STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155505	A. Building B. Wing	09/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Robin Run Health Center	6370 Robin Run W Indianapolis, IN 46268

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interviews, and record review, the facility failed to ensure food in the main kitchen during meal prep were covered and protected from potential contamination, failed to ensure foods in the walk-in refrigerator were labeled/dated and covered from the potential for contamination, and failed to ensure the dish washing machine reached the minimum sanitation temperatures. This deficient practice had the potential to affect 53 of 53 residents served from the kitchen. Findings include:1. During an initial kitchen tour on 9/16/25 at 9:40 a.m., with the Lead [NAME] present, the following was observed: The kitchen floors were littered with food crumbs and spills under prep tables. Behind the stove and hot boxes there was a significant buildup of grease, food debris, and standing water. Three large trash cans were full of refuse and had been left uncovered. Several flies were observed throughout the kitchen near storage and preparation stations. Nearly all food being prepped was left uncovered while flies were active in the area. Approximately 30 portions of cake were cut and placed on racks uncovered, and a large bowl of drained pasta was left in a prep sink uncovered during the observation. In the walk-in freezer, six tubs of ice cream were stored directly on the floor. Multiple items had been removed from their original packaging and were not labeled or dated. In the walk-in refrigerator, uncovered food items included: two trays of prepared fish fillets, three trays of clam chowder, two trays of individual jello, and a pan of pork chops. The Lead [NAME] indicated he had been away from work for several days and had not had the chance to check on food storage, but it was all the staff's responsibility to ensure food was covered, labeled and dated. In the walk-in refrigerator, there was a large red tub at the back of the unit which contained standing water which had accumulated from a cut-off PVC pipe that had been sawed off, allowing condensation from the refrigeration system to drip into the tub. The Lead [NAME] indicated this had been an improvised repair solution, after the refrigeration unit had some constructive repairs done in the previous weeks. The Lead [NAME] did not know when the maintenance department would return to seal the leaking pipe, but until then, the bucket collected the water and staff were supposed to empty it every shift. On 9/17/25 at 2:00 p.m., the Kitchen Manager provided a copy of current facility policy titled, Pest Control, dated 2022. The policy indicated, Team members must take preventative measures to restrict and eliminate pests from the operation. store food and supplies away from walls and six inches from the floor. On 9/17/25 at 2:00 p.m., the Kitchen Manager provided a copy of current facility policy titled, Labeling and Date Marking, dated 2022. The policy indicated, All food must be properly labeled and dated. 2. The industrial dishwasher was labeled as high temperature sanitizing machine but failed to reach the required sanitizing rinse of 180 F, after three observations. The highest recorded rinse temperature was 153 F. There were three separate temperature reading options; the built-in dial temperature, a secondary (Dishwasher Chemical Company name) digital temperature gauge, and a black plastic thermometer disk which could be manually run through the wash. On 9/16/25 at 9:50 a.m., the Kitchen Manager arrived. The Lead Cook, the Dishwasher, an unidentified kitchen aide, and the Kitchen Manager were all asked which of the three temperature gauges was used to test the dishwasher's temperature. The Lead [NAME] and unidentified aide did not know. The Dish Washer indicated he used the digital (Dishwasher Chemical Company name) result, and the Kitchen Manager (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 - Many	indicated she used the plastic dish which she placed in a wash cycle at that time. The disk came out of the wash, and only read 157 F. A review of the dish washer temperature log revealed no recorded high temp of 180 F had been obtained for the month of September 2025. On 9/17/25 at 1:29 p.m., the Kitchen Manager and an Dishwasher Chemical Company Consultant Technician were present for a second visit to the kitchen. At that time, a was cycle was observed and all three of the temperature dials registered the sanitizing cycle to reach 180 F. The Consultant indicated he guessed the staff forgot to turn on the hot water booster, because everything else seemed to be in working order. He confirmed the machine did require temperatures to reach 180 F for the final rinse to sanitize the dishes. The Kitchen Manager indicated she thought the final rinse only needed to be 160 F, but she would re-educate her staff to ensure the booster was turned on and rinse cycles reached 180 F. 3.-21(i)(1)3.-21(i)(3)

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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. A. Based on observation, interview, and record review, the facility failed to ensure a resident's right to make decisions regarding her care and treatments for 1 of 15 residents reviewed for resident rights (Resident K). B. Based on observation, interview, and record review, the facility failed to maintain residents' right to dignity when providing wounds treatments in common areas, using inappropriate clothing protectors at meal times, during activities, and when speaking with residents for 11 of 15 residents reviewed for resident rights (Residents E, F, G, H, J, L, M, P, 28, 48, and 55). Using the reasonable person concept this deficiency had the potential to cause residents discomfort and humiliation. Findings include: A. On 9/16/25 at 2:35 p.m. Resident K was observed as she sat in her wheelchair in her room. Resident K indicated her healthcare POA was not a family member, just someone she had known a long time and previously trusted. She indicated the POA lived in Oregon but instead of talking to her about her care the staff ask her POA. Resident K indicated she did not trust her POA anymore and did not feel she had her best interest at heart. Resident K was able to recall many details from her life both prior to living at the facility and after moving into the facility. The resident had one pair of glasses sitting on her bedside table, she indicated she needed new ones because she could not read with that pair. On 9/17/25 at 10:15 a.m. Resident K's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, chronic kidney disease and hypertension (high blood pressure). There was no dementia diagnosis for this resident. Resident K's most recent Brief Interview for Mental Status (BIMS) score was 11 out of 15 indicating moderate cognitive impairment. Resident K's living will and POA paperwork was signed July, 16th 1998. This document indicated the POA would become effective upon Resident K's disability or incompetence determined by the resident's health care provider. Resident K's current POST form was signed by the former Assisted Living (AL) Director who was the current Minimum Data Set (MDS) Coordinator and another staff member and was dated 2/29/24. This document indicated the Resident was to be a Do Not Resuscitate (DNR), comfort measures only, use antibiotics consistent with treatment goals and no artificial nutrition was to be used. On 9/18/25 at 12:31 p.m. Resident K was observed as she sat in her wheelchair eating lunch in her room, she was able recall the conversation on 9/16/25. Resident K indicated she did not recall the staff members talking to her about her wishes at this time for her code status. She indicated she was unsure of what she would want and was unaware of all the options she had. She indicated she was unaware that a POST form had been signed on her behalf by her POA, voicing again her mistrust of her POA. An optometry consent form, dated 7/15/24, indicated it had been signed by the POA via verbal consent. A flu vaccination consent from, dated 9/12/24, indicated staff received verbal consent from the POA for Resident K to receive the vaccination. A social services progress note, dated 10/3/24, indicated that Resident K's insurance did not cover glasses for the resident, but the resident had already picked out frames to be paid for out of pocket. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The note indicated the POA was notified via voicemail of the cost of the glasses. A social services progress note, dated 10/7/24, indicated that another voicemail was left about the cost of Resident K's glasses. A social services progress note dated 10/10/24 indicated that another voicemail was left about the cost of Resident K's glasses. A social services progress note dated 10/14/24 indicated that another voicemail was left about the cost of Resident K's glasses. A social services progress note, dated 12/5/24, indicated that the Interdisciplinary Team (IDT) met with the POA for a care plan meeting and discussed optometry services and Resident K ordering reading glasses. The POA indicated the resident had many pairs of glasses that she didn't wear. A care plan conference summary, dated 12/5/24, indicated all topics were discussed with the POA and not the Resident. The summary indicated the POA attended the care conference via telephone. A care plan conference summary, dated 2/20/25, indicated all topics were discussed with the POA and not the resident. The summary indicated topics discussed were code status, medications, food, and pain. The summary indicated the POA attended the care conference via telephone. A care plan conference summary, dated 8/14/25, indicated all topics were discussed with the POA who was incorrectly assumed to be her daughter by the staff member filling out the summary and not the resident. The summary indicated the POA gave verbal consent for the flu vaccine, she would send chocolate shakes and snacks monthly, but would not send clothes. The summary indicated the POA attended the care conference via telephone. On 9/23/25 at 1:25 p.m. Resident K was observed as she sat in her wheelchair outside of her room in the hallway eating lunch. Resident K indicated she did not receive anything from her POA monthly. The resident was able to recall the year she signed the POA paperwork. Resident K's record lacked documentation of an order or documentation indicating a physician had deemed Resident K incompetent or incapable of making safe healthcare decisions for herself. During an interview on 9/23/25 at 2:19 p.m. the Social Services Director (SSD) indicated Resident K loved to reminisce about old times, but she knew what she wanted and had great conversations. During an interview on 9/23/25 at 2:34 p.m. QMA 21 and 25 indicated Resident K was more cognitively aware than not. They indicated she had off days but most days she was aware and capable of making decisions for herself. During an interview on 9/23/25 at 2:50 p.m. the DON indicated code status was to be discussed and in the resident's chart within 3 hours of admission. She indicated she did not allow a POA to sign consents unless the POA had been invoked, whether that be upon signature or upon physician decision. The DON indicated given Resident K's current BIMS score she would expect staff to have a discussion with the Resident regarding her care decisions, and to get a new POST form signed based on the resident's preference. Resident K should have been asked for consent before staff went to the POA to sign consents forms. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 9/23/25 at 3:17 p.m. the former AL director indicated she called the POA and she wasn't available in person so they got verbal consent for Resident K's POST form. She indicated Resident K was very out of it when that POST was signed due to being admitted from the hospital after being very ill. Now that Resident K was with it more and her BIMS was higher she would agree with the DON that another POST form should have been discussed and signed by the resident and that consents should be signed by the resident whenever possible before going to the POA. B1. On 9/16/25 at 11:08 a.m., Resident 55 was observed. She was seated in a recliner chair in the main TV lounge with an over-bed table in front of her with the remainder of her breakfast meal. An unidentified Hospice nurse arrived and removed her breakfast tray. Without wiping off the surface of the table, the Nurse set down supplies for a dressing change and put on gloves without hand hygiene. She pulled a chair up beside Resident 55, proceeded to remove an old bandage from Resident 55's right forearm, and completed a wound treatment. The resident was not moved to a private location, and the hospice nurse was not reminded by facility staff to complete medical treatments in private. Cross reference F880. 2. On 9/16/25 at 11:12 a.m., Speech Therapist (ST) 18 entered the unit to provide an activity for several residents. She went to the TV lounge with a plastic container of colorful children's toys. The toys included, but were not limited to, a Pop-It, a colorful cushioned square with raised areas inside that can be pushed in, and a Fidget blanket with buttons, zippers, ribbons etc. ST 18 handed the Pop-It toy to Resident E and indicated in a tone people would use with a baby, awwww would you like to see the pop-pop? She approached Resident F, who appeared to be asleep as her eyes were closed and her head dropped down, but placed the cushioned square on her lap. The ST 18 approached Resident G and placed the Fidget blanket on his lap and indicated in a tone people would use with a baby, do you want to see the blanket? All the Feels on there? Yea, see the zip-zip? 3. On 9/16/25 at 2:41 p.m., Resident G was observed. He was seated in a Broda wheelchair (a specialized wheelchair for residents with positioning needs) in the main TV lounge. At this time, Licensed Practical Nurse (LPN) 12 repositioned Resident G next to common seating area couch. LPN 12 sat on the couch and placed treatment supplies on the surface of the couch without cleaning the surface. LPN 12 proceeded to complete a dressing change on Resident G's left forearm without moving him to a more private location. Cross reference F880. 4. On multiple meal observations of breakfast and lunch, Resident E was observed at the table with either a hospital gown or towel draped over his chest to act as a clothing protector instead of a napkin or appropriate clothing protector. On 9/16/25 at 12:45 p.m., Resident E had not been dressed for the day and was seated at the table wearing a hospital gown, with a towel draped over his chest as the clothing protector. 5. On 9/18/25 at 10:00 a.m., several residents of different ethnicities, including Residents 28, 48 and E, were gathered in the TV lounge and were exposed to a television program containing racially offensive material, and sexually inappropriate jokes. Staff did not change the program until after the offensive content was aired. 6. On 9/17/25 at 10:30 a.m., activity staff conducted a ball-toss game in the Memory Care lounge. Residents E, F, G, H, L, M, and P, who were unable to participate, were struck in the face or body by (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the ball. The residents grimaced, turned away, or withdrew in discomfort. Staff continued the activity until Resident M, verbally complained of pain when the ball rolled into her face, startled her awake, and she indicated, oohhhh ooowww, and rubbed her nose. 7.On 9/18/25 at 10:30 a.m., Activity staff conducted a balloon bat game where the residents were given pool noodles and rubber balloons to bat across the table to each other. Residents E, F, G, J, L, M and P, who were unable to participate, were struck in the face with the balloons, startled awake, grimaced, turned away, and withdrew in discomfort. During an interview on 9/22/25 at 3:00 p.m., the Regional Nurse Consultant (RNC) indicated residents should receive care in private settings, be dressed appropriately in personal clothing, and participate only in activities that preserve dignity and comfort. During an interview on 9/23/25 at 3:02 p.m., the above dignity concerns were reviewed with the Administrator, (ADM). The ADM indicated all residents had the right to be treated with dignity, and in memory care, just because they don't or can't say they don't like something, staff should be aware of their dignity on their behalf. On 9/19/25 at 2:50 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, Dignity, revised February 2021. The policy indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life and feeling of self worth and self esteem. Residents are treated with dignity and respect at all times . The facility culture supports dignity and respect for residents. When assisting with care, residents are supported in exercising their rights, for example, residents are: encouraged to dress and clothing that they prefer. provided with a dignified dining experience. staff speak respectfully to residents at all times. Staff promote, maintain, and protect resident privacy, including bodily privacy, during assistance with personal care and during treatment procedures. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents . Promptly responding to a residence request for toileting assistance. 3.1-3(a)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure grievance resolutions were provided, or effectively addressed ongoing concerns related to call lights response times and staffing availability to meet the resident's needs and preferences for 1 of 15 residents reviewed for grievances (Residents H) and for 6 of 6 residents who participated in a resident council meeting. Findings include: On 9/16/25 at 11:11 a.m., Resident H was observed. She wore shorts and had a thin sheet over her lap as a blanket. Resident H's husband arrived and indicated to Certified Nursing Aide, (CNA) 11, he was upset to keep finding her dressed in shorts because she got cold easily and preferred long pants and long sleeve shirts. Resident H's husband indicated he had complained about it on several occasions and just went to check her closet and found no long pants. He apologized to CNA 11 and indicated it was not her fault, but he was frustrated that he had to keep reminding staff to put her in long pants. During an interview on 9/16/25 at 11:15 a.m., Resident H's husband indicated he had ongoing concerns with her not being dressed the way she preferred, and that she was often served last at meals. He started coming more regularly and adjusted his visit schedule around mealtimes to ensure she got her plate when it was still warm and stayed to help ensure she ate, because he wasn't sure staff would. During a Resident Council Meeting on 9/18/25 at 2:32 p.m., with 6 members present, the council indicated they were short staffed and needed more CNAs. It often took a long time to get call lights answered, or staff would come in, turn off the light, and not come back. On 9/22/25 at 12:07 p.m., Grievances were reviewed and revealed:a. On 3/21/25 the Resident Council complained nursing was not answering call lights. There was no grievance follow up or evidence of investigation or corrective action taken by the facility.b. On 3/3/25, a resident grievance indicated, she had been laid down when her whole body started aching and she pressed the call light. Staff turned off the call light without providing assistance, and she did not receive her pain medication until the next morning. There was no documented investigation or resolution.c. On 4/22/25, a resident's friend filled a grievance which indicated, the resident was left on a bed pan for 3 hours and the resident's wife had to help with peri care every day since admission. The grievance file noted a skin check but lacked evidence of follow-up or corrective action.d. On 7/25/25, a resident filed a grievance and indicated, she waited for over an hour before she received help with her call light. There was no documented investigation or corrective action.e. On 7/30/25, a resident filed a grievance and indicated she experienced a nosebleed in the dining room and staff did not respond promptly.f. On 8/6/25 a resident's daughter filed a grievance which indicated, Resident hasn't had a shower or hair wash since admitting, [only getting bed baths] staff said ?too busy down there,' for showers. The grievance resolution dated 8/15/25 confirmed the resident continued to miss showers, with no corrective action documented.g. On 8/29/25, Resident H's husband filed a grievance which indicated, he was .upset because staff always feed her [Resident H] last and with no empathy or compassion, and aides don't talk to the residents (not all aides were like this). The grievance resolution, dated 9/4/25, indicated, things were better but still needed improvement, without documented corrective steps to ensure sustained improvement. During an interview on 9/22/25 at 3:00 p.m., the Social Service Director (SSD) indicated she was new, and could not find the resident council response forms, and did not know about resolutions or have additional documentation to provide for the above grievances. On 9/19/25 at 2:50 p.m., the SSD provided a copy of current facility policy titled, Resident Rights, revised 2017. The policy indicated, You have the right to voice grievances to the facility or other agencies that hears grievances without the fear of discrimination or reprisal, including: grievances regarding your care and treatment, the behavior or staff. other concerns regarding your facility stay. you have the right to information about how to file a grievance or complaint, including the right to: a copy of the facility's grievance policy, file a grievance verbally or in (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	writing, file a grievance anonymously. a written decision regarding the grievance, immediate action taken to prevent further violations for your rights [NAME] a grievance is being investigated. 