STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155799	A. Building B. Wing	05/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Marion LLC	614 West 14th Street Marion, IN 46953

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48384 Based on interview and record review, the facility failed to honor a resident's right to self-determination and communication for 1 of 1 resident reviewed for Resident Rights. (Resident 19) Findings include: During an observation on 4/27/25 at 10:50 a.m., Resident 19 was lying in bed with a touch pad call light within reach. She indicated she was unable to turn and reposition herself and unable to call her family member. She relied on staff to help with all activities of daily living (ADLs). The Administrator had spoken to her about her frequent calls to her family member, telling her she called him too much and gave him too much information. Resident 19's clinical record was reviewed on 5/1/25 at 11:30 a.m. Diagnoses included cerebral palsy, obsessive-compulsive disorder, mild intellectual disabilities, fibromyalgia, and other abnormalities of gait and mobility. The resident's cognitive status was moderately impaired. An admission Minimum Data Set (MDS) assessment, dated 3/9/25, indicated Resident 19 was dependent on staff for eating, oral hygiene, toileting hygiene, showering/bathing, dressing, all transfers, and personal hygiene. The resident was always incontinent of both bladder and bowel. A Social Services note, dated 4/1/25 at 12:25 p.m., provided by the Administrator on 4/29/25 at 1:39 p.m., indicated both Social Services and the Administrator spoke with the resident regarding privacy and dignity. When staff was providing care for the resident, all electronic devices were to be shut off. Once care was completed, the staff would assist the resident with resuming the phone call. An Administrator note, dated 4/28/25, provided by the Administrator on 4/29/25 at 1:39 p.m., indicated about three to four weeks prior, Social Services and the Administrator went to talk to the resident about her phone usage during resident care.We explained that her being on the phone .with her [family member] during care was a dignity issue and that we would have her hang up during care and then assist her in calling her [family member] back when finished . (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Social Service note, dated 4/28/25, provided by the Administrator on 4/29/25 at 1:39 p.m., indicated around mid-March, the Administrator and Social Service Director went to discuss the phone issue with Resident 19. They told the resident she could not be on the phone while receiving care. The Administrator said, for the resident's own dignity, the resident should be off her phone while receiving care. During an interview with Resident 19 on 5/1/25 at 2:35 p.m., and the resident's family member who was on speaker phone, the resident indicated she was not in agreement with hanging up her phone during care. Both the resident and her family member indicated they used the speaker phone, not video calls, during care. The resident's family member indicated the resident needed help to be understood. Some people could not understand what the resident was saying when she spoke. Both Resident 19 and her family member wanted to be connected by phone, even while care was provided. During an interview with RN 6 on 5/1/25 at 2:39 p.m., she indicated the family member was always on speaker phone with the resident. RN 6 was not bothered by the phone calls, but indicated sometimes it could get loud between the noise going on in Resident 19's room and whatever was going on at the family member's residence. The volume could be turned down and/or the call could be muted during resident care. Whenever a physician or nurse practitioner was with Resident 19, the staff would let the family member know and tell him they would call him back after the provider was finished. During an interview with the Administrator on 5/1/25 at 4:48 p.m., she indicated the local Ombudsman had been apprised of the situation and had suggested the resident's phone should be hung up during care, as it was a dignity/privacy issue. During an interview with the Administrator on 5/1/25 at 4:50 p.m., she indicated the facility lacked a policy addressing resident phone usage during care. The local Ombudsman was unavailable for interview during the survey from April 27 through May 2, 2025 . 3.1-3(a)

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 51985 Based on interview and record review, the facility failed to ensure mail was distributed to the residents on Saturdays. This deficiency had the potential to affect 58 of 58 residents who resided in the facility. Findings include: During a Resident Council meeting, on 4/30/25 beginning at 3:35 p.m., Resident 40 indicated the facility did not deliver mail to the residents on Saturdays. The activity department staff was to deliver mail after the business office manager sorted it. The business office manager did not work weekends. Residents 41, 45, 58, 10, 28, 51, 2, 33, and 25 indicated they did not receive mail on Saturdays. During an interview, on 5/1/25 at 10:06 a.m., the Activity Director (AD) indicated the activity department delivered mail to the residents. Mail was