STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155843	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springs of Richmond, The	400 Industries Road Richmond, IN 47374

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to timely implement wound care orders and interventions for a resident resulting in the deterioration of a sacral wound (Resident 6) and failed to thoroughly complete admission skin assessment for a resident's wound (Resident 2) for 2 of 2 residents reviewed for pressure ulcer management. Findings include: 1. During an observation and interview, on 2/9/2026 at (time not documented), Resident 6 indicated the facility was not changing his wound dressings as they should. He had big wounds on his bottom that he got at home. He reported his wound was severe and that he goes to wound care. Resident 6 did not feel the facility was taking care of his wounds as it should; there were issues with his dressing, protein shakes, turning, and cushions multiple times since he had been there.The clinical record for Resident 6 was reviewed on 02/12/2026 at 2:31 PM. The resident's diagnoses included, but were not limited to, rhabdomyolysis (rapid breakdown of skeletal muscle tissue), a pressure wound to the sacral region (wedge shaped bone located at the base of the lumbar spine), and a pressure area to the ischium (lower-back bone of the pelvic girdle).An admission MDS, dated [DATE], indicated Resident 6 was admitted on [DATE]. The resident was cognitively intact. Resident 6 did not have any behaviors of rejecting care. Resident 6 needed substantial to maximum help with rolling left and right, sitting to lying, and lying to sitting. Resident 6 was dependent on toileting needs and showering. The resident used a manual wheelchair and was dependent on staff for all locomotion needs. A pressure-reducing device was used for the bed and chair; the resident received pressure injury/ulcer care and application of non-surgical dressings and ointments/medications. Resident 6 was at risk for pressure injuries based upon formal and clinical assessment. The resident had one unstageable wound due to a deep pressure injury and one unstageable wound due to eschar/slough.A nursing admission assessment, dated 1/5/2026, indicated Resident 6 was at low to moderate risk for further skin impairments.A current physician's order, dated 1/5/2026, indicated the resident was to have a pressure-reducing cushion in the wheelchair.A wound care plan, dated 1/6/2026, indicated Resident 6 had a pressure ulcer to the sacrum and right buttock with a wound vac (a specialized, medical device used to accelerate healing for wounds). The interventions included, but were not limited to, a pressure-reducing cushion for the chair, a pressure-reducing mattress, providing treatment per MD order, and notifying the MD if treatment was not effective.A letter of pressure ulcer unavoidability was completed by the Director of Nursing Services (DNS) on 1/6/2026. The letter indicated the resident was a high risk for skin breakdown despite preventative measures. A current physician's order, dated 1/5/2026, indicated staff were to encourage the resident's turning and repositioning while in bed.A facility wound assessment, dated 1/6/2026, indicated Resident 6 had a pressure area to the right buttocks. The area was unstageable with measurements of 8 cm x 5 cm x immeasurable depth, with the presence of slough.A facility wound assessment, dated 1/6/2026, indicated Resident 6 had a pressure area to the sacrum. The area was unstageable with measurements of 12 cm x 10.5 cm x 5 cm. There was undermining of 4 cm, without the location of the undermining indicated.A current physician's order, dated 1/7/2026, indicated: indicated staff were to observe the resident's (sacrum and right ischium) dressing to open areas every shift for drainage on dressing and (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 0686 Level of Harm - Actual harm Residents Affected - Few	dislodgement.A physician's order, dated 1/7/2026 through 1/14/2026, indicated staff were to cleanse the resident's sacrum and right ischium with normal saline, pat dry, apply normal saline wet-to-moist (placing normal saline-soaked gauze into the wound bed to maintain moisture), and secure with dry dressing as needed for soiling and dislodgement.A physician's order, dated 1/9/2026 through 1/14/2026, indicated staff were to change the resident's negative pressure dressing (an advanced healing system that used a vacuum pump) every Monday, Wednesday, and Friday.The treatment administration record for Resident 6 indicated a change of negative pressure therapy to the sacral wound on 1/12/2026. This administration was left blank.The treatment administration record for Resident 6 indicated the wound vac was in place and functional on 1/12/2026.A facility wound assessment, dated 1/13/2026, indicated Resident 6 had a pressure area to the right buttocks. The area was unstageable with measurements of 7 cm x 5 cm x immeasurable depth, with the presence of slough.A facility wound assessment, dated 1/13/2026, indicated Resident 6 had a pressure area to the sacrum. The assessment included a note that it was unable to be completed due to the wound vac being in place. The assessment did indicate the area was unstageable with measurements of 12 cm x 10.5 cm; no depth was indicated.A physician's order, dated 1/14/2026, indicated the resident's negative pressure setting was at 125 mm Hg continuous therapy three times a day.A current physician's order, dated 1/14/2026, indicated to cleanse the sacrum