STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155484	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southwood Healthcare Center	2222 Margaret Ave Terre Haute, IN 47802

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. A. Based on observation, interview, and record review, the facility failed to ensure paper towels at handwashing areas were maintained in a sanitary manner for 1 of 2 kitchen observations and 1 of 1 dining observation. B. Based on observation, interview, and record review, the facility failed to ensure food was distributed in a safe and sanity manner and failed to ensure staff assisted residents with their meal in a safe and sanitary manner for 1 of 2 dining observations in the activity room (Residents 59, 1, 19, and 109). Findings include:A. During the initial kitchen observation, on 1/20/26 at 9:52 a.m., a commercial-sized roll of paper towel was sitting on a table next to the handwash sink. Visible wet marks were observed on the side and top of the paper towel roll. At the same time, the Culinary Director indicated the dispenser was out of towels and housekeeping had not been into the kitchen to refill the dispenser. The kitchen staff did not have the ability to load new towels into the dispenser; it had to be done by housekeeping. During an observation of the lunch meal service on the Memory Care Unit, on 1/20/26 at 11:40 a.m., the staff were observed performing handwashing prior to serving the resident meal trays. A commercial size roll of paper towels was observed sitting on the counter next to the handwash sink. The employees were observed to touch the paper towel roll with their wet hands and wet marks were observed on the side and top of the paper towel roll. At the same time, the Resident Services Director indicated the towel dispenser was broken. During an interview, on 1/20/26 at 12:00 p.m., the Housekeeping Director indicated the brown and white towels for the dispensers were on recall. He was waiting on the recall to be over, and they could hopefully get the dispensers filled and working. During an interview, on 1/22/26 at 1:21 p.m., the Regional Director of Clinical Operations (RDCO) indicated she was not aware of any recall on paper towels used by the facility. The expectation was that paper towels should be available and maintained in a clean manner to be used by staff and residents. On 1/23/26 at 9:13 a.m., the RDCO provided an undated document, titled, Standard Precautions, and indicated it was the policy currently used by the facility. The policy indicated, .Procedures: .III. Procedure for Hand Hygiene.B. Using liquid soap and water.6. Dry hands thoroughly with clean paper towel. 7. Turn off faucet with clean, dry paper towel-discard. B1. The following observations were observed in the activity room during lunch meal service on 1/20/26 at 11:32 a.m. thru 11:49 a.m.: The Certified Nurse Aide (CNA) 10 adjusted Resident 59's clothing protector at the table and re-adjusted her wheelchair closer to the table. CNA 10 uncovered a peanut butter and jelly sandwich (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from a plastic wrap and picked up half the sandwich with her bare hands and placed it in Resident 59's left hand. The resident was having a hard time eating the sandwich and the CNA moved the sandwich with her bare hands from the resident's left hand to her right hand. CNA 11 picked up half of a peanut butter sandwich with her bare hands and fed it to Resident 1. The resident took the sandwich with her right hand from the CNA. During an interview, on 1/20/26 at 12:03 p.m., Licensed Practical Nurse (LPN) 7 indicated staff should not touch the residents' food with their bare hands at any time. On 1/20/26 at 2:05 p.m., the Regional Director of Clinical Operations (RDCO) indicated the facility did not have a policy for the staff not touching food with bare hands but followed the State guidelines in the Retail Food Establishment Sanitation Requirements, which indicated, .TITLE 410 IAC 7-24 Section 131 (2) .no direct contact with food by the bare hands.Section 153. ii) prohibits contacting ready-to-eat food with bare hands. 2. On 1/20/26 at 11:15 a.m., observed CNA 19 pass food trays and set up meals for the residents and failed to sanitize her hands between residents. On 1/20/26 at 11:15 a.m., observed noon meal service in the activity room with residents who required assistance. Observed Certified Nurse Aide (CNA) 10, assisting Resident 59 with meal. She assisted another resident and returned to resident to help with meal and did not sanitize her hands. On 1/20/26 at 11:49 a.m., observed CNA 18 assisting Resident 19 and Resident 109 at the same time. The CNA failed to sanitize her hands while alternating between the two residents. On 1/20/26 at 12:09 a.m., during an interview CNA 8 indicated if she were assisting two residents she would sanitize her hands after every third bite. She was unsure if she would sanitize her hands between residents. On 1/27/26 at 1:00 p.m., during an interview the Regional Director Clinical Operations (RDCO) indicated the facility did not have a policy for assisting the residents with meals. 