STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave Indianapolis, IN 46222

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity for 15 of 16 residents reviewed for dignity. (Residents' 6, 8, 9, 12, 13, 14, 16, 24, 28, 34, 37, 42, 44, 47, and an Anonymous Resident) Findings include: 1. The clinical record for Resident 14 was reviewed on 6/4/25 at 11:18 a.m. The diagnoses included, but were not limited to, hypertension and congestive heart failure. A Quarterly Minimum Data Set (MDS) assessment, completed 3/5/25, indicated he was cognitively intact During an interview on 6/4/25 at 2:18 p.m., Resident 14 indicated he felt the facility staff did not care what the residents of the facility had to say. The staff sat in their offices and went to meetings but never came out and talked with the residents to find out about the problems they were having. He felt the upper management made it all about the budget and not about the residents. 2. On 6/4/25 at 2:12 p.m., Resident 44 was observed sitting in her wheelchair in her room. She turned on her call light to get assistance going back to bed. Her call light continued to be on at 2:29 p.m., and she continued to sit in her wheelchair by her bed. The call light was audible at the nurses' station and visible in the hallway. At 2:30 p.m., Licensed Practical Nurse (LPN) 2 walked to the nurses' station and then left the nurses' station, indicating she was heading to lunch. At 2:31 p.m., a dietary staff member walked by the nurses' station and down the hallway outside of Resident 44's room, where the call light was visible. At 2:42 p.m., a Certified Nurse Aide entered Resident 44's room and shut off the call light, shut the door, and assisted Resident 44. 4. An interview was conducted, on 6/4/25 at 11:15 a.m., with Resident 8. She indicated she had overheard aides in the hall warning each other about coming into her room and spending all their time on their phones. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. A resident council meeting was conducted on 6/5/25 at 2:06 p.m. During this meeting, Resident 14 indicated call lights go unanswered for at least thirty minutes, and on the weekends it was worse. Staff will come into our rooms and turn the light off, say they will come back to assist us, and never return. Resident 14 indicated when staff do this it makes him feel helpless and not valued. Residents' 6, 9, 12, 13, 16, 24, 28, 34, 37, 42, and 47 indicated they agreed to Resident 14's comments. Resident 42 indicated having to wait so long for assistance after putting on his call light made him feel like he wanted to die. 6. A confidential interview was conducted during the course of the survey which indicated residents had to wait a long time for call lights to be answered. They had seen call lights be on for hours with no one answering them. When they would tell nursing staff about residents' requests or that a resident needed help the nursing staff would get attitudes with them. Some of the nurses were very nice, but some of the nurses were rude to the residents. The management staff rarely come out of the offices to see what was going on. They had seen urinals at bedside that were about to overflow, and no one would come and empty them. 7. During a confidential interview, an anonymous resident indicated QMA 8 called them a drug addict and was nothing but a junky. On a separate occasion, LPN 4 denied a resident was in that much pain when they had requested pain medication. The Director of Nursing (DON) was interviewed on 6/9/25 at 1:56 p.m. She indicated when staff members enter resident rooms, they were expected to knock first, announce themselves, and ask permission to come in. An interview was conducted with the DON on 6/9/25 at 4:10 p.m. She indicated LPN 4 had been educated regarding usage of her tone of voice. The DON indicated she was unaware of the allegation of LPN 4 denying resident's pain or of QMA 8 calling a resident a drug addict. During an interview on 6/10/25 at 3:20 p.m., the Executive Director indicated she would expect that no staff would walk by a call light and not answer it and attempt to assist the resident. Call lights should be answered timely. On 6/6/25 at 3:52 p.m., the Nurse Consultant provided the Dignity Policy, dated 8/9/2023, which indicated . Conversations 1.) Staff will be polite and respectful at all times- and will be positive in their approach to residents to include residents who make repetitive request and residents who are demanding or use inappropriate language toward staff . 