STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165110	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Southeast Iowa Regional Medical - Klein Center	1307 South Gear Avenue West Burlington, IA 52655

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record, policy review, and staff interviews, the facility failed to obtain a consent and provide information about the risks and benefits of psychotropic medications (medications that affected the mind, altering a person's emotions, thoughts, perceptions, or behavior) for 5 of 6 residents reviewed for medications (Residents #5, #6, #13, #17, #109). The facility reported a census of 141 residents.Findings included: 1. The Minimum Data Set (MDS) assessment tool dated 4/29/26, list of diagnoses for Resident #5 included anxiety, depression, and delirium due to a known condition. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 6 out of 15, indicating severely impaired cognition. The MDS documented Resident #5 prescribed medications in the following high risk drug classes: antipsychotic, antianxiety, and antidepressants. A 7/15/23 Care Plan entry stated the resident would not exhibit side effects resulting from psychotropic medication use. A 6/11/25 Family Practice Office/Clinic Note documented the resident took the following medication: lorazepam (an anti-anxiety medication) 0.5 mg (milligrams) twice daily. A 5/27/26 Behavioral Health Office/Clinic Note documented the resident continued to take lorazepam 0.5 mg. The resident's clinical record lacked documentation the facility informed the resident or the resident representative of the risks and benefits of the medication, the treatment alternatives, or other options so the resident could make an informed choice. 2. Resident #6's MDS assessment tool dated 4/29/26, list of diagnoses included non-Alzheimer's dementia, depression, and high blood pressure. The BIMS score of 3 out of 15, indicated a severe cognitive impairment. The MDS documented Resident #6 prescribed medications in the following high risk drug classes: antipsychotic and antidepressants. A 6/18/21 Care Plan entry stated the resident would not exhibit side effects resulting from psychotropic medication use. Resident #6's Active Orders as of 6/18/26 included, in part: a. Aripiprazole (an antipsychotic medication) 4 mg. Start date 3/08/24. b. Bupropion (an antidepressant) 150 mg. First dose: 12/18/24. c. Duloxetine (an antidepressant) 120 (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mg, First dose 7/01/21. The resident's clinical record lacked documentation the facility informed the resident or the resident representative of the risks and benefits of the medication, the treatment alternatives, or other options so the resident could make an informed choice. On 6/18/26 at 1:11 p.m., via email, the Director of Nursing (DON) stated the facility did not have psychotropic medication consents for Resident #6 because the resident began the medications prior to when the consents began. 3. Resident #13's MDS assessment dated [DATE], list of diagnoses included vascular dementia, unspecified severity, with anxiety. The BIMS score of 5 out of 15 indicated a severe cognitive impairment. The MDS documented Resident #13 prescribed medications in the following high risk drug classes: antipsychotic, antianxiety, and antidepressants. The Care Plan revealed a focus area dated 5/22/26 for psychotropic medication use. Resident #13's Active orders as of 6/18/26 included: a. Amitriptyline (antidepressant) 10 mg. First dose 5/9/25. b. Quetiapine (antipsychotic) 12.5 mg. Ordered 6/4/26. The resident's clinical record lacked documentation the facility informed the resident or the resident representative of the risks and benefits of the medication, the treatment alternatives, or other options so the resident could make an informed choice. During an interview on 6/18/26 at 1:27 PM, Staff H, Registered Nurse (RN)/ Unit Manager queried on the psychotropic consents for Resident #13 and Staff H stated the facility didn't get a consent for amitriptyline because it was a medications Resident #13 has taken at home. Staff H explained Seroquel (quetiapine) got missed because it had been prescribed in the middle of the change in electronic health record systems. Staff H stated the expectation is for medication changes was the nurses spoke to the family about them. 4. The MDS assessment dated [DATE], revealed Resident #109 did not have a BIMS completed. The list of diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood, anxiety disorder. The MDS documented Resident #109 prescribed medications in the following high risk drug classes: antipsychotic and antidepressants. The Care Plan dated 5/4/26 revealed a focus area for psychotropic use. Resident #13's Active orders as of 6/18/26 included: a. Trazodone 50 mg. First dose: 5/19/26. b. Duloxetine 90 mg. First dose: 5/29/26. c. Risperidone 0.5 mg. First dose: 5/27/26. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Quetiapine 25 mg – First dose: 5/19/26. Per an email on 6/18/26 at 12:54 PM, the DON stated there was no psychotropic consent for Resident #109 as she was on psychotropic medications prior to arrival to the facility. During an interview on 6/18/26 at 1:10 PM, Staff H, RN Unit Manager queried on Resident #109 psychotropic consents and Staff H stated Resident #109 was on the psychotropic medications when Resident #109 came to the facility so the facility would of not gotten consents for the medications. During an interview on 6/18/2026 at 2:18 PM, the DON stated when the facility started or increased a medication, the facility received consents. The DON stated they did not do consents if a resident came into the facility with them because it didn't make sense if the resident was already taking them. 5. Review of the MDS assessment, dated 5/26/26 revealed a BIMS score of 13 out of 15, which indicated Resident #17 had intact cognition. The list of diagnoses included cerebrovascular accident (stroke), seizure disorder, and anxiety disorder. The MDS indicated Resident #17 prescribed medications in the following high risk drug classes: anticoagulant and antibiotic Review of a 6/05/26 Care Plan entry stated the resident would not exhibit side effects resulting from psychotropic medication use. Review of Resident #17 Active Order list revealed: a. Quetiapine 12.5 mg. First dose: 6/5/26. Review of an Internal Medicine Progress Note, dated 5/17/26 documented, in part. symptoms of delirium, with agitation at night, and was started on low dose of Quetiapine. Review of the resident's clinical record lacked documentation the facility informed the resident or the resident representative of the risks and benefits of the medication, the treatment alternatives, or other options so the resident could make an informed choice. During an interview on 6/17/26 at 3:20 PM, Staff R, RN Unit Manager, stated that Resident #17's order for quetiapine started during hospitalization for fall on 5/17/26 and order for this medication continued upon return to the facility. Staff R denied obtaining an informed consent for Resident #17's new psychotropic medication. The facility policy Informed Consent, revised 2/2026, stated residents had the right to make informed decisions regarding care. The policy stated this applied to all treatments requiring informed consent. The policy stated the facility would provide information such as the potential risks and benefits of the treatment and stated consents for recurring treatments were valid for up to 12 months.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review facility Call Logs resident and staff interview, the facility failed to ensure sufficient staff available to answer resident calls lights in a timely manner for 6 of 7 residents (Residents #160, #7, #142, #23, #122, and #8) in the sample. The facility reported a census of 141 residents.Findings included: 1. Review of the electronic health record (EHR) Face Sheet revealed Resident #160 admitted to the facility on [DATE], with a primary diagnosis of aftercare for healing traumatic fracture of the left hip. Review of Nursing Assessment and Intervention dated 6/9/26, revealed, in part, an Intervention for Resident #160 for Activity Bed Rest with exceptions; up in chair; ambulate with assistance. Review of a Nursing Note dated 6/15/26, revealed, in part, Transferring and ambulating short distances with assist of one staff, gb (gait belt) and walker. During an interview on 6/15/26 at 10:34 AM, Resident #160 reported concerns with staff answering her call light. Resident #160 explained earlier on this date she had turned her call light on at 6:34 AM, and no one answered the call light until 7:24 AM. She stated she had needed to use the toilet, and her bladder hurt by the time staff responded. During an interview on 6/17/2026 at 3:15 PM, the Administrator explained that staff had a work phone that they received notifications on for the resident call lights. She explained the Call Log included a heading, To Take, which identified when a staff person accepted that they would be the one to respond to a call light. Staff typed their response to take the call on their phone. Review of the Call Log for Resident #160 revealed: a. On 6/15/26, call light on at 6:37 AM for toileting assistance. Staff B, Certified Nursing Assistant (CNA), responded her intent To Take 55 minutes after the resident had turned her call light on. b. On 6/15/26 at 2:20 PM, call light on for toileting assistance. Staff A, CNA, responded her intent To Take 25 minutes after the resident turned the call light on. During an interview on 6/17/2026 at 3:36 PM, Resident #160 stated she knew the length of time she had to wait for her call light to be answered on 6/15/26 because she had used the clock in her room. The resident reported she had to wait about 30 minutes to use the toilet the afternoon of 6/15/26. On 06/17/2026 at 4:29 PM, during an interview, Staff A, CNA, explained that she could see on her phone when a resident turned their call light on. Staff A reported that staff could usually respond to call lights within 15 minutes, unless they were tied up with another resident. Staff A reported she had worked with Resident #160 on Monday evening, 6/15/26. Staff explained that first shift should have taken the resident's call light at 