wound with normal saline, pat dry, and apply normal saline wet-to-moist and secure with dry dressing as needed if unable to apply negative pressure therapy.A physician's order, dated 1/14/2026 through 1/23/2026, indicated to change the resident's negative pressure dressing every Monday, Wednesday, and Friday.A physician's order, dated 1/15/2026, indicated for the resident to have a specialized, air-filled medical seat cushion designed to prevent pressure ulcers (ROHO cushion) .place cushion on wheelchair when it comes in.A wound center provider note, dated 1/15/2026, indicated Resident 6 had two pressure areas. The primary wound was an unstageable pressure area to the sacrum measuring 13.7 cm x 10.3 cm x 2.5 cm. The area had slough with tunneling of 3.6 cm from the 0900-1100 aspect (clock method for describing wound tunneling uses an imaginary clock face over the wound, with 12:00 at the resident's head and ^:00 at the resident's feet). Debridement was provided during the visit, with a resulting wound size of 13.8 cm x 10.4 cm x 2.5 cm. The layer of exposure was necrosis of the muscle. The second wound was an unstageable pressure area to the right ischium measuring 3.5 cm x 4 cm x 0.1 cm. Debridement was provided to the ischium during the visit, with a resulting wound size of 3.6 cm x 4.1 cm x 0.2 cm, with a fat layer exposed. A notation from the visit indicated, .[Resident 6] comes in today with [Brand 1] vac with a [Brand 2] canister and [Brand 3] very small piece of foam.Resident needs a .ROHO [air filled seating] cushion for wheelchair-still has a standard cushion. The plan of care indicated wounds were anticipated to heal in 2-4 months. Wound care orders from the visit included, but were not limited to, .Patient's current wheelchair cushion is inadequate. Please obtain ROHO cushion for patient. and to keep pressure therapy on. If the dressing seal to the sacrum were to be broken and the transparent dressing came loose, reinforce with strips of dressing as needed. If negative pressure wound therapy malfunctions or becomes non-occlusive for more than 2 hours, remove the dressing, clean the wound with normal saline, apply a moistened gauze with saline and then dry gauze, and change twice a day until negative pressure wound therapy can be put back on. If the dressing becomes non-occlusive or malfunctions, call your healthcare provider and wound care during business hours on weekdays.A physician's order, dated 1/15/2026, indicated for the resident to have a specialized, air-filled medical seat cushion designed to prevent pressure ulcers .place cushion on wheelchair when it comes in.A physician's order, dated 1/16/2026, indicated wound care to the right ischium was to cleanse wound with normal saline, pat dry, apply Hydrofera Blue transfer (cut to size of wound and hydrate dressing with NS before applying), cover with ABD, and secure with tape.A physician's order, dated 1/16/2026, indicated wound care to the right ischium was to cleanse wound with normal saline, pat dry, apply Hydrofera Blue transfer (cut to size of wound and hydrate dressing with NS [normal saline] before applying), cover with ABD [abdominal pad], and (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	secure with tape, as needed for soiling or dislodgement.A facility wound assessment, dated 1/20/2026, indicated Resident 6 had a pressure area to the right buttocks. The area was unstageable with measurements of 3.6 cm x 4 cm x 0.1 cm, with the presence of slough in the wound bed.A facility wound assessment, dated 1/20/2026, indicated Resident 6 had a pressure area to the sacrum. The area was unstageable with measurements of 13.5 cm x 10.5 cm x 2.5 cm. There was tunneling of 3.5 cm at the 0900-1100 aspect. The note indicated Resident 6 was at times noncompliant with dressings and turning.The treatment administration record for Resident 6 indicated the negative pressure therapy change to the sacral wound scheduled for 1/21/2026 was not administered, with the reason noted as .Discontinued.The treatment administration record for Resident 6 indicated negative pressure therapy to the sacral wound was not in place due to .discontinued. twice on 1/21/2026.A wound center provider note, dated 1/22/2026, indicated Resident 6 had two pressure areas. The primary wound was an unstageable pressure area to the sacrum measuring 13.1 cm x 11 cm x 2.2 cm. The area had slough with tunneling of 3.4 cm from the 0900-1200 aspect. Debridement was provided during the visit, with a resulting wound size of 13.2 cm x 11.1 cm x 2.3 cm. The layer of exposure was bone involvement without evidence of necrosis. The second wound was an unstageable pressure area to the right ischium measuring 3.7 cm x 2.9 cm x 0.1 cm. Debridement was provided to the ischium during the visit, with a resulting wound size of 3.8 cm x 3 cm x 0.2 cm, with a fat layer exposed. A notation from the visit indicated, .