3.1-3(g)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure residents who resided in the secured memory care unit received necessary care and services for activities of daily living (ADL) including eating, toileting, and grooming for 10 of 15 residents reviewed for ADLS (Residents E, F, G, H, J, K, L, M, N and P). Findings include:During a continuous observation on 9/16/25 from 10:10 a.m. until 1:00 p.m., in the secured memory care unit (MCU), the following was observed: Resident N was asleep on a couch in the TV lounge area and there was a strong odor of urine from him. Resident E was provided a small plastic cup of a supplemental chocolate shake but had fallen asleep and spilled the shake on his lap. LPN 12 took the empty cup from him but did not wipe off his lap. Residents F, G, H, J, and M's hair were observed to be unbrushed. Resident G's hair appeared greasy, Resident M's hair was falling out of a loose ponytail, and Resident F's hair was unbrushed and fell over her face. Resident G's fingernails were observed to be long and had debris under them. At 12:20 p.m., lunch was brought to the MCU and staff began to pass trays. LPN 13 and CNA 14 came to help residents eat. Residents E, F, G, J, L, M, and P all required total assistance and/or constant reminders/encouragement to eat. LPN 13 assisted Residents E and L at the same time. CNA 14 assisted Resident P while CNA 11 assisted Resident G and LPN 12 assisted Resident M. No one was available to assist or give constant reminder to Residents F and J who both just stared at their plates and other residents until eventually Resident J fell asleep at the table. When CNA 11 finished helping Resident G eat, she got up to encourage Resident J to eat. Resident J began to feed herself slowly and used her fingers. As she took the time to encourage and help Resident J eat, Resident G did not have any assistance to finish his lunch. LPN 13 left the table for several minutes to assist a resident who returned to the unit from therapy, which left Residents E and L without assistance. CNA 11 woke Resident F up and helped her take one bite, but then had to return to assist Resident G. Resident F did not attempt to take any more bites. It took over an hour to get the totally dependent residents fed. Resident K was observed to wear a name brand pair of socks which appeared to be too tight as they compressed into his lower legs and a red abrasion was observed around the whole of his right middle leg. He indicated the abrasion was because his socks were too tight and he couldn't pull them up far enough. Cross reference F686. On 9/17/25 at 9:04 a.m., Resident F was asleep at the table with only about 25% of her meal consumed. Her hair was unbrushed and hung loose in her face. Resident M was in the TV lounge in her wheelchair with her hair unbrushed and falling out of a messy, loose ponytail. Resident G's hair remained long unbrushed, and he had facial stubble. His fingernails remained long with debris under the nails. On 9/17/25 at 1:39 p.m., a resident was calling out to go to the bathroom. CNA 11 and 14 who had been assisting Residents L and P to finish their lunch, had to stop assisting them with eating as they took a Hoyer lift into the room to assist the other resident to the bathroom. On 9/17/25 at 1:40 p.m., Resident N was in his wheelchair sitting beside the couch he liked to sleep in and called over to LPN 12 that he was ready to go to the bathroom and lay down. LPN 12 was assisting Residents M and E with their lunch and indicated back to Resident N that he would have to wait a few minutes. On 9/17/25 at 1:44 p.m., another resident stood from her table and indicated she needed to go to the bathroom. LPN 12 had to stop assisting the residents she was helping eat and took the other resident to the bathroom. At that time there were 12 unsupervised residents as both aides and the nurse were behind closed door helping other residents for over 5 minutes. When LPN 12 returned to the table to finish helping with lunch, another resident attempted to go into the front public bathroom. LPN 12 called out that she could not use that bathroom but did not get up to assist her to her room or allow her to use the public restroom. On 9/17/25 at 1:50 p.m., Resident N indicated he needed to use the bathroom and wanted to lay down. LPN 12 indicated he would still have to wait as she needed to finish helping Resident M eat. On 9/17/25 at 2:10 p.m., LPN 12 assisted a resident down the hall past Resident N, who called to her that he needed to use the bathroom and wanted to lay down. She walked past him without answering. By 2:19 p.m., Activity Assistant (AA) 17 began to (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	set up a hand message activity, but was told that Resident N was still waiting to go to the bathroom. AA 17 indicated she was also a CNA, and could help him, so she took him to the bathroom at 2:20 p.m. Resident N waited over 30 minutes to be assisted to the restroom, and upon AA 17 returning him to the activity space, she indicated he had been incontinent of urine and had a soiled brief. On 9/18/25 at 9:05 a.m., upon entrance into MCU, breakfast was being cleared away and residents were gathered in the TV lounge. Resident E was observed with facial stubble. Resident G's hair remained unbrushed and his nails were long. Resident L's hair was unbrushed and pressed to the side of her head from sleeping on it. On 9/18/25 at 12:30 p.m., CNA 14 had to assist multiple residents at once for lunch and indicated there were not enough staff to help all the residents who needed assistance, so sometimes they had to wait. On 9/19/25 at 9:12 a.m., Resident G's hair remained unbrushed and his facial stubble had grown more prominent. Resident E's facial stubble had become more prominent. During an interview, on 9/22/25 at 2:43 p.m., Resident L's husband indicated he was still able to and preferred to help his wife with as much as he could, but often if he couldn't be there, Resident L and others were not assisted in a timely manner and things like oral care, hair brushing and nail trimming might not get done. On 9/19/25 at 2:50 p.m., the Director of Nursing (DON) provided a copy of current facility policy titled, Activities of Daily Living (ADLs), Supporting, revised March 2018. The policy indicated, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services will be provided for residents who are unable to carry out ADL's independently with the consent of the resident and in accordance with the plan of care. This deficiency was cited on 8/18/25. The facility failed to implement a systemic plan of correction to prevent recurrence.3.1-38(a)(3)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, and record review, the facility failed to provide sufficient nursing staff to meet the needs of residents in the secured memory care unit as evidence by unmet or untimely assistance with activities of daily living (ADL) care for 10 of 15 residents reviewed for ADLs (Residents E, F, G, H, J, K, L, M, N and P), failed to ensure the appropriate assistance was available for the transfer of a resident in a hoyer lift which tipped and caused the resident to receive a skin tear for 1 of 4 resident reviewed for accidents (Resident P), and failed to ensure enough staff to timely answer call lights and assist residents for 4 of 7 months of grievances reviewed. Findings include:1. During a continuous observation on 9/16/25 from 10:10 a.m. until 1:00 p.m., in the secured memory care unit (MCU), the following was observed: There was only Certified Nursing Aide (CNA)11 on the unit and Licensed Practical Nurse (LPN) 12 on the unit. Resident N was asleep on a couch in the TV lounge area and there was a strong odor of urine from him. Resident E was provided a small plastic cup of a supplemental chocolate shake but had fallen asleep and spilled the shake on his lap. LPN 12 took the empty cup from him but did not wipe off his lap. The I-Love-Lucy TV show had been playing for several residents gathered in the TV lounge area. When it turned off, the TV auto-played the next video in the queue which a video of two men riding a motorcycle cross-country and speaking in a foreign language. No one was available to change the TV. Both the CNA and LPN were in a room with another resident. Residents F, G, H, J, and M's hair were observed to be unbrushed. Resident G's hair appeared greasy, Resident M's hair was falling out of a loose ponytail, and Resident F's hair was unbrushed and fell over her face. Resident G's fingernails were observed to be long and had debris under them. At 12:20 p.m., lunch was brought to the MCU and staff began to pass trays. LPN 13 and CNA 14 came to help residents eat. Residents E, F, G, J, L, M, and P all required total assistance and/or constant reminders/encouragement to eat. LPN 13 assisted Residents E and L at the same time.CNA 14 assisted Resident P while CNA 11 assisted Resident G and LPN 12 assisted Resident M.No one was available to assist or give constant reminder to Residents F and J who both just stared at their plates and other residents until eventually Resident J fell asleep at the table.When CNA 11 finished helping Resident G eat, she got up to encourage Resident J to eat. Resident J began to feed herself slowly and used her fingers. As she took the time to encourage and help Resident J eat, Resident G did not have any assistance to finish his lunch. LPN 13 left the table for several minutes to assist a resident who returned to the unit from therapy, which left Residents E and L without assistance. CNA 11 woke Resident F up and helped her take one bite, but then had to return to assist Resident G. Resident F did not attempt to take any more bites. This continued throughout the lunch observations, as staff members would be interrupted with other resident needs or need to get supplies, and would have to get up and down from the table which left several residents without assistance. It took over an hour to get the totally dependent residents fed. Resident K was observed to wear a name brand pair of socks which appeared to be too tight as they compressed into his lower legs and a red abrasion was observed around the whole of his right middle leg. He indicated it was because his socks were too tight and he couldn't pull them up far enough. Throughout the next several days until the 9/19/25, no staff noticed and or assisted him to pull the socks up to a proper height or find a better fitting pair. Cross reference F686. On 9/17/25 at 9:04 a.m., Resident F was asleep at the table with only about 25% of her meal consumed. On 9/17/25 at 1:39 p.m., a resident was calling out to go to the bathroom. CNA 11 and 14 who had been assisting Residents L and P to finish their lunch, had to stop assisting them as they took a Hoyer lift into the room to assist the other resident to the bathroom. On 9/17/25 at 1:40 p.m., Resident N was in his wheelchair sitting beside the couch he liked to sleep in and called over to LPN 12 that he was ready to go to the bathroom and lay down. LPN 12 was assisting Residents M and E with their lunch and indicated back to Resident N, that he would have to wait a few minutes. On 9/17/25 at 1:44 p.m., another resident stood from her (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	table and indicated she needed to go to the bathroom. LPN 12 had to stop assisting the residents she was helping eat, and took the other resident to the bathroom. At that time there were 12 unsupervised residents as both aides and the nurse were behind closed doors helping other residents for over 5 minutes. When LPN 12 returned to the table to finish helping with lunch, another resident attempted to go into the front public bathroom. LPN 12 called out that she could not use that bathroom but did not get up to assist her to her room or allow her to use the public restroom. On 9/17/25 at 1:50 p.m., Resident N indicated he needed to use the bathroom and wanted to lay down. LPN 12 indicated he would still have to wait as she needed to finish feeding Resident M. On 9/17/25 at 2:10 p.m., LPN 12 assisted a resident down the hall past Resident N, who called to her that he needed to use the bathroom and wanted to lay down. She walked past him without answering. By 2:19 p.m., Activity Assistant (AA) 17 began to set up a hand message activity, but was told that Resident N was still waiting to go to the bathroom. AA 17 indicated she was also a CNA, and could help him, so she took him to the bathroom at 2:20 p.m. Resident N waited over 30 minutes to be assisted to the restroom, and upon AA 17 returning him to the activity space, she indicated he had been incontinent of urine and had a soiled brief. On 9/18/25 at 9:05 a.m., upon entrance into MCU, breakfast was being cleared away and residents were gathered in the TV lounge. Resident E was observed with facial stubble. Resident G's hair remained unbrushed and his nails were long. Resident L's hair was unbrushed and pressed to the side of her head from sleeping on it. On 9/18/25 at 12:30 p.m., CNA 14 had to assist multiple residents at once for lunch and indicated there were not enough staff to help all the residents who needed assistance, so sometimes they had to wait. On 9/19/25 at 9:12 a.m., Resident G's hair remained unbrushed and his facial stubble