization procedures in the kitchen. These failures affected all 35 residents that consume nutrition from the kitchen. Findings include: Facility census (5/11/2026) documents 37 residents reside in the facility. Facility nothing by mouth (NPO) list (undated) documents 2 residents do not consume oral nutrition.On 05/11/2026 at 9:18 am, completed initial tour of the kitchen with V9 (Dining Director). V9 affirmed V9 is the Dietary Manager for the skilled nursing facility. Observed crushed red pepper container in the food preparation area, with a good by date of 8/8/2025. The taco seasoning was unlabeled. V9 confirmed these observations. V9 stated, Yeah, you can see how often we don't use the red pepper flakes. The taco seasoning looks like it washed off or something. We will have to relabel it. Observed a pitcher of an unidentifiable tan, milky colored liquid, that separated into a dark brown and light brown liquid. There was no label/date on the liquid. Confirmed observation with V9. V9 was unsure what the liquid was or when it was made. V9 smelled the liquid and explained it smelled like milk/dairy with a hint of cinnamon. V9 affirmed the liquid should have been dated. V9 dumped the liquid into the sink within the food preparation area. Observed the filters over the ovens, range, griddle and deep fryer. The filters hood and wall behind the appliances had think large, dried grease stains/droppings approximately 60% of the wall and the filters. Confirmed observations with V9. V9 explained, That is grease, it is just hard to get to. There's a bit of grease build up and splatters. If it is on the filters that is okay, it means the ventilation is doing its job. Observed the freezer with V9. Observed plastic bags containing deli-style ham with a use by date of 4/30/2026. V9 confirmed this observation, stated, Yeah these bags of ham are past date, I'll address it now. Observed a bag of deli-style turkey slices in the freezer that was undated and unlabeled. V9 confirmed this observation. V9 affirmed the turkey should be dated and labeled so staff know when it can be used by. V9 removed the turkey from the freezer. Observed a hole in the wall of the kitchen next to the ice machine, that was approximately six by six inches. V9 stated, I don't know how long that hole has been there or what exactly was the reason for the hole. I think that hole is from when we had a fly infestation. Maintenance is aware of it, yes, they were the ones that cut a hole in the wall. Observed V12 (Kitchen Utility) in the kitchen area cleaning. V12 had a visible beard/facial hair and was not wearing a facial hair restraint. V9 confirmed this observation. V9 stated, (V12) should be wearing a beard net. V9 instructed V12 to put on a facial hair restraint.On 5/11/2026 at 11:08 am, observed V12 utilize the dish machine. V12 completed the quality assurance process for the dish machine using a test strip. V12 accessed the Test Strip Results log for 5/2026 and affirmed there was no test strip placed for 5/10/2026, indicating the testing was not completed. The other sanitation quality assurance logs including the dish machine temperature log (5/2026), pot-sink temperature sanitizer log (5/2026), red bucket log (5/2026), sanitizer solution from dispenser log (5/2026) had no data collected for 5/10/2026. Confirmed these observations with V12. V12 stated the testing was not completed because V12 did not work on 5/10/2026.On 5/11/2026 at 11:12 am, the sanitation quality assurance logs (5/2026) were reviewed with V10 (Registered Dietician). V10 confirmed there was no data collected for 5/10/2026. V10 stated the staff should be monitoring sanitizer and temp levels. V10 affirmed the monitoring is important because it makes sure bacteria and viruses are killed and dishes/utensils are sanitized properly to prevent food-borne illness.On 5/11/2026 at 12:15 pm, kitchen tour completed with V5 (Maintenance Director). Observed the six-by-six-inch hole in the wall by the ice machine. V5 operated a flashlight and shined the flashlight into the hole. Observed a second hole inside the wall of the first hole that was approximately 4 inches (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	by 3 inches. V5 confirmed these observations and explained the hole was caused by electrical work that was completed by electricians a while ago. V5 could not recall exactly when the work was completed. V5 affirmed the wall was not patched after the work was completed, and the second hole inside was caused by the saw going too far into the wall and damaged the second wall. V5 observed the grease over the walls and appliances of the food preparation area/appliances and explained, I only complete maintenance on the hood itself with the ventilation company. The filers and the walls and such are maintained by the Dietary staff. Observed a puddle of yellow tinged grease approximately 7 inches in length near the griddle area. Confirmed observation with V5. V5 stated, Yeah, that is grease. It needs to be cleaned up. V5 asked V9, how often should the grease be cleaned on the filters?, V9 replied, We clean the filters like every 2 weeks. V5 confirmed grease can be a fire hazard.Facility policy titled, CLEANING OF FOOD AND NONFOOD CONTACT SURFACES (1/2025) documents, The food-contact surfaces of all cooking equipment shall be kept free of encrusted grease deposits and other accumulated soil. Nonfood contact surfaces of utensils and equipment must be made of materials that are safe, corrosion resistant, nonabsorbent, smooth and easily cleanable, and maintained in good condition.Nonfood contact surfaces of equipment, such as handles on reach-in units, sides of sinks, gaskets on cooler and freezer doors, tracks of sliding doors on equipment, and the exterior of ice machines, shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris.The United Stated Food and Drug Administration Food Code (2022) documents, (A) Except when PACKAGING FOOD using a REDUCED OXYGEN PACKAGING method as specified under S 3-502.12, and except as specified in (E) and (F) of this section, refrigerated, READY-TO-EAT, TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and held in a FOOD ESTABLISHMENT for more than 24 hours shall be clearly marked to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded when held at a temperature of 5 C (41 F) or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. (A) A FOOD specified in 3-501.17(A) or (B) shall be discarded if it: (1) Exceeds the temperature and time combination specified in 3-501.17(A), except time that the product is frozen; (2) Is in a container or PACKAGE that does not bear a date or day; or (3) Is inappropriately marked with a date or day that exceeds a temperature and time combination. A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES . Non-FOOD-CONTACT SURFACES shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance . (A) Utility service lines and pipes may not be unnecessarily exposed. (B) Exposed utility service lines and pipes shall be installed so they do not obstruct or prevent cleaning of the floors, walls, or ceilings. contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES.Walls and ceilings that are of smooth construction, nonabsorbent, and in good repair can be easily and effectively cleaned. Special requirements related to the attachment of accessories and exposure of wall and ceiling studs, joists, and rafters are intended to ensure the cleanability of these surfaces.