[Family Member 11] notes vac started beeping Monday. Alarm turned off but continued to alert until Tuesday when vac removed. Dressing in place today was a Hydrofera Blue transfer folded in half and covering about 25% of the wound.There is now exposed bone, and deep tissue injury of intact skin of proximal aspect.Has a new foam cushion on top of original foam cushion. Needs ROHO cushion or equivalent, as previously requested. Wound care orders, dated 1/22/2026, indicated .Patient's current wheelchair cushion is inadequate. Please obtain ROHO cushion for patient. Please no foam cushions.Wound must have dressing on at all times. Patient did not have dressing on the sacrum wound today. Patient's undermining has increased depth. Increased pressure injury noted at 12:00 aspect of sacral wound. Bone exposure noted. Wound care orders indicated to keep pressure therapy on. If the dressing seal to the sacrum were to be broken and the transparent dressing came loose, reinforce with strips of dressing as needed. If negative pressure wound therapy malfunctions or becomes non-occlusive for more than 2 hours, remove the dressing, clean the wound with normal saline, apply a moistened gauze with saline and then dry gauze, and change twice a day until negative pressure wound therapy can be put back on. If the dressing becomes non-occlusive or malfunctions, call your healthcare provider and wound care during business hours on weekdays.A physician's order, dated 1/23/2026 through 1/26/2026, indicated to change the resident's negative pressure dressing every Sunday, Tuesday, and Thursday.The treatment administration record for Resident 6 indicated the order for [Sacrum]: Cleanse wound with normal saline, pat dry, apply NS [Normal Saline] wet to moist and secure with dry dressing PRN [as needed] if unable to place wound vac . was ordered on 1/14/2026 with no end date. There were no signed off administrations of this on the treatment record. The treatment administration record for Resident 6 indicated .[Sacrum and right ischium] dressing to open area(s) every shift for draining on dressing and dislodgement. An associated nurses note stated, .not administered: Other wet to moist on Wound center today . A facility wound assessment, dated 1/27/2026, indicated Resident 6 had a pressure area to the right buttocks. The area was unstageable with measurements of 3 cm x 4 cm x 0.1 cm, with the presence of slough in the wound bed.A facility wound assessment, dated 1/27/2026, indicated Resident 6 refused to allow the facility to measure his wounds.A wound center provider note, dated 1/30/2026, indicated Resident 6 had two pressure areas. The primary wound was an unstageable pressure area to the sacrum measuring 13.6 cm x 10 cm x 2 cm. The area had slough with tunneling of 3 cm from the 0900-1100 aspect. Debridement was provided during the visit, with a resulting wound size of 13.7 cm x 10.1 cm x 2.1 cm. The layer of exposure was bone involvement without evidence of necrosis. The second wound was an unstageable pressure area to the right (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ischium measuring 4.7 cm x 2.7 cm x 0.2 cm. Debridement was provided to the ischium during the visit, with a resulting wound size of 4.8 cm x 2.8 cm x 0.3 cm, with a fat layer exposed. A notation from the visit indicated Resident 6 .just received a new cushion, which feels like a one-piece block of foam. Resident 6 needed a ROHO or equivalent cushion, as previously requested, and Family Member 11 indicated the facility told Family Member 11 that a ROHO had been ordered. Wound care orders indicated Resident 6's cushion was inadequate, requested no foam cushions, and indicated to keep negative pressure therapy on. If the dressing seal to the sacrum were to be broken and the transparent dressing came loose, reinforce with strips of dressing as needed. If negative pressure wound therapy malfunctions or becomes non-occlusive for more than 2 hours, remove the dressing, clean the wound with normal saline, apply a moistened gauze with saline and then dry gauze, and change twice a day until negative pressure wound therapy can be put back on. If the dressing becomes non-occlusive or malfunctions, call your healthcare provider and wound care during business hours on weekdays.A facility wound assessment, dated 2/3/2026, indicated Resident 6 had a pressure area to the right buttocks. The area was unstageable with measurements of 2.7 cm x 3.5 cm x immeasurable depth, with the presence of slough.A facility wound assessment, dated 2/3/2026, indicated Resident 6 had a pressure area to the sacrum. The area was unstageable with measurements of 13 cm x 10 cm x 0.2 cm. There was undermining of 4 cm at the 0900-1200 aspect.A wound center provider note, dated 2/5/2026, indicated Resident 6 had two pressure areas. The primary wound was an unstageable pressure area to the sacrum measuring 12.6 cm x 9.5 cm x 1.8 cm. The area had slough with tunneling of 2.2 cm from the 0900-1100 aspect. Debridement was provided during the visit, with a resulting wound size of 12.7 cm x 9.6 cm x 1.9 cm. The layer of exposure was bone involvement without evidence of necrosis. The second wound was an unstageable pressure area to the right ischium measuring 4 cm x 2.5 cm x 0.1 cm. Debridement was provided to the ischium during the visit, with a resulting wound size of 4.1 cm x 2.6 cm x 0.2 cm, with a fat layer exposed. A notation from the visit indicated Resident 6 needed a ROHO or equivalent cushion, as previously requested, and Family Member 11 indicated the facility told Family Member 11 that a ROHO had been ordered. Wound care orders indicated Resident 6's cushion was inadequate, requested no foam cushions, and indicated to keep negative pressure therapy on. If the dressing seal to the sacrum were to be broken and the transparent dressing came loose, reinforce with strips of dressing as needed. If negative pressure wound therapy malfunctions or becomes non-occlusive for more than 2 hours, remove the dressing, clean the wound with normal saline, apply a moistened gauze with saline and then dry gauze, and change twice a day until negative pressure wound therapy can be put back on. If the dressing becomes non-occlusive or