had grown more prominent. Resident E's facial stubble had become more prominent. During an interview with Resident L's husband on 9/22/25 at 2:43 p.m., he indicated, he was still able to and preferred to help his wife with as much as he could, but often if he couldn't be there, Resident L and others were not assisted in a timely manner and things like oral care, hair brushing and nail trimming might not get done. During an interview on 9/16/25 at 11:11 a.m., Resident H's husband indicated he had several issues with the unit being short staffed. They often ran out of her clothes and left her in shorts which made her cold. Sometimes there would not be enough staff to get her to the bathroom before she had an accident and sometimes there would only be one CNA on the unit. During an interview on 9/18/25 at 1:25 p.m., Licensed Practical Nurse (LPN) 19 indicated the facility really needed more staff on memory care. There was often only one or two CNAs and they could not get everything done. They used to have a lot of activities, but mostly the residents all sat in front of the TV now. There was also a sensory room that got set up, but it was never used. It was potentially dangerous sometimes because if two CNAs were helping a dependent resident for example with a Hoyer lift, and the nurse got called to a resident room, then there was no one to supervise the remainder of the residents. During an interview on 9/19/25 at 9:10 a.m., LPN 20 indicated, she had just come off orientation, and this was her first time in memory care. She did not know the residents and it had been hard to get the CNAs to help her since they were so busy. During an interview on 9/16/25 at 11:15 a.m., Resident H's husband indicated he had ongoing concerns with her not being dressed the way she preferred, and that she was often served last at meals. He started coming more regularly and adjusted his visit schedule around mealtimes to ensure she got her plate when it was still warm and stayed to help make sure she ate because he wasn't sure staff would. Cross reference F677. 2. During an interview on 9/22/25 at 2:43 p.m., Resident L's husband indicated that the memory care unit would benefit from having more CNAs or activity assistants just to help provide care and supervise. There had been an incident a couple of weeks earlier where there was only one CNA to transfer Resident L in the Hoyer lift. The lift tipped over and she was dropped, fortunately into a chair and not onto the floor, but she still got a laceration on her forehead. Resident L's husband filed a grievance on 6/8/25 which indicated, When [Resident L] was being transferred to wheelchair, the Hoyer lift tipped, dropping her into the chair resulting in a small cut on her forehead. Only one person was handling the Hoyer lift. Findings of the investigation concluded: Aide moved (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident with mechanical lift without assist of 2. education regarding assist of 2 for total lift to aide in question. Cross reference F689. 3. On 9/16/25 and 9/17/25, activity staff conducted activities on the memory care unit in which residents rolled a ball or batted a balloon, but there were not enough staff to assist dependent residents to prevent them from being struck in the face with the balloons. Residents were observed to be startled awake, grimacing, turning away, and withdrawing in discomfort. Cross reference F550. 4. During a Resident Council Meeting on 9/18/25 at 2:32 p.m., with 6 members present, the council indicated they were short staffed and needed more aides. It often took a long time to get call lights answered, or staff would come in, turn off the light, and not come back. Grievances were reviewed and revealed:a. On 3/21/25 the Resident Council complained nursing was not answering call lights. There was no follow up.b. A resident filed a grievance on 3/3/25 which indicated she had been laid down when her whole body started aching and she pressed the call light. They did not come for a long time, and when they did come in they turned off the light and did not come back. It was morning before she received pain medication. There was no follow up.c. A resident's friend filed a grievance on 4/22/25 which indicated the resident had been left on a bed pan for 3 hours and the resident's wife had to help with peri care every day since admission. The resident received a skin check with no concerns noted, but the grievance lacked documentation of follow up and/or resolution.d. A resident filed a grievance on 7/25/25 which indicated, she waited for over an hour before she received help with her call light.e. A resident filed a grievance on 7/30/25 which indicated, she had a nose bleed in the dining room and it took a long time for staff to assist her.f. A resident's daughter filed a grievance on 8/6/25 which indicated, Resident hasn't had a shower or hair wash since admitting, [only getting bed baths] staff said too busy down there, for showers. Resolution for the grievance on 8/15/25 indicated: resident complained and reported she still is not receiving baths.g. Resident H's husband filed a grievance on 8/29/25 which indicated, .upset because staff always feed her last and with no empathy or compassion, and aides don't talk to the residents. Resolution to the grievance on 9/4/25 indicated, .Resident H's husband stated that things were better but still needed improvement. Cross reference F585. On 9/22/25 at 3:10 p.m., the RNC indicated the facility did not have a staffing policy. During an interview on 9/23/25 at 2:45 p.m., the Regional Nurse Consultant (RNC) indicated, the facility was trying to hire like crazy. During an interview on 9/23/25 at 3:02 p.m., the above concerns were reviewed with the Administrator, (ADM). The ADM indicated, staffing patterns were based on census and moving forward identifying staff strengths for memory care would be a priority. 3.1-17

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to ensure medications stored in medication carts were appropriately stored, labeled, and dated. This deficient practice had the potential to affect 9 of 57 residents receiving medication from the facility (Residents 24, 59, 9, 57, 4, 36, 7, 32, and 8). Findings include:On 9/16/25 at 10:45 a.m. medication cart one was reviewed with Qualified Medication Aide (QMA) 21. The medications reviewed were as follows:1. Resident 24 had three Atrovent inhalers with no open date or expiration date.2. Resident 59 had a Dorzolamide eye drop (a prescription eye drop medication used to treat elevated pressure in the eye) with no open date and no expiration date. Three open Lantanoprost eye drop (an eye drop used to lower elevated pressure in the eye) containers with no open date or expiration date and a sticker on them that said refrigerate. A Fluticasone nasal spray (a steroid nasal spray used to treat symptoms of allergies and other conditions by reducing inflammation in the nose) with no cap covering the applicator and had no open date or expiration date.3. Resident 9 had five Lantanoprost eye drops with no open date or expiration date and a sticker on them that said refrigerate. One of the bottles was open and four were sealed.4. Resident 57 had an Albuterol inhaler with no open date or expiration date, a oxymetazoline nasal spray (a decongestant nasal spray) with no open date or expiration date.5. Resident 4 had Clotrimazole topical solution (an antifungal medication used to treat various fungal skin infections) for the groin that was being stored in with the eye drops.6. Resident 36 had two Fluticasone inhaler with no open date or expiration date, one inhaler had 5 puffs left and the other had 9 puffs left.7. Resident 7 had a Fluticasone nasal spray with no open date or expiration date.8. Resident 32 had a bottle of acetaminophen oral solution that was being stored in with topical creams.9. There was a tube of medical grade honey cream being stored with inhalers.10. There was a tube of hydrocortisone cream being stored with oral medications. On 9/16/25 at 11:30 a.m. QMA 21 indicated all eye drops and nasal sprays should have been labeled with an open date and expiration date upon opening them, topicals should not have been stored with oral solutions, oral medications, eyedrops, or nasal sprays. On 9/16/25 at 11:35 a.m. the insulin cart was reviewed with Licensed Practical Nurse (LPN) 22. Resident 32 had a Lantus insulin vial with an expiration date of 8/27/25. On 9/16/25 at 12:00 p.m. the memory care unit Medication storage room was reviewed with LPN 23. Resident 8 had a Lorazapam vial with an open date of 5/27/25 in the refrigerator.On 9/16/25 at 12:05 p.m. LPN 23 indicated Lorazapam vials should be destroyed 30 days after they were open. During an interview on 9/17/25 at 10:15 a.m. the DON indicated they had been using mostly QMAs on the medication carts due to staffing difficulties, but they were in the process of changing to all LPNS or Registered Nurse (RN)s on the medication carts. The DON indicated topical medications should not have been stored in with oral solutions. She indicated it was the expectation of whoever opened the eye drops, nasal sprays or inhalers to put an open date and expiration date on the bottle. The Regional Nurse Consultant (RNC) indicated they used a cycle refill system so they sometimes would end up with multiple new medications before the open medication was finished leading to multiple of the same medication being open at the same time if whoever was on the cart didn't pay close attention. The DON and the RNC indicated they were going to stop using cycle refilling and do education with nursing staff. On 9/22/25 at 10:50 a.m. the RNC provided a copy of a current facility policy titled, Labeling of Medication Containers, dated 4/2019. This policy indicated, . All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. 2. Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. 3. Labels for individual resident medications include all necessary information such as:. h. the expiration date when applicable.On 9/22/25 at 10:50 a.m. the RNC provided a copy of a current facility policy titled, Storage of Medications, dated 11/2020. This policy indicated, . The (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility stores all drugs and biologicals in a safe, secure and orderly manner. 4. Discontinued, outdated or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.7. Medications requiring refrigeration are stored in a refrigerator located in the drug room at the nurses station or other secured location. On 9/22/25 at 10:50 a.m. a policy related to dating medications was requested but was not provided at the time of exit or by 5:00 p.m. the next day. 3.1-25(j)3.1-25 (m)3.1-25(n)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interview, and record review, the facility failed to ensure appropriate infection prevention measures were taken during wound treatments for 2 of 2 residents reviewed for wounds (Residents G and 55). Based on interview and record review, the facility failed to ensure an effective infection surveillance tracking and trending procedure was in place for 4 of 9 months of infection surveillance reviewed. Findings include:1. On 9/16/25 at 11:08 a.m., Resident 55 was observed. She was seated in a recliner chair in the main TV lounge with an over-bed table in front of her with the remainder of her breakfast meal. An unidentified Hospice nurse arrived and removed her breakfast tray. Without wiping off the surface of the table, the Nurse set down supplies for a dressing change and put on gloves without hand hygiene. She pulled a chair up beside Resident 55, and proceeded to remove an old bandage from the Resident's right forearm, and completed a wound treatment on top of the bedside table, and did not perform hand hygiene between gloves changes. On 9/16/25 at 2:41 p.m., Resident G was observed in the main TV lounge. Licensed Practical Nurse (LPN) 12 repositioned Resident G next to common seating area couch. LPN 12 sat on the couch and placed treatment supplies on the surface of the couch without cleaning the surface. She put on gloves without performing hand hygiene and removed the old dressing. She got up from the couch to get more supplies from the cart, removed her soiled gloves and tossed them on top of the med cart. She put on new gloves without hand hygiene and completed Resident G dressing change. When she returned to her cart, she threw away the old gloves, and did not wipe the surface of the cart down after coming in contact with the contaminated gloves. On 9/23/25 at 2:50 p.m., the DON provided a copy of current facility policy titled, Wound Care, revised 2010. The policy indicated, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Steps in the procedure: 1. use disposable cloth, (paper towel is adequate) to establish clean field on residence overbed table. Place all items to be used during the procedure on the clean field. Arrange the supplies so they can be easily reached. 