2:20 PM. Staff A reported that she did not come in for her evening shift report until 2:20 PM to 2:30 PM. The length of report time depended, but it was no longer than 10 to 15 minutes. During an interview on 6/17/2026 at 4:37 PM, Staff B, CNA, reported that she received shift report at (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	about 6:30 AM, and report usually lasted about 15 to 20 minutes. If a call light was turned on between 6:30 AM to 6:40 AM, Staff B explained that usually night shift responded to those call lights. Staff A reported one of the day shift CNAs would respond if all of the night shift CNAs were helping residents. Staff B reported when a resident turned their call light on, it showed up on the work phone of all staff working the neighborhoods on this floor. Staff B reported she pressed take on her phone to indicate that she was taking the call light, and she normally pressed take when she was on her way to the resident's room. Staff B confirmed she worked with Resident #160 on Monday day, 6/15/26. Staff B explained that she had given another resident a shower first before responding to Resident #160's call light. Staff B reported Staff E, Physical Therapy Assistant (PTA) was going by Resident #160's room, and went into Resident #160's room just before Staff B got there. Staff B reported Resident #160 did say something about her call light had been on and needing to go to the bathroom. On 6/18/2026 at 11:12 AM, during an interview, Staff E, PTA, confirmed she had worked on Monday, 6/15/26, during the day. Staff E explained she had been walking down the hall around 7:20 AM to 7:30 AM to go to another resident's room when she heard Resident #160 say something. Resident #160 reported she had been waiting a long time for staff and needed to go to the bathroom. Staff E, PTA, reported she had gone into the resident's room less than a minute before Staff B, CNA. 2. Review of the Minimum Data Set (MDS) assessment for Resident #142 dated 5/16/26, revealed a diagnosis of multiple sclerosis and the Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated intact cognition. The MDS indicated the resident had impairments on both sides upper and lower body, and dependent on staff for all activities of daily living (ADLs). During an interview on 6/15/2026 at 11:10 AM, Resident #142 reported she did not feel the facility had enough staff. Resident #142 explained she had to wait until they had two staff available to help her transfer with the Hoyer (type of mechanical lift). She reported there were times she had to wait more than 15 minutes for staff to answer her call light, and she recently had to wait one, one-half hours for staff to help transfer her from her bed to her wheelchair. Review of the Call Log for Resident #142 revealed: a. On 6/14/26, call light on at 4:52 PM for assistance with transferring. A CNA responded their intent To Take 44 minutes after the resident had turned her call light on. b. On 6/16/26, call light on at 4:54 PM. A CNA responded their intent To Take 33 minutes after the resident had turned her call light on. c. On 6/16/26, call light on at 9:00 AM for transfer assistance. Staff C, CNA, responded her intent To Take 20 minutes after the resident had turned her call light on. During an interview on 6/18/2026 at 9:35 AM, Staff C, CNA, reported she worked on the same neighborhood (unit) that Resident #142 resided. Staff C reported when a resident turned their call light on, she would click a button on her phone to take the call prior to entering the resident's room. She would then go to the resident's room, turn off the call light and mark complete on her phone. Staff C, CNA, reported if the call log report identified it took her 20 minutes to take the call light for Resident #160 on 6/16/26, then that was probably accurate. Staff C explained they had a lot of heavy care residents, and they struggled at times to meet the needs of the residents. The last 2 to 3 weeks had been very difficult, and Staff C reported she expressed concerns to the Director of Nursing (DON). In addition to heavier care residents, Staff C felt like she was training new staff every day. Staff C (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported she had remembered a specific incident last week when she and another CNA had been assisting a resident for about 45 minutes, and Resident #142 had been waiting during that time for assistance. Staff C explained that it doesn't usually happen, but there had been times that Resident #142 had to wait for one and one-half hours to transfer. 