STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155219	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of South Bend	52654 N Ironwood Rd South Bend, IN 46635

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer medications as ordered by the Physician for 9 of 9 residents reviewed for medications. (Residents 3, 8, 29, 51, 67, 69, 14, 1 and 4)Findings include:1. During an interview on 8/13/2025 at 10:00 A.M., Resident 3 indicated his medications were given late a lot and he was not receiving his insulin with his meals. Resident 3's record review was completed on 8/15/2025 at 12:00 P.M. Diagnoses included, but were not limited to: heart failure, type 2 diabetes mellitus, generalized anxiety disorder, major depressive disorder and chronic obstructive pulmonary disease. Resident 3's current Physicians' orders included, but were not limited to: -5 milligram (mg) tablet of amlodipine (treats hypertension) once daily -insulin Lispro - 12 units subcutaneously with meals, -insulin lispro - sliding scale based on blood glucose four times daily -insulin glargine - 45 units subcutaneously twice daily -multivitamin- 1 tablet daily -5 mg Eliquis (anticoagulant) tablet twice a day -5 mg Tradjenta (Anti-diabetic medication) -17 grams polyethylene glycol (laxative) powder once daily -100 mg gabapentin (nerve pain medication) capsule twice a day -325 mg ferrous sulfate tablet once daily -10 mg Jardiance (anti-diabetic) tablet once daily -0.4 mg tamsulosin capsule once daily -12.5 mg carvedilol (anti-hypertensive) twice a day A review of Resident 3's July and August 2025 Medication Administration Records (MAR) indicated (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the following medications were given late: -On 7/13/2025 12 units insulin lispro scheduled for 5:00 P.M. was not administered until 6:39 P.M. -On 7/17/2025 amlodipine, scheduled for 7:00 A.M.,, was not administered until 12:13 P.M.; Humalog insulin, scheduled for 8:00 A.M., was not administered until 11:05 A.M., 12 units of Insulin lispro, scheduled for 8:00 A.M.,, was not given until 11:06 A.M.; 45 units of insulin glargine, scheduled for 8:00 A.M., was not administered until 11:06 A.M. -On 7/19/2025 5 mg Eliquis, 5 mg Tradjenta, 17 grams polyethylene glycol powder, 100 mg gabapentin, 12.5 mg carvedilol, 10 mg Jardiance, 5 mg amlodipine, 0,4 mg tamsulosin, 20 mg torsemide scheduled for 7:00 A.M., were not administered until 12:09 P.M. Also, on 7/19/2025 ,45 units insulin glargine scheduled for 8:00 A.M., was not administered until 10:08 A.M. -On 7/20/205 insulin lispro sliding scale (dose will depend on the resident's blood glucose assessment), 45 units insulin glargine and 12 units insulin lispro scheduled for 8:00 A.M., were not administered until 10:09 A.M. -On 7/22/2025 5 mg Eliquis, 100 mg gabapentin, 12.5 mg carvedilol, 10 mg Jardiance, 20 mg torsemide, 0.4 mg tamsulosin, 5 mg amlodipine and 5 mg Tradjenta, scheduled for 7:00 A.M., were not administered until 12:08 P.M. -On 7/23/2025 the following medications were scheduled for 7:00 A.M., but were not administered until 12:04 P.M.: 5 mg of Eliquis, 5 mg Tradjenta, polyethylene glycol powder, 100 mg gabapentin, 325 mg ferrous sulfate, 10 mg Jardiance, 0.4 mg Tamsulosin, insulin lispro sliding scale (dose depended on blood glucose assessment) , 5 mg amlodipine and 12.5 mg carvedilol. -On 7/28/2025 insulin lispro sliding scale (dose depended on blood glucose assessment), 45 units insulin glargine and 12 units insulin lispro were scheduled for 8:00 A.M., but were not administered until 10:01 A.M. -On 7/29/2025 45 units insulin glargine, scheduled for 8:00 A.M.,, was not administered until 10:55 A.M. -On 7/30/2025 45 units insulin glargine, scheduled for 8:00 A.M., was not administered until 10:10. -On 7/30/2025 12 units insulin lispro and insulin lispro sliding scale (dose depended on blood glucose assessment) were scheduled for 12:00 P.M., but were not administered until 1:56 P.M. -On 7/31/2025 12.5 mg carvedilol and 5 mg amlodipine, scheduled for 7:00 A.M.,, were not given until 12:16 P.M. -On 7/31/2025 45 units insulin glargine, 12 units insulin lispro and insulin lispro sliding scale (dose depended on blood glucose assessment) were scheduled for 8:00 A.M., but were not administered until 10:50 A.M. -On 7/31/2025 12 units insulin lispro and insulin lispro sliding scale (dose depended on blood glucose assessment) scheduled for 12:00 P.M., were not administered until 5:56 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/1/2025 325 mg ferrous sulfate, scheduled for 7:00 A.M., was not administered until 12:24 P.M. -On 8/2/2025 5 mg Eliquis, 100 mg gabapentin, scheduled for 7:00 A.M.,, was not administered until 11:05 A.M. -On 8/3/2025 5 mg Eliquis and 100 mg gabapentin, scheduled for 7:00 A.M., was not administered until 11:57 A.M. -8/3/2025 12 units insulin lispro and insulin lispro sliding scale (dose depended on blood glucose assessment) scheduled for 12:00 P.M., was not administered until 1:50 P.M. -On 8/5/2025 12 units insulin lispro and insulin lispro sliding scale (dose depended on blood glucose assessment),scheduled for 12:00 P.M., were not administered until 5:09 P.M. -On 8/10/2025 48 units insulin glargine, scheduled for 8:00 A.M., was not administered until 11:29 A.M. -On 8/12/2025 12 units insulin lispro, scheduled for 12:00 P.M., was not administered until 2:54 P.M. -On 8/13/2025 12.5 mg carvedilol, and 5 mg amlodipine, scheduled for 7:00 A.M., was not administered until 1:04 P.M. Resident 4's record lacked documentation indicating why the medications had not been administered timely 2. Resident 8's record review was completed on 8/15/2025 at 11:00 A.M. Diagnoses included, but were not limited to: malignant neoplasm of bladder, type 2 diabetes mellitus, anxiety disorder, malignant neoplasm of prostate and hypertension. Resident 8's current Physicians' orders included, but were not limited to: -36000-114000 unit creon capsule three times a day -20 mg oxycodone tablet every 4 hours -Novolog (insulin aspart) sliding scale (dose will depend on blood glucose) -25 mg trazodone (insomnia) tablet at bedtime -60 mg Nifedipine (anti-hypertensive) -40 mg pantoprazole capsule once a day -100 mg thiamine tablet once a day -CertaVite/antioxidants (multivitamin) tablet once a day -10 gram Lokelma (treats hyperkalemia) two times a day (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 8's July and August 2025 MARs indicated the following medications were given an hour and a half late or later: -On 7/18/2025 20 mg oxycodone, scheduled for 12:00 P.M., was not administered until 1:32 P.M. -On 7/18/2025 36000-114000 unit creon capsule, scheduled for 7:00 P.M, was not administered until 9:59 P.M. Also, 20 mg oxycodone, scheduled for 8:00 P.M., was not administered until 9:58 P.M. -On 7/22/2025 36000-114000 unit creon capsule, 60 mg nifedipine tablet, 40 mg pantoprazole tablet and 100 mg thiamine tablet, scheduled for 7:00 A.M., was not administered until 12:07 P.M. -On 7/25/2025 20 mg oxycodone, scheduled for 8:00 P.M., was not administered until 9:35 P.M. -On 7/26/2025 CertaVite/Antioxidant tablet, scheduled for 9:00 A.M., was not administered