3.1-21(i)(1) 3.1-21(i)(3)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure consent documents had been obtained for antipsychotics (medications used to manage symptoms of psychosis [a loss of contact with reality], such as delusions [a firmly held false belief that does not match reality], hallucinations [seeing or hearing things that are not there], insomnia [persistent difficulty falling asleep, staying asleep, or waking up too early], and severe agitation) medications for 3 of 5 residents reviewed for unnecessary medications (Residents 11, 59, and 62). Findings include:1. Resident 11's record was reviewed on 1/21/26 at 2:54 p.m. The profile indicated the resident's diagnoses included, but were not limited to, severe manic episode without psychotic symptoms (a week-long [or longer] period of extremely elevated, euphoric, or irritable mood and excessive energy that severely disrupts daily life) and unspecified psychosis (a diagnostic label for psychotic symptoms that don't fit a specific disorder). A significant change Minimum Data Set (MDS) assessment, dated 12/24/25, indicated the resident had severe cognitive deficit and received antipsychotic medications on a routine basis. A physician's order, dated 2/26/25 with a discontinued date of 10/7/25, indicated to administer one 200 milligram (mg) tablet of Seroquel (antipsychotic medication) at bedtime for mania. A signed consent, dated 3/27/25, was observed for the Seroquel, but lacked documentation of the required black box warning information (the Food and Drug Administration's [FDA's] strictest warning for prescription drug labeling, highlighting severe, life-threatening, or permanently disabling adverse reactions). A physician's order, dated 8/12/25 with a discontinuation date of 8/13/25, indicated to administer one 200 mg tablet of Seroquel on the morning of 8/13/25 for mania. The record lacked documentation of consent for the initiation of the additional 200 mg of Seroquel administration order. A physician's order, dated 10/7/25, indicated to administer one 200 mg tablet of Seroquel, in addition to a 50 mg tablet, to equal total dose of 250 mg, at bedtime for insomnia. The record lacked documentation of consent for the increase in dose and initiation of the antipsychotic medication. During an interview, on 1/22/26 at 12:01 p.m., the Regional Director of Clinical Operations (RDCO) indicated they were unable to find any consent documentation for the residents' medication increases and/or initiations. The consent forms needed to be updated to include the proper verbiage on black box warnings. To her knowledge, there was not a specific policy for consents. The expectation was that the facility would follow federal guidance. 2. Resident 59's record was reviewed on 1/22/26 at 11:14 a.m. The profile indicated the resident's diagnoses included, but were not limited to, unspecified dementia (when confusion or mild cognitive impairment can't be clearly diagnosed as a specific type of dementia), major depressive disorder (a serious mood disorder causing persistent sadness, loss of interest, and impacts daily life through symptoms like sleep/appetite changes, fatigue, and concentration issues), and psychotic disorder with hallucinations (psychotic disorders involving losing touch with reality, with common symptoms (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including hallucinations [seeing, hearing, feeling things not there] and delusions [false beliefs]). Facility census information indicated Resident 59 was admitted to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment, dated 1/2/26, indicated the resident was rarely understood and received anti-psychotic medication during the look back period. A physician order, dated 11/25/25 and discontinued on 12/17/25, indicated to administer risperidone (anti-psychotic medication) 0.25 mg by mouth two times a day for hallucinations. A physician order, dated 12/17/25, indicated to administer risperidone 0.5 mg (milligram) by mouth two times a day for delusional disorder. The electronic record lacked documentation that a psychotropic informed consent was obtained when there was an increase in the dose of the risperidone medication. During an interview on 1/22/26 at 11:15 a.m., the Regional Director of Clinical Operations (RDCO) indicated she was unable to find the psychotropic consent for when Resident 59 was ordered an increased dose of risperidone by the physician. Staff had missed getting the consents when the doses were increased. She indicated a consent should have been completed with any changes to the psychotropic medications. During an interview on 1/22/26 at 2:49 p.m., the RDCO indicated they were unable to find a policy regarding psychotropic consents, but it was the expectation that the facility would follow state and federal regulations. 3. On 1/22/26 at 1:41p.m., The medical record of Resident 62 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, congestive heart failure (CHF) (a condition that develops when your heart doesn't pump enough blood for your body's needs), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities), anxiety (a feeling of fear, dread, and uneasiness), and depression (an illness characterized by persistent sadness and a loss of interest in activities that you normally enjoy, accompanied by an inability to carry out daily activities, for at least two weeks). A physician order, dated 3/2/25, indicated to administer Effexor (antidepressant) 75 mg 1 tablet daily. On 3/2/25 and 9/25/25 the medication dose was decreased to 37.5 mg daily. The medical record lacked consent for psychotropic medication. A physician order, dated 7/23/25, indicated administer Paxil (antidepressant) 10 mg daily. On 8/7/25 the medication dose was increased to 20 mg daily. On 9/25/25 the medication dose was increased to 30 mg daily. The medical record lacked consent for psychotropic medication for the Paxil medication orders. A physician order, dated 8/20/25, indicated administer Buspirone (antianxiety medication) 5 mg twice daily. The consent did not include black box warning information