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on observation, interview, and record review, the facility failed to complete an accurate facility assessment, failed to ensure all requirements of the facility assessment were reviewed and addressed, failed to ensure residents/their representatives were involved in the completion of the facility assessment, failed to identify any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services, failed to consider specific staffing needs for each resident unit and shift in the facility, and failed to identify utilized agency nursing contracts to provide agency nursing staffing services during normal operations. These failures has the potential to affect all 37 residents that reside within the facility.Findings include: Facility census (5/14/2026) documents 37 residents reside in the facility. On 5/11/2026 at 9:45 am, V1 (Administrator) affirmed the facility had 2 floors/units during the entrance conference. V1 affirmed the units were both mainly short-term rehab but the upstairs unit was a locked unit that required a keycode to leave the unit. V1 identified the facility utilizes third party contracts/vendors for Dietary department services, Housekeeping services, Maintenance services, Rehab services, Minimum Data Set completion/care plan development, and licensed nursing staff/certified nursing assistants. V1 affirmed the facility utilizes 4 staffing agencies to staff the facility with licensed nurses and certified nursing assistants. Record review of facility assessment (reviewed 2/11/2026) documents the following: A) Racial/ethnic make-up of resident needs is not identified, documents all races/ethnicities are represented. The assessment does not identify the cultural or ethnic needs or services residents require or the facility is providing, including food/nutrition services and activities. Disability, socioeconomic status, preferred language, health literacy, other factors that affect access to care and health outcomes related to health equity is blank B) Facility resources (staff) does not identify staffing needs per shift and per unit. C) The utilization of contract licensed nursing services and certified nursing assistants provided in the facility is not identified. Additionally, the staffing agencies utilized for nursing staffing are not identified on the facility assessment. D) Residents/their representatives were not included in the development of the facility assessment. E) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. On 5/13/2026 at 11:42 am, V1 (Administrator) affirmed V1 last reviewed the facility assessment with the governing body in February 2026. V1 explained the purpose of the facility assessment is to provide the most up-to-date information about the facility, and determine what resources are needed to adequately care for the residents. V1 accessed the facility assessment on the computer. Reviewed facility assessment with V1. V1 explained the facility has a diverse population and consists of African American residents, Asian American residents, residents that are of Latin decent. V1 affirmed the facility celebrates diversity and had completed events like Chanukah, Cinco de Mayo, Greek Easter, Chinese New Year, Kwanzaa, Mexican Mother's Day and other holidays depending on census and resident needs. V1 reviewed the facility assessment and affirmed these ethnic needs were not identified or addressed within the facility assessment. V1 affirmed the staffing for the facility is 1 nurse per floor with around 2 certified nursing assistants (CNAs) on each shift. V1 reviewed the facility assessment and affirmed the staffing is not identified by unit and shift needs. V1 stated, I must have misread that (the requirement to consider specific staffing needs for each resident unit per shift in the facility and adjust as necessary based on changes to its resident population). V1 affirmed the facility uses agency staffing to supplement licensed nursing staff and CNAs. V1 reviewed the assessment and confirmed these agencies are not identified on the assessment. V1 stated, I am putting it now under the HVAC contract. V1 explained when there are variations in the staffing needs (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of the facility, the facility uses agency staff to cover those needs. If unable to get agency staff, V1 would get staff from other sister facilities to help cover the staffing needs. V1 affirmed these contingency staffing plans were not identified in the facility assessment. V1 reviewed the signatures of all who participated in the development of the facility assessment. V1 confirmed the resident representative/family members portion was blank. V1 stated, We had a resident participate, but we did not include any family members. Facility policy titled, Facility Assessment (Revised 2/11/2026) documents, This facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. 1. The facility assessment will, at a minimum, address or include: . v. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. b. The facility's resources, including but not limited to; . v. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies . In conducting the facility assessment, the facility will ensure: . iii. The facility must also solicit and consider input received from residents, resident representatives, and family members. 3. The facility will use the facility assessment to: a) Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. b) Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. c) Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population. d) Develop and maintain a plan to maximize recruitment and retention of direct care staff. e) Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. 4. The Administrator is responsible for ensuring the completion of the facility assessment and maintaining all documents that pertain to the assessment. The Administrator serves as the leader of the facility assessment process, or may designate someone to lead the process . 8. Based on the assessment of resident characteristics, the facility will determine what care/services, staff competencies, and staffing needs are required to meet the needs of our residents. This will be compared to the specific care/services, including by contract, and training that we provide. Action plans will be implemented as necessary . 10. The facility assessment will be reviewed and updated as necessary and at least annually, whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. Additionally, the facility will consider specific staffing needs for each shift (e.g., day, evening, night, weekend shifts) and for each resident unit in the facility based on changes to resident population. Any changes to the assessment will be documented, along with a revision history.

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F 0923 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough outside ventilation via a window or mechanical ventilation, or both. Based on observation, interview, and record review, the facility failed to ensure adequate ventilation of steam released above the dish machine which caused water damage and degradation of the ceiling tiles above the dish machine/dishwashing area. These failures have the potential to affect all 35 residents that consume food from the kitchen. Findings include: Facility census (5/11/2026) documents 37 residents reside in the facility. Facility nothing by mouth (NPO) list (undated) documents 2 residents do not consume oral nutrition.On 5/11/2026 at 11:08 am, observed V12 utilize the dish machine. V12 completed the quality assurance process for the dish machine using a test strip. Observable steam was produced above the dish machine which rose and hit the ceiling tiles above the dish machine. The ceiling above the dish machine was bowed, peeling and had yellow foam/insulation hanging from the ceiling. The ceiling around the ventilation duct from the machine left approximately a 4-inch rectangular hole the length of the duct and was in disrepair. Confirmed observation with V12 (Kitchen Utility). V12 stated, The ceiling gets like that (warped); it's the steam. On 5/11/2026 at 12:15 pm, kitchen tour completed with V5 (Maintenance Director). Observed the warped ceiling above the dish machine with V5. V5 affirmed the ceiling tiles were in disrepair, and the yellow foam insulation was exposed was from the degradation of the ceiling tiles. V5 affirmed the insulation within the tiles was fire-rated to prevent fire damage. V5 explained the degradation of the ceiling tiles was caused by inadequate ventilation of steam over from the dish machine. V5 recalled repeatedly having to exchange and repair ceiling tiles in that area due to the steam. V5 affirmed the ceiling tiles damaged can cause issues if the insulation falls into the area of the clean dishes. Facility policy titled, Building Ventilation (Updated 12/01/2025) documents, The purpose of this policy is to ensure proper throughout the facility in order to maintain a safe, comfortable, and healthy environment for residents, staff, and visitors. Proper ventilation helps reduce odors, airborne contaminants, humidity. and heat buildup while supporting indoor air quality standards. This policy applies to all facility areas including resident rooms, common areas, offices, kitchens, laundry rooms, restrooms, maintenance areas, and storage spaces. PROCEDURES 1. General Ventilation Requirements All occupied areas shall have adequate airflow and ventilation .Exhaust systems shall be used in bathrooms, kitchens, and in laundry areas to reduce moisture and odors . Staff shall monitor for excessive heat, humidity, odors, dust, or poor air circulation . Department supervisors shall ensure ventilation concerns are reported promptly .Facility policy titled, Equipment Maintenance Program (revised 1/2026) documents, Proper maintenance of the physical plant and all equipment in the Department is the responsibility of the Director in cooperation with the Maintenance Department and subject to policies and procedures set forth by the facility's administration. The Director is directed or has knowledge of all routine, periodic, and critical maintenance work done to the physical plant or equipment in the Department. Jointly with the Maintenance Department, plans in writing a program of preventive maintenance for all Food and Nutrition equipment requiring regular maintenance. Cover: o Regular inspection/maintenance by maintenance department, o Periodic servicing by service companies contracted through the Maintenance Department. Reviews the effectiveness of the Preventive Maintenance program annually with the Maintenance Department, and document meetings .