until 10:38 A.M. -On 7/27/2025 NovoLog (insulin) sliding scale (dose depended on blood glucose assessment),scheduled for 9:00 P.M., was not administered until 10:44 P.M. - On 7/29/2025 CertaVite/Antioxidant tablet, scheduled for 9:00 A.M., was not administered until 10:56 A.M. -On 7/31/2025 NovoLog (insulin aspart) sliding scale (dose will depend on blood glucose) was scheduled for 8:00 A.M., but had not been administered until 10:49 A.M. -On 7/31/2025 NovoLog (insulin aspart) sliding scale (dose will depend on blood glucose) was scheduled for 12:00 P.M., but had not been administered until 5:51 P.M. - On 8/1/2025 CertaVite/Antioxidant tablet was scheduled for 9:00 A.M., was not administered until 10:35 A.M. -On 8/3/2025 20 mg oxycodone tablet, scheduled for 12:00 P.M., was not administered until 1:51 P.M. -On 8/4/2025 25 mg trazodone, scheduled for 9:00 P.M., was not administered until 10:36 P.M. -On 8/5/2025 100 mg thiamine tablet, scheduled for 7:00 A.M., was not administered until 4:04 P.M. -On 8/5/2024 NovoLog (insulin) sliding scale (dose depended on blood glucose assessment), scheduled for 12:00 P.M., was not administered until 5:11 P.M. -On 8/5/2025 20 mg oxycodone, scheduled at 8:00 P.M., was not administered until 9:29 P.M. Also, NovoLog (insulin) sliding scale (dose depended on blood glucose assessment), scheduled for 9:00 P.M., was not administered until 11:08 P.M. -On 8/7/2025 NovoLog (insulin) sliding scale (dose depended on blood glucose assessment), scheduled for 9:00 P.M., was not administered until 10:32 P.M. -On 8/11/2025 36000-114000 units creon, scheduled for 7:00 P.M., was not administered until 8:34 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 8/13/2025 2025 NovoLog (insulin) sliding scale (dose depended on blood glucose assessment), scheduled for 9:00 P.M., was not administered until 11:55 P.M. -On 8/12/2025 10 gram lokelma packet, scheduled at 7:00 A.M., was not administered until 11:12 A.M. Resident 8's record lacked documentation regarding why medications had not been administered on time. 3. A review of Resident 29's record was completed on 8/15/2025 at 1:48 P.M. Diagnoses included, but were not limited to: Alzheimer's disease, insomnia and osteoarthritis. Resident 29's current Physicians' orders included, but were not limited to: - 25 mg quetiapine (regulates mood and behaviors) tablet 3 times daily - 50 mg quetiapine tablet 3 times a day -0.5 mg risperidone (an antipsychotic) tablet twice a day -50 micrograms (MCG) levothyroxine (treats hypothyroid) tablet once daily -15 mg Meloxicam (pain reliefer) tablet A review of Resident 29's July and August 2025 MARs indicated the following medications were given an hour and a half late (or later) past the scheduled administration time: - On 7/27/2025 25 mg quetiapine, scheduled for 7:00 A.M., was not administered until 9:57 A.M. - On 7/28/2025 25 mg quetiapine, scheduled for 11:15 A.M., was not administered until 2:42 P.M. - On 7/29/2025 25 mg quetiapine, scheduled for 7:00 A.M., was not administered until 8:34 A.M. - On 7/29/2025 25 mg quetiapine, scheduled for 11:15 A.M., was not administered until 12:55 P.M. - On 7/31/2025 25 mg quetiapine, scheduled for 7:00 A.M., was not administered until 8:32 A.M. - On 8/1/2025 25 mg quetiapine, scheduled for 7:00 A.M., was not administered until 9:28 A.M. -On 8/1/2025 0.5 mg risperidone, scheduled for 4:00 P.M., was not administered until 8:10 P.M. - On 8/2/2025 25 mg quetiapine, scheduled for 7:00 A.M., was not administered until 10:50 A.M. - On 8/3/2025 50 mg quetiapine, scheduled for 7:00 A.M., was not administered until 9:38 A.M. - On 8/6/2025 50 mg quetiapine, scheduled for 7:00 A.M., was not administered until 8:49 A.M. -On 8/8/2025 50 mg quetiapine, scheduled for 11:15 A.M., was not administered until 12:52 P.M. -On 8/9/2025 50 mg quetiapine and 15 mg meloxicam, scheduled for 7:00 A.M., was not administered (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	until 12:20 P.M. - On 8/10/2025 75 MCG levothyroxine, scheduled for 6:00 A.M., 50 mg quetiapine and 15 mg meloxicam, scheduled for 7:00 A.M., were not administered until 10:25 A.M. -On 8/10/2025 50 mg quetiapine, scheduled for 11:15 A.M., was not administered until 3:44 P.M. Resident 29's record lacked any documentation indicating why medications had not been administered on time. 4. During an interview on 8/14/2025 at 11:05 A.M., Resident 51 indicated his medications were late four days out a typical week. A review of Resident 51's record was completed on 8/15/2025 at 2:08 P.M. Diagnoses included, but were not limited to: cellulitis, congestive heart failure, esophageal varices, atrial fibrillation and type 2 diabetes mellitus. Resident 51's current Physicians' orders included, but were not limited to: - 40 mg furosemide (diuretic) tablet twice a day -insulin Lispro inject 10 units before meals -20 mg omeprazole (stomach acid reducer) one time daily -20 mg escitalopram (anti-depressant) tablet once daily -150 mg bupropion (anti-depressant) tablet once daily -5 mg apixaban (blood thinner) tablet twice daily -25 mg metoprolol (anti-hypertensive) tablet once daily -20 milliequivalent (MEQ) Potassium chloride tablet once a day on Monday, Wednesday and Friday. A review of Resident 51's July and August 2025 MARs indicated the following medications were given an hour and a half late (or later) past the scheduled time: -On 7/17/2025 10 units insulin Lispro, scheduled for 7:30 A.M., was not administered until 11:07 A.M. - On 7/20/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., was not administered until 8:56 A.M. - On 7/22/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., 10 units insulin Lispro, scheduled for 7:30 A.M. and 40 mg furosemide, scheduled for 8:00 A.M., were not administered until 9:58 A.M. -On 7/23/2025 20 mg escitalopram tablet, 150 mg bupropion tablet, 25 mg metoprolol, 20 MEQ potassium chloride tablet, 40 mg furosemide tablet scheduled for 7:00 AM and 10 units insulin Lispro, scheduled for 7:30 A.M., were not administered until 12:22 P.M. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/26/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., was not administered until 9:01 A.M. 10 units of insulin Lispro, scheduled for 7:30 A.M., was not administered until 10:19 A.M. -On 7/30/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M. and 40 mg furosemide tablet, scheduled for 8:00 A.M., were not administered until 12:00 P.M. -On 7/31/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., was not administered until 9:07 A.M. 10 units insulin Lispro, scheduled for 7:30 A.M., was not administered until 11:03 A.M. 10 units insulin Lispro, scheduled for 12:30 P.M., was not administered until 5:55 P.M. -On 8/5/2025 40 mg furosemide tablet, scheduled for 8:00 A.M., was not administered until 10:09 A.M. 10 units insulin Lispro,scheduled for 12:30 P.M., was not administered until 5:15 P.M. -On 8/6/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., was not administered until 8:50 A.M. -On 8/8/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., was not administered until 8:46 A.M. -On 8/10/2025 20 mg omeprazole capsule, scheduled for 7:00 