malfunctions, call your healthcare provider and wound care during business hours on weekdays.A facility wound assessment, dated 2/10/2026, indicated Resident 6 had a pressure area to the right buttocks. The area was unstageable with measurements of 2.5 cm x 3.5 cm x immeasurable depth, with the presence of slough.A facility wound assessment, dated 2/10/2026, indicated Resident 6 had a pressure area to the sacrum. The area was unstageable with measurements of 12 cm x 9.5 cm x 0.2 cm. There was undermining of 4 cm at the 0900-1200 aspect.An order sheet provided by ADNS, dated 12/10/2025 at 2:45, indicated the cushion provided to Resident 6 was a .Pressure Retribution Foam Cushion with Cutout.During an interview, on 12/10/2026 at 2:45 PM, ADNS indicated Resident 6 was on the foam cushion (pressure Retribution Foam cushion) from 1/12/2026 until the air filled cushion was delivered on 2/3/2026. The facility received a call after Resident 6's wound care appointment on 2/5/2026 and it was disclosed to cushions that were still not adequate, so they had the air filled dry floating low profile cushion same day delivered on 2/6/2026.During an interview, on 2/11/2026 at 11:17 AM, LPN 7 indicated she had taken care of Resident 6 multiple times before. When she took care of him prior to sending to wound care, she would make sure he had his antibiotic, breakfast, and dressing was in place. The LPN indicated the resident was sent to wound care on a 3 to 4 inch thick foam cushion with a U-shape cut out. Resident 6 received an air cushion over the weekend, but was on strict bedrest, so he had not used it yet to her (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	knowledge.During an interview, on 2/11/2026 at 12:10 p.m., LPN 9, indicated on 1/21/2026 she received in report Resident 6's wound vac was on hold due to frequent stools. She was not sure if she worked 8 hours or 12 hours with him that day, but Resident 6 had a wet to moist dressing on both wounds. She changed the dressings once during her shift with a wet to moist but did not attempt to reapply the wound vac. LPN 9 was unsure how long it had been off. LPN 9 confirmed she did not notify the physician or wound care because she believed the previous nurse had.During an interview on 2/12/2026 at 12:07 PM, Physician 10 indicated she had seen Resident 6 for treatment of his wounds. Resident 6 had substantial wounds to his coccyx with bone and muscle involvement. The interventions had not been implemented for Resident 6's care. The cushion Resident 6 came to his appointments on had been inadequate. The facility continued to use foam cushions, even sending the resident with two foam cushions to the last two wound care visits. The cushions being provided were not sufficient for the severity of the ulcer he had. On 1/15/2026, she recalled the wound vac (negative pressure wound therapy) that was in place was a mismatch of wound vac pieces and utilized the wrong type of foam. It was not likely detrimental to the wound, but it was not effective in healing. On 1/22/2026, Resident 6's sacral wound looked .much worse. Family Member 11 said that the vac had stopped working and been left in place for at least 24 hours. Resident 6 had a .small dinner-plate-sized wound and now had bone exposure in the central aspect. that had not been noted previously. There was no dressing in place for the sacral wound except for a folded piece of Hydrofera Blue over the exposed bone. Case Manager 15 called the facility on 1/23/2026 to report concerns, including the need for a Hoyer sling, ROHO cushion, and the wound not being covered. Case Manager 15 also clarified wound care orders included the importance of compliance with wound vac treatment. On 1/30/2026, Physician 10 saw Resident 6 in the office. Resident 6 had a double foam cushion in his wheelchair. Resident 6 reported the facility did not provide his protein supplement or turn him often. Physician 10 indicated she last saw him on 2/5/2026 and the dressing was a little bit not on point. Every time Resident 6 came to wound care, except for 1/22/2026 when no vac was in place, the foam had not been applied completely. Resident 6 had an improper cushion and reported interventions were not consistent. Case Manager 15 had reached out several times to the facility, including 1/23/2026 and 2/5/2026. It was her opinion that the wound will heal, but Resident 6 was .fragile, so that is a difficult part. They [the facility] have to optimize nutrition and minimize pressure to the area if he [Resident 6] has any hope. The physician indicated the inadequate cushion could impact the wound even if just when going to the appointment. As severe as the wound was, even coming across the road on the wrong cushion can be detrimental. When asked to describe a Roho cushion or adequate alternative, she indicated Resident 6 needed a air-cell-based cushion and should not be on a foam cushion.During an interview on 2/13/2026 at 8:20 AM, Family Member 11 indicated when she had visited the resident in the facility the wound vac (treatment to the coccyx) was not observed to be functional.During an interview on 2/13/2026 at 9:35 AM, Physician 10 reported the wound vac was noted to be applied inappropriately during the visit on 2/13/2026. The bulb (where the hose attached to the dressing to apply the negative pressure) was placed directly over the bone, but it should have been bridged. Bridging was a closure technique that extends foam from a wound bed across intact skin not over a boney prominence to connect the bulb. The wound had resulted in deterioration