2. Wash and dry your hands thoroughly. 3. Position resident. Place disposable cloth next to resident (under the wound) to serve as barrier to protect the bed linen and other body sites. 4. Put on exam gloves. Loosen tape and remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. 2. On 9/23/25 10:18 a.m., the Infection Preventionist (IP) provided the facility's Infection and Antibiotic surveillance binder. Upon review of the binder at that time, there was no evidence of documentation for infection tracking or trend recognition for the months of January and February. The IP indicated, she tried to print the infection report at the end of each month for review, but also being the Wound Nurse, it was sometimes reviewed late. The IP indicated she did use maps for trending infections, but the maps were not color coded, did not indicate who admitted with infection and who acquired infections. The Infection Surveillance Monthly report for January was not reviewed until 2/26/25. Upon review of the February Infection Log, Resident 19 was included on the log for an acquired urinary tract infection. The infection surveillance lacked evidence that a culture had been obtained for the infection to ensure the appropriate antibiotic was prescribed. Further, surveillance record failed to include antibiotics that were added for Resident 19's house acquired wound infection on 2/22/25. The Infection Surveillance Monthly report for March was not reviewed until 4/16/25. On 3/24/25 two (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents in the secured memory care unit, Resident G and 55 were both diagnosed with conjunctivitis and prescribed the same antibiotic. The surveillance log failed to identify the trend. The Infection Surveillance Monthly report for August was not reviewed until 9/17/25. No infections for the Month of September had been plotted at the time of the infection program review. During an interview on 9/23/25 at 2:45 p.m., the Regional Nurse Consultant (RNC) indicated the facility was trying to hire more staff. The RNC, Director of Nursing (DON), and the IP had worked on the floor on several occasions to help cover nurse shortage, which may have contributed to the Infection Surveillance documentation not being completed. On 9/23/25 at 2:50 p.m., the DON provided a copy of current facility policy titled, Healthcare-Associated Infections, Identifying, revised 2017. The policy indicated, The infection preventionist will conduct ongoing surveillance for healthcare associated infections and other epidemiologically significant infections that have substantial impact on potential resident outcome and that may require transmission based precautions and other preventative interventions. Infections that may be considered in surveillance include those with limited transmissibility in the healthcare environment and or limited prevention strategies when infection or colonization with epidemiology. Equally important organisms is suspected cultures may be sent, if appropriate, to a contracted laboratory for identification or confirmation. Cultures will be further screened for sensitivity to antimicrobial medications to help determine treatment measures. 3.1-18(b)(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. Based on observations, interviews, and record reviews, the facility failed to ensure residents had clear orders for code status to reflect the resident's/family's choices for 2 of 2 residents reviewed for code status (Residents B and K), and failed to adhere to a resident's physician order for Do Not Resuscitate (DNR) for 1 of 2 residents reviewed for code status (Resident B). Findings include:1. On 9/18/25 at 1:29 p.m., a record review was completed for Resident B. He had the following diagnoses which included but were not limited to constipation, insomnia, Parkinson's disease (a progressive neurological disorder that affects movement), and urinary retention. A Physician's Orders for Scope of Treatment (POST) form in his electronic health record (EHR), dated 7/17/25, indicated Resident B desired Do Not Resuscitate (DNR) comfort measures only. A physician order, dated 7/31/25, indicated Resident B desired a code status of Do Not Intubate (DNI)/intubate/shock. He had an order for a hospice referral on 7/31/25. Resident B's baseline care plan did not discuss his desire for his code status. Resident B's record lacked documentation of a care plan for his code status. A progress note, on 8/4/25, indicated Resident B's pulse and respirations ceased. During an interview on 9/19/25 at 3:00 p.m., RN 5 indicated they were notified Resident B was unresponsive, and she went to assess the resident. She indicated he had no pulse or respirations. She indicated his order was for DNI with intubation and shock. She questioned the order and while another nurse stayed with the resident, she called the Director of Nursing (DON). The DON told her resident was a full code and perform cardiopulmonary resuscitation (CPR). She started CPR with chest compression and felt it did not seem right, so she called Resident B's family. The family told the nurse that if the resident died in his sleep than do not code him. By the time she got off the phone with family the Emergency Medical Technicians (EMT) were present and indicated to stop CPR per the family's request. The nurse indicated the Automatic Electronic Defibrillator (AED) pads were on the resident and no shock was advised. On 9/18/25 at 2:00 p.m., the family was phoned with no answer. A message was left for a return call. During an interview on 9/19/25 at 10:49 a.m. the DON indicated the family requested an autopsy. When Resident B was admitted to the facility, he was only there for 5 days. When the family came to the facility, the family member was upset because they were not aware of his discharge to the facility. She discussed resident's code status with the family member because the hospital indicated he was a DNR. The day he admitted to the facility the daughter wanted him sent to the hospital if he tanks. She indicated RN 5 phoned her after he passed away. She indicated to code resident given the daughter's response of going back and forth for what she wanted for resident. She indicated she did not know if he was provided with CPR and she knew that the AED was placed, and no shock was advised. On 9/22/25 at 5:00 p.m., Nurse 6 was interviewed. He indicated he was working on the memory care (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unit and was summoned to assist the nurse on the other unit. When he arrived, he felt the code status was strange. He confirmed the code status but did not provide any CPR for the resident. He indicated the AED pads were on the resident, and he believed the resident was shocked. He indicated the EMTs did not intubate resident due to the nurse indicating the family member did not want CPR. 2. On 9/16/25 at 2:35 p.m. Resident K was observed as she sat in her wheelchair in her room. Resident K indicated her healthcare POA was not a family member, just someone she had known a long time and previously trusted. She indicated the POA lived in Oregon but instead of talking to her about her care the staff asked her POA. Resident K indicated she did not trust her POA anymore and did not feel she had her best interest at heart. Resident K was able to recall many details from her life both prior to living at the facility and after moving into the facility. On 9/18/25 at 12:31 p.m. Resident K was observed as she sat in her wheelchair eating lunch in her room, she was able recall the conversation on 9/16/25. Resident K indicated she did not recall the staff members talking to her about her wishes at this time for her code status. She indicated she was unsure of what she would want and was unaware of all the options she had. She indicated she was unaware that a POST form had been signed on her behalf by her POA, voiced again her mistrust of her POA. On 9/23/25 at 1:25 p.m. Resident K was observed as she sat in her wheelchair outside of her room in the hallway eating lunch. The resident was able to recall the year she signed the POA paperwork. On 9/17/25 at 10:15 a.m. Resident K's medical record was reviewed. She was a long-term care resident whose diagnoses included, but were not limited to, chronic kidney disease and hypertension (high blood pressure). There was no dementia diagnosis for this resident. Resident K's most recent Brief Interview for Mental Status (BIMS) score was 11 out of 15 indicating moderate cognitive impairment. Resident K's living will and POA paperwork was signed July, 16th 1998. This document indicated the POA would become effective upon Resident K's disability or incompetence determined by the resident's health care provider. Resident K's current POST form was signed by the former Assisted Living (AL) Director who was the current Minimum Data Set (MDS) Coordinator and another staff member and was dated 2/29/24. This document indicated the resident was to be a Do Not Resuscitate (DNR), comfort measures only, use antibiotics consistent with treatment goals and no artificial nutrition was to be used. A care plan conference summary, dated 12/5/24, indicated all topics were discussed with the POA and not the Resident. The summary indicated the POA attended the care conference via telephone. A care plan conference summary, dated 2/20/25, indicated all topics were discussed with the POA and not the resident. The summary indicated topics discussed were code status, medications, food, and pain. The summary indicated the POA attended the care conference via telephone. A care plan conference summary, dated 8/14/25, indicated all topics were discussed with the POA who was incorrectly assumed to be her daughter by the staff member filling out the summary and not the resident. The summary indicated the POA attended the care conference via telephone. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident K's record lacked documentation of an order or documentation indicating a physician had deemed Resident K incompetent or incapable of making safe healthcare decisions for herself. During an interview on 9/23/25 at 2:19 p.m. the Social Services Director (SSD) indicated Resident K loved to reminisce about old times, but she knew what she wanted and had great conversations. During an interview on 9/23/25 at 2:34 p.m. QMA 21 and 25 indicated Resident K was more cognitively aware than not. They indicated she had off days but most days she was aware and capable of making decisions for herself. During an interview on 9/23/25 at 2:50 p.m. the DON indicated code status was to be discussed and in the resident's chart within 3 hours of admission. She indicated she did not allow a POA to sign consents unless the POA had been invoked, whether that be upon signature or upon physician decision. The DON indicated given Resident K's current BIMS score she would expect staff to have a discussion with the Resident regarding her care decisions, and to get a new POST form signed based on the resident's preference. Resident K should have been asked for consent before staff went to the POA to sign consents forms. During an interview on 9/23/25 at 3:17 p.m. the former AL director indicated she called the POA and she wasn't available in person so they got verbal consent for Resident K's POST form. She indicated Resident K was very out of it when that POST was signed due to being admitted from the hospital after being very ill. Now that Resident K was with it more and her BIMS was higher she would agree with the DON that another POST form should have been discussed and signed by the resident and that consents should be signed by the resident whenever possible before going to the POA. On 9/22/25 at 10:45 a.m. the DON provided a current facility policy titled, Advanced Directives, dated 9/2022. This policy indicated, . The resident has the right to formulate an advanced directive, including the right to accept or refuse medical or surgical treatment. Advanced directives are honored in accordance with state law and facility policy. (2) durable power of attorney for healthcare (i.e., Medical power of attorney) - a document delegating authority to a legal representative to make health care decisions in case the individual delegating that authority subsequently becomes incapacitated. e. Healthcare decision-making capacity- refers to possessing the ability (as defined by state law) to make decisions regarding health care and related treatment choice. 5. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced directive, the information may be provided to the residents legal representative. a. If the resident becomes able to receive and understand this information later, he or she will be provided with the same written materials as described above, even if his or her legal representative has already been given the information. 2. The interdisciplinary team conducts ongoing review of the resident's decision making capacity and invokes the residence representative or healthcare agent if the resident is determined not to have decision making capacity. Changes are documented in the care plan and medical record. A policy titled, Advanced Directives dated September 2022, was provided by the DON on 9/22/25 at 10:45 a.m. It indicated, .Prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family member and/or his or her legal representative, about the existence of any written advanced directives. This citation relates to Intakes 2600397 and 2595761. 3.1-4(d) (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-4(e) 3.1-38(f) 3.1-4(l)(4)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on record review and interview, the facility failed to follow up with a pharmacy recommendation for psychotropic medications for 1 of 5 resident reviewed for pharmacy recommendations (Resident 5). Findings include: On 0/18/25 at 10:46 a.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to fracture of left lower leg, type 2 diabetes, hypertension, multiple fractures of ribs left side, major depressive disorder, and difficulty in walking.Resident 5 had current pharmacy orders for aripiprazole (an antipsychotic drug used to treat bi-polar and schizophrenia) 10 milligrams (mg) daily. She also had an order for Prozac (an antipsychotic drug used to treat depression) 40 mg daily.She had a pharmacy recommendation on June 30, 2025. It was recommended she get CMS (Centers for Medicare and Medicaid Services) diagnoses or titrate the aripiprazole off. This recommendation was not followed up with. She had a care plan that indicated she used psychotropic medications dated 6/16/25.On 9/19/25 at 1:32 p.m., during an interview with the Director of Nursing (DON), she indicated resident admitted with that medication and the nurse practitioner would see her next week. A policy titled Antipsychotic Medication Use dated July 2022 was provided by the Regional Nurse Consultant (RNC) on 9/19/25 at 2:07 p.m. It indicated, .Residents who are admitted from the community or transferred from a hospital and who are already receiving antipsychotic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will.3.1-3(w)3.1-26(k)3.1-26(l)3.1-26(o)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on documentation and interview, the facility failed to adequately investigate an allegation of misappropriation for an unidentified resident for 1 of 1 abuse allegation investigation reviewed. Findings include: An Indiana Department of Health incident report, dated 8/18/25, indicated the incident occurred on 6/30/25 at 12:10 p.m. A Qualified Nurse Aide (QMA) had been accused of stealing an unknown resident's credit card and used it to pay the QMA's cell phone bill. The report indicated a family member of the QMA called the facility on 8/18/25 to inform them that the QMA had told them on 8/17/25, she had taken the resident's credit care information and their social security number and used it to pay her cell phone bill. The family member provided a picture of the piece of paper with the information, but it did not have the resident's name, and the social security number was cut off. The incident report indicated witnesses were interviewed, staff were educated, and the police were notified. The report lacked explanation of why the incident report indicated the incident date was 6/30/25. The investigation for the 8/18/25 reported allegation was requested. The investigation file indicated on 8/18/25 the facility reported an allegation of misappropriation due to the possible use of an unknown resident's credit card by a staff member to pay a staff member's bill. The reported incident was unsubstantiated by the facility after attempting to match all the residents' social security numbers to the information provided with the allegation. A statement was obtained from the Qualified Medication Assistant (QMA) who was named. The local police department was notified. The investigation lacked any documentation of any education provided to staff and residents. The investigation lacked interviews with other staff and/or residents. During an interview on 9/22/26 at 2:59 p.m., the Regional Nurse Consultant (RNC) indicated she had no idea why education was mentioned in the reportable since education was not provided. No documentation was provided to show staff or residents were interviewed regarding concerns with the QMA or possible misappropriation. She indicated they do not have a policy for misappropriation. The abuse and neglect policy was what they used. The abuse and neglect policy also addressed allegations. The provided abuse and neglect policy was reviewed and lacked information that covered allegations or misappropriations. This citation relates to Intake 2592817. 3.1-28(d)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop a baseline care plan (a care plan that is developed at the time of admission through 48 hours of admission) for 1 of 7 residents reviewed for baseline care plans (Resident 66). Findings include: Findings include:On 9/18/25 at 1:06 p.m., a record review was completed for Resident 66. She had the following diagnoses which included but were not limited to hypertension, heart disease, pacemaker, chronic kidney disease, and dizziness. She admitted on [DATE].Her record lacked a baseline care plan as of 9/18/25.On 9/19/25 at 9:52 a.m., Resident 66's record had a baseline care plan. During an interview, the Minimum Data Set (MDS) Coordinator indicated she had added the care plan.A policy titled Care Plans-Baseline dated March 2022, was provided by the Regional Nurse Consultant (RNC) on 9/19/25 at 2:09 p.m. It indicated, The baseline care plan includes instruction needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including but not limited to the following.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record review and interview, the facility failed to implement a care plan for residents' desired advanced directives for 2 of 7 residents reviewed for care plans (Residents 5 and 21) and failed to implement a care plan for a resident's behaviors for 1 of 7 residents reviewed for care plans (Resident 7) reviewed for care plans. Findings include:1. On 9/18/25 at 10:46 a.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to fracture of left lower leg, type 2 diabetes, hypertension, multiple fractures of ribs left side, major depressive disorder, and difficulty in walking. Resident 5's record lacked a care plan containing advanced directives. On 9/18/25 at 1:50 p.m., the Minimum Data Set (MDS) nurse indicated she added a care plan for resident's advanced directives, and a full code status. 2. On 9/17/25 at 2:21 p.m. Resident 21's medical record was reviewed. She was a long-term care resident who was residing in the facility for rehabilitation from a wound. Resident 21 had an active order for a full code status. Resident 21's care plans were reviewed. Resident 21's record lacked a care plan containing code status. On 9/18/25 at 10:30 a.m. the Director of Nursing (DON) provided a care plan for Resident 21, dated 9/18/25, that indicated she had a full code status. 3. On 9/16/25 at 2:35 p.m. Resident 7 was not in his room at this time. There was a large brown stain at the foot of his bed that appeared to be dry. A barely touched breakfast tray with a pile of eggs and a small piece of toast on the plate, a bowl of fruit and an open milk carton were on the tray that was sitting on the window ledge. Several gnats were observed on the food. Next to the tray were approximately 13 Ensure bottles, all sealed, with an unknown brown substance that appeared to be sticky on the bottles. There was an unknown white debris observed on the second bed in the room. On 9/17/25 at 2:10 p.m. Resident 7 was not in his room at this time. The breakfast tray with a pile of eggs and a small piece of toast on the plate, a bowl of fruit and an open milk carton that appeared to be the same tray observed on 9/16/25 was still sitting on the Residents window ledge with the ensure bottles still next to them. The second bed in the room still had the same white debris on it as observed on 9/16/25. On 9/18/25 at 12:31 p.m. Resident 7 was not in his room at this time. The room smelled strongly of urine, the source was unknown. On 9/19/25 at 11:12 a.m. Resident 7's medical record was reviewed. He was a long term care resident whose diagnoses included but were not limited to myocardial infarction (heart attack), dementia, and bipolar disease. On 9/22/25 at 1:46 p.m. Resident 7 was not in his room at this time. The room had a strong foul odor. A bag with visibly soiled clothes in it was observed on the floor in the corner next to the resident's (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bed. The bag had multiple gnats in, on and around it. There were also several sticks from half eaten suckers and some fully eaten suckers' sticks on his bedside table and floor, with multiple gnats all over them. During an interview on 9/22/25 at 1:49 p.m. the DON indicated Resident 7's behaviors were much better then than they used to be. She indicated he still would sometimes refuse to let the CNAs change him when his clothes were soiled, which lead to foul odors in his room. The DON indicated he often wouldn't let housekeeping or staff clean his room, especially when he was in the room. She indicated he did this all the time, he would eat grapes and spit the peels on the ground and would leave the trash from suckers and other snacks in his room and on the ground. She indicated she would have