being provided to resident and resident's responsible party. A physician order, dated 10/29/25, indicated administer Buspirone 10 mg twice daily. The record (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	lacked evidence of psychotropic consent. A physician order, dated 12/2/25, indicated administer Buspirone 10 mg three times a day. The record lacked evidence of psychotropic consent. A physician order, dated 6/30/25, indicated administer Lorazepam (antianxiety medication) 0.5 mg daily. The medical record lacked documentation of black box warning information being provided to resident and resident's responsible party for Lorazepam and Paxil medications. An annual MDS, dated [DATE], indicated the resident was cognitively impaired and was administered antipsychotic, antianxiety, and antidepressant medications during the assessment period. On 1/22/26 at 2:49 p.m., during an interview, the Regional Nurse Consultant indicated the facility did not have the psychotropic medication consents for the dates and medications indicated. She indicated the facility did not have a policy for psychotropic consents and the facility should follow the federal guidelines. 3.1-3(n)(2) 3.1-3(n)(3)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure call lights were kept within residents' reach for 3 of 32 residents reviewed for call lights (Resident 19, 55, and 10).Findings include:1. During an observation, on 1/21/26 at 9:17 a.m., Resident 19 was lying in bed with a touch pad call light at the foot of the bed, next to the resident's feet. The call light was out of the resident's reach. During an observation, on 1/21/26 at 2:56 p.m., Resident19 was lying in bed, and the bed was next to the wall. The call light was stuck between the bed and the wall, out of the resident's reach. During an observation, on 1/22/26 at 2:11 p.m., Resident19 was lying in bed, and the bed was next to the wall. The call light was stuck between the bed and the wall, out of the resident's reach. Resident 19's record was reviewed on 1/23/26 at 2:00 p.m. An annual Minimum Data Set (MDS) assessment, dated 11/25/25, indicated the resident had a severe cognitive impairment, required partial/moderate assistance from staff for transfers, and had two or more falls since the prior assessment. A care plan, last revised on 12/4/25, indicated the resident was at risk for falls and had a history of multiple falls. Interventions included, but were not limited to, place call light within reach and remind the resident to ask for assistance, remind the resident how to operate the call light, remind the resident to call for staff for assistance to the bathroom, and remind resident to call for staff before transferring into bed. A post fall evaluation indicated the resident fell on [DATE] at 7:00 p.m. The resident attempted to go to the bathroom without using the call light to ask for assistance. Interventions to prevent further falls included, but were not limited to, educating the resident to use call light for staff assistance prior to transfers. A post fall evaluation indicated the resident fell on [DATE] at 6:45 a.m. The root cause was the resident attempted to take himself to the bathroom without staff assistance. The intervention to prevent further falls was to educate the resident to use the call light for staff assistance. 2. During an observation, on 1/20/26 at 11:40 a.m., Resident 55 was lying in bed. The call light was clipped to something hanging on the wall behind the resident's head of the bed. At the same time, the resident indicated he used the call light to ask for staff assistance, but he did not know where it was. During an observation, on 1/20/26 at 11:43 a.m., Qualified Medication Aide (QMA) 17 entered Resident 55's room to provide care. During an observation, on 1/20/26 at 11:45 a.m., QMA 17 exited Resident 55's room. At the same time, the resident's call light remained clipped to something hanging on the wall behind the head of the bed, out of reach. During an observation, on 1/21/26 at 2:53 p.m., the resident was lying in bed. The call light remained clipped to something hanging on the wall behind the head of the bed, out of reach. At the same time, the resident indicated he was not able to find his call light. During an observation, on 1/22/26 at 10:35 a.m., the resident was lying in bed. The call light remained clipped to something hanging on the wall behind the head of the bed, out of reach. Resident 55's record was reviewed on 1/23/26 at 9:46 a.m. An annual Minimum Data Set (MDS) assessment, dated 11/12/25, indicated the resident had a moderate cognitive impairment. A care plan, last revised on 10/30/25, indicated the resident had an activities of daily living (ADL) self-care performance deficit and required the assistance of one staff member with transfers. A care plan, last revised on 12/15/25, indicated the resident was at risk for falls. Interventions included, but were not limited to, educate the resident to work the call light. During an interview, on 1/23/26 at 11:12 a.m., Certified Nurse Aide (CNA) 14 indicated Resident 55 used his call light to request assistance, and it should have been placed where he was able to reach it. 3. During an observation, on 1/20/26 at 11:20 a.m., Resident 10 was lying in bed. The touch pad call light was at the foot of the resident's bed and out of reach. At the same time, the resident indicated he did not know where the call light was located. During an observation, on 1/20/26 at 11:46 a.m., Resident 10 was sitting in a chair in his room. The resident's right hand was contracted (severe, chronic muscle stiffness which cause