of the exposed bone, which was now crumbling.During an interview, on 2/13/2026 at 11:02 AM, LPN indicated she cared for Resident 6 prior to going to wound care on 1/22/2026. Prior to going to wound care, she reapplied a wet to moist dressing to both of Resident 6's wounds. She did not attempt to reapply the wound vac because he would be getting it changed in just a couple of hours at wound care. She could not remember what dressing she removed that day. When Resident 6 was transferred on 1/22/2026, he was sent out on a foam cushion with a U-shaped cut out.During an interview, on 2/13/2025 at 1:03 PM, ADON indicated Resident 6's wound VAC should be bridged.An article by the National Institute of Health, last updated September 4, 2023, defined negative pressure wound therapy (NPWT) as a broad term used to describe a unique and versatile system that aids the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	optimization of wound healing through the application of sub-atmospheric pressure to help reduce inflammatory exudate and promote granulation tissue. This is also referred to as a wound VAC (vacuum assisted closure).2. During an interview, on 2/9/2026, Family Member 12, indicated Resident 2 had pressure wounds and ulcers.The clinical record for Resident 2 was reviewed on 02/13/2026 9:57 AM. The admission MDS Assessment, dated 11/30/2025 indicated that Resident 2 was cognitively intact and needed partial/moderate staff assistance with hygiene care. A cognition screening, completed on 2/10/2026, indicated Resident 2 was cognitively impaired. A nursing skin note from admission, dated 2/6/2026, indicated a skin assessment was completed. The nurse noted an open area on the left buttock measured 6 cm x 4 cm, open areas on the right buttock measured 2 cm x 1 cm and 1 cm x 1 cm, and the right heel had a deep purple maroon discoloration measured at 4.5 cm x 0.75 cm. The resident had two other skin alterations listed to the left lower extremity. A wound management assessment, completed 2/6/2026, indicated Resident 2 had an unstageable deep tissue pressure ulcer to the right heel measured at 1 cm x 4 cm x immeasurable depth, an unstageable deep tissue pressure ulcer to the right buttock measured 4.5 cm x 2 cm x immeasurable with no open areas, and an unstageable pressure area to the left buttock measuring 5 cm x 5 cm x immeasurable depth with eschar. During an interview, on 02/12/2026 at 1:19 PM, ADON indicated the admitting nurse could not assess staging because she was an LPN. There was no depth listed for the wound on admission so that was why none was listed, the admitting nurse had some measurements inverted, and there was no description other than open areas to the pressure areas to the buttocks.A policy entitled, Pressure/Stasis/Arterial/Diabetic Wound Guidelines, was provided by the DNS on 2/11/2026 at 11:30 AM. The policy indicated .If skin alteration is noted upon admission, admitting nurse should complete progress note assessment.Documentation descriptions of wound using: a. Length - 12 o'clock to 6 o'clock, b. Width - 3 o'clock to 9 o'clock, c. Depth - deepest area of wound bed, d. Exudate, e. Color, f. Odor, g. Wound margins, h. Surrounding tissue, t. Tunneling and/or undermining if applicable. 3.1-40

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. Based on interview and record review, the facility failed to ensure call lights were answered timely for 5 of 6 residents reviewed for accommodations of needs. (Resident 92, Resident 6, Resident 61, Resident 55, and Resident 26) Findings include:During an interview for Resident Council on 2/11/26 at 1:03 p.m., Resident 61, Resident 55 and Resident 26 indicated the residents were unable to get their call lights answered to get assistance. It would take the staff from 20 to 30 minutes to answer a call light. Review of the resident council meetings, dated October 2025, November 2025, December 2025, and February 2026, indicated the residents had concern of call lights not being answered timely. During an interview with Resident 92 on 2/9/26 at 1:37 p.m., the resident indicated he had to wait for assistance with toileting. It took up to thirty minutes for his call light to be answered, especially during mealtimes. During an interview with Resident 6 on 2/9/26 at 2:14 p.m., the resident indicated when the resident pushed his call light for help, it took up to thirty minutes for it to get answered. The staff would sometimes come in and shut it off and then would not return. During a confidential interview, from 2/9/26 to 2/13/26, the confident indicated they had timed it and it had taken up to thirty minutes for the call light to be answered and sometimes the staff did not come at all during the night. The resident had to lay in urine for long periods of time. During an interview with the Executive Director (ED) on 2/12/2026 at 10:31 a.m., The ED indicated call lights should be answered as soon as possible. The facility did not have a way to track call light time responses. During an interview with the Activity Director on 2/12/26 at 11:05 a.m., the Activity Director indicated call light wait times had been a concern in resident council. The resident council had reported a concern about call light wait time in January 2026, but she did not document it. January 2026 was the first time she had conducted a resident council meeting. The call light policy provided by the ED, on 2/12/26 at 11:40 a.m., indicated call lights should be answered as quickly as possible. 