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based upon observation, interview, and record review, the facility failed to ensure that the correct date was documented on resident dry erase boards and failed to ensure call lights were within reach for six of 20 residents (R15, R25, R31, R33, R34, R43) in the sample reviewed for accommodation of needs. Findings include: 1.R15's diagnoses include dementia and weakness. R15's (4/29/26) functional assessment affirms the resident requires partial/moderate assistance with rolling left and right. On 5/11/26 at 11:42am, R15 was observed lying in bed leaning towards the (right) side rail, however, the call light was dangling from the (left) side rail - out of reach. R15 attempted to locate the call light, however was unable to do so. On 5/11/26 at 11:47am, V15 (Registered Nurse) entered the room and stated, It (call light) should be within his reach. V15 then moved the call light near R15's (left) shoulder, however, failed to secure the call light and/or place it within reach. 2.R31's face sheet documents diagnoses that include but are not limited to cognitive communication deficit, unsteadiness on feet, need for assistance with personal care, and muscle weakness. R31's BIMs (Brief Interview for Mental Status), dated 4/01/26, is 11, which indicates R31's cognition is moderately impaired. R31's care plan, dated 5/12/26, documents, Cognitive Loss/Dementia: I (R31) have cognitive loss deficits related to my short-term memory problems as evidenced by my inability to recall three words in a short period of time even with cues. Dx: vascular dementia. I (R31) would like to maintain and/or improve my current level of cognitive functioning as evidenced by showing orientation to significant persons like family and/or staff members and I would like to remain mentally active through next review. On 5/11/26 at 10:34am, a dry erase board was hanging on the wall in R31's room that documents, Today is Friday May 8th 2026. R31 was asked what the date was today. R31 replied, The day is Monday. The actual date, well. ummm. It's not the 8th like the board says. That board is good for someone like me because things get to be the same every day. 3.R34's face sheet documents diagnoses that include but are not limited to insomnia, cellulitis of left lower limb, and bacteremia. R34's BIMs (Brief Interview for Mental Status), dated 3/09/26, is 14, which indicates R34 is cognitively intact. R34's care plan, dated 5/12/26, documents, I (R44) am HOH (hard of hearing). On 5/11/26 at 10:45am, a dry erase board was hanging on the wall in R34's room that documents, (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Today is Thursday, May 7, 2026. R34 was asked what the date was today. R34 looked behind R34 at the dry erase board and replied, Well, I don't think it's Thursday. Sunday?? No, it's Monday. Don't ask me who the president is because I know who he is, and I just don't want to say his name. I really like that they have that (dry erase board) up, and they do at times fix the date, but not all the time. I am not too concerned about the staff being right because I know most of them (staff). No, I do like the board with the date. I look at it (dry erase board) a lot. 4.R25's face sheet documents diagnoses that include but are not limited to cognitive communication deficit and muscle weakness. R25's BIMs (Brief Interview for Mental Status), dated 4/16/26, is 15, which indicates R25 is cognitively intact. R25's care plan, dated 5/08/26, documents, Resident (R25) has hearing deficits uses left ear amplifier. Son brought in new hearing aids. Please establish meanings of non-verbal cues with me. On 5/11/26 at 10:56am, a dry erase board was hanging on the wall in R25's room that documents, Today is May 7, 2026. R25 was asked what the date was today, R25 replied, Oh honey. They all run together. R25 looked at the dry erase board and saids, Oh it's the 7th (5/7/26). Anyways, can I get a pain pill for my neck? 5.R33's face sheet documents diagnoses that include but are not limited to cognitive communication development, osteomyelitis of vertebra, sacral and sacrococcygeal region. R33's BIMs (Brief Interview for Mental Status), dated 5/03/26, is 14, which indicates R33 is cognitively intact. On 5/11/26 at 11:14am, a dry erase board was hanging on the wall in R33's room that documents, Today is Thursday, May 4, 2026. R33 was asked what the date was today. R33 replied, Well, that's a question that I don't have the answer to. It's 2026. I do wish they (staff) would remember to change the date every day, but they do have other important stuff they're doing. 6.R43's face sheet documents an admission date of 4/29/26. R43's face sheet does not document R43's diagnoses nor does R43's EMR (electronic medical record). R43's BIMs (Brief Interview for Mental Status), dated 5/5/26, is 10, which indicates R43's cognition is moderately impaired. R43's care plan, dated 4/30/26, documents, Cognitive Loss/Dementia: I (R43) have cognitive loss deficits related to my short-term memory problems as evidenced by my inability to recall three words in a short period of time even with cues. I (R43) would like to maintain and/or improve my current level of cognitive functioning as evidenced by showing orientation to significant persons like family and/or staff members and I would like to remain mentally active through next review. R43's care plan, dated 4/30/26, documents, Resident (R43) has impaired functional abilities. Assist with functional abilities ambulation, stairs, transfer, bed mobility, set up, and toileting. On 5/11/26 at 11:22am, R43's call light was observed behind R43, hanging over R43's table, not within reach. R43 said, Hmmm. I'm not sure where my light is at to get help form the nurses. Well, I (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	don't always need help, but sometimes I do. Yes, I do need it (call light). On 5/11/26 at 11:25am, V18 (Certified Nursing Assistant/CNA) said, I did not realize I did not put her call light back. I just got her back to bed a few minutes ago. No, she cannot reach it (call light). V18 took the call light and put it within reach to R43. V18 said, We're supposed to change the date and put the names of the staff working that day every morning. The CNA or the nurse usually changes it. Got a little busy today so some of them (dry erase boards with date) didn't get changed. On 5/13/26 at 11:50am, V2 (Director of Nursing/DON) said, Call lights should be within reach and available to the resident so they don't fall out of bed and get care if needed. The boards are supposed to have the correct date on them as a reminder to the residents. It's (dry erase boards with the date) to keep the residents alert and oriented. Some (residents) are forgetful, and some have dementia. Record review of facility policy titled, Call Lights: Accessibility and Timely Response, dated 2/11/26, documents, Policy: The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside, toilet, and bathing facility to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response. Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure that drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles. This failure has the potential to affect all 21 residents residing on the second floor reviewed for labeling of medications and biologicals.On 5/13/2026 at 10:30 am, surveyor inspected the 2nd floor medication storage room with V22, LPN (Licensed Practical Nurse). In the inside door of the refrigerator, one multi-dose vial of Tuberculin 5T/0.1 ml (milliliters), stored in the original packaging box, was opened and not dated. V22 (LPN) affirmed there was no open date on the Tuberculin vial. V22 (LPN) stated generally Tuberculin is good for 45 days and then discarded. On 05/13/2026 at 1:59 pm, V2 Director of Nursing (DON) was asked about labeling of medications. V2 (DON) stated, Medications need to be dated with a use by date, so we know how long the medication is effective for. Review of the facility's Medication Storage Policy, dated 2/11/26, documents, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medication rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security. Review of the Symbria Rx Services Medication Storage Policy in The Facility ID1: Storage of Medications, dated July 2024, documents, Expiration Dating (Beyond-use dating) section D. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1) The nurse shall place a date opened sticker on the medication (if dedicated area not on label/container) and enter the date opened and the new date of expiration (NOTE: the best stickers to affix contain both a date opened and expiration notation line). The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating.

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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 interview and record review, the facility failed to ensure the Advance Directives care plan was congruent with the POLST (Practitioner Order for Life-Sustaining Treatment) and/or Physician Orders for one of 20 residents (R15) in the sample reviewed for resident rights. Findings include:R15's ([DATE]) POLST states NO CPR (Cardiopulmonary Resuscitation): Do Not Attempt Resuscitation.R15's ([DATE]) Physician Order states Resuscitate: No; DNR (Do Not Resuscitate) for both Pre-Arrest Emergency & Full-Arrest Emergency. R15's ([DATE]) care plan states CATEGORY: Social Service. Resident has chosen to not make any Advance Directives: FULL CODE. R15's Advance Directives care plan was initiated on [DATE] - the same date physician orders were received for Advance Directives.On [DATE] at 3:19pm, V3 (Assistant Director of Nursing) reviewed R15's ([DATE]) POLST and stated The POLST says no CPR do not attempt resuscitation. V3 was asked about R15's code status per Physician Orders. V3 responded, It says DNR. V3 was asked if resident code status is on the care plan. V3 replied, I don't think that's actually something they put in the care plan. V3 subsequently accessed R15's care plan and stated, It does say he has chosen to not make any directives: Full Code. That is not accurate, due to the POLST or orders that we have on file. The care plan is not up to date. V3 was asked why Social Service documents code status on the care plan. V3 responded, She's (Social Service) the one that actually does the POLST with the family and reviews it at the care conference.The ([DATE]) residents' rights policy regarding treatment and advance directives states upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff. Decisions regarding advance directives and treatment will be periodically reviewed as part of the comprehensive care planning process, the existing care instructions and whether the resident wishes to change or continue these instructions. Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated to the interdisciplinary team and staff responsible for the resident's care.