A.M., 500 mg cephalexin capsule and 40 mg furosemide tablet , scheduled for 8:00 A.M., were not administered until 9:46 A.M. Resident 51's record lacked any documentation indicating why medications had not been administered on time. 5. A review of Resident 67's record was completed on 8/15/2025 at 2:30 P.M. Diagnoses included, but were not limited to: alcoholic cirrhosis of liver with ascites, constipation, chronic kidney disease, generalized anxiety disorder, post-traumatic stress disorder and chronic pain. Resident 67's current Physicians' orders included, but were not limited to: - 1 drop carboxymethyl [NAME]-glycerin each eye twice a day - 8.6-50 mg sennosides-docusate (stool softener) tablet once daily - 25 mg lamotrigine (treats bipolar disorder) once daily -400 units ergocalciferol (Vitamin D2) tablet twice daily -50 mg doxepin (anti-depressant) capsule once daily -2.5 mg apixaban(blood thinner) tablet twice daily -81 mg aspirin tablet once daily -100 mg doxycycline (antibiotic) tablet two times daily for 7 days. A review of Resident 67's July and August 2025 MARs indicated the following medications were given an hour and a half late (or later), past the scheduled time: (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/16/2025 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 10:10 A.M. -On 7/17/2025 25 mg lamotrigine tablet, 10 MCG ergocalciferol tablet, 1 drop into each eye of carboxymethyl [NAME] – glycerin, 50 mg doxepin capsule and 2.5 mg apixaban tablet, scheduled for 7:00 A.M., were not administered until 2:07 P.M. 8.6-50 mg sennosides-docusate and 81 mg aspirin tablet once daily, scheduled for 7:00 A.M., were not administered until 2:07 P.M. -On 7/18/2025 100 mg doxycycline tablet, scheduled for 7:00 A.M., was not administered until 11:47 A.M. - On 7/21/2025 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 9:42 A.M. -On 7/25/2025 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 10:40 A.M. -On 7/27/2025 8.6-50 mg sennosides-docusate tablet was scheduled for 8:00 A.M., was not administered until 10:10 A.M. - On 7/31/2025 81 mg aspirin tablet, scheduled for 7:00 A.M., was not administered until 3:29 P.M. 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 10:10 A.M. -On 8/2/2025 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 11:01 A.M. -On 8/4/2025 1 drop into each eye of carboxymethyl [NAME] – glycerin, scheduled for 7:00 P.M., was not administered until 8/5/2025 at 12:33 A.M. -On 8/5/2025 10 MCG ergocalciferol tablet, 81 mg aspirin tablet, 50 mg doxepin capsule and 2.5 mg apixaban tablet, 25 mg lamotrigine and 1 drop into each eye of carboxymethyl [NAME] – glycerin, scheduled for 7:00 A.M., were not administered until 3:43 P.M. -On 8/12/2025 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 9:51 A.M. -On 8/13/2025 8.6-50 mg sennosides-docusate tablet, scheduled for 8:00 A.M., was not administered until 9:50 A.M. Resident 67's record lacked any documentation indicating why medications had not been administered on time. 6. During an interview on 8/14/2025 at 2:00 P.M., Resident 69 indicated her medications were late almost daily and the facility's staff had not followed the Physician's orders related to administering her blood pressure medication. A review of Resident 69's record was completed on 8/15/2025 at 2:55 P.M. Diagnoses included, but were not limited to: bradycardia, chronic obstructive pulmonary disease, generalized anxiety disorder, insomnia, Parkinson's disease, type 2 diabetes mellitus, end stage renal disease, major depressive (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disorder and paroxysmal atrial fibrillation. Resident 69's current Physicians' orders included, but were not limited to: -150 mg oxcarbazepine (anti-convulsant) tablet twice daily -800 mg sevelamer carbonate (phosphate binder) tablet with meals -75 mg pregabalin (treats nerve pain) capsule twice daily -100 mg docusate (stool softener) capsule one time a day. -10-325 mg hydrocodone-acetaminophen (pain reliever) three times daily -5 mg midodrine (raises blood pressure) tablet three times daily. Hold medication if systolic blood pressure is greater than 125. -25-100 mg carbidopa-levodopa (treats Parkinson's) tablet three times daily -81 mg aspirin tablet once daily -100-25 mcg fluticasone furoate-vilanterol (treats chronic obstructive pulmonary disease) 1 puff once daily -75 mg Rimegepant (treats migraines) tablet once daily -20 mg omeprazole (decreases stomach acid) tablet -0.5 mg lorazepam (anti-anxiety) A review of Resident 69's July and August 2025 MARs indicated the following medications were given an hour and a half late (or later), past the scheduled time: - On 7/14/2025 75 mg pregabalin capsule, 150 mg oxcarbazepine tablet and 100 mg docusate tablet, scheduled for 9:00 A.M., were not administered until 10:41 A.M. -On 7/18/2025 75 mg pregabalin capsule, 150 mg oxcarbazepine tablet and 100 mg docusate tablet , scheduled for 9:00, were not administered until 10:25 A.M. -On 7/20/2025 10-325 mg hydrocodone-acetaminophen tablet and 800 mg sevelamer carbonate tablet,scheduled for 7:00 A.M., were not administered until 8:57 A.M. -On 7/21/2025 800 mg sevelamer carbonate tablet, scheduled for 12:00 P.M., was not administered until 1:41 P.M. - On 7/22/2025 10-325 mg hydrocodone-acetaminophen tablet and 800 mg sevelamer carbonate tablet, scheduled for 7:00 A.M., and 5 mg midodrine tablet and 25-100 mg carbidopa-levodopa tablet, scheduled for 8:00 A.M., were not administered until 10:02 A.M. (continued on next page)

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Majestic Care of South Bend	52654 N Ironwood Rd South Bend, IN 46635

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 7/23/2025 81 mg aspirin tablet, 1 puff 100-25 mcg fluticasone furoate-vilanterol and 75 mg Rimegepant tablet, scheduled for 7:00 A.M., and 5 mg midodrine tablet, scheduled for 8:00 A.M., were not administered until 12:25 P.M. -On 7/24/2025 5 mg midodrine tablet and 25-100 mg carbidopa-levodopa tablet, scheduled for 2:00 P.M., were not administered until 4:44 P.M. -On 7/26/2025 800 mg sevelamer carbonate tablet, scheduled for 7:00 A.M., was not administered until 8:42 A.M. -On 7/28/2025 800 mg sevelamer carbonate tablet and 10-325 mg hydrocodone-acetaminophen tablet, scheduled for 7:00 A.M., were not administered until 8:37 A.M. -On 8/1/2025 5 mg midodrine tablet and 25-100 mg carbidopa-levodopa tablet, scheduled for 2:00 P.M., were not administered until 3:33 P.M. -On 8/3/2025 75 mg pregabalin capsule, 150 mg oxcarbazepine tablet and 100 mg docusate tablet, scheduled for 9:00, were not administered until 11:58 A.M. -On 8/4/2025 5 mg midodrine tablet and 25-100 mg carbidopa-levodopa tablet, scheduled for 2:00 P.M., were not administered until 3:36 P.M. -On 8/5/2025 75 mg pregabalin capsule, 150 mg oxcarbazepine tablet and 100 mg docusate tablet, scheduled for 9:00, were not administered until 10:49 A.M. -On 8/6/2025 800 mg sevelamer carbonate tablet, scheduled for 11:00 A.M, was not administered until 3:15 P.M. 5 mg midodrine tablet and 25-100 mg carbidopa-levodopa tablet, scheduled for 2:00 P.M., were not administered until 3:15 P.M. -On 8/7/2025 