distributed on the days that the Business Office Manager /Financial Coordinator (BOM) was at the facility. The BOM received and sorted the mail and placed it on the front desk when it was ready for distribution to the residents. During an interview, on 5/1/25 at 10:14 a.m., the BOM indicated that she sorted the facility mail. She removed anything that the facility or the resident's representative was responsible for. Once mail was sorted, she took the mail to the front desk for the activity department to distribute to the residents. Her regular work schedule was Monday through Friday. A current facility policy, updated September 2015, titled Mail Policy, provided by the Social Services Director on 5/1/25 at 4:23 p.m., indicated the following: Policy: The residents have a right to receive mail. Guidelines: The follow procedure will be followed: .3. Mail will be delivered Monday thru Saturday 3.1-3(s)(1)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48384 Based on interview and record review, the facility failed to provide an accurate code status for 1 of 1 resident reviewed for advance directives. (Resident 10) Findings include: Resident 10's clinical record was reviewed on [DATE] at 10:13 a.m. Diagnoses included hypertension and dementia. A quarterly Minimum Data Set (MDS) assessment, dated [DATE], indicated the resident was moderately cognitively impaired. The current, main page on Resident 10's electronic health record indicated a Do Not Resuscitate (DNR) code status. A current physician's order, dated [DATE], indicated Do Not Resuscitate. A current care plan, initiated on [DATE], indicated Resident 10 had a signed and valid DNR in the event she should stop breathing and display no pulse, as a result of failure of the heart to contract effectively or at all. Interventions included I will be enabled to live to the limit of my potential ability physically, mentally, and spiritually, administer medications as ordered, encourage the resident and family members to discuss concerns, ensure the DNR is noted in the chart, follow advance directives as depicted in the resident's chart, honor choices made by the resident and/or family member, surrogate, or POA, and notify the physician of changes. Resident 10's physician orders for Scope of Treatment (POST) form, provided by the Administrator on [DATE] at 11:13 a.m., indicated Resident 10 had a full-code status and was to be provided cardiopulmonary resuscitation (CPR) and full interventions. The resident's POA (power of attorney) gave verbal consent for the full-code status. The Administrator indicated she was not aware of the conflicting advance directives information. The document she provided was the only signed code status for Resident 10. A current facility policy, titled Advance Directives, provided by the Administrator on [DATE] at 11:49 a.m., indicated the following: .Guidelines: For purposes of this policy and procedure, Advanced Directives means a written instrument, such as a living will or life prolonging procedure declaration, appointment of health care representative and power of attorney for health care purposes. These directives are established under state law and relate to the provision of medical care when the individual is incapacitated .1. At the time of admission each resident will be asked if they have made advanced directives and provided educational information regarding state and federal law .6. Copies of the resident's Advanced Directive shall be made and maintained in the resident's clinical record and financial folder .10. Advanced Directives shall be included in the resident's plan of care and will be reviewed during the care plan meeting with the resident and/or the resident's legal representative when present (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3XXX,d+[DATE](5)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 45122 Based on interview and record review, the facility failed to follow physician orders regarding physician/nurse practitioner notification of a resident's weight gain for 1 of 23 residents reviewed for medications. (Resident 17) Findings include: Resident 17's clinical record was reviewed on 4/29/25 at 12:01 p.m. Diagnoses included essential (primary) hypertension (high blood pressure), type 2 diabetes mellitus with diabetic neuropathy, personal history of other diseases of the urinary system, presence of urogenital implants, presence of cardiac pacemaker, obstructive and reflux uropathy (blockage and flow from the bladder backs up into the ureters which connect to the kidneys), and chronic kidney disease, stage 3a (moderate decline in kidney function). A current order, dated 3/27/25, indicated to weigh the resident daily and notify the physician or nurse practitioner if the resident had a weight gain of three pounds in a day or five pounds in a week. The resident weighed 178 pounds on 4/11/25. On 4/18/25, she weighed 183.4 pounds with a greater than five-pound weight gain in the week. The physician was not notified. The resident weighed 178.5 pounds on 4/15/25 and 182.6 pounds on 4/16/25 which resulted in a greater than four pound weight gain in a day. The physician was not notified. During an interview, on 5/1/25 at 10:32 a.m., RN 6 indicated if the resident had a weight gain greater than three pounds, the physician was notified. The physician notification was documented in the progress notes. During an interview, on 5/1/25 at 10:46 a.m., RN 6 indicated she was unable to find where the physician had been notified of the resident's weight gain. During an interview, on 5/1/25 at 4:31 p.m., the DON indicated she expected the physician to be notified as ordered for the resident's weight gain.