3.1-3(v)(1)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide dependent residents with nail care and failed to provide timely incontinent care for 3 of 3 residents reviewed for Activities of Daily Living (ADL) care (Resident 91, Resident 28 and Resident 62). Findings include:1.During an observation and interview with Resident 91 on 2/9/26 at 12:41 p.m., the resident's fingernails were long. The resident indicated the staff had not assisted him with trimming his fingernails. During observation and interview with Resident 91 on 2/10/26 at 1:20 p.m., the resident's fingernails were long on both hands. The resident indicated his fingernails had been long since he was admitted . He had asked Certified Resident Care Assistant (CRCA) 1 and CRCA 6 to trim them for him, but they never showed up to trim them. The resident had a stroke and was unable to trim them himself, he had never let his fingernails get long like they were now before he had the stroke. The resident was afraid he would scratch himself with them being so long. Review of the clinical record of Resident 91 on 2/11/2026 at 2:54 p.m., indicated the resident's diagnosis included, but was not limited to, Cerebral Vascular Accident (CVA) (stroke). The Occupational Therapy (OT) cognitive assessment for Resident 91, dated 2/5/26, indicated the resident was cognitively intact for daily decision. The care plan for Resident 91, dated 2/6/26, indicated the resident had functional impairment due to left side hemiparesis (weakness) and stroke. The interventions included, but were not limited to, provide nail care on shower days and as needed. 2. The clinical record for Resident 28 was reviewed on 2/10/26 at 12:43 p.m. The resident's diagnosis included, but was not limited to, congestive heart failure. The admission Minimum Data Set (MDS) assessment, dated 12/28/26, indicated Resident 28 was severely cognitively impaired, required partial/moderate assistance with personal hygiene, and had no behaviors toward others or rejection of care. During an observation and interview with Resident 28 on 2/9/26 at 2:26 p.m., the resident's fingernails were long and appeared dirty. Resident 28 indicated his nails needed to be trimmed. During an observation and interview with Resident 28 on 2/10/26 at 1:58 p.m., his nails were long, specifically both thumbs, and both middle fingers had jagged, sharp edges to them. During an observation and interview with Resident 28 on 2/11/26 at 10:39 a.m., his nails continued to be long, specifically both thumbs and both middle fingers were rough and jagged. Resident 28 indicated no staff had gotten around to trimming his nails yet. During an interview with the Director of Health Services (DHS) on 2/13/26 at 10:35 a.m., they indicated residents should be offered nail care and trimming on their shower days and nursing was who was responsible to ensure nail care was provided to residents. 3. The clinical record for Resident 62 was reviewed on 2/10/2026 at 12:41 p.m. The diagnoses included, but were not limited to, spinal stenosis, muscle weakness, diarrhea (loose stools), and urinary incontinence. The resident was alert and oriented. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission Observation and Data Collection report, dated 2/1/26, indicated Resident 62 was incontinent with bowel and bladder and had weakness in bilateral lower extremities. A bowel and bladder plan of care, dated 2/2/26, indicated Resident 62 experienced periods of incontinence due to debility and weakness. The interventions included, but were not limited to, offer and assist with toileting as needed and per resident request, and provide incontinence care as needed. During an interview with Resident 62 on 2/10/26 at 10:20 a.m., the resident indicated they would lay in bed soiled for up to a half hour waiting for help. A progress note, dated 2/10/26 at 9:45 a.m., indicated Resident 62 had complaints of discomfort in the groin area. Moisture-Associated Skin Damage (MASD - inflammation and skin erosion caused by prolonged exposure to fluids like urine and stool) noted to the groin area. During an observation on 2/10/26 at 1:15 p.m., Resident 62 was yelling, will someone help me, help me, someone help me. During an interview with Resident 62 on 02/10/2026 at 1:47 p.m., the resident indicated they pushed their call light because they were incontinent and needed to be changed. Someone came in and said I'll go get someone to help you and never come back. I had to yell out for help.over thirty minutes waiting on someone, so I had to yell out for help. During an observation and interview with Resident 62 on 02/11/2026 at 10:44 a.m., the resident indicated they turned their call light on because they were incontinent and needed cleaned up. CNA 13 was observed to enter the resident's room and assisted the resident with incontinence care. Resident 62's vaginal area was red, raw, and excoriated from the vaginal area up to the buttocks. Resident 62 moaned out in discomfort during cleaning. An observation on 2/11/26 at 11:01 a.m., Resident 62 was heard moaning and yelling for help from the doorway. Resident 62's call light was on. Family Member 14 was standing at the doorway saying, she needs help, she went again and whistling for someone's attention. No staff were observed down either hallway. During an interview with Family Member 14 on 2/11/2026 at 1:33 p.m., he indicated he came into the facility twice a day to see Resident 62 and nearly every day that he came in, Resident 62 would push her call light for help getting cleaned up. Staff would come in, turn off the call light, say someone would be back in to help, and no one would come back. Family Member 14 indicated Resident 62 would tell him how uncomfortable she was and how much it burned to have that left on her skin for any period-of-time. Lunchtime was the worst with trying to get help. He had even stood in the doorway looking for help or trying to flag someone down. An interview with the Executive Director (ED) on 2/12/2026 at 10:31 a.m., the ED indicated staff should answer call lights as soon as possible. A Perineal Care for Incontinence policy was provided by the DHS on 2/12/26 at 10:18 a.m. It indicated .To provide incontinence care that will keep skin from being exposed to prolonged periods of urine and feces. The DHS indicated (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-38(a)(3)(A) 3.1-38(a)(3)(E)