800 mg sevelamer carbonate tablet, scheduled for 11:00 A.M, was not administered until 12:55 P.M. -On 8/8/2025 20 mg omeprazole tablet, scheduled for 7:00 A.M., was not administered until 12:27 P.M. -On 8/11/2025 250 mg cephalexin capsule, 81 mg aspirin tablet, 0.5 mg lorazepam tablet and 1 puff 100-25 mcg fluticasone furoate-vilanterol, scheduled for 7:00 A.M., were not administered until 12:14 P.M. -On 8/13/2025 5 mg midodrine tablet, scheduled for 2:00 P.M., was not administered until 4:22 P.M. Resident 69's record lacked any documentation indicating why medications had not been administered on time. During an interview on 8/18/2025 at 9:40 A.M., the Director of Nursing (DON) indicated she felt the staff had been administering medications timely, but were not signing off the medications in the electronic charting system until later. The DON indicated the facility's policy was to sign off on medications as soon as the medication had been administered. The DON indicated medications were considered late if they were administered one hour after the ordered administration time. The DON indicated Physicians orders should have been completed as ordered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/18/2025 at 11:00 A.M., QMA 20 indicated she had not noticed the parameters in some of the medication orders and administered the medication without noting the parameters. QMA 20 indicated medications were to be signed off once the medication had been given. QMA 20 indicated she had received many skills validations, but was not sure if medication administration had been part of those validations. During an interview on 8/18/2025 at 2:00 P.M., QMA 2 indicated medications were to be signed off once the medication had been given to the resident. QMA 2 indicated if medications were given, but not signed off on in the chart, she would have add ed a note indicating what medications were given and what time they were given, and she would then have marked the medication as administered in the Medication Administration Record (MAR). QMA 2 indicated the facility had performed skills validations with her upon hire and yearly. She indicated she believed medication administration had been part of her skills validation. An interview with QMA 18 was completed on 8/18/2025 at 2:15 P.M. QMA 18 indicated if an order indicated to not give a medication based on the blood pressure, the medication should not have been given. QMA 18 indicated medications should be signed off as administered as soon as the medications were given. QMA 18 indicated she had been educated reagarding medication administration in the past and medication administration had been part of her skills validations. During a follow-up interview on 8/19/2025 at 9:50 A.M., the DON indicated it was the facility's policy to follow the Physician's orders as ordered. She indicated if a medication was scheduled to be administered, but administering the medication was dependent on a blood pressure, assessment a blood pressure assessment was to be obtained at the time, or shortly before the medication was to be administered. If the blood pressure was outside of the medication ordered parameters, the medication was not to be given. In addition, the DON indicated if the blood pressure assessment was within parameters of a medication administration, the medication should have been given. During an interview on 8/19/2025 at 10:00 A.M., RN 5 indicated she had plenty of time to get all her work done during the shift. RN 5 indicated medications should be signed off once they had been administered. RN 5 indicated she had received a skills validation on medication administration upon hire. RN 5 indicated she was unable to recall if timeliness was part of the facilities medication administration validation, but following the order, including checking parameters for vitals, had been included in the validation. 7. On 8/13/2025 at 10:15 A.M., Resident 15 was observed without TED hose (medical-grade compression stockings used to prevent blood clots and swelling in the legs) on her legs. On 8/14/2025 at 11:10 A.M., observed Resident 15 without compression hose on either leg. On 8/15/2025 at 1:49 P.M., observed Resident 15 without TED hose visible on legs. The clinical record of Resident 15 was reviewed on 8/14/2025 at 11:06 A.M. The resident's diagnoses included, but were not limited to: wedge compression fracture of T10-T11 vertebrae with subsequent encounter for fracture with delayed healing, heart failure, post-traumatic stress disorder, schizoaffective disorder - bipolar type, chronic pain syndrome, anxiety, chronic obstructive pulmonary disorder, cellulitis of left lower limb, hypertension and non-pressure ulcer of left lower leg. A Significant Change Minimum Data Set (MDS) assessment, dated 6/10/2025, indicated Resident 15 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was cognitively intact. The Significant Change MDS assessment indicated the resident required supervision for upper body dressing and partial assistance for lower body dressing. A Physician order, dated 1/30/2025, indicated Resident 15 was to wear TED hose in the morning and have them removed in the evening. The August 2025 Medication Administration Record indicated nursing staff had applied the TED hose to Resident 15 on the following dates at the administration time of 0700: 8/13/2025, 8/14/2025 and 8/15/2025. During an interview, on 8/14/2025 at 11:28 A.M., Employee 13 indicated Resident 15 did not wear TED hose.During an interview, on 8/14/2025 at 1:08 P.M., Employee 2 indicated Resident 15 sometimes wore her TED hose, it just depended if the resident let the facility staff put the compression hose on her. Employee 2 indicated if Resident 15 refused, she would have notified the nurse. During an interview, on 8/15/2025 at 1:53 P.M., the Corporate Regional Nurse Consultant indicated when a resident refused treatment, the nurse should have documented on the Treatment Administration Record (TAR) and select refused and then would have been no other documentation. The Corporate Regional Nurse Consultant indicated if the nurse documented OTHER, the nurse should have documented in the progress notes and indicated the nurse should have tried to reapproach the resident but cause stress to the resident. 