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 51985 Based on observation, interview, and record review, the facility failed to maintain a homelike environment related to a clean, sanitary environment in a resident's room for 1 of 3 resident's reviewed for environment. (Resident 34) Findings include: During an observation on 4/27/25 at 2:55 p.m., Resident 34's trash can overflowed. Trash was on the floor beside the bed. A mask lay on the floor in the entryway of the room. A second mask lay on the floor beside the oxygen concentrator. The bedside table was visibly dirty. A pile of clothing was on the bathroom floor underneath the sink. A navy-blue clothing item lay on top of the pile. During an observation on 4/28/25 at 10:48 a.m., the resident's room continued to have trash surrounding the trash can and on the floor beside her bed. The previously observed masks remained on the floor, laying in the same locations. The bedside table had a large area (the size of large dining plate) of dried, sticky residue. During an interview on 4/29/25 at 9:54 a.m., Resident 34 indicated that housekeeping emptied her trash and swept the floor on occasion. The floor had trash around the trash can and on the floor beside the bed. The masks continued to be on the floor, unmoved from previous locations. The bedside table continued to have large area (size of large plate) of dried, sticky residue. A pile of clothing lay on the floor underneath the bathroom sink, a navy-blue piece of clothing continued to lay on top of the pile. During an interview on 4/29/25 at 1:22 p.m., Housekeeper 12 indicated that housekeeping was to clean residents' rooms daily. Cleaning of Resident 34's room included vacuuming the carpet and mopping the hard floors daily if needed or a minimum of one day in between floor cleanings. Floors were to be swept where crumbs and debris could be seen. Bedside tables, countertops, and nightstands were to be cleaned off daily. The clothing on the resident's bathroom floor was to be picked up and taken to laundry by the nursing staff. Trash was emptied daily and the trash on the floor, including the masks, was to be picked up and disposed of. Resident 34's clinical record was reviewed on 4/30/25 at 9:53 a.m. Diagnoses included Guillain-Barre syndrome (condition in which the immune system attacks the nerves), difficulty in walking, abnormality of gait and mobility, chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breath), and osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wear down). A 2/5/25, annual, Minimum Data Set (MDS) assessment indicated the resident was severely cognitively impaired. She required supervision or touching assistance with toileting hygiene, upper body assistance, and roll from left to right and moderate assistance with showering, lower body dressing, footwear, personal hygiene, toilet transfer, and sit to stand. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The resident's care plan lacked indication of non-compliance or refusal of housekeeping and/or environmental services. During an interview on 4/30/25 at 10:32 a.m., Resident 34 indicated that housekeeping had offered to sweep her floor. Her floor was swept from the entryway to the window, the open area of the room, but not around her bed. The two masks remained on the floor in their previous locations. The bedside table remained with a dried, sticky residue. The resident was unable to recall the last time that someone wiped off her bedside table. Trash remained on the floor beside the bed. During an interview on 5/1/25 at 4:32 p.m., the Administrator indicated she was overseeing the housekeeping department. Resident rooms were to have daily cleaning, with the focus being on floors, trash, bathroom, and then any other necessary area. She had staff clean Resident 34's carpet earlier this week. The resident's sticky bedside table should have been cleaned as well as any trash on floor should have been picked up. This was portrayed on the housekeeping schedule under the daily category. She clarified that a small area of Resident 34's carpet may have been cleaned due to staining, rather than the entire carpet. A current, undated facility policy, titled Housekeeping Services Policy, provided by the Administrator on 5/1/25 at 3:55 p.m., indicated the following: .Policy: It is the policy of the facility to maintain a clean, odor free, comfortable, and orderly environment in all health care and public areas, which meet the sanitation needs of the facility and residents right for a safe, clean, comfortable homelike environment. Guidelines: .2. The department shall routinely clean the environment of care, using accepted practices, to keep the facility free from offensive odors, the accumulation of dust, rubbish, dirt and hazards . Environment: .Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior environment are provided A current, undated facility policy, titled Housekeeping Cleaning Schedule, provided by the Administrator on 5/1/25 at 4:23 p.m., indicated the following: Purpose: To establish a schedule which ensures the building and equipment is maintained in a clean and sanitary manner. All items may be cleaned more frequently, if necessary. 1. Daily .c. work surfaces d. Resident Furniture e. Resident room floors 3.1-19(f)(5)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure each resident receives an accurate assessment. 48384 Based on observation, interview, and record review, the facility failed to accurately assess and document a resident's dental status for 1 of 1 resident reviewed for Minimum Data Set (MDS) assessments. (Resident 56) Findings include: During an observation and interview on 4/28/25 at 11:01 a.m., Resident 56 indicated he had no upper teeth, and only three teeth on the bottom. Resident 56's clinical record was reviewed on 4/28/25 at 11:00 a.m. Diagnoses included malignant neoplasm of stomach, gastric ulcer, unspecified cirrhosis of the liver, and major depressive disorder. An admission Minimum Data Set (MDS) assessment, dated 2/28/25, indicated the resident was moderately cognitively impaired and required partial to moderate assistance with eating. The resident was not edentulous (lacked teeth), nor had any tooth fragments. Resident 56's current care plan lacked information regarding the resident's dental status. During an observation on 4/30/25 at 12:17 p.m., Resident 56 indicated he did not have dentures. He had no upper teeth and the three teeth on the bottom included two on the left lower side, with a space between, and one on the right lower side. A current Resident Assessment Instrument (RAI), dated October 2024, retrieved from https://www.cms.gov/files/document/finalmds-30-rai-manual-v1191october2024.pdf on 5/6/25 at 10:19 a.m., indicated the following: Oral/Dental Status - Intent: This item is intended to record any dental problems present in the 7-day look-back period .Health-related Quality of Life - Poor oral health has a negative impact on quality of life, overall health, nutritional status. Assessment can identify periodontal disease that can contribute to or cause systemic diseases and conditions, such as aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes .Steps for Assessment: 1. Ask the resident about the presence of chewing problems or mouth or facial pain/discomfort. 2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.) 3. If the resident has dentures or partials, examine for loose fit. Ask them to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment. 4. Conduct exam of the resident's lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. The assessor should use their gloved fingers to adequately feel for masses or loose teeth. 5. If the resident is unable to self-report, then observe them while eating with dentures or (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	partials, if indicated, to determine if chewing problems or mouth pain are present. 6. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents and any resident who exhibits dental or oral issues

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 45122 Based on interview and record review, the facility failed to ensure residents and/or resident representatives received a copy of their baseline care plans on admission for 5 of 5 residents reviewed for care plans. (Resident 8, 52, 57, 61, and 264) Findings include: 1. Resident 52's clinical record was reviewed on 4/29/25 at 10:48 a.m. Diagnoses included alcoholic hepatic (liver) failure without coma, hepatic encephalopathy (disease or damage that affects the brain, leading to a change in mental state), type 2 diabetes mellitus with hyperglycemia (high blood sugar), unspecified anemia, and thrombocytopenia (low platelet count in the blood which can cause prolonged bleeding). A progress note, dated 12/5/24 at 12:45 p.m., indicated the resident was admitted to the facility. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan prior to the completion of the comprehensive care plan. During an interview, on 5/1/25 at 11:04 a.m., the Social Services Director (SSD) indicated she had recently been educated that the baseline care plans were to be discussed with and given to the residents and their representatives during the admission process. She had a care plan meeting with the resident's representative 2/2025. She did not have a care plan meeting with the resident or the resident's representative 12/2024 nor provide a baseline care plan. 2. Resident 61's clinical record was reviewed on 4/29/25 at 9:12 a.m. Diagnoses included essential (primary) hypertension (high blood pressure), gastroesophageal reflux disease (stomach acid and content flow back up into the esophagus) without esophagitis (inflammation of the esophagus, Charcot's joint, right ankle, right foot, left ankle, and left foot (nerve damage, often due to diabetes, leads to weakening and collapse of bones and joints in the foot, resulting in a deformed shape), repeated falls, and cellulitis of the right lower limb and the left lower limb. Census information indicated the resident was admitted on [DATE]. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan prior to the completion of the comprehensive care plan. During an interview, on 5/1/25 at 11:04 a.m., the SSD indicated she had not provided or discussed the baseline care plan with Resident 61. 51985 (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Resident 8's clinical record was reviewed on 4/30/25 at 11:34 a.m. Diagnoses included repeated falls, hyperlipidemia, nicotine dependence, low back pain, unspecified secondary osteoarthritis (arthritis that occurs when flexible tissue at the ends of bones wear down), fibromyalgia (long-term condition that involves widespread body pain and tiredness), chronic viral hepatitis C (liver disease that results from hepatitis C virus), fracture of unspecified parts of lumbosacral spine (low back) and pelvis, subsequent encounter for fracture with routine healing, unspecified sequelae of cerebral infarction (long term effects of a stroke), dysphagia (difficulty swallowing) following cerebral infarction (stroke), irritable bowel syndrome, major depressive disorder, recurrent, unspecified, hemiplegia, unspecified affecting left nondominant side, unspecified severe protein-calorie malnutrition, and other abnormalities of gait and mobility Census information indicated the resident was admitted on [DATE]. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. During an interview, on 4/30/25 at 3:00 p.m., the SSD indicated she tries to have a care plan within the first week of a resident's admission to the facility. She recently had been given instructions regarding baseline care plans. She had not been doing baseline care plans prior to receiving this education. 4. Resident 57's clinical record was reviewed on 5/01/25 at 11:20 a.m. Diagnoses included acute respiratory failure with hypoxia (lack of adequate oxygen supply), dissection (tear) of aorta, dysphagia (difficulty swallowing) following cerebral infarction (stroke), other paralytic syndrome following cerebral infarction affecting unspecified side (loss of movement or sensation), other neuromuscular dysfunction of bladder, neurogenic bowel (lack of communication between brain and bowel causing loss of normal bowel function), unspecified systolic congestive heart failure (heart unable to pump blood adequately), myopathy (disease process that affects the skeletal muscles), kidney failure, anemia, type 2 diabetes mellitus (high blood sugar), essential (primary) hypertension (high blood pressure), unspecified injury at T 11-T 12 level of thoracic spinal cord, pressure ulcer of sacral region, muscle wasting and atrophy (shrinking in size), difficulty in walking, and other abnormalities of gait and mobility. Census information indicated the resident was admitted on [DATE]. The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. 5. Resident 264's clinical record was reviewed on 5/01/25 at 12:33 p.m. Diagnoses included constipation, chronic obstructive pulmonary disease (a group of lung diseases that make it difficult to breath), malignant neoplasm of supraglottis (cancer of the upper part of the larynx, known as the voice box), gastrostomy status (tube feeding), unspecified atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow), essential (primary) hypertension (high blood pressure), hyperlipidemia (high cholesterol), unsteadiness on feet, aphasia (language disorder that makes it difficult to read, write, and speak)), encounter for palliative care (receiving hospice care), and tracheostomy. Census information indicated the resident was admitted on [DATE]. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The clinical record lacked documentation that the resident or the resident's representative was provided with a copy of the baseline care plan. A current facility policy, last revised 11/17/17, titled Baseline Care Plan, and provided by the DON on 5/1/25 at 4:39 p.m., indicated the following: .The resident and/or their representative shall receive a summary of the Baseline Care Plan prior to completion of the comprehensive care plan . As a best practice, the interdisciplinary team should attempt to schedule an initial meeting with the resident and/or resident representative within 5 days of admission to review the baseline plan of care and make updates or revisions as indicated based on feedback and input of the resident and/or representative prior to the development of the comprehensive care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. 45122 Based on interview and record review, the facility failed to follow physician orders regarding daily weight monitoring and administration of blood pressure medication according to ordered parameters for 2 of 23 residents reviewed for medications. (Residents 17 and 5) Findings include: 1. Resident 17's clinical record was reviewed on 4/29/25 at 12:01 p.m. Diagnoses included essential (primary) hypertension (high blood pressure), type 2 diabetes mellitus with diabetic neuropathy, personal history of other diseases of the urinary system, presence of urogenital implants, presence of cardiac pacemaker, obstructive and reflux uropathy (blockage and flow from the bladder backs up into the ureters which connect to the kidneys), and chronic kidney disease, stage 3a (moderate decline in kidney function). A current order, dated 3/27/25, indicated to weigh the resident daily and notify the physician or nurse practitioner if the resident had a weight gain of three pounds in a day or five pounds in a week. The medication administration record for 4/1/25 through 4/1/28 indicated the resident was not weighed for 11 of 28 days. During an interview, on 5/1/25 at 10:32 a.m., RN 6 indicated the resident required daily weights. The medication administration record was lacking multiple weights. She was unable to locate additional weights for the resident. During an interview, on 5/1/25 at 4:31 p.m., the DON indicated she expected weights to be obtained daily as ordered. 