housekeeping go down and clean his room at this time. On 9/23/25 at 9:24 a.m. Resident 7 was observed as he sat up in his wheelchair next to his bed. There was still what appeared to be the same bag of soiled clothes on the floor in the corner next to his bed and he still had trash from suckers on his table. It was unclear if the trash was the same trash from the suckers he ate on 9/22/25 or if it was new trash. Gnats were observed on the clothes and the trash. On 9/23/25 at 2:50 p.m. Resident 7s room was observed. There was still what appeared to be the same bag of soiled clothes on the floor in the corner next to his bed and he still had trash from suckers on his table. It was unclear if the trash was the same trash from the suckers he ate on 9/22/25 or if it was new trash. Gnats were observed on the clothes and the trash. During an interview on 9/23/25 at 4:50 p.m. the DON indicated his room was on the list for daily cleaning, but he wouldn't let them clean the room while he was in there. He didn't want them to take anything out of the room. She indicated housekeeping would go back and try again if he was in his room and refused to have his room cleaned. The DON indicated she was going to have housekeeping clean his room right now. Resident 7's care plans were reviewed. The resident's record lacked care plans indicating he had these behaviors of refusing to be changed, refusal of his room being cleaned, behaviors of collecting food and/or trash. The care plans lacked interventions for when he had these behaviors. A policy titled, Care Plans, Comprehensive Person-Centered, dated March 2022, was provided by the Regional Nurse Consultant (RNC) on 9/18/25 at 2:09 p.m. It indicated, .The interdisciplinary team (IDT) in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. 3.1-35(a)

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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 observations, interviews and record reviews, the facility failed to update care plans related to wounds for a resident (Resident 5) and new fall interventions for a resident (Resident 7) for 2 of 5 residents reviewed for care plan concerns. Findings include: 1. On 9/19/25 at 11:12 a.m. Resident 7's medical record was reviewed. He was a long-term resident whose diagnoses included but were not limited to myocardial infarction (heart attack), dementia, and bipolar disease. An Interdisciplinary Team (IDT) note, dated 9/11/24, indicated Resident 7 had a fall on 9/9/24. The note indicated the new fall interventions were to put antiroll backs and extended brakes on the resident's wheelchair and put nonskid strips next to the resident's bed. The note indicated the care plan had been updated. An Interdisciplinary Team (IDT) note, dated 9/13/24, indicated Resident 7 had a fall on 9/13/24. The note indicated the new fall interventions were to put brightly colored tape on the resident's call light and add a bolster mattress to the resident's bed. The note indicated the care plan had been updated. An Interdisciplinary Team (IDT) note, dated 12/23/24, indicated Resident 7 had a fall on 12/22/24. The note indicated the new fall interventions to have been put in place were to offer to assist the resident to lay down after meals. Resident 7's care plans were reviewed. Resident 7 had a care plan with an initial date of 3/11/25 and a revision date of 8/11/25, that indicated the resident had an actual fall with no injury. The interventions for this care plan were, to have the resident's bed in the lowest position when the resident was sleeping, to have fall mats on both sides of the bed, night shift was to assist the resident to the bathroom before rising, occupational therapy was to evaluate the resident, and to instruct the resident to call for assistance before transferring. The care plan lacked the interventions listed on the IDT notes 9/11/24, 9/13/24, and 12/23/24. No other care plans related to falls were present in Resident 7's medical record at the time of review. 2. On 9/18/25 at 10:46 a.m., a record review was completed for Resident 5. She had the following diagnoses which included but were not limited to fracture of left lower leg, type 2 diabetes, hypertension, multiple fractures of ribs left side, major depressive disorder, and difficulty in walking. During an observation on 9/19/25 at 11:04 a.m., Resident 5 was in bed with her left leg and heel on a flat pillow. Her heel protectors were in her windowsill. She had orders, dated 8/11/25, to cleanse her right and left heel diabetic ulcers with wound cleanser and pat dry, apply betadine, let dry, and leave open to air daily. She had orders, dated 8/14/25, for heel protectors bilateral (both) heels at all times when in bed every shift for decrease mobility. She had a current care plan for a documented pressure ulcer and management of pressure ulcers. The care plan lacked the intervention of resident having heel protectors on at all times when in bed. On 9/19/25 at 10:32 a.m., during an interview with the Minimum Data Set (MDS) Nurse, she indicated (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she would address Resident 5's care plan. A policy titled, Goals and Objectives, Care Plans, was provided by the Regional Nurse Consultant (RNC) on 9/19/25 at 2:08 p.m. It indicated, .Goals and objectives are reviewed and/or revised: when there has been a significant change in the resident's condition, when the desired outcome had not been achieved, when the resident has been readmitted to the facility from a hospital/rehabilitation stay and at least quarterly. 3.1-35(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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to prevent the potential for the development of pressure ulcers when a resident's socks were too tight and left abrasions around his calf, and failed to ensure a resident had a pressure reducing cushion added to her wheelchair as ordered by her physician for 2 of 5 residents reviewed for pressure (Residents K and F). Findings include:1. On 9/17/25 at 10:24 a.m., Resident K was observed. He was seated in a wheelchair in the doorway of his bedroom. A plastic brace was in place on his left ankle that pressed to the skin on the back of his calf as his sock did not come above his calf. There was a red abrasion that encircled his right calf. The sock on his right foot was observed to be tight around his lower leg. During an interview on 9/18/25 at 9:57 a.m., Resident K indicated the abrasion around his right leg was from his socks being too tight, and the brace on his left foot was part of a specialized shoe to help his foot alignment. He indicated sometimes the brace pressed into the back of his leg and hurt, because he couldn't get his socks up over his calf anymore. On multiple occasions throughout the survey period, Resident K was observed wearing the brace, pressed against the back of his calf, and his socks cut into his lower legs as the elastic appeared to be too tight. On 9/18/25 at 1:25 p.m., Licensed Practical Nurse (LPN) 19 was asked about the abrasion on Resident K's leg. LPN 19 indicated she did not work in the memory care unit often, and was not aware that he had any skin issues or a foot brace. She observed the abrasion and brace and indicated she would talk to the wound nurse. On 9/19/25 at 9:45 a.m., the Nurse Practitioner (NP) and the Wound Nurse (WN) came to evaluate Resident K's legs. The WN indicated she was not aware that the resident had a new skin abrasion as no one had brought it to her attention. During the assessment a second abrasion/skin tear was noted under her left sock near his ankle. After the assessment, the NP and WN agreed that the abrasion had been caused by his socks being too tight, and the brace needed to be padded or his skin protected to prevent the potential for more breakdown. At that time the NP placed an order for compression socks to help with the swelling in his legs, a house lotion to help with dry itchy skin, and would consider ways to pad the edges of the brace to prevent the plastic from pressing into his leg. On 9/18/25 at 9:11 a.m., Resident K's record was reviewed. He was a long-term care resident who resided on the secured memory care unit with diagnoses which included, but were not limited to, psychotic disorder due to known physiological condition, muscle weakness and need for assistance with personal care. His record lacked documentation that an abrasion that encircled his right leg, and/or that he wore an orthotic brace on his left foot. A nursing progress note, dated 9/18/25 at 11:00 p.m., indicated, Resident observed with a new skin tear and abrasion on the lower leg (right/left). Small amount of bleeding noted; no drainage observed. Surrounding skin intact without signs of infection. Wound cleansed with normal saline and covered with a sterile dressing per facility protocol. Resident tolerated wound care well. Physician and family notified of new skin tear. Will continue to monitor wound status, provide dressing changes as ordered, and document progress. A nursing progress note, dated 9/19/25 at 10:22 a.m., indicated, Resident seen today by wound care NP related to some edema and some dry scab areas with some red area on the circumference of his bilateral lower legs. He has on some tight elastic socks. His family here and will supply some compression stockings and the NP has ordered some Eucerin for the dryness of his skin to be applied prior to hose in the AM and at bedtime when hose is removed. His family will check to see when the brace can be replaced and let staff know. A new physician's order reflecting the above orders were added to his chart the same day.On 9/22/25 at 9:40 a.m., Resident K was observed to still wear the tight elastic socks that were not pulled up all the way and continued to cut into his legs. During an interview on 9/23/25 at 3:02 p.m., the Administrator, (ADM) indicated any new areas of skin breakdown should be reported to the nurse immediately, and resident physician orders should be followed. 2. Resident F was observed in a regular wheelchair with no pressure reducing cushion to the seat on the following dates and times during the survey: 9/16/25 at 12:34 p.m., 9/16/25 at 12:48 p.m., 9/16/25 at 12:53 p.m., 9/16/25 at (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1:00 p.m., 9/17/25 at 9:04 a.m., 9/17/25 at 11:46 a.m., 9/18/25 at 9:05 a.m., 9/18/25 at 10:35 a.m., 9/19/25 at 9:22 a.m., 9/19/25 at 9:58 a.m., 9/19/25 at 11:17 a.m., 9/19/25 at12:23 p.m., and 9/22/25 at 9:37 a.m. On 9/19/25 at 9:25 a.m., Resident F's record was reviewed. She was a long-term care resident who resided on the secured memory care unit and had a diagnosis which included, but were not limited to, dementia. She had a physician's order, dated 3/17/25, for a gel pressure reducing cushion to be placed in her wheelchair. She had a comprehensive care plan, revised 6/24/25, which indicated she was at risk for impairment to skin integrity due to decreased mobility with potential for friction and sheer, incontinence with moisture to skin, chair fast at times and impaired sensory perception. Interventions for this plan of care included, but were not limited to, .Gel cushion in wheelchair while up in the chair. On 9/19/25 at 2:00 p.m., the Regional Nurse Consultant (RNC) provided a copy of current facility policy titled, Pressure Ulcers/Skin Breakdown- Clinical Protocol, revised October 2010. The policy indicated, The nursing staff and practitioner will assess and document an individual's significant risk factors for developing pressure ulcers, for example, immobility, recent weight loss, and a history of pressure ulcers. the physician will help identify factors contributing or predisposing residents to skin breakdown. This deficiency was cited on 8/18/25. The facility failed to implement a systemic plan of correction to prevent recurrence. This citation relates to Intake 2595761. 3.1-40