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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. Based on interview and record review, the facility failed to refer one resident (R4) with a possible serious mental disorder for Screening and Resident Review to the appropriate state-designated authority for further assessment as required. This failure affected one resident (R4) reviewed for pre-admission screening in the sample list of 37 residents.Findings include:R4's face sheet documents an admission date of 2/23/26 and diagnosis that includes but is not limited to bipolar disorder.R4's BIMs (Brief Interview for Mental Status) score, dated 3/26/26, is 15 which indicates R4 is cognitively intact.R4's care plan, dated 3/4/26, documents, At risk for changes in mood due to diagnosis of Bipolar.R4's physician order, start date 2/23/26, documents, Trazadone 200mg by mouth every night for bipolar disorder.On 5/13/26 at 1:12pm, V25 (Medical Records) said, Yes, I take care of the PASARRs (Pre-admission Screening and Resident Review) for the facility. (R4's) PASARR was done prior to coming here and her bipolar diagnosis was added later, after admission. Yes, a PASARR II should have been initiated after the bipolar diagnosis.Record review of R4's Notice of PASRR Level I Screen Outcome, dated 2/18/26, documents, PASRR Level I Determination: No Level II Required - No SMI/ID/RC.On 5/13/26 at 2:55pm, V25 (Medical Records) said, PASARR IIs are initiated when a resident has a mental health or intellectual disability. Other services may need to be provided for these residents. I initiated a PASARR II for (R4) today (5/13/26).On 5/13/26 at 3:45, V1 (Administrator) stated, The breakdown occurred (reason for R4's PASARR II not being completed) because the psych provider saw (R4) after the initial PASARR was completed, diagnosed (R4) with bipolar disease, but never notified us (facility) so that a new screening can be done.Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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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. Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) care to one of 20 dependent residents (R16) in the sample reviewed for quality of life.Findings include:R16's (3/31/26) BIMS (Brief Interview Mental Status) determined a score of 14 (cognition intact).R16's (3/31/26) functional assessment affirms resident is dependent on staff for toileting and personal hygiene.On 5/11/26 at 11:08am, a strong urine odor was noted while interviewing R16. R16 was asked when R16's incontinence brief was last changed. R16 stated, Yesterday, I haven't seen her (staff) yet. I'll take that back they did change me, I just forgot. R16 was asked if R16's incontinence brief was wet. R16 responded, A little bit. Long, thick hairs were observed on R16's upper lip and chin. R16 was asked about concerns with R16's long facial hair. R16 replied, It's hard to get an appointment to take care of it because there's only one beautician here (facility). On 5/11/26 at 11:15am, V17 (Certified Nursing Assistant) affirmed she's assigned to R16. V17 was asked when R16's incontinence brief was last checked and/or changed. V17 stated, This morning when I came in around 8:00. V17 was asked when incontinent residents should be checked and/or changed. V17 responded, Normally I try to change them three to four times before I go. V17 inspected R16's incontinence brief. The front of R16's brief appeared saturated, and the lines were blue (indicating the brief was wet). V17 subsequently removed R16's brief, which was saturated with urine. Upon further inspection, R16's toenails were noted to be thick, long, and broken. V17 was asked about the appearance of R16's toenails. V17 replied, Long. Thick dry scaly skin was observed on both of R16's shins. V17 was asked about the appearance of R16's skin on lower extremities. V17 stated, A little bit ashy and dry, and proceeded to apply lotion. On 5/12/26 at 12:45pm, V22 (LPN/Licensed Practical Nurse) affirmed he's assigned to R16. V22 was asked about concerns with R16's facial hair. V22 subsequently inspected the resident and stated, Well, she needs that taken care of, its long hair. V22 was asked about the appearance of R16's toenails. V22 replied, The toenails are long and dry. V22 was asked if R16's toenails were also thick. V22 stated, Yes ma'am she needs to be added to the podiatry list. The ADL policy (reviewed 2/11/26) states care and services will be provided for the following activities of daily living: grooming, toileting. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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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. Based on observation, interview, and record review, the facility failed to ensure that hospice orders/hospice care plan was accessible to staff, failed to identify resident change in condition, failed to notify the physician of change in condition timely, failed to document an accurate physical assessment and failed to obtain physician orders for two of 20 residents (R16, R28) in the sample reviewed for quality of care.Findings include: 1.R16's diagnoses include the following: eye abnormalities: ectropion (a condition where eyelid, typically the lower lid, turns outward and sags away from the eye, exposing the inner eyelid surface) of unspecified eye and presbyopia (age-related loss of eye's ability to focus on close objects). R16's (3/31/26) BIMS (Brief Interview Mental Status) determined a score of 14 (cognition intact). On 5/11/26 at 11:08am, both of R16's lower eyelids were red, and notably swollen. Yellow crust was also observed on R16's bilateral lower eyelashes. Surveyor inquired about R16's eyes R16 stated, It's kind of an inflammation. On 5/11/26 at 11:15am, V17 was asked about concerns with R16's eyes. V17 (Certified Nursing Assistant) stated. I think that's just the color of her eyes. On 5/11/26 at 12:11pm, V15 (Registered Nurse) affirmed she's assigned to R16. V15 was asked about R16's eyes. V15 replied, She gets red eyes a lot, the conjunctiva (a thin, clear, mucous membrane that lines the inner eyelids and covers the white part of the eye). V15 reviewed R16's EMR (Electronic Medical Record) and stated, She does have issues like presbyopia. V15 was asked if any medications and/or treatments were prescribed for R16's eyes. V15 responded, No, when the doctor comes, I'll have them take a look at her. V15 was asked about the current appearance of R16's eyes. V15 subsequently entered the room and stated, It's a little red on the bottom lids and crust a little bit on the corners. R16 proceeded to touch her right eye. V15 responded, She's picking at it, does your eye itch? R16 nodded her head yes. R16's (5/11/26) progress note states 3:19pm, resident is alert to self, has red eyes referring to MD (Medical Doctor) when rounding. [documentation excludes lower eyelid redness/swelling/yellow crust, itching, vital signs, physician notification, and/or orders received]. On 5/12/26 at 12:00pm, no additional documentation regarding R16's change in condition was found in the progress notes. [An entry was created by V34/Physician on 5/11/26 at 8:03pm, however nothing was documented – the entry was blank]. On 5/12/26 at 12:41pm, R16's lower eye lids were notably red and swollen. A yellow crusty substance was also observed on R16's bilateral lower eyelashes. R16 was asked how R16's eyes feel. R16 responded, Gritty, and affirmed they were also itchy. R16 was asks if R16 was seen by the physician yesterday. R16 replied, No, I don't think so. R16 was asked if medications were prescribed for R16's eyes. R16 stated, I don't think it's been ordered. On 5/12/26 at 12:43pm, V22 (Licensed Practical Nurse) affirmed he's assigned to R16. V22 was asked if R16 is prescribed eye medication. V22 stated, She's just getting regular eye drops. V22 subsequently accessed R16's EMR and added, Just the refresh liquid gel eye drops. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/12/26 at 12:45pm, V22 assessed R16's eyes and stated, I see that she has, sometimes they are a little crusted with like eye boogers. V22 was asked what crusted eyes and eye boogers are indicative of. V22 responded, An infection, an eye infection. On 5/12/26 at 12:52pm, V22 was asked if R16 was seen by the provider (Physician or NP) yesterday or today. V22 accessed R16's progress notes and stated, I don't see a note, it's nothing from the physician. Shedoesn't have a note here yet. On 5/12/26 at 1:49pm, V6 (Medical Director) was asked about staff requirement for resident change in condition. V6 (Medical Director) stated, We expect the CNAs (Certified Nursing Assistants) to let the Nurses know if there's a problem and expect the Nurses to inspect them (residents). We also have the NP (Nurse Practitioner) who is here Monday through Friday (9am to 1pm). The NP can assess them during the hours they are onsite but during the hours they (NP) are not onsite, they would call the Physician to relay concerns. V6 was asked about potential harm to R16 if eye abnormalities (discharge, redness, inflammation) are not addressed. V6 responded, If it's an infection and it's not addressed on time, then there's a risk for worsening condition. If this is a chronic condition this would be in the practitioner's note. R16's (5/11/26) progress notes (received on 5/12/26 at approximately 3:00pm) were timestamped 20:03 (8:03pm) and include HEENT (Head, Eyes, Ears, Nose, Throat): MMM (Moist Mucous Membranes), no pharyngeal exudates, no JVD (Jugular Vein Distension). The entire entry was also noted to be redacted (each entry was crossed out). The 5/11/26 (8:03pm) documentation was modified by V34 (Physician) on 5/12/26 at 2:17pm. The (2/11/25) notification of changes policy states the facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include: Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. Circumstances that require a need to alter treatment. 