8. The clinical record for Resident 1 was reviewed on 8/18/2025 at 8:47 A.M. The resident's diagnoses included, but were not limited to: bipolar disorder, hypertension, restless leg syndrome, hemiparesis and hemiplegia following cerebral infarction affecting left non-dominant side, schizoaffective disorder, diabetes mellitus and atrial flutter. A Quarterly Minimum Data Set (MDS) assessment, dated 7/17/25, indicated Resident 1 was cognitively intact and received antipsychotic, antidepressant, anticoagulant and insulin medications. A Physician Order, dated 7/26/2024, indicated Resident 1 was to receive an Accu Check (refers to a brand of blood glucose monitoring systems and related products designed for people with diabetes) four times daily before meals and at bedtime. A Physician Order, dated 4/22/2025, indicated Resident 1 was to receive Humalog Injection Solution 100 unit/milliliter (mL) injection per sliding scale: if 151-200 = 3 units; 201-250 = 5 units; 251-300 = 8 units; 301-350 = 10 units; 351-400 = 12 units; greater than 400 = 15 units and notify MD, subcutaneously before meals and at bedtime. A current Care Plan, revised on 7/15/2025, indicated Resident 1 had interventions including, but not limited to: blood sugars as ordered by the doctor. The August 2025 Medication Administration Record (MAR) indicated Resident 1 had not had his blood sugar monitored as ordered on the evening of 8/5/2025 and had not received any subsequent sliding scale insulin on the evening of 8/5/2025. During an interview, on 8/18/2025 at 10:49 A.M., Employee 14 indicated Resident 1 had his blood sugar checked before every meal and at bedtime. Employee 14 indicated Resident 1 had sliding scale (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coverage for any blood sugar that was out of range according to the orders. Employee 14 indicated if a resident refused a blood sugar check, then she re-approached the resident and educated the resident on the importance of having their blood sugar monitored. Employee 14 indicated if the blood sugar assessment had been forgotten and not performed, she would have checked the resident's blood sugar as soon as possible and then notified the doctor and notified the supervisor regarding the delay in care. During an interview, on 8/18/2025 at 12:12 P.M., the Director of Nursing (DON) indicated she believed the nurse had performed the blood sugar on 8/5/2025 and the nurse should have signed off the Medication Administration Record (MAR). 9. The clinical record for Resident 4 was reviewed on 8/14/2025 at 2:05 P.M. The resident's diagnoses included, but were not limited to: urinary tract infection, diabetes mellitus with neuropathy, giant cell arteritis, prosthetic heart valve, dissection of aorta, vascular dementia, depression, anxiety, abnormal coagulation profile and chronic pain syndrome. A Significant Change Minimum Data Set (MDS) assessment, dated 7/14/2025, indicated Resident 4 was moderately cognitively impaired. A Physician Order, dated 8/4/2025, indicated Resident 4 received Ertapenem Sodium Solution Reconstituted 1 gram (an antibiotic) intravenously every 24 hours for ESBL (refers to a urinary tract infection caused by bacteria that produce extended-spectrum beta-lactamases) for 13 days. The August MAR indicated Resident 4 had not received the dose of Ertapenem Sodium scheduled for 8/15/2025. A current Care Plan, dated 7/29/2025, indicated Resident 4 required intravenous (IV) antibiotics due to urinary tract infection and interventions included but were not limited to: administer IV antibiotics as ordered. During an interview, on 8/19/2025 at 9:12 A.M., Employee 15 indicated the nurse had probably forgotten to chart the antibiotic on 8/15/2025 for Resident 4. Employee 15 indicated the nurse had until the end of her shift to chart all of the medications she had administered. On 8/15/2025 at 9:00 A.M., the DON provided a policy titled, &ldq

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on record review and interview, the facility failed to ensure nursing staff had the competencies to administer medications timely and/or administer medications as ordered by the Physician for 8 of 8 residents (Resident's 1, 3, 4, 8, 29, 51, 67 and 69.) See F684 for additional information regarding Resident's 1, 3, 4, 8, 29, 51, 67 and 69. Findings include: 1. A record review of Resident 1 was completed on 8/15/2025 at 11:00 A.M. Resident 1's record indicated Physician orders for administering insulin before meals. RN 3 administered the breakfast time insulin on 7/17/2025 at 1:30 P.M. and administered the lunch time insulin on 7/17/2025 at 1:30 P.M. On 7/19/2025, RN 3 administered the breakfast insulin at 11:30 A.M. On 7/23/2025, the breakfast insulin was administered at 11:38 A.M by QMA 22. On 7/29/2025 the lunch (12:00 P.M) insulin was administered by RN 3 at 3:05 P.M. On 8/14/2025 RN 3 administered the lunch meal insulin at 2:24 P.M. Between 7/15/2025 and 8/15/2025, Resident 1 received medications at least an hour and a half (90 minutes) late 24 out of the last 60 shifts. (2 shifts per day)During an interview on 8/18/2025 at 9:40 A.M., the Director of Nursing (DON) indicated she felt the staff had been administering medications timely, but were not signing off the medications until later. The DON indicated the facility's policy was to sign off on medications as soon as the medication were administered. The DON indicated medications were considered late if they were administered one hour after the ordered administration time. The DON indicated Physicians orders should have been completed as ordered. A review of the scheduled mealtimes provided at the survey entrance conference indicated breakfast at the facility was served at 8:00 A.M. and lunch was served at 12:00 P.M.2. Resident 3's record review was completed on 8/15/2025 at 12:00 P.M. Resident 3's record indicated Physician orders for administering insulin before meals. On 7/17/2025, RN 3 administered the breakfast mealtime insulin at 11:05 A.M. On 7/23/2025, the Social Service Director (SSD) administered the breakfast mealtime insulin at 12:27 P.M. On 7/29/2025, QMA 22 administered the breakfast time insulin at 10:55 A.M and the lunch time insulin at 1:56 P.M. On 7/31/2025, RN 3 administered the breakfast time insulin at 10:49 A.M. and the lunch time insulin at 5:56 P.M. On 8/3/2025, RN 6 administered the lunch time insulin at 1:50 P.M. On 8/5/2025, RN 3 administered the lunch time insulin at 5:09 P.M. On 8/12/2025, QMA 22 administered the lunch time insulin at 1:54 P.M. Between 7/15/2025 and 8/15/2025, Resident 3 received medications at least an hour and a half (90 minutes) late 22 out of the last 60 shifts. (2 shifts per day)During an interview on 8/18/2025 at 1:10 P.M., RN 3 indicated she had not given the breakfast and lunch insulin at the same time on 7/17/2025, but had administered the breakfast meal time insulin around 8:00 A.M. (breakfast time) without signing off the electronic record. RN 3 indicated she administered medications timely, but was signing off on the medication administrations later in the shift. She indicated medications should be signed off as administered in the EMR (Electronic Medical Record) as soon as the medication had been given. 