49411 2. Resident 5's clinical record was reviewed on 4/30/25 at 8:56 a.m. Diagnoses included heart failure, chronic obstructive pulmonary disease (breathing difficulty), chronic respiratory failure (decreased oxygen), hypertension (high blood pressure), and dementia. Current orders included carvedilol (antihypertensive) 12.5 milligrams twice a day (start date 4/5/25). Hold if systolic blood pressure is less than 120 millimeters of mercury (mmhg). A Mediation Administration Report (MAR), for April 2025, indicated the resident received carvedilol when her systolic blood pressure was below the physician indicated parameters as follows: On April 8th p.m., had a systolic blood pressure of 112 mmhg. On April 12th a.m., had a systolic blood pressure of 112 mmhg. On April 12th p.m., had a systolic blood pressure of 107 mmhg. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 13th a.m., had a systolic blood pressure of 116 mmhg. On April 14th a.m., had a systolic blood pressure of 116 mmhg. On April 16th a.m., had a systolic blood pressure of 104 mmhg. On April 17th a.m., had a systolic blood pressure of 118 mmhg. On April 17th p.m., had a systolic blood pressure of 116 mmhg. On April 18th a.m., had a systolic blood pressure of 110 mmhg. On April 18th p.m., had a systolic blood pressure of 110 mmhg. On April 21st a.m., had a systolic blood pressure of 100 mmhg. On April 21st p.m., had a systolic blood pressure of 114 mmhg. On April 26th a.m., had a systolic blood pressure of 103 mmhg. On April 26th p.m., had a systolic blood pressure of 98 mmhg. On April 29th p.m., had a systolic blood pressure of 95 mmhg. A 4/7/25, admission, Minimum Data Set (MDS) assessment indicated the resident had an active diagnosis of hypertension and heart failure. During an interview, on 4/30/25 at 9:20 a.m., QMA 13 indicated if the resident's vital signs were below the physician parameters, she would hold the medication and notify the nurse on duty. She would then write a progress note explaining why the medication was held. On the MAR, it would show a reason code if the medication was held instead of a check mark indicating the medication was administered. During an interview, on 4/30/25 at 10:21 a.m., LPN 14 indicated if a medication was outside the parameters, she would notify the physician. In the MAR, she would indicate the medication was not administered with a reason code. During an interview, on 4/30/25 at 2:40 p.m., the ADON indicated Resident 5's carvedilol showed it was administered when her blood pressure was below the medication parameter. During an interview, on 4/30/25 at 3:05 p.m., the Administrator indicated the facility did not have a policy on medication administration regarding parameter, but the facility followed the state guidelines. A facility policy, last revised 10/17/19, provided by the Social Services Director on 5/1/25 at 4:23 p.m., titled Weights, indicated the following: .Each resident shall be weighed on admission and at least monthly thereafter or in accordance with Physician orders (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-37(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. 49411 During observation, record review, and interview, the facility failed to change, label, and date oxygen and nebulizer supplies for 4 of 4 residents (Resident 5, 34, 56, and 264) and ensured residents received the correct flow rate of oxygen for 1 of 4 residents reviewed for oxygen use of 8 residents in the facility who required supplemental oxygen (Resident 56). Findings include: 1. Resident 34's clinical record was reviewed on 4/30/25 at 9:53 a.m. Diagnoses included respiratory failure, hypertension (high blood pressure), anxiety, and heart failure. Current orders included change out, date, and label oxygen humidifier and tubing every Sunday night. Oxygen at 4 liters per minute (LPM) continuously via nasal cannula. During an observation, on 4/27/25 at 2:55 p.m., Resident 34's oxygen tubing bag was dated 2/2/25. During an observation, on 4/30/25 at 10:32 a.m., Resident 34's oxygen tubing bag was dated 2/2/25. During an interview, on 4/27/25 at 3:54 p.m., QMA 21 indicated Resident 34's oxygen tubing bag was labeled 2/2/25. During an interview, on 4/29/25 at 1:39 p.m., LPN 22 indicated oxygen tubing, bag, and nebulizers were changed every Sunday night. LPN 22 verified Resident 34's oxygen tubing bag was dated 2/2/25. 