2.) Staff will not speak in a manner that could be interpreted as even minimally condescending/ critical or argumentative nor in a volume any louder that is absolutely necessary as this can be interpreted as meeting abuse criteria .Privacy 1.) Staff will knock prior to entering a resident's room. They will announce themselves and ask permission to enter .Care .3.) Should a resident have an episode of incontinence, staff will change them upon discovery of the episode .Note: Residents are to have all aspects of their dignity maintained by staff regardless of the resident's cognitive level or ability to realize or understand what is being said or done by others. 3.1-3(t) (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The clinical record for Resident 24 was reviewed on 6/9/25 at 2:03 p.m. The diagnoses included, but were not limited to, atrial fibrillation (a heart condition where the heart beats chaotic and rapid), congestive heart failure (the heart becomes weak and cannot pump blood very well), and diabetes. A Quarterly MDS assessment, dated 4/17/25, indicated the resident was cognitively intact. Resident 24 was interviewed on 6/4/25 at 1:47 p.m. He indicated he has a hard time reaching his bottom to wipe after a bowel movement, due to his health conditions. He asked for help getting wiped, but the staff tells him it's not their job to help him wipe his bottom. Resident 24 was randomly observed activating his call light on 6/5/25 at 3:16 p.m. Qualified Medication Aide (QMA) 8 approached Resident 24's closed room door, put on a gown and gloves, and opened the door, asking Yeah? as she entered the room. She did not knock or identify herself. He asked for help getting cleaned up and she indicated she would be back to assist him.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to adequately document a discharge in a resident's electronic health record (EHR) for 1 of 1 resident reviewed for discharge in a closed record review (Resident 43). Findings include: The clinical record for Resident 43 was reviewed on 6/9/25 at 9:46 a.m. The diagnoses included, but were not limited to, congestive heart failure (the heart becomes weakened and cannot pump blood very well), dementia, and myocardial infarction (heart attack). Resident 43 admitted to the facility on [DATE] and was discharged to another long-term care facility on 5/23/25. A Care Plan Meeting progress note, dated 5/12/25, indicated Resident 43's friend discussed senior living for the resident, but facility nursing and the MDS (Minimum Data Set) Coordinator explained that Resident 43 had dementia and memory issues and would require supervision 24 hours a day. Resident 43's friend indicated she would investigate alternatives. A Discharge MDS assessment, dated 5/22/25, indicated Resident 43 was discharging to another long-term care facility on 5/23/25. The facility was not named. There was no documentation in the clinical record that a discharge order had been placed by the physician. No other documentation or discussion of discharge/discharge planning could be located in Resident 43's EHR. The Regional Director of Operations (RDO) was interviewed on 6/9/25 at 11:39 a.m. He indicated they did not have any other discharge documentation for Resident 43. A facility policy titled Guidelines for Discharge/Transfer, dated 8/26/23, was provided by the Director of Nursing (DON) on 6/9/25 at 12:07 p.m. It indicated A resident will be discharged /transferred [home or another entity] by order of their attending physician in accordance with the specific State/Federal standard and practice guidelines .1) Upon receiving an order from the physician to discharge the resident - the order will be processed into the resident's medical record. 2) Notification will be made to the resident, their responsible party, and any other interested family member as appropriate and indicated. This notification will be documented in the resident's medical record . 3.1-12(a)(5) 3.1-12(a)(6)(B)

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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 interview and record review, the facility failed to ensure care plan meetings were conducted quarterly for 1 of 1 resident reviewed for care planning. (Resident 42) Findings include: The clinical record for Resident 42 was reviewed on 6/5/25 at 10:00 a.m. The diagnoses included, but were not limited to, paraplegia and major depressive disorder. A Quarterly Minimum Data Set (MDS) assessment, dated 4/30/25, indicated Resident 42 was cognitively intact. During an interview on 6/5/25 at 10:11 a.m., Resident 42 indicated he had not been invited to any care plan meetings since his admission in January of 2025. On 6/5/25 at 3:20 p.m., the Regional Director of Operations (RDO) provided a care plan meeting progress note dated 1/28/25. This progress note included a list of interdisciplinary team members present and a summary of his care plan meeting. No other care plan meeting progress notes were provided. During an interview on 6/6/25 at 1:59 p.m., the MDS Nurse indicated the facility conducted care plan meetings quarterly or as needed. Resident 42 was scheduled to have a care plan meeting after the week of 4/22/25, but it had been cancelled. She indicated she was unsure as to why a care plan meeting had not been rescheduled. On 6/6/25 at 3:52 p.m., the Nurse Consultant (NC) provided a Baseline Care Plan Assessment/Comprehensive Care Plans Policy, last revised 09/13/24. It indicated . Procedure .6. The facility Social Service Director or designee will notify the resident of their scheduled Care Plan Conference and will invite and encourage the resident to attend. This notification will continue for any subsequent Care Plan Conferences .9. The Comprehensive Care Plans will be reviewed and updated every quarter at a minimum . 3.1-35(d)(2)(B)