3. A record review for Resident 4 was completed on 8/15/2025 at 1:00 P.M. Resident 4's record included a Physician's order to receive insulin at 8:00 P.M. On 7/16/2025, QMA 8 administered the 7/15/2025 8:00 P.M. insulin at 3:12 A.M. On 7/26/2025 at 4:53 A.M.RN 23 administered the 7/25/2025 8:00 P.M. insulin. Resident 4's record also included Physician's orders for administering ertapenem (an antibiotic) once every day. On 8/15/2025, Resident 4 did not receive her dose of ertapenem. Between 7/15/2025 and 8/15/2025, Resident 4 had been administered medications at least an hour and a half (90 minutes) late on 28 out of the last 60 shifts. (2 shifts per day)4. A review of Resident 8's record was completed on 8/15/2025 at 1:30 P.M. Between 7/15/2025 and 8/15/2025, Resident 8 had been administered medications at least an hour and a half late on 29 out of the last 60 shifts. (2 shifts per day)5. A review of Resident 29's record was completed on 8/15/2025 at 1:48 P.M. Between 7/15/2025 and 8/15/2025, Resident 29 had been administered medications at least an hour and a half late on 17 out of the last 60 shifts. (2 shifts per day)6. A review of Resident 51's record was completed on 8/15/2025 at 2:08 P.M. Between (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/15/2025 and 8/15/2025, Resident 51 had been administered medications at least an hour and a half late on 16 out of the last 60 shifts. (2 shifts per day)7. A review of Resident 67's record was completed on 8/15/2025 at 2:30 P.M. Between 7/15/2025 and 8/15/2025, Resident 67 had been administered medications at least an hour and a half late 12 out of the last 60 shifts. (2 shifts per day)8. A review of Resident 69's record was completed on 8/15/2025 at 2:55 P.M. Resident 69's record indicated Physician orders for administering midodrine (increases blood pressure) when Resident 69's systolic blood pressure (bp) was 125 or less and administering hydralazine (decreases blood pressure) when Resident 69's systolic bp was greater than 160. On 7/10/2025 at 8:00 P.M., Resident 69's systolic bp was 141 and QMA 16 administered the midodrine medication. On 7/13/2025 at 8:00 P.M., Resident 69's systolic bp was 143 and QMA 18 administered the midodrine medication. On 7/16/2025 at 8:00 P.M., Resident 69's systolic bp was 130 and QMA 16 administered the midodrine medication. On 7/20/2025 at 8:00 A.M., Resident 69's systolic bp was 155 and QMA 21 administered the midodrine medication. On 7/20/2025 at 8:00 P.M., Resident 69's systolic bp was 134 and QMA 21 administered the midodrine medication. On 7/23/2025 at 8:00 A.M., Resident 69's systolic bp was 142 and the SSD administered the midodrine medication. On 7/27/2025 at 8:00 P.M., Resident 69's systolic bp was 153 and QMA 19 administered the midodrine medication. On 7/31/2025 at 8:00 A.M., Resident 69's systolic bp was 149 and QMA 20 administered the midodrine medication. On 7/31/2025 at 2:00 P.M., Resident 69's systolic bp was 151 and QMA 20 administered the midodrine medication. On 8/4/2025 at 8:00 A.M., Resident 69's systolic bp was 150 and QMA 7 administered the midodrine medication. On 7/31/2025 at 2:00 P.M., Resident 69's systolic bp was not recorded in the resident's record and QMA 7 administered the midodrine medication. On 8/5/2025 at 8:00 A.M., Resident 69's systolic bp was 159 and QMA 17 administered the midodrine medication. On 8/5/2025 at 2:00 P.M., Resident 69's systolic bp was 142 and QMA 17 administered the midodrine medication. On 8/6/2025 at 8:00 A.M., Resident 69's systolic bp was 185 and QMA 18 administered the midodrine medication, but did not administer the hydralazine. medication On 8/15/2025 at 8:00 A.M., Resident 69's systolic bp was 152 and QMA 20 administered the midodrine medication. Between 7/15/2025 and 8/15/2025, Resident 69 had been administered medications at least an hour and a half hour late 19 out of the last 60 shifts. (2 shifts per day)During an interview on 8/18/2025 at 11:00 A.M., QMA 20 indicated she had not noticed the parameters in the order for the midodrine and administered the medication. QMA 20 indicated medications were to be signed off on once the medications had been given. QMA 20 indicated she had received many skills validations, but was not sure if medication administration had been part of those validations. During an interview with QMA 18, completed on 8/18/2025 at 2:15 P.M, she indicated if an order indicated to not give a medication based on a blood pressure, the medication should not have been given. QMA 18 indicated medications should be signed off as administered as soon as the medications were given. QMA 18 indicated she had been educated on medication administration in the past and medication administration had been part of her skills validations. During an interview on 8/18/2025 at 2:00 P.M., QMA 2 indicated the midodrine medication should not have been given to the resident any time the resident's systolic bp was over 125. QMA 2 indicated medications were signed off once the medication had been given to the resident. QMA 2 indicated if medications were given, but not signed off on in the chart, she would have added a note indicating what medications had been given and what time they were given, and she would then have marked the medication as administered in the Medication Administration Record (MAR). QMA 2 indicated the facility had performed skills validations with her upon hire and yearly. She indicated she believed medication administration had been part of her skills validations. During an interview on 8/19/2025 at 9:50 A.M., the DON indicated it is the facilities policy to follow the Physician's orders as ordered. She indicated if a medication was scheduled to be administered, but administering the medication was dependent of a blood pressure, a blood pressure should be obtained at the time, or shortly before the medication should be administered. If the blood pressure was outside of the medication parameters, the medication should not have been given, and if the blood pressure was within the parameters of a (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration, the medication should have been given. During an interview on 8/19/2025 at 10:00 A.M., RN 5 indicated she had plenty of time to get all her work done during the shift. RN 5 indicated medications should be signed off on once they had been administered. RN 5 indicated she had received a skills validation on medication administration upon hire. RN 5 indicated she was unable to recall if timeliness was part of the facilities medication administration validation, but following the orders, including checking parameters for vitals, had been included in the validation. On 8/18/2025 at 11:50 A.M., the DON provided three documents titled, Medication Administration Competency for QMAs 7, 8 and 16. The facility was not able to provide the Medication Administration Competency documents for QMA 2, RN 3, the SSD or QMAs 19 or 22. On 8/15/2025 at 9:00 A.M., the DON provided a policy titled, Medication Administration, dated 12/12/2023 and indicated the policy was the one currently used by the facility. The policy indicated .Physicians will be notified timely of medication omissions. Instructions on how to proceed (example: administer medication when it becomes available) will be followed per physician order .On 8/18/2025 at 3:00 P.M., the DON provided a policy titled, Physician Orders, dated 11/13/2023 and indicated the policy was the one currently used by the facility. The policy indicated, .