2. Resident 56's clinical record was reviewed on 4/29/25 at 2:01 p.m. Diagnoses included stomach cancer, gastric ulcers, breathing abnormality, and depression. Current orders included change out, date, and label oxygen tubing and humidifier every Sunday night, and oxygen at 2 LPM via nasal cannula as needed (PRN). During an observation, on 4/27/25 at 4:05 p.m., Resident 56's oxygen tubing was dated 3/30/25, but had been marked over as 4/13/25. His oxygen was running at 3 LPM. During an interview, on 4/27/25 at 4:21 p.m., LPN 17 indicated oxygen tubing should be changed weekly. She verified Resident 56's oxygen tubing was dated 4/13/25. During an observation, on 4/30/25 at 2:24 p.m., Resident 56's oxygen was set at 3 LPM. During an interview, on 4/30/25 at 2:44 p.m., LPN 14 indicated she wasn't sure how many liters per minute Resident 56 required. LPN 14 verified Resident 56's flow rate was 3 LPM. 3. Resident 5's clinical record was reviewed on 4/30/25 at 8:56 a.m. Diagnoses included heart failure, chronic obstructive pulmonary disease (breathing difficulty), chronic respiratory failure (decreased oxygen), hypertension, dementia, dependence on supplemental oxygen, and obstructive sleep apnea (breathing pauses during sleep). (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Current orders included change out, date, and label nebulizer mask and tubing every Sunday on night shift. Change out, date, and label oxygen humidifier and tubing every Sunday. During an observation, on 4/27/25 at 2:44 p.m., Resident 5's nebulizer mask was dated 4/13/25. There was no label or date on Resident 5's oxygen tubing or humidifier. During an interview, on 4/27/25 at 3:59 p.m., LPN 14 indicated oxygen tubing, humidifier and nebulizer mask are changed every Sunday. The third shift nurse was responsible for changing out the oxygen tubing, nebulizer mask and humidifier. Resident 5's nebulizer mask was dated 4/13/25 and her oxygen tubing and humidifier were not dated. 4. Resident 264's clinical record was reviewed on 5/1/25 at 12:33 p.m. Diagnoses included hypertension, status tracheostomy, and chronic obstructive pulmonary disease (difficulty breathing). Current orders included change out, date and label all tubing, bags, and set up every Sunday night. During an observation, on 4/27/25 at 11:29 a.m., Resident 264's humidification bottle was not dated. During an observation, on 4/28/25 at 10:46 a.m., Resident 264 did not have an oxygen bag or date on his humidification bottle or nebulizer mask. During an interview, on 4/27/25 at 3:54 p.m., QMA 21 indicated she was unable to locate Resident 264's oxygen tubing bag and there was no date on his oxygen tubing, nebulizer mask or humidifier bottle. During an interview, on 4/29/25 at 1:39 p.m., LPN 22 indicated Residents oxygen tubing, bag, and nebulizers get changed every Sunday night. LPN 22 verified Resident 264 did not have an oxygen tubing bag and his humidification bottle was undated. A current facility policy, revised on 1/17/19, titled Oxygen & Respiratory Equipment - Changing / Cleaning, provided by the Administrator on 5/1/24 at 12:21 p.m., indicated the following: Guidelines: Purpose: 1. To provide guidelines to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection. Procedure: .2. Nasal Cannula. a. Nasal cannulas are to be changed once a week and PRN c. A clean plastic bag with a zip loc or draw string, etc. will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed .4. Oxygen Humidifiers. a. Oxygen humidifiers should be changed weekly or as needed and will be dated when changed 3.1-47(6)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 45122 Based on interview and record review, the facility failed to ensure the Dietary Manager completed the required education to meet the qualifications for a dietary manager. This deficiency had the potential to impact 58 of 58 facility residents who received meals from the facility kitchen. Finding includes: The employee record form, completed by the facility and provided following entrance conference on 4/27/25, indicated the Dietary Manager had been employed by the facility since 2/1/25 and lacked a dietary manager certification. During an interview, on 4/30/25 at 3:00 p.m., the Dietary Manager indicated he was in the process of getting his food manager certification. During an interview, on 5/1/25 at 11:59 a.m., the Nurse Consultant indicated the Dietary Manager did not have any food service manager certifications. During an interview, on 5/1/25 at 3:08 p.m., the Dietary Manager indicated he had twenty years of food service experience but was not technically a dietary manager until he started at the facility. He was not currently certified but was getting ready to take the examination to be certified. The Corporate Dietary Consultant came to the facility about every two weeks. He had seen the dietician once since he had started the position in February 2025. He stayed in contact with the dietician through emails and phone as needed. A current dietary manager job description, signed by the Dietary Manager on 2/1/25, provided by the Administrator on 5/1/25 at 4:51 p.m., indicated the following: .Must be possess Food Service Sanitation Manager Certification 3.1-20(e)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 45122 Based on observation, interview, and record review, the facility failed to ensure meals were at an appetizing temperature for 12 of 15 residents reviewed for palatable meals. (Resident 17, 35, 61, 116, 23, 4, 53, 38, 56, 7, 2, and 30) Findings include: During an interview, on 4/27/25 at 10:12 a.m., Resident 61 indicated