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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 timely perineal (genital and anal area) care for 1 of 1 resident observed for activities of daily living (ADLs). (Resident 24) Findings include: The clinical record for Resident 24 was reviewed on 6/9/25 at 2:03 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD, lung and airway disease which restricts breathing), chronic heart failure, pulmonary embolism (clot in lung), weakness, vertigo (dizziness), and difficulty walking. A Quarterly Minimum Data Set (MDS) assessment, dated 4/17/25, indicated the resident was cognitively intact and needed set up or clean up assistance with toileting hygiene. A care plan for ADLs noted an intervention, initiated on 6/17/22, to where staff were to assist Resident 24 with toileting as needed. Another intervention, initiated on 6/17/22, indicated staff were to keep skin clean and dry, provide peri-care (genital/groin/anal area cleaning) and clothing changes as needed. An intervention, initiated on 3/25/25, indicated staff were to provide peri-care as needed with repositioning and keep linens dry, clean, and wrinkle-free. An intervention, initiated on 6/17/22, indicated staff were to promptly assist with toileting when the resident requested and assist with transfers on and off the toilet, adjusting clothing and peri-care as needed. Resident 24 was interviewed on 6/4/25 at 1:47 p.m. He indicated he had a hard time reaching his bottom to wipe after a bowel movement, due to his health conditions. He asked for help getting wiped, but the staff told him it's not their job to help him wipe his bottom. Resident 24 was interviewed on 6/5/25 at 2:33 p.m. He indicated his bottom still had stool on it from yesterday, and he could feel it itching and burning. He had asked the day shift Certified Nurse Aide (CNA) to help him get cleaned up about 20 minutes ago, but she left and had not been back since. No staff was observed entering Resident 24's room, so he activated his call light at 3:10 p.m. Qualified Medication Aide (QMA) 8 was observed entering the resident's room at 3:16 p.m. QMA 8 was interviewed on 6/5/25 at 3:24 p.m. She indicated there was no reason why Resident 24 couldn't clean himself. The Nurse Consultant (NC) provided a policy titled Activities of Daily Living on 6/10/25 at 1:30 p.m. It indicated Residents are given routine daily care and HS [nighttime] care by a CNA [Certified Nurse Aide] or a Nurse to promote hygiene, provide comfort and provide a homelike environment. ADL care is provided throughout the day, evening and night as care planned and/or as needed. ADL care is coordinated between the resident and the care givers with emphasis on resident preference as much as possible .ADL care of the resident includes: Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care [as indicated and as per care plan] . 3.1-38(a)(2)(C) (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(a)(3)(A)

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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 interview and record review, the facility failed to hold cardiac medication when vital signs were outside of prescribed parameters and to administer insulin as ordered for 2 of 5 residents reviewed for unnecessary medications. (Resident 14 and Resident 17) Findings include: 1. The clinical record for Resident 14 was reviewed on 6/4/25 at 11:18 a.m. The diagnoses included, but were not limited to, hypertension and congestive heart failure. A physician's order, dated 4/9/24, indicated he was to receive digoxin (cardiac medication) 125 micrograms (mcg); one tablet daily for heart failure. The parameters were listed to hold the medication dose for pulse under 60 beats per minute. A physician's order, dated 4/9/24, indicated he was to receive metoprolol succinate extended release (ER) 50 milligrams (mg) twice daily for hypertension. The parameters were listed to hold the medication dose for systolic blood pressure below 100 or pulse below 60. A care plan, last revised on 6/19/24, indicated Resident 14 had the potential for cardiac distress related to a diagnosis of coronary artery disease. The goal was for him to be free of cardiac