2.R28's face sheet documents an admission date of 6/20/2025, with diagnoses that include but are not limited to fibromyalgia, cervical region, encounter for palliative care, adjustment disorder with mixed anxiety and depressed mood, osteoarthritis, personal history of urinary (tract) infections, and severe protein-calorie malnutrition. R28's comprehensive assessment section C Cognitive Patterns, dated 04/22/2026, documents a BIMS (Brief Interview for Mental Status) score of 11, which indicates R28 has moderate cognitive impairment. On 5/11/2026 at 9:45 am, R28 was asleep in bed, with head of bed raised with oxygen at 4 liters per nasal canula. Reviewed R28's hospice binder which did not have hospice standing orders nor hospice care plan. R28's plan of care in the electronic records system (Care Plan Type: MEDREC) reviewed on 5/11/2026 at 1:30 pm documents care interventions and oxygen therapy were excluded. On 5/12/26 at 9:50am, V3 (ADON/Assistant Director of Nursing) was asked if oxygen was ordered for R28. V3, ADON (Assistant Director of Nursing), subsequently reviewed R28's EMR (Electronic Medical (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Records) and hospice binder then stated, The hospice standing orders and hospice care plan should be on the hospice binder, and they are not here. Let me call and check with the hospice group taking care of her and I will get back to you. R28's plan of care provided to the surveyor on 5/12/2026 at 10:41 am by email from V3 (ADON) indicates resident is on hospice in the electronic records system and noted oxygen therapy was not identified in the care plan. R28's plan of care plan sent and dated 5/12/2026 at 10:41 am documents, Category 200: Hospice (G) Resident will receive care and support services by nursing and coordinate all care needs with hospice to meet and maintain a maximum comfort level through next reviews. These interventions were dated 2/03/2026. There was no mention of interventions for oxygen therapy. On 5/13/2026 at 11:30 AM, reviewed R28's hospice binder and the resident's hospice care plan and physician order were not in the hospice binder. Review of the facility's Coordination of Hospice Services, dated 1/10/2025, documents, The facility will coordinate and provide care in cooperation with hospice staff, in order to promote the resident's highest practicable, physical, mental, and psychosocial well being. Review of the facility's contract with R28's hospice provider, dated 8/2/2023, documents, The Hospice Plan of Care is maintained for each individual and reflects hospice philosophy, policies, and practice related to an individualized hospice patient's/family needs, with input provided by facility staff. The Hospice Plan of Care will be integrated with the facility's Plan of Care for that patient. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must provide services to keep your physical and mental health, at their highest practical levels.

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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, interview, and record review, the facility failed to ensure a LALM (Low Air Loss Mattress) was turned on while in use, failed to identify a skin integrity impairment, failed to implement preventive interventions, failed to notify the physician/nurse practitioner of change in skin condition, failed to document a wound assessment for two days and administered dressings without physician orders, and failed to obtain treatment orders for two of 20 residents (R15, R25) in the sample reviewed for pressure ulcers. These failures resulted in R25's right heel wound identified by surveyor on 5/11/26. Findings Include: 1.R25's medical history is significant for colon cancer with liver metastasis, congestive heart failure, peripheral vascular disease, falls with compression fractures of the thoracic vertebrae (at level T5-T6), and atrial fibrillation. R25 was admitted to the facility 4/10/2026, however, had a one-night hospital stay 5/7/2026 to 5/8/2026 due to an exacerbation of her heart failure. R25's Minimum Data Set (MDS), dated [DATE], includes a Brief Interview for Mental Status (BIMS) of 15, indicating R25 is cognitively intact, and MDS documents R25 requires partial/moderate assistance for rolling left to right in bed as well as bed-to-chair transfers. On 5/11/2026 at 11:02am, R25 was observed lying in bed on her back. No interventions were in place to offload the heels. Protective boots were in the corner of the room, not on the patient. Low air loss mattress was on the bed. On 5/11/2026 at 3:42PM, R25 was observed lying on her back. No interventions were in place to offload the heels, nor protective boots on the resident. Heels were in direct contact against the mattress. Patient was stating she is uncomfortable and wanting to get up. V28 (Certified Nursing Assistant/CNA) was present and assisting R25. As R25 turned to her left side, surveyor observed a purple blistered area to the posterior right heel, approximately the size of a quarter. V28 (CNA) denied seeing the skin alteration previously. V27 (Registered Nurse/RN) came to the room and assessed the resident's heels. V27 (RN) denied seeing any impairment to the right heel previously. V27 (RN) described the area as a blister, likely a deep tissue injury. V27 (RN) confirmed the location of posterior heel wound aligned where the heel rests against the mattress. The left heel wound (previously examined by the wound physician) did not have a dressing on as ordered (order entered for left heel wound dressing on 5/11/2026) and was open to air. V27 (RN) cleansed both heels and applied a vaseline gauze with adhesive foam dressing to each heel. A sacral dressing was noted; V27 (RN) removed the soiled dressing during incontinence care and no wound was noted in that location. Scant excoriation noted under the abdominal fold on the left side of abdomen. On 5/12/2026 at 3:00om, R25 was resting in bed, lying on her back. Bilateral legs were flush against the bed, no offloading of heels. Heel protective boots were not on the resident; boots were present in the corner of the room. On 5/13/2026 at 11:00am, V16 (CNA) was at bedside, assisting R25 into sitting position. Bedsheet was noted to be stained with moderate amount of serosanguinous fluid. V16 (CNA) removed R25's socks, bilateral foam dressings were noted on R25's heels. V16 (CNA) confirmed that both dressings were dated today (5/13/26). Dressings both appeared to be clean and dry. On 5/13/2026 at 1110am, V19 (Registered Nurse/RN) confirmed both heel dressings were changed (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prior to the start of the day shift today, however, the left heel wound had been leaking fluid, so V19 (RN) changed that dressing. On 5/13/2026 at 11:41am, V2 (Director of Nursing/DON) confirmed when a new skin alteration is discovered, the staff nurse should be notifying the DON and/or the Assistant Director of Nursing (ADON); a physician should also be contacted to obtain orders for the wound treatments. V2 (DON) stated V3 (ADON) assists the wound physician weekly during rounds and is more familiar with the wound documentation and residents receiving wound treatments. V2 (DON) affirmed the only wound locations noted in R25's medical record are on the left heel and the right forearm. V2 (DON) denied being notified regarding a new right heel wound. On 5/13/2026 at 11:55am, V3 (ADON) affirmed there was no notification to her regarding a new skin alteration on the right heel: This was not brought to my attention and is a problem. V3 confirmed wound doctor visits R25 weekly (last assessment was 5/5/2026) and the doctor classified the left heel wound as arterial and unavoidable due to the resident's diagnoses. V3 (ADON) stated the physician completed doppler ultrasound at bedside during assessment and that arterial studies were ordered for the legs but not yet completed due to her hospital stay. On 5/13/2026 at 1:25pm, V26 (Wound Physician, vascular