the hand to be fixed). The resident's call light was clipped to the chair behind, and to the right, of the resident's head. At the same time, the resident indicated he did not know where the call light (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was. Once the resident was made aware of where the call light was he attempted to reach across his body with his left arm to reach the call light, but he was unable to reach far enough. During an observation, on 1/21/26 at 2:51 p.m., Resident 10 was lying in bed, and the bed was next to the wall. The call light was placed on top of a box that holds gloves attached to the wall, above the resident's bed, and out of the resident's reach. During an observation, on 1/23/26 at 9:31 a.m., Resident 10 was up in a chair in his room. The call light was on the glove box, attached to the wall, above the resident's bed, and out of the resident's reach. Resident 10's record was reviewed on 1/23/26 at 2:26 p.m. The resident's profile included a diagnosis of hemiplegia (paralysis affecting one side of the body) affecting right dominant side. A care plan, last revised on 4/24/25, indicated the resident was at risk for falls and had a history of falls. A care plan, last revised on 8/21/25, indicated the resident had an activities of daily living (ADL) self-care performance deficit and was dependent on staff assistance for transfers. During an interview, on 1/27/26 at 10:19 a.m., Licensed Practical Nurse (LPN) 12 indicated all residents should have had their call lights within their reach. The CNAs and nurses should have made sure call lights were within the residents' reach prior to leaving a residents' room. On 1/27/26 at 10:32 a.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, Resident Rights, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents.Procedure: 1. Residents will be treated with dignity and respect including but not limited to.c. To have a method to communicate needs to staff i. Call light or bell access will be within reach of the resident as one method to communicate needs to staff. 3.1-3(v)(1)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure accurate advance directives were ordered when the POST form was not the same as the physician order and care plan for 1 of 32 residents reviewed for advanced directives (Resident 15). Findings include:On [DATE] at 10:00 a.m., the medical record of Resident 15 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included but was not limited to multiple myeloma (a cancer of plasma cells (a type of white blood cell) that grow out of control in the bone marrow), dementia (the loss of cognitive functioning thinking, remembering, and reasoning to such an extent that it interferes with a person's daily life and activities) and diabetes, (a disease that occurs when your blood glucose, also called blood sugar, is too high). An admission Minimum Data Set Assessment (MDS) dated [DATE] indicated that the resident was cognitively impaired. A Physician Orders for Scope of Treatment (POST) form (a legally recognized medical order document designed for individuals that translates a patient's treatment preferences regarding end-of-life care into actionable medical orders that must be followed by healthcare providers), dated [DATE], indicated Resident 15 had a Do Not Resuscitate (DNR) status. A care plan, dated [DATE], indicated that the resident had a CPR code Status. Interventions included, but not limited to, code status would be established at time of admission,re-admission, and would be reviewed quarterly and as needed. A physician order, dated [DATE], indicated to administer CPR (cardiopulmonary resuscitation). The physician order did not match the POST form. A Physician order, dated [DATE], indicated DNR. On [DATE] at 10:50 a.m., during an interview the Regional Director Clinical Operations (RDCO) indicated the facility had identified the discrepancy with the POST form and physician order and had corrected the order on [DATE].On [DATE] at 11:40 a.m., the RDCO provided an undated document titled, Cardiopulmonary Resuscitation, and indicated it was the policy currently being used by the facility. The policy indicated, . 2. Facility staff should verify the presence of advanced directives or the resident's wishes with regard to CPR, upon admission. If the resident's wishes are different than the admission orders, or if the admission orders do not address the resident's code status and the resident does not want to receive CPR, facility staff should document the resident's wishes in the medical record and contact the physician to obtain the order. 3.1-4(c)(6)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based record review and interview, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR) (screening for serious mental illness and intellectual disability required before admission to a long term care facility) was updated when a psychiatric diagnosis was added to a resident's profile for 1 of 1 residents reviewed for PASRR (Resident 55). Findings include:Resident 55's record was reviewed on 1/23/26 at 9:46 a.m. Census information indicated the resident was admitted to the facility on [DATE]. An annual Minimum Data Set (MDS) assessment, dated 11/12/25, indicated the resident was not considered by the state to have a Level II PASRR (an in-depth, mandatory federal evaluation for individuals suspected of having serious mental illness) with a serious mental illness. A Notice of PASRR Level I Screen Outcome, dated 4/10/24, indicated no Level II was required because the resident did not have a serious mental illness. The resident's profile indicated