distress. The interventions included to serve diet as ordered and administer medications as ordered. The May 2025 and June 2025 Medication Administration Record (MAR) indicated the digoxin 125 mcg had been administered when Resident 14's pulse was below 60 on the following days: 5/6/25, 5/7/25, 5/19/25, 5/20/25, 5/21/25, and 6/5/25. The May 2025 and June 2025 MAR indicated the metoprolol succinate 50 mg had been administered when his pulse was below 60 on the following days: 5/6/25, 5/7/25, 5/19/25, 5/20/25, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/21/25, 6/5/25, and 6/8/25. During an interview on 6/9/25 at 12:19 p.m., the Director of Nursing (DON) indicated the digoxin, and metoprolol should have been held when Resident 14's pulse was below 60. 2. The clinical record for Resident 17 was reviewed on 6/5/25 10:30 a.m. The diagnoses included, but were not limited to, cocaine abuse, opioid use, and major depressive disorder. An Annual Minimum Data Set assessment, dated 3/24/25, indicated Resident 17 was cognitively intact. A physician order, dated 1/9/25, was noted for insulin lispro-aabc injection solution (fast-acting insulin) 100 unit/milliliter (mL), inject per sliding scale subcutaneously four times a day for type 2 diabetes. A physician order, dated 1/9/25, was noted for Lantus SoloStar Subcutaneous Solution Pen-Injector (long-acting insulin) 100 unit/mL (insulin glargine), inject 90 units subcutaneously two times a day for diabetes. Review of the May 2025 MAR indicated Resident 17 was not administered his insulin lispro-aabc injection solution as ordered on the following days and times: 05/03/25 at 12:00 p.m., 05/10/25 at 12:00 p.m., 05/20/25 at 9:00 p.m., 05/25/25 at 12:00 p.m., 05/26/25 at 7:00 a.m. and 12:00 p.m., 05/27/25 at 07:00 a.m. and 12:00 p.m., and 05/28/25 at 5:00 p.m. and 9:00 p.m. Review of the May 2025 MAR indicated Resident 17 was not administered his Lantus SoloStar Injection Solution (insulin glargine) as ordered on the following days and times: 05/01/25 at 8:00 p.m., 05/26/25 at 8:00 a.m., 05/27/25 at 8:00 a.m., and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/28/25 at 8:00 p.m. During an interview on 6/9/25 at 4:14 p.m., the facility Nurse Consultant (NC) indicated she was unable to find documentation as to why the doses of insulin had not been administered as ordered. On 6/9/25 at 3:26 p.m., the DON provided the Medication Administration Policy which indicated .Purpose: To administer medications safely and appropriately to aide residents to overcome illness, relieve and prevent symptoms, and help in diagnosis . 12. Obtain and record any vital signs as necessary prior to medication administration. 16. Give the resident the medication . 3.1-37(a)

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure medications were received timely from the pharmacy for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for tube feedings (Resident 14 and Resident 41). Findings include: 1. The clinical record for Resident 14 was reviewed on 6/4/25 at 11:18 a.m. The diagnoses included, but were not limited to, hypertension and congestive heart failure. A physician's order, dated 6/3/25, indicated Resident 14 was to receive trazadone (medication for depression) 50 milligram (mg); two tablets at bedtime nightly for insomnia. The June 2025 Medication Administration Record (MAR) indicated Resident 14 had not received his prescribed dose of trazadone on 6/3/25, 6/4/25, and 6/5/25. He began receiving the prescribed dose on 6/6/25. During an interview on 6/9/25 at 2:14 p.m., the Director of Nursing (DON) indicated Resident 14 had not received his trazadone on 6/3/25, 6/4/25, and 6/5/25 because the medication had not been delivered from the pharmacy and was not available in the Cubex (a machine located at the facility for obtaining medication as needed). 2. The clinical record for Resident 41 was reviewed on 6/4/25 at 2:56 p.m. The diagnoses included, but were not limited to, dysphagia (inability to swallow) and aspiration pneumonia (pneumonia caused by material from the stomach or mouth entering the lungs). A physician's order, dated 5/13/25, indicated he was to have a scopolamine transdermal patch (medication used to prevent nausea and vomiting) applied to the skin every 72 hours for nausea. A care plan, last reviewed 6/6/25, indicated Resident 41 had a feeding tube due to dysphagia and was at high risk for aspiration. The goal was for him to maintain adequate nutrition and hydration using his feeding tube without complications. The interventions included to monitor for intolerance of feedings such as vomiting or nausea and to elevate the head of his bed at least 30 degrees at all times. The June 2025 MAR indicated Resident 41's scopolamine transdermal patch had not been applied on 6/3/25 and 6/6/25 due to the patch not being available. During an interview on 6/9/25 at 2:14 p.m., the DON indicated the scopolamine patch had been reordered from the pharmacy and had not been sent to the facility timely. On 6/6/25 at 3:52 p.m., the Nurse Consultant provided the Pharmacy Services policy, dated October 2021, which indicated . is responsible for rendering the required services in accordance with local, state, and federal laws and regulation, facility policies and procedures, and community standards of practice .Providing routine and timely pharmacy services 7 days per week and emergency pharmacy service 24 hours a day, seven days per week . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-25(a)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 3. On 6/6/25 at 11:04 a.m., Licensed Practical Nurse (LPN) 2 was randomly observed administering medications to Resident 33. LPN 2 removed the medication cards from the medication cart and began to place the prescribed medication doses into a plastic medication cup. LPN 2 indicated that Resident 33's folic acid, multivitamin, vitamin B-12 and Thiamine (Vitamin B-1) were not available to be given in the medication cart. LPN 2 went to the Cubex (machine that supplies medications at the facility) to obtain the folic acid, multivitamin, vitamin B-12 and Thiamine for Resident 33. LPN 2 was unable to obtain the medications from the Cubex. LPN 2 went to the drug overflow cart and attempted to find the folic acid, multivitamin, vitamin B-12 and Thiamine to administer. LPN 2 was unable to locate the missing medications from the overflow medication cart. LPN 2 indicated the medications had been previously reordered from the pharmacy and had been delivered to the facility yet. The pharmacy often did not deliver medications timely. LPN 2 indicated Resident 33 would not receive the folic acid, multivitamin, vitamin B-12 and Thiamine due to the medications being unavailable. LPN 2 then administered the Resident 33 nine of his thirteen prescribed morning medications. During an interview with the DON on 6/6/25 at 9:45 a.m., she indicated there was often a delay in the delivery of medications from the pharmacy once medications have been reordered electronically and often has to e-mail or call the pharmacy to expedite delivery. 3.1-48(c)(1) Based on observation, interview, and record review, the facility failed to ensure medications were available as ordered resulting in a medication error rate of greater than 5% for 3 of 3 residents observed during medication pass. There were 38 opportunities with 11 errors resulting in a 29% medication error rate. The errors involved 3 residents in the sample of 16. (Resident 8, Resident 33, and Resident 38) Findings include: 1. An observation of medication administration was conducted with the Director of Nursing (DON) on 6/6/25 at 9:21 a.m. The DON indicated Resident 8 had the following medications ordered to give that morning (06/06/25): benzonatate 100 milligrams (mg), Cranberry capsule 250 mg, fluoxetine hydrochloric acid (HCL) 40 mg, furosemide 20 mg, ipratropium - albuterol aerosol inhaler, gabapentin 300 mg, vitamin D 125 micrograms (mcg), (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westpark A Waters Community	1316 N Tibbs Ave Indianapolis, IN 46222

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Lidoderm patch, Singulair 10 mg, vitamin C 1000 mg, triamcinolone acetonide nasal spray, Eliquis 5 mg, ferrous sulfate 325 mg, and erythromycin 5 mg ointment. The DON indicated Resident 8's ipratropium-albuterol inhaler, vitamin D 125 mcg tablet, Lidoderm patch, Singulair 10 mg, ferrous sulfate 325 mg, and erythromycin ointment were unavailable, but had previously been reordered. The DON attempted to retrieve these medications from the overflow medication cart and the Cubex (a machine that supplies medications at the facility) and was unsuccessful due to unavailability. Resident 8 did not receive 6 of her 14 medications as ordered that morning. 2. An observation of medication administration was conducted with the DON on 6/6/25 at 9:55 a.m. The DON indicated Resident 38 had the following medications ordered to give that morning (06/06/25): buspirone 5 mg, clopidogrel 75 mg, apixaban 5 mg, Keppra 1000 mg, fluticasone propionate nasal spray, pantoprazole 40 mg, Folic Acid 1 mg, potassium chloride 10 milliequivalents (mEq) extended release, venlafaxine 150 mg, Geodon 20 mg, and vitamin B-12. The DON indicated the facility was out of Resident 38's fluticasone nasal spray and she would need to contact the pharmacy to have it reordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on interview and record review, the facility failed to ensure a partial dose of a controlled substance (oxycodone) was destroyed and recorded in the presence of two licensed personnel for 1 of 5 residents reviewed for unnecessary medications. (Resident 17) The clinical record for Resident 17 was reviewed on 6/5/25 