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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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. Based on observation, interview, and record review, the facility failed to set up follow up appointments with the optometrist (eye doctor) as recommended for 1 of 1 resident reviewed for vision (Resident 51). During an observation and interview with Resident 51 on 2/10/2026 at 9:55 a.m., the resident had a book in her hand and was moving her glasses around to read it. The resident indicated she had not had her glasses very long but had to move her glasses around to see out of them to read. The resident would rather read then watch television. The resident needed different glasses and she did not care if it was reading glasses, whatever worked so she could see to read. The resident was observed to have 7 books and magazines on her night stand. Review of the clinical record of Resident 51 on 2/11/2026 at 9:54 a.m., indicated the resident's diagnosis included, but was not limited to, bilateral changes in retinal vascular appearance (abnormal alterations in the blood vessels of both eyes). The significant change Minimum Data Set (MDS) assessment for Resident 51, dated 12/11/25, indicated it was very important to the resident to have books, newspaper and magazines to read. The quarterly MDS assessments for Resident 51, dated 1/22/26, indicated the resident was cognitively intact. The resident was reasonable and consistent. The resident required corrective lenses for vision. The optometrist appointment for Resident 51, dated 3/13/25, indicated the resident was to have a follow up in 1 to 3 months for electroretinography (ERG) (measures the electrical responses of light sensitive cells and test for retinal disorders). The optometrist appointment for Resident 51, dated 10/17/25, indicated the resident was to have a follow up in 1 to 3 months for a dilated fundus exam (diagnostic procedure). Review of the physician's order for Resident 51, dated February 2026, indicated the resident may see an optometrist as needed. During an interview with the Social Service Director (SSD), on 2/11/26 at 11:02 a.m., indicated nursing were responsible to schedule residents for their follow up appointment with the eye doctor. The SSD would review Resident 51's record to see if she had her follow up appointments between April 2025 to June 2025 as ordered by the eye doctor and November 2025 to January 2026 as ordered by the eye doctor. During an interview with the SSD, on 2/11/2026 at 2:18 p.m., the SSD indicated Resident 51 did not have the eye doctor appointments/test in the time frame they were suppose to be completed. During an interview with Director Of Health Services (DOHS), on 2/12/26 at 2:19 p.m., the DOHS indicated it was nursing staffs' responsibility to schedule the follow up eye doctor appointments for Resident 51. The facility did not have a policy for ancillary services. 3.1-39(a)(1)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide a resident with prescribed prn (as needed) Imodium when experiencing loose stools (Resident 62) and assess a resident with increased frequency and urgency of urination (Resident 72) for 2 of 2 residents reviewed for bowel and bladder Incontinence/UTI. Findings include: 1.The clinical record for Resident 62 was reviewed on 2/10/2026 at 12:41 p.m. The resident's diagnoses included, but were not limited to, diverticulosis (condition of small bulging pouches in the digestive track lining, primarily the colon, caused by high pressure), muscle weakness, diarrhea (loose stool), and urinary incontinence. The resident was alert and oriented. An admission Observation and Data Collection report, dated 2/1/26, indicated Resident 62 was incontinent with bowel and bladder, had weakness in bilateral lower extremities, no skin impairments identified upon skin assessment, and was at risk for pressure ulcers. Dated 2/2/26, the resident was alert and oriented A plan of care, dated 2/2/26, indicated Resident 62 had diverticulosis. The interventions included, but were not limited to, administering medications as ordered by the physician, and recording the duration and frequency of diarrhea. A plan of care, dated 2/2/26, indicated Resident 62 was at risk for skin breakdown related to decreased mobility. The interventions included, but were not limited to, keeping as clean and dry as possible and minimizing skin exposure to moisture. A progress note, dated 2/4/26 at 9:52 p.m., indicated the provider put in a referral for the resident to be seen by a gastroenterologist (medical doctor specializing in digestive systems) for loose stools. The physician's order, dated 2/4/26, indicated Resident 62 was prescribed Imodium (over the counter medication to treat loose stools) A-D 2 