surgeon) confirmed via telephone he has been treating R25 for a right arm wound and left heel wound. V26 denied being notified of a new wound to the right heel. V26 stated the left heel was classified as an arterial wound due to patient's diagnoses metastatic cancer, coronary artery disease, peripheral vascular disease, heart failure, malnutrition, anasarca, and atrial fibrillation. Doppler ultrasound was performed by V26 at bedside to evaluate pedal pulses during his last assessment, which showed impaired circulation/no signals. Per V26, order for arterial dopplers was entered on 5/5/2026 but not yet completed. The expectation of when the order should be completed depends on who they have to complete the test and was not intended to be ordered immediately (STAT). In discussion of the cause for the new right wound, V26 (physician) stated the wound could have multiple etiologies, she has poor blood circulation and the cause could be multifactorial. V26 acknowledged R25 is not exempt from risk of pressure wounds despite extensive medical history, but relayed her left wound was classified as arterial due to the findings in bedside doppler ultrasound despite the location. V26 affirmed pressure relief measures are ordered and are expected to be followed, treatment orders are to be completed as ordered, and a provider should be contacted for new orders when a new skin integrity issue is found. V26 was asked what potential harm could come to a patient is a skin integrity issue is not addressed timely. V26 replied, 1. Nothing, 2. It could stay the same, 3. It could worsen. On 5/13/2026 at 3:00pm, V3 (ADON) performed an assessment of the bilateral heel wounds in R25's room. Heel protector boots were on, as well as heels offloaded with pillows at the start of the assessment. Bilateral heel dressings were removed. Right heel was described by V3 (ADON) as a closed blister, approximately 2 centimeters (length) by 2 centimeters (width). The location of the wound was confirmed by V3 (ADON) to be the right posterior heel and that yes, that area is the part of the foot that rests on the bed when heels are not being offloaded. The left heel wound was the source of the serosanguinous fluid noted in previous observation, as V3 (ADON) confirmed the blistered wound appears much more deflated than in previous assessment. Braden Score on 4/30/2026 reflects a score of 14 (No response in diagnosis section that would influence skin integrity). Braden score on 5/9/2026 documents a score of 14 with a response of 1 in the diagnosis section that may influence skin integrity. Per the instructions on the form Braden Scale for Predicting Pressure Sore Risk, If diagnosis tab response is 1, consider advancing to the next level (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of care. This advancement to the next level of care would indicate that resident is at risk for skin breakdown. readmission orders on 5/8/2026 document, Turn and reposition resident every two hours as tolerated, Barrier cream to periarea and buttocks three times a day (TID) and as needed (PRN) after incontinence episodes, Offload resident's heels when in bed as tolerated every shift, and Wound care physician to evaluate and treat as needed. Additional orders on 5/11/2026 include Low Air Loss (LAL) Mattress in place, monitor for proper inflation and functioning, Clean wounds to Right Forearm (RFA) and Left (L) heel with Normal Saline solution (NSS), pat dry, apply xerofoam (vaseline gauze) and cover with dry dressing three times a week, and may apply abdominal (ABD) pad to extremities and secure with kerlix (rolled gauze) if extremity is weeping, monitor for breakdown. Review of records shows there were no wound orders in place for the known left heel arterial wound and right forearm skin tear, nor order for a LAL mattress for wound prevention for 5/8/2026, 5/9/2026, and 5/10/2026. On 5/11/2026, there was no order obtained for the new right heel wound care. Prior to the evaluation of the wound with V3 on 5/13/2026 at 300pm, there was no order obtained for right heel wound treatments. There was a dressing applied by V27 on Monday 5/11/26 when the wound was discovered. There was also a dressing over the right foot wound (dated 5/13/26) noted during observation on 5/13/26 at 11:00am. Treatment Record for 4/2026 was reviewed: Heel Protectors on while in bed; there was no documentation that heel protectors were on from 4/12/2026 through 4/30/2026, nor any refusals documented in treatment record. Treatment Record for 5/2026 was reviewed: LAL Documentation began on 5/11/2026 after order received (No LAL mattress ordered on 5/8/2025, 5/9/2026, 5/10/2026). Cleanse wounds to Right Forearm and Left Heel with Normal Saline Solution, pat dry, apply xerofoam and cover with dry dressing three times per week – treatment was not documented on Treatment Record, was scheduled for 6am, however order was obtained after this time. Wound care on left heel was not completed until right heel wound was discovered at 342pm on 5/11/2026. No documentation of those dressings is present in the treatment record nor progress note. Skin Evaluation Form on 5/11/2026 at 747am documents the presence of a Right forearm Full thickness wound, skin tear as well as a Left Heel partial thickness wound, arterial ulcer, fluid filled blister. There is no documentation of a Right Heel Wound. Initial Wound Evaluation & Management Summary on 4/14/2026 documents, a stage II pressure wound on the sacrum as well as a skin tear wound on the right arm. No heel wounds were present on this date. Wound Evaluation & Management Summary on 5/5/2026 documents, a skin tear wound of the right arm and an arterial wound of the left heel. Ankle Brachial Index (ABI) is recommended. There is no mention of a right heel wound present on this date. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V26 (Wound Physician) confirmed no notification was made of new right heel wound prior to interview with surveyor 5/13/26 at 125pm. V26 affirmed when there is a new skin integrity issue, the staff nurse is to notify the Assistant Director of Nursing or the Director of Nursing, and then the physician (either the wound physician or the attending/oncall physician) would be notified to obtain temporary orders until the wound physician evaluates the wound. At 1150am on 5/14/2026, both V2 (Director of Nursing) and V3 (Assistant Director of Nursing) confirmed they were not made aware of the new wound to the right posterior heel and therefore did not make a notification to the wound doctor. There were no progress notes from any staff nurses which document a notification to either the wound doctor not attending doctor/nurse practitioner following the discovery of the wound 5/11/2026. Resident care plan (printed 5/13/26) documents R25 is at risk for skin breakdown due to previous wounds and diagnosis of Peripheral Arterial Disease (PAD). Goal of care plan is to receive no new skin breakdown through review and wounds will resolve. Interventions include: .assist with turning and repositioning often while in bed, ensure proper offloading and pressure distribution is occurring often, LAL initiated per orders.Perform daily skin checks, notify nurse if new areas of redness are seen. Monitor left heel and skin tear site for signs/symptoms of infection and/or worsening.heel protectors per orders. There is no revision to the care plan noted on 5/11/26, 5/12/26, or 5/13/26 that reflects the monitoring or treatment of a new wound to the right heel. Interdisciplinary Notes Reviewed: 5/12/2026 10:53PM (Nursing) – Skin condition: No new findings. No resident refusals of preventative measures documented 5/11/2026 11:38PM (Nursing) – Skin condition: No new findings. No resident refusals of preventative measures documented 5/10/2026 3:36PM (Nursing) – No resident refusals of preventative measures documented 5/9/2026 4:51PM (Nursing) – No resident refusals of preventative measures documented 5/4/2026 3:48PM (Nursing) – Observed to have purplish fluid filled blister at the left and right heel. Left heel blister is bigger than the right. Dr. Shen made aware. Protective foam placed to bilateral heels, feet elevated with pillows. No subsequent note entries nor skin assessments addressed the right heel wound, nor treatment orders obtained. Skin Evaluation Form charted on 5/13/2026 at 3:45pm by V3 documents, right heel blister, fluid filled in addition to resident's refusal to wear the protective boots at that time. No prior refusals of preventative measures were noted in skin assessments nor interdisciplinary notes. The facility policy Notification of changes, dated 2/11/2025, documents, The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include.3. Circumstances that require a need to alter treatment. This may include: a) New Treatment. Facility policy Pressure Injury Prevention and Management (dated 2/11/25) documents, Avoidable (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	means that the resident developed a pressure ulcer/injury and that the facility did not do ONE or more of the following: .define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice; .or revise the interventions as appropriate. 