a diagnosis of bipolar II disorder (a chronic mental health condition characterized by a pattern of recurring, severe depressive episodes and milder elevated mood episodes known as hypomania, without ever experiencing full mania) was added on 8/28/24. The resident's record lacked documentation the PASRR was re-assessed for the possible necessity of a Level II after the addition of the bipolar diagnosis. On 1/27/26 at 10:05 a.m., Risk Management 13 provided an updated Notice of PASRR Level I Screen Outcome, dated 1/23/26. The document included the resident's bipolar II disorder diagnosis and indicated the resident was referred for an on-site Level II evaluation. At the same time, Risk Management 13 indicated the PASRR should have been re-evaluated when the resident received the new bipolar diagnosis, in August 2024, but it was missed. On 1/27/26 at 10:32 a.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, Indiana PASRR, and indicated it was the policy currently being used by the facility. The policy indicated, .PASRR: The preadmission screening and resident review process, otherwise known as PASRR, is a federally mandated process to ensure nursing facility applicants and residents with serious mental illness.are identified and placed appropriately in the least restrictive setting.8. Level-of-Care Assessment Requirements: a) For NF applicants, a LOC [level of care] determination is required for the following.(2) Residents who experience a significant change in medical condition.10. Level I Screen Requirements.(2) For NF residents who have a significant change in mental status indicating the need for an updated Level I screen, a subsequent Level I screen, or an updated Level II evaluation.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to assess and initiate a care plan to support the use of elopement risk preventive measures for 1 of 23 residents reviewed for care plans (Resident 34). Findings include:On 1/21/26 at 10:33 a.m., during initial observation and interview, Resident 34 indicated he had an ankle bracelet alarm on his right ankle and did not understand why it was there. He indicated he had never been outside since he came to the facility and did not understand why he could not go outside. On 1/23/26 at 11:30 a.m., the medical record of Resident 34 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, chronic obstructive pulmonary disease (COPD) (a group of diseases that cause airflow blockage and breathing-related problems), and bipolar disorder (formerly called manic-depressive illness or manic depression a mental illness that causes unusual shifts in a person's mood). A physician order, dated 10/3/24, indicated to place Wander Guard bracelet on the right ankle. Check wander guard placement every shift. A care plan, dated 10/3/24, indicated Resident 34 was an elopement risk. Intervention included but not limited to Wander Guard placement to right ankle. The care plan record lacked indication or documentation of resident exhibiting exit seeking behavior. Assessments titled Wandering and Elopement risk, dated 6/30/25, 10/6/25 and 1/8/26, indicated the resident was not an elopement risk. A quarterly Minimum Data Assessment (MDS), dated [DATE], indicated wandering and exit seeking behaviors was not exhibited and the resident was cognitively intact during the assessment period. A quarterly MDS, dated [DATE], indicated wandering and exit seeking behaviors was not exhibited and the resident had limited cognition during the assessment period. A quarterly MDS, dated [DATE], indicated wandering and exit seeking behaviors was not exhibited and the resident had limited cognition during the assessment period. An annual MDS, dated [DATE], indicated wandering was not exhibited and the resident had limited cognition during the assessment period. A quarterly MDS, dated [DATE], indicated wandering and exit seeking behaviors was not exhibited and indicated the resident was cognitively intact during the assessment period. A quarterly MDS, dated [DATE], indicated wandering and exit seeking behaviors was not exhibited and the resident had limited cognition during the assessment period. On 1/23/26 at 1:00 p.m., during an interview, LPN 7 indicated the resident had a wander guard because he had dementia and when he first came into the facility he got lost easily and would try to go outside. She did not recall if he had any issues with wandering since admission.The medical record lacked supporting diagnosis of dementia. On 1/23/26 at 1:44 p.m., during a phone interview, the resident's guardian indicated she was not sure why the resident still had a wander guard. She indicated when he first arrived at the facility he was wandering some, but she did not know if he still was. She indicated she would follow up with the facility to determine if he was still wandering to determine if he continued to require the wander guard. On1/23/26 at 3:07 p.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, Clinical Documentation Standards, and indicated it was the policy currently being used by the facility. The policy indicated, .Procedure.b. The nurse is expected to; I. Document accurately and truthfully to the best of his/her knowledge, what is heard or seen during assessments or encounters that concern the resident.iv. Document the status of the resident including changes. 