mg (milligram), one tablet oral, every four hours as needed for diarrhea. The physician's order, dated 2/5/26, indicated Resident 62 was prescribed Imodium A-D 2 mg, one to three tablets three times a day as needed. A progress note, dated 2/9/26 at 1:38 p.m., indicated Resident 62 was complaining of buttock pain, was having frequent soft/loose stools, and the resident's coccyx was red with blanching and noted shearing to upper coccyx area. A review of the February Medication Administration Record (MAR) indicated no prn Imodium was given to Resident 62 since the order was received on 2/4/26. A progress note, dated 2/10/26 at 9:45 a.m., indicated Resident 62 had complaints of discomfort in the groin area. Moisture-Associated Skin Damage (MASD - inflammation and skin erosion caused by prolonged exposure to fluids like urine, stool, or wound exudate, often resulting in painful, burning, and itchy skin) noted to the groin area. During an interview on 2/10/2026 at 10:36 a.m., Resident 62 indicated their private area was all red (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and excoriated from lying in their urine and feces all the time. The staff had put powder on the red area that morning. A progress note, dated 2/11/26 at 1:46 p.m., indicated the nurse practitioner was notified of Resident 62 having loose stools, she would be in to assess the resident, and gave a referral for the resident see a gastroenterologist. A progress note, dated 2/11/26 at 5:22 p.m., indicated the nurse practitioner changed the Imodium order to 2 mg, one tablet by mouth, three times a day. During an interview with the Assistant Director of Health Services (ADHS) on 2/12/26 at 1:20 p.m., they indicated MASD was caused by moisture, sweating, or incontinence. It was the facilities expectation that residents were checked for incontinence during every two-hour rounding (checking and changing) or when the resident called for assistance with care. The expectation was to keep them clean and dry. During an interview with Resident 62 on 2/13/2026 at 9:51 a.m., the resident indicated no one had offered them any Imodium when they were having diarrhea. The first time the resident received an Imodium was within the last couple days and the Imodium had helped a lot. During an interview with the DHS on 2/13/26 at 10:55 a.m., they indicated it was their expectation that if a resident was experiencing diarrhea and had an order for Imodium, the nurse would offer it. The facility did not have a policy for following the physician orders. The floor nurse was responsible to provide Resident 62 with her Imodium medication if needed for her diarrhea. A Perineal Care for Incontinence policy was provided by the DHS on 2/12/26 at 10:18 a.m. It indicated .to provide incontinence care that will keep skin from being exposed to prolonged periods of urine and feces. 2. During an observation and interview with Resident 72 on 2/09/2026 at 12:19 p.m., the resident was in the bathroom with the door shut. The resident ambulated out of the bathroom to her chair independently. The resident indicated the last 3 to 4 days she had been running to the bathroom constantly and sometimes she could urinate and sometimes she could not. The resident felt like she needed a bedside commode next to her recliner because she was going so frequently to the bathroom, almost every 10 minutes. The resident had reported her concerns to the staff member today that had provided her with her routine medications, but was unsure of her name. During an interview with LPN 2 on 2/10/2026 at 12:58 p.m., the LPN indicated she did not care for Resident 72 on 2/09/26 she was off work. LPN 2 asked QMA 4 if Resident 72 had reported to her anything on 2/9/26. QMA 4 indicated the resident reported to her that she was experiencing urgency with urination, but could not always urinate. QMA 4 reported it to LPN 3. LPN 2 verified there was no documentation of an assessment, the change in condition with urination or a urinalysis labs completed for the resident on 2/9/26. LPN 2 indicated an event should have been opened for the resident and the facility nurses would follow up on the resident for 72 hours. An event was opened up for anything new like the urgency with urination. There was no event started for the resident. LPN instructed QMA 4 to put a urine collection container in the resident's toilet so they could test her urine for a UTI and to start encouraging fluids. During an interview with the Director of Nursing Services (DNS) on 2/10/2026 at 2:15 p.m., the DNS (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated she would expect LPN 3 to follow up with Resident 72 after QMA 4 had reported to her the resident's concerns. Review of the record of Resident 72 on 02/12/2026 at 1:53 p.m., indicated the resident's diagnoses included, but were not limited to, history of urinary tract infection. The physician's order for Resident 72, dated 1/22/26, indicated staff may dip the resident's urine for signs and symptoms of a UTI. The care plan for Resident 72, dated 1/22/26, indicated the resident was at risk for a UTI. The care plan for Resident 72, dated 1/22/26, indicated the resident was continent, but was at risk for incontinence related to decreased mobility. The interventions included, but were not limited to, observe continence status and report changes as needed. The admission Minimum Data Set (MDS) assessment for Resident 72, dated 1/26/26, indicated the resident required supervision for ambulation and toileting. The resident was occasionally incontinent of urine. 3.1-41(a)(2)