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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** A. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when a resident was assisted with only one CNA and the Hoyer lift tipped over for 1 of 4 residents reviewed for accidents (Resident L). B. Based on observation, interview, and record review, the facility failed to prevent the potential for accidents when a resident on the secured memory care unit was observed wandering and asking to go home, had access to the locked door codes, and the facility failed to maintain an Elopement Binder in case of an elopement for 1 of 4 residents reviewed for accidents (Resident 39). C. Based on observation, interview, and record review, the facility failed to ensure fall interventions were in place for 1 of 4 residents reviewed for accidents (Resident 7), and failed to ensure fall risk assessments were completed quarterly for 1 of 4 residents reviewed for accidents (Resident 19). Findings include:A. On 9/19/25 at 9:08 a.m., Resident L's record was reviewed. She was a long term care resident with diagnoses which included, but were not limited to Alzheimer's disease, and unspecified dementia. She had a comprehensive care plan revised 6/17/25 which indicated she was at risk for falls and an intervention placed on 8/21/24 indicated she required the assistance of at least two staff members for Hoyer lift transfers. A nursing progress note, dated 6/9/25 at 10:38 a.m., indicated, .Resident was lowered into wheelchair, mechanical lift boom swiveled and unessentially made contact with resident's forehead, causing small cut. CNA educated on positioning of lift after transfer. Resident L's husband filed a grievance on 6/8/25 which indicated, When [Resident L] was being transferred to wheelchair, the Hoyer lift tipped, dropping her into the chair resulting in a small cut on her forehead. Only one person was handling the Hoyer lift. Findings of the investigation concluded: Aide moved resident with mechanical lift without assist of 2. education regarding assist of 2 for total lift to aide in question. This citation relates to Intake 2600397. B. On multiple occasions throughout the survey period, Resident 39 was observed wandering through the unit, in and out of his room, and repeatedly asked staff why he was at the facility and when he could go home. On 9/18/25 at 10:00 a.m., Resident 39's record was reviewed. He admitted to the facility on [DATE] with diagnoses which included, but were not limited to, Alzheimer's disease, anxiety, adjustment disorder and repeated falls. An elopement risk assessment, dated 8/21/25, indicated Resident 39 was at risk for elopement. A nursing progress note, dated 9/10/25 at 10:33 p.m., indicated, resident appeared to be restless from 4:00 p.m. until 8:00 p.m. Resident came out of his room multiple times to ask who brought me here? and when is my son coming? Resident 39's comprehensive care plan lacked implementation or interventions for being at risk for elopement. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Elopement Binder could not be located at either nurses' stations, or anywhere in the memory care unit. During an interview on 9/18/25 at 10:50 a.m., Licensed Practical Nurse (LPN) 19 indicated she did not know if there was an elopement binder on the unit, and upon looking through the nurse's station she could not find one. She indicated there was supposed to be one at each nurse's station and the front desk. Additionally, there was a bright red binder with the labeled spine facing up which read, DOOR CODES in bold capital letters. Upon review of the codes taped to the inside of the binder cover, they were the correct codes. The binder was easily accessible over the nurse's station counter. During an interview on 9/18/25 at 10:53 a.m., the Receptionist indicated the facility did keep an elopement binder at the front desk, and she turned around to a three shelve unit with binders on it. One white binder was labeled Elopement Binder. No additional Elopement binders were observed. Upon opening the binder and reviewing the dates, the entries were from the year 2023. The Receptionist was asked to double check if that was the only or most recent binder. She checked the shelf again, and indicated it was the only binder. On 9/18/25 at 11:00 a.m., the Director of Nursing (DON) and Regional Nurse Consultant (RNC) were asked about the location of the Elopement binder and if there was an updated binder. The RNC and DON indicated there should be an elopement binder at each nurse's station and at the front desk. There was no binder at either nurses' station, and the 2023 binder was returned. The RNC and DON were notified that there was also a Door Code binder at the Memory care nurses station accessible to the residents. On 9/18/25 at 1:05 p.m., the RNC produced an Elopement binder and indicated, she had found the current binder with entries from 2024, but that Resident 39 had not been added. The RNC indicated the Receptionist must have provided the wrong binder. On 9/19/25 at 2:50 p.m., the DON provided a copy of current facility policy titled, Wandering and Elopement, revised March 2019. The policy indicated, The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while remaining in the least restrictive environment for residents. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety. C1. On 9/16/25 at 2:35 p.m. Resident 7 was not in his room at this time. There was a regular mattress on the bed frame of the bed that was made and there was a pad type call light on the bed. On 9/19/25 at 11:12 a.m. Resident 7's medical record was reviewed. He was a long-term care Resident 7's diagnoses included but were not limited to myocardial infarction (heart attack), dementia and bipolar disease. An Interdisciplinary Team (IDT) note, dated 9/11/24, indicated Resident 7 had a fall on 9/9/24. The note indicated the new fall interventions to have been put in place were to put antiroll backs and extended brakes on the resident's wheelchair and put nonskid strips next to the resident's bed. An Interdisciplinary Team (IDT) note, dated 9/13/24, indicated Resident 7 had a fall on 9/13/24. The note indicated the new fall interventions to have been put in place were to put brightly colored tape on the Residents call light and add a bolster mattress to the Resident bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A health status note, dated 11/22/24, indicated Resident 7 had a fall on 11/22/24. The note indicated the Resident had an increased need for redirection to allow staff to assist him with Activities of Daily Living (ADLs). The note indicated Resident 7 was educated on the need for assistance with toileting and the new intervention to have been put in place was to praise the resident when he used his call light. An Interdisciplinary Team (IDT) note, dated 11/25/24, indicated Resident 7 had a fall on 11/22/24. The note indicated the new fall intervention to have been put in place was to refer the resident to occupational therapy for positioning and fall risks. An Interdisciplinary Team (IDT) note, dated 12/23/24, indicated Resident 7 had a fall on 12/22/24. The note indicated the new fall interventions to have been put in place were to offer to assist the resident to lay down after meals. An Interdisciplinary Team (IDT) note, dated 3/11/25, indicated Resident 7 had a fall on 3/10/25. The note indicated the new fall intervention to have been put in place was that the resident would ask for assistance with transfers. An Interdisciplinary Team (IDT) note, dated 3/31/25, indicated Resident 7 had a fall on 3/29/25. The note indicated the new fall intervention to have been put in place was to put fall mats on both sides of the bed. A health status note, dated 6/21/25, indicated Resident 7 had a fall on 6/21/25. The note indicated the resident fell self-transferring from the bed to his wheelchair. A post fall evaluation note, dated 6/21/25, indicated there was no floor mat next to the bed at the time of the fall. An Interdisciplinary Team (IDT) note, dated 6/23/25, indicated Resident 7 had a fall on 6/21/25. The note indicated the new fall intervention to have been put in place was to refer the resident to occupational therapy for evaluation and treatment for transfers. A health status note, dated 7/8/25, indicated Resident 7 had a fall on 7/8/25. The note indicated the Resident fell when he was trying to get into his wheelchair from the bed and it started to roll away from him. A post fall evaluation note, dated 7/8/25, indicated there was no floor mat next to the bed at the time of the fall. A health status note, dated 7/13/25, indicated Resident 7 had a fall on 7/13/25. The note indicated the Resident rolled out of bed. A post fall evaluation note, dated 7/13/25, indicated there was no floor mat next to the bed at the time of the fall. An Interdisciplinary Team (IDT) note, dated 7/14/25, indicated Resident 7 had a fall on 7/13/25. The note indicated the new fall interventions to have been put in place were to have the bed in the lowest position and a floor mat next to his bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 7 had a care plan with an initial date of 3/11/25 and a revision date of 8/11/25. The care plan indicated the resident had an actual fall with no injury. The interventions for this care plan were, to have the resident's bed in the lowest position when the resident was sleeping, to have fall mats on both sides of the bed, night shift to assist the resident to the bathroom before rising, occupational therapy was to evaluate the resident and to instruct the resident to call for assistance before transferring. On 9/19/25 at 2:15 p.m. Resident 7's room was observed. There were no non-skid strips to the side of the bed, no brightly colored tape on the call light, no bolster mattress in place, and no mats in the room. On 9/22/25 at 12:245 p.m. Resident 7's room was observed. There were no non-skid strips to the side of the bed, no brightly colored tape on the call light, no bolster mattress in place, and no mats in the room. On 9/23/25 at 9:27 a.m. Resident 7's wheelchair and room were observed. There were no anti-roll backs or extended brakes on his wheelchair, no non-skid strips to the side of the bed, no brightly colored tape on the call light, no bolster mattress in place, and no mats in the room. On 9/23/25 at 2:50 p.m. Resident 7's room was observed. There were no non-skid strips to the side of the bed, no brightly colored tape on the call light, no bolster mattress in place, and no mats in the room. During an interview on 9/23/25 at 4:27 p.m. the Director of Nursing (DON) indicated the interventions from the IDT notes should have been updated in the care plans and put in place to prevent future falls. A policy related to fall prevention and fall interventions was requested but was not provided at the time of exit or by 5:00 p.m. the next day. C2. On 9/18/25 at 11:13 a.m., a record review was completed for Resident 19. She had the following diagnoses which included but were not limited to heart failure, dementia, anxiety, hyperlipidemia (high cholesterol), and muscle weakness. Resident 19 had falls on 6/24/25 and 7/1/25. She had a current care plan indicating she was at risk for falls related to history of falls prior to admission, possible side effects from medications, impaired cognition with impaired safety awareness, unsteady gait, and use of assistive devices. Her record lacked a fall risk assessment which was due on a quarterly basis. The last assessment she had was on 12/19/24 and it indicated she had no history of falls. On 9/23/25 at 1:00 p.m., the Director of Nursing indicated she was aware of missing quarterly assessments. 3.1-45(a)