the food was always cold. During an interview, on 4/27/25 at 4:28 p.m., Resident 17 indicated the food was generally not hot at all. She was getting used to eating cold scrambled eggs. During a Resident Council meeting, on 4/30/25 at 3:35 p.m., the resident group indicated the room tray meals, especially in the evening, were cold. A facility document, provided during the entrance conference on 4/27/25, indicated breakfast was at 7:45 a.m. , lunch at 12:30 p.m., and dinner at 5:45 p.m. During an observation, on 4/30/25 at 6:27 p.m., a closed meal cart was on the D Hall unit. At the same time, RN 6 indicated the meal cart had just arrived. During an observation, on 4/30/25 at 6:31 p.m., CNA 18, 19, and 20 began serving trays. During an observation, on 4/30/25 at 6:47 p.m., the meal cart on the E Hall unit arrived During an observation, on 4/30/25 at 6:56 p.m., the last meal tray on the meal cart for D Hall was delivered. During an interview, on 4/30/25 at 6:58 p.m., Resident 56 stuck his finger in his food and indicated his chili dog and French fries were served ice cold. During an interview, on 4/30/25 at 7:01 p.m., Resident 23 indicated her French fries were served cold. During an interview, on 4/30/25 at 7:02 p.m., Resident 30 indicated his French fries were served cold. During an interview, on 4/30/25 at 7:03 p.m., Resident 35 indicated the French fries were cold when he got the tray, but he was hungry, so he ate them. During an interview, on 4/30/25 at 7:06 p.m., Resident 4 indicated his French fries were served cold. During an interview, on 4/30/25 at 7:07 p.m., Resident 7 indicated his burger and fries were served cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 4/30/25 at 7:11 p.m., Resident 116 indicated her French fries were not even warm. They were very cold. During an interview, on 4/30/25 at 7:12 p.m., Resident 53 indicated her French fries were cold, and she did not eat them. During an interview, on 4/30/25 at 7:13 p.m., Resident 38 indicated her chili dog was more cold than warm. During an interview, on 4/30/25 at 7:16 p.m., Resident 17 indicated her French fries were cold and the chili dog was barely warm when she got it. She had stayed in the facility previously, and she thought the meals used to come out on heavy warmer plates, now they were on regular plates. During an interview, on 4/30/25 at 7:17 p.m., Resident 2 indicated her food was cold and not good. During an interview, on 4/30/25 at 7:32 p.m., CNA 18 indicated, most of the time when the food came out on the carts, it was not hot. She had to warm up the residents' food in the microwave often. During an interview, on 5/1/25 at 4:21 p.m., the Administrator indicated the residents' food should be warm when it was served. She had heard about the cold food at supper from last evening, and an in-service had been completed. A facility policy, dated 2020, provided by the Social Services Director on 5/1/25 at 4:23 p.m., titled Monitoring Food Temperatures for Meal Service, indicated the following: .Food temperatures will be monitored to prevent foodborne illness and ensure foods are served at palatable temperatures 3.1-21(a)(2)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49411 Based on observation and interview, the facility failed to ensure food was prepared and served under safe sanitary conditions regarding food handling and hand washing. This deficient practice had the potential to affect 55 of 55 residents who received their meals from the kitchen. Findings include: During a lunch service observation, on 04/29/25 12:30 p.m. to 1:15 p.m., the following food handling and food service concerns were observed: Dietary Employee 7 (DE 7) propelled a resident forward in her wheelchair and locked the wheelchair brake. She did not perform hand hygiene before touching a set of tongs to place a lemon slice into a drink. She then touched the back of another female staff member before she lifted a container of lemon slices, with her left thumb touching the inside of the lemon slice container. Dietary Employee 8 (DE 8) grabbed a hot dog bun with his bare hands, place it on a plate, and opened it. No hand hygiene was performed. DE 8 crossed his ungloved hands, placing his hands on his waist and lower back. He went through meal tickets one by one like he was dealing cards. He scratched his left nostril with his left index finger. He then grabbed a plate, and his left thumb touched the food portion of the plate. No hand hygiene was performed. DE 8 grabbed two hot dog buns and a hamburger bun with his bare hands. He used his hands to open the hot dog/ hamburger bun on the plate. No hand hygiene was performed. DE 8's left thumb kept touching the food portion of the plate while he plated food. During an interview, on 4/29/25 at 1:20 p.m., DE 7 indicated she did not reposition a resident's wheelchair, but she did lock their brake. During an interview, on 4/29/25 at 1:24 p.m., DE 8 indicated he touched the buns with his bare hands. He also touched his hips and shirt with his bare hands. During an interview, on 4/30/25 at 3:00 p.m., the Dietary Manager indicated staff should not touch buns with their bare hands. The dietary employees should not touch any part of their clothing, glasses, or face without performing hand hygiene. 3.1-21(i)(3)