2.R15's diagnoses include metabolic encephalopathy, dementia, weakness, signs/symptoms involving musculoskeletal system and cognitive communication deficit. R15's (4/29/26) BIMS (Brief Interview Mental Status) affirms resident was unable to complete the interview. 05/11/2026 at 11:42am, R15 was lying on a LALM, however, the mattress was not turned on. On 5/11/26 at 11:48am, V15 (Registered Nurse) was asked if R15's LALM was turned on. V15 (Registered Nurse) inspected R15's LALM device and stated, I don't see anything go on (while pressing several buttons), I'll call maintenance. The (2/11/26) Low Air Loss Mattress policy states the mattress pump must be set according to the manufacturer's instructions based on the resident's current weight. Staff must check that the mattress is functioning (plugged in, working properly) every shift.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure that an opened gallon of distilled water used for tube feeding flushes was labeled with an open date for one resident (R33). This failure affected one resident (R33) reviewed for tube feeding management in the total sample of 37 residents.Findings include:R33's face sheet documents diagnoses that include but are not limited to artificial opening of digestive tract, dysphagia, and osteomyelitis of vertebra, sacral and sacrococcygeal region.R33's BIMs (Brief Interview for Mental Status), dated 5/03/26, is 14 which indicates R33 is cognitively intact.R33's care plan, dated 4/28/26, documents, Potential for complications related to the use of GJ (gastrojejunostomy) due to dysphagia, recent displacement.R33's physician order, order date 4/27/26, documents, Enteral feeding: Flush with 250ml of sterile water every 6 hours, four times daily.On 5/11/26 at 11:14am, observed a gallon of distilled water on R33's bedside dresser that was opened and not labeled with a date.On 5/11/26 at 11:15am, R33 said, I'm not sure what that water (pointed to the opened gallon of distilled water) is for. I don't drink anything.On 5/11/26 at 11:17am, V19 (Registered Nurse/RN/Agency) said, Oh, there should be an open date on that (R33's gallon of distilled water). It's dated to see how new it is.On 5/13/26 at 11:50am, V2 (Director of Nursing/DON) said, The sterile water for tube feeding is usually dated to make sure how old the water is. It's beneficial to date the water once opened to prevent cross contamination.Record review of facility policy titled, Care and Treatment of Feeding Tubes, dated 2/11/26, documents, Policy: It is a policy of this facility to utilize feeding tubes in accordance with current clinical standards of practice, with interventions to prevent complications to the extent possible.Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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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. Based on observation, interview, and record review, the facility failed to ensure policy procedures include storage for respiratory devices when not in use and failed to contain respiratory equipment when not in use for two of 20 residents (R16, R23) in the sample reviewed for quality of care. Findings include:1.On 5/11/26 at 10:51am, R23's incentive spirometer was observed on the windowsill and uncontained. On 5/11/26 at 11:02am, V15 (Registered Nurse/RN) was asked about R23's (uncontained) incentive spirometer. V15 stated, She had pneumonia that's why we're using it. V15 was asked if R23's incentive spirometer was contained while not in use. V15 responded, We need to have (brand name) bags and affirmed the device was not contained at this time.2.R16's (10/30/24) physician orders include CPAP (Continuous Positive Airway Pressure) at bedtime. R16's (2/17/25) care plan includes CPAP however the interventions exclude containment when not in use. On 5/11/26 at 11:08am, R16's CPAP mask was observed (uncontained) behind the dresser and touching the curtain.On 5/11/26 at 11:15am, V17 (Certified Nursing Assistant) was asked about concerns with R16's CPAP mask. V17 (Certified Nursing Assistant) state,d It's behind here (referring to the dresser), and there's no bag on here.On 5/12/26 at 12:45pm, R16's CPAP mask was on the dresser and (uncontained). V22 (Licensed Practical Nurse/LPN) was asked about concerns with R16's CPAP mask. V22 (Licensed Practical Nurse) stated, When it's not in use, we can have the mask in a (name brand bag). V22 was asked if R16's CPAP mask was contained in a bag. V22 responded No ma'am.On 5/13/26, surveyor requested the facility policy for containment of respiratory equipment when not in use. Surveyor received the noninvasive ventilation (CPAP, BiPAP) policy (revised 2/11/26) which states, It is the policy of this facility to provide noninvasive ventilation as per physician's orders and current standards of practice however storage/containment of respiratory equipment when not in use is excluded.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician's order was written and in the electronic medical record physician orders for one (R29) resident of one resident reviewed for dialysis care. Findings include:R29 is [AGE] years of age. Current diagnoses include but are not limited to End Stage Renal Disease, Dependence on Renal Dialysis, Type 2 Diabetes Mellitus, Hypertension, Hypothyroidism, Benign Prostatic Hyperplasia, and Malignant Neoplasm of Prostate.R29's comprehensive assessment section C Cognitive Patterns, dated 05/06/2026, documents a BIMS (Brief Interview for Mental Status Score) of 11, which indicates R29 has moderate cognitive impairment.On 05/11/2026 at 10:50 am, R29 was in his room asleep in bed. He has oxygen in place via concentrator set at 1.5ml/min humidified via nasal cannula. Noted dialysis port to his chest wall. On enhanced barrier precautions related to his dialysis access. Will attempt to interview at a later time.On 05/11/2026 at 2:00 pm, during review of R29's electronic medical records, there is no physician's order documenting his dialysis treatment and transportation.On 05/12/2026 at 12:23 pm, R29 is sitting up in bed eating his lunch with a friend at his bedside alert and oriented. R29 said, They take me to the hospital for my dialysis. It's on time, but I missed yesterday because I wasn't feeling good. R29 appeared to be clean in no distress. He did not complain of pain or SOB (shortness of breath). He didn't have any concerns with his dialysis treatment or transportation. Oxygen remains at 1.5ml/min via concentrator humidified per nasal cannula. On 05/13/2026 at 1:40 pm, V2, DON/Director of Nursing, was asked about R29's dialysis order. V2 said, There should be an order for dialysis in the computer. It's to make sure he's (R29) on schedule, gets the right dialysis, at the right place for the right amount of time. We have a dialysis folder for the nurses to communicate with the dialysis staff. Our doctors and nurse practitioners have access to enter orders into our system. The hospital would send the order for dialysis and the nurse on duty would be responsible for putting the order in. V2 reviewed R29's physician orders and said, I don't see the order.On 05/13/2026 at 2:20 pm, V2, DON, brought a physician order for R29's dialysis to this surveyor. The physician order states- order date 05/13/2026, start date 05/13/2026. Order text- Dialysis twice a week on Monday and Friday. Physician name and contact number. R (Right) Chest CVC (Central Venous Catheter). Hospital name and contact number. Ambulance to transport back and forth. No fluid restriction. Changed on 12/17/25.The Hemodialysis policy, dated 05/01/2025, states: Policy: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive person-centered care plan, and the residents' goals and preferences, to meet the special medical, nursing, mental, and psychological needs of residents receiving hemodialysis.Purpose: The facility will ensure that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice. this will include:The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility. Ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.Compliance guidelines:13. The facility will ensure that the physician's orders for dialysis include:a. The type of access of dialysis (e.g. graft, arteriovenous shunt, external dialysis catheter) and location.b. The dialysis schedule.c. The nephrologist name and phone number.d. The dialysis facility name and phone number.e. Transportation arrangements to and from the dialysis facility.f. Any medication administration or withholding of specific medications prior to dialysis treatments.g. Any fluid restriction if ordered by the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain accurate records and document administration of controlled substances for one (R51) of one resident reviewed for pharmacy services in a sample of 21 residents residing on the second floor.Findings include: On 05/11/26 at 9:30am, V1 (Administrator) stated the facility census is 37 residents residing at the facility. On 05/13/2026 at 10:45 am, surveyor inspected accounting of controlled substances for the medication cart for rooms (#). The controlled substances count on 5/13/26 at 10:45 am with V22 (Licensed Practical Nurse/LPN) for medication cart for rooms (#) was inaccurate for one resident (R51). R51 has an order for Pregabalin 100 mg (milligrams) capsule, 1 capsule by mouth twice daily. The controlled drug receipt/record disposition form for R51 listed 17 capsules of Pregabalin 100 mg (milligrams) capsule but 16 capsules remain in the package. V22 stated, I gave one this morning and did not sign it yet. R51 was admitted on [DATE] with current diagnoses that include but are not limited to acute systolic congestive heart failure, acute kidney failure, chronic kidney disease, polyneuropathy, and rheumatoid arthritis. On 05/13/2026 at 1:59 pm, V2, DON (Director of Nursing), was asked about the process of accounting for controlled substances. V2 (DON) stated, After administering controlled medications, the nurse needs to sign the Controlled Drug/Receipt Record Disposition Form immediately for accuracy of medication given. Review of the facility's Controlled Substance Administration and Accountability Policy dated 3/2/2026 documents in section 1. f. ii. All controlled substances obtained from a non-automated medication cart or cabinet are recorded on the designated usage form. Written documentation must be clearly legible with all applicable information provided. Review of the facility's Symbria Rx Services Pharmacy Policy II A7: Controlled Substances, dated July 2024 documents in section E. the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR):1) Date and time of administration (MAR, Controlled Drug/Receipt Record Disposition Form)2) Amount Administered (Controlled Drug/Receipt Record Disposition Form)3) Remaining quantity (Controlled Drug/Receipt Record Disposition Form) 4) Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Controlled Drug/Receipt Record Disposition Form)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to follow policy and procedure and failed to ensure a resident was free from significant medication errors. These failures affect one resident (R33) in a sample of 37 residents reviewed for medication administration. Findings include:R33's face sheet documents diagnoses that include but are not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region.R33's BIMs (brief interview for mental status) score, dated 5/03/26, is 14 which indicates R33 is cognitively intact.R33's care plan, dated 4/28/26, documents, in part, I (R33) have an infection OM (osteomyelitis). My infection will be resolved after the completion of my antibiotic course. I (R33) will take my antibiotic as prescribed.R33's physician order, order date 5/5/26, documents, in part, Vancomycin 1G/250ml in 0.9% sodium chloride intravenous (IV) twice a day for osteomyelitis.On 5/11/26 at 11:14am, observed R33's Vancomycin IV (antibiotic medication) being administered through R33's left PICC line and infusing at 132ml/hr. Record review of R33's Vancomycin IV label documents, in part, Compounded: Infuse 250ml (1G) 125 ml/hr. over 120 minutes twice a day for osteomyelitis. Once activated product expires.On 5/11/26 at 11:15am, R33 said, I get that IV (Vancomycin antibiotic) for my infection.On 5/11/26 at 11:17am, V19 (Registered Nurse/RN/Agency) said, Its R33's Vancomycin medication supposed to go at 125 ml/hr. I was trying to change the rate, and it kept going to 175ml/hr. I should have gotten another pump. This pump was working fine before. No, never had this issue before. No, there is something wrong with this pump. I will get a working one (IV pump) and put a tag on it (IV pump that is not working properly) so it (IV pump that is not working properly) gets checked out. Running it (R33's Vancomycin medication) at the wrong rate can cause an adverse reaction to the resident.On 5/13/26 at 11:50am, V2 (Director of Nursing/DON) stated that the purpose of administering Vancomycin IV at the ordered rate is to ensure the body can handle the medication, there is a timing window for when it will expire, and lab troughs have to be done and are based of the timing of the last dose.Record review of facility policy titled, Medication Administration, dated 2/11/26, documents, in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Administer medication as ordered in accordance with manufacturer specifications. Correct any discrepancies and report to manager.Record review of facility policy titled, Provision of Physician Ordered Services, dated 2/11/26, documents, in part, Policy: The purpose of this policy is to provide a reliable process for the proper and consistent provision of physician ordered services according to professional standards of quality. Definition: Professional Standards of Quality means that care and all services are provided according to accepted standards of clinical practice. Standards may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting.Record review of CMS's RAI (Resident Assessment Instrument) 3.0 Manual Chapter 3 MDS Items (N), dated October 2025, documents in part the following: N0415: High-Risk Drug Classes: Use and Indication: Antibiotic.Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure essential equipment was maintained in safe operating condition when an IV pump identified as malfunctioning continued to be used for resident care. These failures affect one resident (R33) in a sample of 37 residents reviewed for medication administration. Findings include:R33's face sheet documents diagnoses that include but are not limited to osteomyelitis of vertebra, sacral and sacrococcygeal region.R33's BIMS (Brief Interview for Mental Status), dated 5/03/26, is 14, which indicates R33 is cognitively intact.R33's care plan, dated 4/28/26, documents, I have an infection OM (osteomyelitis). My infection will be resolved after the completion of my antibiotic course. I will take my antibiotic as prescribed.R33's physician order, order date 5/5/26, documents, Vancomycin 1G/250ml in 0.9% sodium chloride intravenous (IV) twice a day for osteomyelitis.On 5/11/26 at 11:14am, observed R33's Vancomycin IV (antibiotic medication) being administered through R33's left PICC line and infusing at 132ml/hr. Record review of R33's Vancomycin IV label documents, Compounded: Infuse 250ml (1G) 125 ml/hr. over 120 minutes twice a day for osteomyelitis. Once activated product expires.On 5/11/26 at 11:15am, R33 said, I get that IV (Vancomycin antibiotic) for my infection.On 5/11/26 at 11:17am, V19 (Registered Nurse/RN/Agency) said, It's (R33's) Vancomycin medication supposed to go at 125 ml/hr. I was trying to change the rate, and it kept going to 175ml/hr. I should have gotten another pump. This pump was working fine before. No, never had this issue before. No, there is something wrong with this pump. I will get a working one and put a tag on it (IV pump that is not working properly) so it gets checked out. Running it at the wrong rate can cause an adverse reaction to the resident.On 5/13/26 at 11:50am, V2 (Director of Nursing/DON) stated the purpose of administering Vancomycin IV at the ordered rate is to ensure the body can handle the medication, there is a timing window for when it will expire, and lab troughs have to be done and are based on the timing of the last dose. V2 said, No, an IV pump that is not working properly should not be used on a resident. The nurse should get a new pump from central supply and put a ticket in to have the pump looked at and fixed. We have plenty of pumps. We rent some and own some. There is no need to use a pump that is not working properly.Record review of facility policy titled, Safety and Equipment Maintenance, dated 1/26, documents, Proper maintenance of the physical plant and all equipment in the Department is the responsibility of the Director in cooperation with the Maintenance Department and subject to policies and procedures set forth by the facility's administration. The Director is directed or has knowledge of all routine, periodic, and critical maintenance work done to the physical plant or equipment in the Department.Record review of Infusion Pump Instructions For Use, dated 2017, documents, (Name Of IV Company) will assume no responsibility for any incidents that may occur if the device is not utilized strictly in accordance with its product labeling. CAUTION: Always verify displayed infusion parameters (Primary Rate, Primary VTBI, Secondary Rate, Secondary VTBI) with the prescription before starting infusion. If a (Manufacturer Name) Pump fails to respond as described in this Instruction for Use and the cause cannot be determined, do not use the affected instrument. Contact qualified service personnel.Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.