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 .On 8/19/2025 at 1:10 P.M., the Executive Director provided a policy dated 1/2/2024 and title, Orientation. The ED identified the policy as the one currently used by the facility. The policy indicated, .b. Departmental orientation checklist reflect the skills and competencies that each new team member will require to fulfill his or her job responsibilities .5. Checklists will be used to document training and competency evaluations conducted during the orientation process .9. Competency evaluation form process: a. Each new team member is responsible for keeping track of his/her competency evaluation form throughout the orientation process. b. The preceptor, or designee, shall verify competency in each skill or content area a the time competency is demonstrated. The preceptor's initials/signature indicate competency . d. The compiled form is forwarded to the IPSD (if the community has one assigned) otherwise the Director of Nursing, to verify competency in all areas .11. All documentation to support completion of the orientation process shall be maintained in the team member's personal file. 3.1-14 (i)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observation, interview, and record review, the facility failed to revise care plans to reflect the current status for 1 of 22 residents whose care plans were reviewed. (Residents 29)Findings include: During a record review on 8/14/20205 at 11:39 A.M., an admission Minimum Data Set (MDS) assessment indicated Resident 29's cognition was severely impaired, his mobility and locomotion required the use of a manual wheelchair and his activity preferences that were very important to him included listening to music and being around animals and pets. An Activity Care Plan problem, initiated on 7/27/2025, indicated Resident 29 preferred playing cards, watching reality shows, and enjoyed rock and roll music. An intervention indicated that the resident would be verbally reminded of the time and place of the activity. There was no intervention to ensure the resident was physically assisted and taken to the desired activities and there was no intervention to ensure the resident was invited to activities including any animals or pet visits. During an interview on 8/18/2025 at 12:10 P.M. the DON indicated Resident 29 was not able to take herself to any of the activities programs. On 8/18/2025 the DON provided a current policy, dated 5/16/2024, and titled, Comprehensive Care Plan. The policy indicated, .Resident/patient specific interventions that reflect the resident's/patient's needs and preferences and .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment 3.1-35(d)(2)(B)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide personalized activity programs for 2 of 3 residents reviewed for activities. (Resident 29 and 10)Findings included: 1. On 8/13/2025 at 12:36 P.M., Resident 10 was observed seated in her room, watching television. During a continuous observation, on 8/15/2025 from 1:54 P.M. through 2:12 P.M., Resident 10 was observed seated in her room by herself, while bingo was being held by Activities staff in the dining hall. During an interview, on 8/15/2025 at 10:33 A.M., the Activities Director (AD) indicated the activity interventions for a resident depended on their likes and abilities. The AD indicated Resident 10 liked to be around people, listen to music and play bingo. During an interview, on 8/15/2025 at 2:19 P.M., Resident 10 indicated she liked to drink and go outside. During an interview, on 8/18/2025 at 10:23 A.M., the AD indicated outdoor time means the resident was taken outside by facility staff. The AD indicated the resident was recently taken outside by her sister. The Activity Director indicated she had not taken the resident out lately due to the severe heat but the AD indicated the resident liked to play bingo. The clinical record of Resident 10 was reviewed on 8/15/2025 at 2:19 P.M. The resident's diagnoses included, but were not limited to: hemiparesis and hemiplegia following non-traumatic subarachnoid hemorrhage affecting left non-dominant side, malignant neoplasm of left kidney, extrapyramidal and movement disorder, chronic obstructive pulmonary disorder, aphasia following cerebral infarction, vascular dementia, traumatic cerebral edema, schizophrenia, hypertension, depression and dysphagia. A Significant Change Minimum Data Set (MDS) assessment, dated 6/18/2025, indicated the resident was rarely or never understood. and was dependent on staff for all activities of daily living. The Significant Change MDS assessment indicated it was somewhat important for the resident to have music, very important to have pets, somewhat important for the resident to do things with groups of people and very important for the resident to go outside. A current Activity Care Plan, revised on 6/30/2025, included interventions but were not limited to: provide assistance/escort to activity functions. An Activity Report, for Resident 10 for June 2025 and July 2025 indicated the resident participated in her preferred activities on the following dates: - 6/13/2025: social - 6/13/2025: music -7/24/2025: music During an interview, on 8/15/2025 at 10:49 A.M., the AD indicated social means a group activity and not applicable means hydration and movie is a group activity. This is in regards to the printed activity (continued on next page)

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	155219	A. Building B. Wing	08/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Majestic Care of South Bend	52654 N Ironwood Rd South Bend, IN 46635

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report sheet from the Electronic Medical Record (EMR). 2. During observations on 8/12/2025 at 10:52 A.M. and 8/13/2025 at 10:28 A.M., Resident 29 was in her wheelchair wandering without any noted purpose about the unit. During an observation on 8/14/2025 at 1:38 P.M., Resident 29 was in the dining room on the unit. There was CNA staff in the dining room, but Resident 29 was not engaged in meaningful activity. During an observation on 8/15/2025 at 2:21 P.M., Resident 29 was at the nurses desk picking at her clothes. The nurse was at the desk, but Resident 29 was not engaged in any activity. During an observation on 8/18/2025 at 10:34 A.M., Resident 29 was in bed. CNA 12 indicated the resident had days when she sometimes slept late into the day and then was up all evening. During an interview on 8/18/2025 at 10:14 A.M., the Activity Director indicated Resident 29 had a sensory box in her room and would use it on occasion. She also occasionally attended activities but was a passive observer. The AD indicated the resident liked Rusty, the facility cat, and staff sometimes brought the cat to the activity room to visit with the resident. During an observation of Resident 29's room, on 8/18/2025 at 2:28 P.M., the sensory box was not present where the resident would have been able to access it. During a record review for Resident 29, completed on 8/14/20205 at 11:39 A.M., an admission Minimum Data Set (MDS) assessment indicated Resident 29's cognition was severely impaired and her activity preferences that were very important to her included listening to music and being around animals and pets. An Activity Care Plan problem, initiated on 7/27/2025, indicated Resident 29 preferred playing cards, watching reality shows, and enjoyed rock and roll music. Interventions included verbally reminding the resident of the time and place of the activities ;and reminding the resident that she could leave activities at any time. Activity documentation