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview, the facility failed to ensure the resident was provided the necessary services to maintain grooming and daily care needs for 1 of 32 residents reviewed for daily care needs (Resident 12). Findings include:On 1/20/26 at 10:00 a.m., during an initial observation, observed Resident 12 lying in bed with excessive facial hair, dried pureed food on her shirt, oxygen tubing lying in the dried food, and hair was greasy and disheveled. On 1/21/26 at 10:15 a.m., the medical record of Resident 12 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (high blood pressure), anxiety (a feeling of fear, dread, and uneasiness) and osteomyelitis (a painful bone infection that causes inflammation and swelling in the bone) of the left foot. The medical record lacked supporting documentation of respiratory diagnosis. The medical record lacked documentation of a care plan indicating the resident refused care. An annual Minimum Data Set Assessment (MDS), dated [DATE], indicated Resident 12 was cognitively intact and required extensive to maximum assistance for daily care needs. The MDS did not indicate refusal of care or exhibited behaviors during the assessment period. On 1/21/26 at 2:54 p.m., during a routine observation Resident 12 was lying in bed with excessive facial hair observed. On 1/22/26 at 2:48 p.m., during a routine observation Resident 12 was lying in bed with excessive facial hair noted. On 1/23/26 at 9:15 a.m., during an interview, Licensed Practical Nurse (LPN) 7 indicated the resident refused to allow the staff to shave her. On 1/23/26 at 9:20 a.m., during an interview Certified Nurse Aide (CNA) 8 indicated the resident allowed her to shave her and to provide assistance with care needs. On 1/23/26 at 9:25 a.m., during an observation and an interview Resident 12 indicated she allowed the staff to shave her and did not refuse assistance with care needs. On 1/23/26 at 10:23 p.m., the Administrator provided an undated document titled, Routine Resident Care, and indicated it was the policy currently being used by the facility. The policy indicated, .2. Provide routine daily care by a certified nursing assistant.g. Assisting and teaching activities of daily living.k. Providing an environment that contributes to a positive self-image preserves dignity and promotes privacy.3. Unlicensed staff.b. Routine care by a nursing assistant includes but is not limited to the following: i. Assisting or provides personal care. 3.1-38(a)(3)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure safe smoking protocols were followed for 1 of 1 residents reviewed for smoking (Resident 9). Findings include:During an interview, on 1/21/26 at 9:38 a.m., Resident 9 indicated she smoked one or two cigarettes at a time when she went outside. Resident 9 indicated she was able to go out and smoke whenever she liked and was allowed to keep her own cigarettes and lighter in her room. The resident indicated the facility had not provided her with anything to lock her cigarettes and lighter inside, and she kept them in her purse. The resident indicated she had a history of seizures. During a continuous observation, on 1/22/26 from 2:32 p.m. to 2:40 p.m., the following was observed. Resident 9 exited her room pushing her wheelchair down the hallway, proceeded down two hallways towards the smoking exit door, exited the building, removed cigarettes and lighter from her purse, lit a cigarette and smoked. The cigarettes and lighter were kept freely in the resident's purse and were not secured in a locked bag. During the continuous observation, no staff offered or provided assistance or supervision. During an observation, on 1/23/26 at 9:26 a.m., Resident 9 was observed up in the wheelchair, in the hallway, with no oxygen tank. At the same time, the resident indicated she did not always use oxygen and just needed it sometimes in her room. Resident 9's record was reviewed on 1/22/26 at 1:33 p.m. Census information indicated the resident was admitted to the facility on [DATE]. Diagnoses on the resident's profile included, but were not limited to, Alzheimer's disease unspecified (a brain disorder that slowly destroys a person's memory and thinking skills), chronic obstructive pulmonary disease (COPD) unspecified (progressive, but treatable, group of lung diseases), epilepsy (seizure disorder) unspecified, and cigarette nicotine dependence. A significant change Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact, used tobacco, and received oxygen therapy. A smoking assessment, dated 9/16/25, indicated the resident smoked cigarettes and had a diagnosis of Alzheimer's or other dementia. The assessment determined the resident was a safe, independent smoker. A physician's order, dated 12/16/25, indicated to administer oxygen via nasal cannula at two liters (l) continuously for COPD. A post fall assessment, dated 12/22/25, indicated the resident fell coming back into the facility from the smoking area. A post fall assessment, dated 12/27/25, indicated the resident was found on her knees outside the smoking door. A smoking assessment, dated 12/27/25, indicated smoked cigarettes and had a diagnosis of Alzheimer's or other dementia. The assessment narrative indicated, [Resident name] is not currently an independent smoker. She has difficulty getting in and out of smoking area. She has poor safety awareness. She has had falls out in smoking area. She is currently not safe to smoke. The assessment lacked documentation the resident's inability to smoke safely was communicated to other staff members or the resident. A post fall assessment, dated 1/1/26, indicated the resident fell outside the door to the smoking area. A care plan, last revised on 11/20/24, indicated the resident smoked cigarettes independently and followed the facility's smoking protocols. Interventions included, but were not limited to, provide