at 10:30 a.m. The diagnoses included, but were not limited to, cocaine abuse, opioid use, and major depressive disorder. An Annual Minimum Data Set assessment, dated 3/24/25, indicated Resident 17 was cognitively intact. A physician's order, dated 4/3/25, noted to administer oxycodone 5 milligrams (mg) tablet, give one tablet by mouth every six hours as needed for pain. A nursing progress note, dated 5/21/25, indicated Resident 17 requested a dose of oxycodone for pain, but the facility had run out of oxycodone 5 mg tablets. Available in the Cubex (a machine that supplies medications at the facility) was oxycodone 10 mg tablets. Licensed Practical Nurse (LPN) 4 called the facility Nurse Practitioner (NP) to obtain a one-time order for a half tablet of oxycodone 10 mg. A nursing progress note, dated 5/21/25, indicated LPN 4 was able to pull the oxycodone 10 mg for Resident 17, split the pill in half and would save the other half for later. During an interview on 6/9/25 at 1:59 p.m., the Director of Nursing (DON) indicated if a narcotic was pulled and the full dose was not administered, the remainder of the dose should have been wasted or destroyed. A Controlled Drug Receiving Record/Disposition Form, dated 5/21/25, indicated a half tablet of oxycodone 10 mg was administered, with a half tablet remaining on 5/21/25 at 4:00 p.m. The record did not contain a signature from the administering staff member. An entry, dated 5/22/25 at 1:00 a.m., indicated the remaining half tablet was administered and signed off on by the administering staff member. An interview was conducted with LPN 4 on 06/10/25 at 2:19 p.m. She indicated Resident 17 was upset and acting out of character due to not having his available pain medication. She called the facility NP to obtain a one-time order for oxycodone 10 mg since that was what was available in the Cubex. LPN 4 split the oxycodone 10 mg in half to give Resident 17 the ordered 5 mg and then put the remaining half tablet in a medication cup and stored it in the narcotics lock box. LPN 4 indicated she saved it so the following shift would have a dose to give Resident 17 until the pharmacy refilled his pain medication. On my way home, I realized I had forgotten to fill out a narcotic record sheet. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Controlled Substance Medications Policy, dated March 2023, was provided by the facility Nurse Consultant on 6/10/25 at 9:15 a.m. It indicated Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and record keeping in the facility, in accordance with federal and state laws and regulations . The disposal of unused partial tablets and unused portions of single dose ampules must be destroyed and recorded in the presence of two licensed personnel . 3.1-25(r)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to ensure palatable food was provided for 12 of 14 residents reviewed for food. (Residents' 6, 8, 9, 13, 14, 16, 24, 26, 28, 34, 37, and 42) Findings include: 1. The clinical record for Resident 14 was reviewed on 6/4/25 at 11:18 a.m. The diagnoses included, but were not limited to, hypertension and congestive heart failure. A Quarterly Minimum Data Set (MDS) assessment, completed 3/5/25, indicated he was cognitively intact. During an interview on 6/4/25 at 2:18 p.m., Resident 14 indicated the food was raggedy and low grade. The same things were served over and over. 5. The clinical record for Resident 8 was reviewed on 6/4/25. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Quarterly MDS assessment, dated 5/14/25, indicated the resident was cognitively intact. During an interview on 6/4/25 at 11:12 a.m., Resident 8 indicated she did not like the taste of the food. 6. A resident council meeting was conducted on 6/5/25 at 2:06 p.m. During this meeting, Resident 28 indicated residents eat the same thing for breakfast 4 out of 7 days a week, and that the food was terrible. Resident 28 indicated the food used to be different and believed the facility had changed suppliers, once they switched the food quality went from bad to worse. Residents' 6, 9, 13, 14, 16, 24, 34, 37, and 42 indicated they agreed to Resident 28's comments. On 6/5/25 at 11:54 a.m., the Dietary Manager (DM) provided a lunch test tray which contained chicken parmesan, noodles, and green beans. The plate contained an unbreaded chicken breast in a thin red sauce and no cheese. The noodles were over cooked and had a slimy texture. The green beans were presented in a bowl on the plate. 3.1-21(a)(1) 3.1-21(a)(2) 2. The clinical record for Resident 9 was reviewed on 6/6/25 at 9:53 a.m. The diagnoses included, but were not limited to, depression, migraines, diabetes, and malnutrition. A Quarterly MDS assessment, dated 3/28/25, indicated the resident was cognitively intact. Resident 9 was interviewed on 6/4/25 at 11:30 a.m. He indicated the food at the facility was not good, and it had no salt or seasoning. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The clinical record for Resident 24 was reviewed on 6/9/25 at 2:03 p.m. Diagnoses included, but were not limited to, diabetes, congestive heart failure (the heart is weak and cannot pump efficiently), chronic obstructive pulmonary disease (a lung disease which restricts breathing), gastroesophageal reflux (heartburn), heart disease, and anemia. A Quarterly MDS assessment, dated 4/17/25, indicated the resident was cognitively intact. Resident 24 was interviewed on 6/4/25 at 1:47 p.m. He indicated some of the food was good but some of it was bad, and sometimes the meat smelled spoiled. He was supposed to get double portions of meat, but the portions were really small, and he had lost weight since being at the facility. Resident 24 was interviewed on 6/5/25 at 2:33 p.m. He indicated the lunch meal earlier that day was really gross. The meat in the sauce was so tough that he couldn't eat it. The food on the plate that looked like rice was extremely soggy and had no flavor or taste at all. He could not eat that either. 4. The clinical record for Resident 26 was reviewed on 6/5/25 at 1:37 p.m. Diagnoses included, but were not limited to, chronic pain syndrome, anxiety, and malnutrition. A Quarterly MDS assessment, dated 4/7/25, indicated the resident was cognitively intact. Resident 26 was interviewed on 6/4/25 at 11:57 a.m. She indicated the food usually tasted bad, was cold sometimes, and the portions were very small.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. Based on interview and record review, the facility failed to ensure residents with severe cognitive impairment did not enter into binding arbitration agreements for 1 of 3 residents reviewed for arbitration. (Resident 20) Findings include: The clinical record for Resident 20 was reviewed on 6/6/25 and 2:30 p.m. The diagnoses included, but were not limited to, stroke. An admission Minimum Data Set (MDS) assessment, completed 5/2/25, indicated he was severely cognitively impaired. He was able to make himself understood and able to respond adequately to simple direct questions. On 6/6/25 at 2:27 p.m., the Executive Director provided a copy of a Voluntary Binding Arbitration Agreement, that was electronically signed by Resident 20, on 4/28/25, which indicated .This is a voluntary agreement. You are not required to sign this agreement as a condition of admission to this Facility or to continue to receive care at this facility .You are strongly encouraged to consult with an attorney or trusted advisor before signing this agreement. You have the opportunity to ask questions before signing this document . The Resident/ Resident's Legally Authorized Representative, by signing this agreement, also acknowledges that he/she had been informed and understands the entire agreement including that .b. The agreement may not be submitted to a Resident for approval when the Resident has been deemed incompetent by two physicians .d. The agreement waives the Resident's right to a trial in a court for any future malpractice claim the Resident may have against the healthcare provider, absent revocation of the agreement consistent with state law . During an interview on 6/9/25 at 1:40 p.m., the Regional Director of Operations (RDO) indicated that upon admission, there was not always a guardian or family member involved and able to complete the admission paperwork with the resident being admitted . During an interview on 6/9/25 at 3:50 p.m., the Executive Director indicated the admission paperwork was filled out electronically, and there was an option to sign all which puts initials or electronic signatures on all forms that need to be signed, including the Voluntary Binding Arbitration Agreement. She would ensure the Voluntary Binding Arbitration Agreement was not signed by residents without capacity to make the decision going forward.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure infection control was maintained during medication administration by not performing hand hygiene before coming into contact with a resident and donning gloves, not donning new gloves before touching a resident's medications, ensuring medications were not touched with bare hands, administered medications after being dropped on to a medication cart, and not disinfecting insulin pen hubs prior to use for 3 of 3 residents randomly observed during medication administration (Resident 8, Resident 33, and Resident 47). Findings include: 1. The clinical record for Resident 33 was reviewed on 6/6/25 at 10:12 a.m. The diagnoses included, but were not limited to, hypertension. On 6/6/25 at 10:12 a.m., Licensed Practical Nurse (LPN) 2 was observed administering medications to Resident 33. LPN 2 performed hand hygiene and began gathering Resident 33's available medications from the medication