indicated Resident 29 had been engaged in independent activities on a daily basis for the current month and she had only attended one group activity during the current month. During an interview on 8/18/2025 at 12:10 P.M. The DON indicated the resident was not able to propel her wheelchair by herself to any activity program. On 8/18/2025 at 12:10 P.M. the DON provided a current policy titled, Activity Services, and dated 11/1/2024. The policy indicated, .Activities will be designed with the intent to: .i. Reflect choices of the residents/patients 3.1-33(a)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation and interview, the facility failed to serve food in a sanitary manner for 1 of 1 dining rooms observed during the lunch meal service. This had the potential to affect 70 of 70 residents in the facility.Finding includes: During a continuous observation on 8/12/2025, from 12:16 P.M. through 12:28 P.M., CNA 11 was observed to serve food with her thumb over the rim of the plate for 2 of 2 residents in the dining hall. During an interview, on 8/12/2025 at 12:29 P.M., CNA 11 indicated she always held plates from the bottom. On 8/13/2025 at 11:30 A.M., the Regional [NAME] President of Operations provided a policy titled, Meal Supervision, dated 12/12/2023 and indicated the policy was the one currently used by the facility. The policy indicated .The facility will utilize a systemic approach to ensure safety throughout the resident's environment .3.1-21(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Number of residents sampled:Number of residents cited:Based on observation, record review and interview, the facility failed to ensure aseptic technique and enhanced barrier precautions were maintained during PICC (peripherally-inserted central catheter) care for 1 of 1 residents reviewed for PICC line care. (Resident 7). In addition, the facility failed to ensure oxygen equipment was cleaned for 1 of 2 residents reviewed for respiratory care. (Resident 4) Findings included:1.During an observation, on 8/12/2025 at 2:33 P.M., Resident 4's had a PICC (a peripherally inserted central catheter, or a long, thin, flexible tube inserted into a vein into the arm and threaded into a larger vein near the heart) line dressing on her right upper arm but the date on the dressing not legible because the ink was smudged. The clinical record of Resident 4 was reviewed on 8/14/2025 at 2:05 P.M. The residents' diagnoses included, but were not limited to: urinary tract infection, diabetes mellitus with neuropathy, giant cell arteritis, prosthetic heart valve, dissection of aorta, vascular dementia, depression, anxiety, abnormal coagulation profile and chronic pain syndrome. A Significant Change Minimum Data Set (MDS) assessment, dated 7/14/2025, indicated Resident 4 was moderately cognitively impaired. A Physician Order, dated 8/14/2025, indicated Resident 4 was to have her PICC line dressing changed every 7 days. An August 2025 Medication Administration Record (MAR) indicated Resident 4 had been sent to an acute care center's emergency room for an evaluation and placement of a PICC line for IV (intravenous) antibiotics on 8/1/2025 at 8:08 A.M. A PICC line dressing change was not documented as having been completed until 8/14/2025., 14 days after the PICC line had been placed. A current Care Plan, initiated on 7/29/2025, indicated Resident 4 required intravenous (IV) antibiotics due to urinary tract infection and interventions included but were not limited to: change dressing as ordered. During an interview, on 8/14/2025 at 2:23 P.M., the South Unit Manager indicated the PICC line dressings should be changed once a week, and the PICC line dressing changes should be documented on the Medication Administration Record (MAR) or the Treatment Administration Record (TAR). During an interview on 8/19/2025 at 12:22 P.M., the Director of Nursing (DON) indicated nursing employees completed a skill check off for the PICC lines upon hire and at their yearly skill check-off. On 8/19/2025 at 1:05 P.M., the DON provided a policy titled, Assessment, Care and Dressing Changes of Vascular Access Devices, dated 4/6/2018 and indicated the policy was the one currently used by the facility. The policy indicated .Site care, including skin antisepsis and dressing changes, are performed at established intervals .A sterile dressing is applied and maintained on all peripheral, non-tunneled, peripherally inserted central catheters (PICCs) .Dressings are labeled with the date performed or the date to be changed based on facility policy . During an observation of flushing of a peripherally inserted central catheter (PICC line, a flexible tube inserted into a vein in the arm and threaded into a larger vein near the heart. It was used to administer and antibiotic) for Resident 4 on 8/15/2025 at 10:50 A.M., RN 6 did not don a gown before performing (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the flush until asked when a gown should have been donned. RN 6 also attempted to apply a contaminated cap to the end of the PICC line until the issue was brought to her attention after she was stopped from applying the contaminated cap. During an interview on 8/15/2025 at 10:59 A.M., RN 6 indicated she should have donned a gown before flushing the PICC line per Enhanced Barrier Precaution guidelines. She further indicated she should have used sterile technique to apply the cap to the PICC line. On 8/19/2025 at 12:47 P.M. the DON provided a current policy titled, Enhanced Barrier Precautions and dated, 5/1/2024. The policy indicated, .High-contact resident care activities include: .g. Device care or use: central lines 2. During an observation on 8/13/2025 at 10:15 A.M., Resident 7's oxygen concentrators' filter had a heavy buildup of dust and the nasal canula attached to the concentrator was dated 8/3/2025. Resident 7's record review was completed on 8/15/2025 at 9:20 A.M. Diagnosis included, but were not limited to: chronic obstructive pulmonary disease, end stage renal failure, major depressive disorder and generalized anxiety disorder. A current Physician's order indicated Resident 7 was to have her nasal cannula changed weekly and the oxygen filter was to be cleaned weekly. Resident 7's August Treatment Administration Record (TAR) indicated the nasal cannula had been changed on 8/10/2025, despite the observation on 8/13/2025 with a date of 8/3/2025. In addition, the TAR indicated the the oxygen filter had been cleaned on 8/10/2025. During an observation and interview, on 8/14/2025 at 2:45 P.M. with the Director of Nursing (DON) of Resident 7's oxygen concentrator, the DON indicated the nasal cannula should have been changed weekly and the filter of the oxygen concentrator should not have had a build up of dust. On 8/20/2025 at 1:40 P.M., the Executive Director provided an undated policy titled, Oxygen Concentrator and identified the policy as the one currently used by the facility. The policy indicated, .a. Follow the manufacturer recommendations for the frequency of cleaning filters and servicing the device .c. Nurse responsibilities: i. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated 3.1-18 (a)