a locked bag/box for safe storage of smoking materials. The care plan lacked documentation it was updated when the smoking assessment, dated 12/27/25, showed the resident to be unsafe to smoke. A resident smoker list, last updated on 1/8/26 and provided at survey entrance, indicated Resident 9 was an independent smoker and had been provided with a lockbox for smoking material storage. During an interview, on 1/23/26 at 9:28 a.m., Certified Nurse Aide (CNA) 14 indicated Resident 9 was able to go out to smoke independently. The resident was able to store her own cigarettes, but CNA 14 was not sure where she kept them. Some residents were able to keep their own cigarettes, and the nurses held cigarettes for some of the other residents and gave them a couple of cigarettes at a time. CNA 14 indicated she would find out if residents were able to keep their own cigarettes from the nurse. During an interview, on 1/23/26 at 9:37 a.m., (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Practical Nurse (LPN) 9 indicated smoking assessments were completed upon admission and periodically. Nursing completed smoking assessments at admission and hospital returns, and sometimes activities staff also completed assessments. If a smoking assessment showed a change, then it should have been communicated to the staff. Residents who were able to smoke independently kept their own cigarettes and lighter, and she did not think there was a requirement to lock them up. LPN 14 thought Resident 9 was assessed as being able to smoke safely. On 1/23/26 at 10:23 a.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, Resident Smoking Guidelines, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: It is the policy of this facility to promote resident centered care by providing a safe smoking area for residents that request to smoke and are capable of safe smoking behaviors either independently or with supervision.Procedure: 1. Assessment, observation and designation of independent or supervised smoker will be made by the IDT [interdisciplinary team] recommendations, the designation may be changed based on recent assessments by the team and will include: a. Documentation in the resident medical records including reason for change. b. Update Care Plan to reflect changes. c. Resident/family notification. A document titled, Facility Specific Smoking Policy Addendum, was attached to and provided with the facility's smoking policy. The addendum indicated, This smoking policy for Independent Smokers is made by [facility name] and all smoking residents/parties to agreement September 2021. The Addendum follows: a. Secure smoking materials in locked area when not used by resident/patient for dependent smokers. b. Independent smokers will secure their own smoking materials in a locked bag when not in use.Smoking safety instructions for Independent smokers will include: a. Facility will provide locked bag for independent smokers to secure all smoking materials when not in use. 3.1-45(a)(1)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interview, the facility failed to ensure that nebulizer equipment was properly cleaned and stored after each use for 2 of 2 residents reviewed for oxygen and nebulizer use (Residents 12 and 63). Findings include:1. On 1/21/26 at 9:57 a.m., during an initial observation, Resident 12 was lying in bed. She indicated she had received a nebulizer treatment. A nebulizer is (an electrically powered machine that turns liquid medication into a mist so that it can be breathed directly into the lungs through a face mask or mouthpiece). The nebulizer tubing and mask were lying on the bedside nightstand on top of a clear plastic bag dated 1/19/26. The medication chamber was observed to have clear liquid inside. On 1/21/26 at 10:15 a.m., the medical record of Resident 12 was reviewed. The resident was admitted to the facility on [DATE]. Diagnosis included, but were not limited to, diabetes (a disease that occurs when your blood glucose, also called blood sugar, is too high), hypertension (high blood pressure), anxiety (a feeling of fear, dread, and uneasiness), and osteomyelitis (a painful bone infection that causes inflammation and swelling in the bone) of the left foot. The medical record lacked supporting documentation of respiratory diagnosis. A physician order, dated 12/18/25, indicated to administer ipratropium-albuterol 0.5-2.5 (3) mg/3ml (milligram/milliliter) solution inhale contents of 1 vial by mouth three times daily for respiratory. An annual Minimum Data Set Assessment (MDS), dated [DATE], indicated the resident was cognitively intact and required extensive to maximum assistance for daily care needs. A care plan, dated 1/20/26, indicated the resident received oxygen therapy. Interventions included, but was not limited to, give medications as ordered by physician. The care plan record lacked documentation of an intervention to administer respiratory nebulizer treatments. On 1/21/26 at 2:54 p.m., during a routine observation of Resident 12, noted the nebulizer tubing, mask and medication chamber were lying on the bedside nightstand on top of a plastic storage bag. A clear liquid was observed inside of the medication chamber. On 1/22/26 at 10:05 a.m., during a routine observation of Resident 12, noted the nebulizer equipment was lying on top of a clear plastic bag on the bedside nightstand. Clear liquid was noted in the medication chamber. On 1/22/26 at 2:48 during a routine observation of Resident 12, noted the nebulizer tubing, mask and chamber were lying on a plastic storage bag on top of the bedside nightstand. The medication chamber contained clear liquid. On 1/23/26 at 9:15 a.m., during an interview Licensed Practical Nurse (LPN) 7, indicated she would wash the nebulizer equipment, place it on a paper towel to dry, and once dried she would place it in a bag. On 1/23/26 at 9:25 a.m., during a routine observation of Resident 12, noted the nebulizer equipment inside of storage bag lying on top of the bedside nightstand. Observed a small amount of clear liquid in the medication chamber. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 1/20/26 at 2:43 p.m., Resident 63's unbagged nebulizer mouthpiece and tubing were observed on the seat of the chair next to the resident's bed. The medication chamber contained a clear liquid in it along with small bubbles on the inside of the chamber. Resident 63 indicated she was prescribed nebulizer breathing treatments as needed for shortness of breath. On 1/21/26 at 2:52 p.m., Resident 63's unbagged nebulizer mouthpiece and tubing were observed on the seat of the chair next to the resident's bed. The medication chamber contained a clear liquid in it along with small bubbles on the inside of the chamber. On 1/22/26 at 9:48 a.m., Resident 63's unbagged nebulizer mouthpiece and tubing were observed on the seat of the chair next to the resident's bed. The medication chamber contained a clear liquid in it along with small bubbles on the inside of the chamber. Resident 63's record was reviewed on 1/21/26 at 3:18 p.m. The profile indicated the resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD- a group of diseases that cause airflow blockage and breathing related problems) and acute respiratory failure with hypoxia (critical condition where the lungs cannot adequately transfer oxygen to the blood, resulting in a sudden, dangerous drop in oxygen levels). A quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, indicated the resident was cognitively intact and was not on oxygen therapy. A care plan, dated 6/23/25, indicated the resident had COPD with shortness of breath while lying flat. Interventions included but were not limited to, administer medication per medical provider's orders, monitor vitals, and observe for signs and symptoms of COPD. A physician order, dated 6/22/25, indicated albuterol sulfate inhalation nebulization solution (a medication that can help people with lung problems, like asthma or obstructive pulmonary disease, breathe easier); 2.5mg (milligrams)/3ml (milliliter) 0.083%. Administer one orally via nebulizer every 6 hours as needed for wheezing. Review of the January 2026 Medication Administration Record (MAR) indicated Resident 63 received a nebulizer treatment on January 20, 2026, at 7:52 p.m. During an interview, on 1/23/26 at 8:40 a.m., Licensed Practical Nurse (LPN) 9 indicated after the resident had completed their nebulizer treatment, the nurse was to rinse out the nebulizer equipment and then place it in a plastic bag for storage when not in use. During an interview, on 1/23/26 at 10:23 a.m., the Regional Director of Clinical Operations (RDCO) indicated the facility did not have a policy regarding the storage of nebulizer equipment while not in use but should be stored in a bag that was dated. On 1/23/26 at 10:23 a.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, Nebulizer Treatments, and indicated it was the current policy being used by the facility. The policy indicated, .l. Rinse the nebulizer with sterile water and allow it to dry. Alternatively, discard it after therapy if applicable. 3.1-47(a)(6)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a resident was provided routine dental services for 1 of 32 residents reviewed for dental services (Resident 9). Findings include:During an interview, on 1/21/26 at 9:31 a.m., Resident 9 indicated she wanted to see a dentist, but she did not think dental services had been offered to her since she was admitted to the facility. The resident indicated she had missing teeth and teeth that had fallen out that she wanted checked. Resident 9's record was reviewed on 1/22/26 at 1:33 p.m. Census information indicated the resident was admitted to the facility on [DATE]. A significant change Minimum Data Set (MDS) assessment, dated 12/19/25, indicated the resident was cognitively intact. A care plan, last revised on 5/21/25, indicated the resident had the potential for oral/dental problems due to carious (cavities or tooth decay) teeth. Interventions included, but were not limited to, dental consult as needed. The resident's electronic record lacked documentation the resident was offered, provided, or refused dental care. During an interview, on 1/23/26 at 2:40 p.m., Risk Management 15 indicated she was not able to find documentation the resident had been offered dental services since her admission to the facility. Dental services should have been offered to all residents at admission, but she was unable to find documentation this was completed. They planned to offer her dental services at this time. On 1/23/26 at 3:03 p.m., the Regional Director of Clinical Operations (RDCO) provided an undated document titled, Dental Services, and indicated it was the policy currently being used by the facility. The policy indicated, .Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents.Dental and Oral health can impact the physical as well as the mental/emotional and psychological health of a resident. Poor dentition and/or poor oral health may impact nutritional and weight loss status. Procedure: I. The facility will assist the resident in: a. Obtaining routine Dental Services.c. Obtaining services to the resident to meet the needs of each resident. 3.1-24(a)(1)