cart. She was not observed to clean the top of the medication cart prior to preparing Resident 33's medications. She used her keys to open the cart and removed the medication cards from the cart one at a time. She removed a capsule of Cymbalta from the medication card and the Cymbalta capsule fell onto the medication cart. LPN 2 picked up the Cymbalta capsule with her bare hand and placed it in the medication cup with the other medications. LPN 2 indicated Resident 33 received his medication crushed with applesauce. The medication cup contained capsules and pills. LPN 2 removed the capsules from the medication cup and placed them into another medication cup. She poured the pills into a plastic sleeve and crushed them, then poured the crushed pills into a new medication cup. She then removed each capsule from a plastic medication cup and opened them, pouring the contents into the medication cup with the crushed pills. LPN 2 did not perform hand hygiene or wear disposable gloves while touching the capsules to open them. She put applesauce into the medication cup with the crushed medication. LPN 2 then took the medications to Resident 33 and administered them to him. During an interview on 6/6/25 at 10:35 a.m., LPN 2 indicated she did not consider a pill to be dropped unless it went onto the floor, and she cleaned the top of her medication cart often. She routinely opened capsules without gloves on. 2. The clinical record for Resident 47 was reviewed on 6/6/25 at 11:45 a.m. The diagnoses included, but were not limited to, diabetes. On 6/6/25 at 11:45 a.m., the Director of Nursing (DON) was observed administering insulin to Resident 47. She indicated his blood sugar was 186 and he was to receive two units of lispro insulin (fast acting insulin). She gathered her supplies and entered Resident 47's room. The DON removed the insulin pen from the box, removed the cap from the pen and placed the needle onto the pen. She did not cleanse the hub of the pen prior to placing the needle on. She did hand hygiene and donned disposable gloves. She dialed two units on the pen, cleansed Resident 47's skin, and injected the insulin medication. During an interview on 6/6/25 at 11:57 a.m., the DON indicated she should have cleansed the hub of the insulin pen prior to placing the needle on the pen. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The clinical record for Resident 8 was reviewed on 6/4/25 at 2:30 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic bronchitis. An observation of medication administration for Resident 8 was conducted with the DON on 6/6/25 at 9:21 a.m. The DON was observed performing hand hygiene upon arrival to the medication cart. She pulled and prepared Resident 8's medication from the [NAME] Hall medication cart. Due to multiple medications not being available, the DON went to the overflow medication cart and Cubex (a machine that supplies medications at the facility) to see if any of the missing medications were available. The DON then entered Resident 8's room with the medication cup and a cup of water. No hand hygiene was performed after contact with high traffic surface areas or before entering the resident's room. The DON donned a pair of gloves and administered the resident's nasal spray. Afterward, while holding Resident 8's medication cup, the DON touched and pushed around the resident's pills with her gloved finger. The DON did not perform hand hygiene after administering Resident 8's nasal spray or don new gloves before touching the resident's pills. An interview was conducted with the DON on 6/6/25 at 10:20 a.m. She indicated it was not best practice to touch the resident's pills without donning new gloves. During an interview on 6/6/25 at 2:38 p.m., the Nurse Consultant indicated medication should not be used when it was dropped on the medication cart and medications should not be touched with bare hands. A Hand Hygiene Policy, dated 8/21/13, was provided by the facility Nurse Consultant (NC) on 6/6/25 at 3:52 p.m. It indicated .If hands are not visibly soiled, use an alcohol-based hand rub for routinely decontaminating hands in all other clinical situations. Some of these situations include before and after contact with residents, before putting on and taking off gloves . On 6/6/25 at 3:52 p.m., the NC provided the current Gloves- Non Sterile Policy which indicated .Perform Hand Hygiene . Appy Latex free non-sterile gloves on at a time, stretching over wrists .If for any reason there is a need to remove the gloves and reapply new gloves, Hand Hygiene must occur between the removal of the used pair of gloves and the application of the new pair of gloves . On 6/9/25 at 3:26 p.m., the DON provided the Insulin Pen Injection Administration Policy, dated July 2024, which indicated .6. Remove pen cap and wipe rubber stopper with alcohol swab . 3.1-18(b)(1) 3.1-18(l)