3. Review of the MDS Assessment for Resident #7 dated 5/9/26, revealed a BIMS score of 15 out of 15 which indicated an intact cognition. The MDS listed a diagnosis of stroke, with impairments on one side both upper and lower body, and required partial to moderate assistance with toileting and transfers. During an interview on 6/15/2026 at 10:59 AM, Resident #7 stated there were times she used the call light and had to wait more than 15 minutes. She thought it was worse over the last couple weeks. Review of the Call Log for Resident #7 revealed: a. On 6/10/26 at 1:06 PM, call light turned on for toileting assistance. A CNA responded their intent To Take 33 minutes after the resident had turned on the call light. b. On 6/10/26 at 7:20 AM, call light turned on for toileting assistance. A CNA responded their intent To Take 1 hour and 13 minutes after the resident had turned on the call light. c. On 6/13/26 at 4:20 PM, call light turned on for toileting assistance. A CNA responded their intent To Take 24 minutes after the resident turned on the call light. d. On 6/15/26 at 8:37 AM, call light turned on for toileting assistance. Staff D, CNA responded her intent To Take 27 minutes after the resident turned on the call light. During an interview on 6/18/2026 at 10:32 AM, Staff D, CNA, reported she would press take on her phone prior to answering call lights for residents. She explained that if she was helping another resident, she would not accept a call light for another resident. Staff D reported that if the call log identified it took her 27 minutes to take a call for Resident #7, then that would be accurate. Staff D reported that there were times it took a long time to get Resident #142 transferred because they needed two aides to transfer the resident. During an interview on 6/18/26 at 2:23 PM, the Director of Nursing (DON) reported being aware of staffing concerns. The DON reported Resident #160 had complained of being left on the toilet for long periods of time, but review of the call log revealed the longest staff had left the resident on the toilet was 20 minutes. The DON explained that she understood 20 minutes could feel like a long time, but they had a lot of other residents to take care of. The DON reported she had a staff person come to her and express concern over the heavy loads on the neighborhoods that Residents #160, #142 and #7 resided on. The DON reported she was looking at increasing staffing for all units by adding a float CNA for each area and explained they had an increase in acuity. The DON reported staffing concerns on the memory unit as well. Review of the facility's job description, titled CNA/Universal Worker, dated 2/20/26, revealed, in part, .Utilizes a resident centered approach based on resident centered principles to provide personal care and assistance with activities of daily living. The CNA/ Universal Worker provides each resident with routine daily nursing care and other desired services in accordance with the resident's assessment, choices, and care plan under the supervision of a licensed nurse to ensure the highest degree of (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	quality of care is maintained at all times. 4. The MDS assessment dated [DATE], revealed Resident #8 had a BIMS score of 14 out of 15, which indicated intact cognition. Review of the Call Log for Resident #8 revealed: a. On 6/02/26 at 6:50 AM, call light turned on. A staff responded their intent To Take 52 minutes and 5 seconds after the resident turned on the call light. b. On 6/06/26 at 9:57 AM, call light turned on. A staff responded their intent To Take 52 minutes and 16 seconds after the resident turned on the call light. c. On 6/08/26 at 9:58 PM, call light turned on. A staff responded their intent To Take 52 minutes and 32 seconds after the resident turned on call light. d. On 6/09/26 at 2:37 PM, call light turned on. A staff responded their intent To Take 30 minutes and 12 seconds after the resident turned on the call light. e. On 6/11/26 at 10:00 AM, call light turned on. A staff responded their intent To Take 2 hours, 56 minutes, and 41 seconds after the resident turned on the call light. f. On 6/14/26 at 9:49 PM, call light turned on. A staff responded their intent To Take 25 minutes and 6 seconds after the resident turned on the call light. During an interview on 6/15/26 at 10:00 AM, Resident #8 stated it often could take a half hour or more for staff to answer call light when she pushes it for help. Resident #8 reported that long call light waits times happen at any time of the day depending on staffing available for the shift. 5. The MDS assessment dated [DATE], revealed Resident #23 had a BIMS score of 15 out of 15, which indicated intact cognition. During an interview on 6/15/26 at 9:29 AM, Resident #23 queried on staffing and Resident #23 stated they felt the facility short staffed on the weekends. Resident #23 stated she had sat over 15 minutes for someone to help when she was in the bathroom. Resident #23 stated she called the nurse's station after 15 minutes when staff did not come. Review of the Call Log for Resident #23 revealed: a. On 6/6/26 at 9:54 PM, call light turned on. A staff responded their intent To Take 35 minutes and 46 seconds after the resident turned on the call light. b. On 6/12/26 at 11:37 AM, call light turned on. A staff responded their intent To Take 44 minutes 28 seconds after the resident turned on the call light. 6. The MDS assessment dated [DATE], revealed Resident #122 had a BIMS score of 13 out of 15, which indicated intact cognition. During an interview on 6/15/26 at 2:38 PM, Resident #122 queried on call lights and Resident #122 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, staff interview, and facility policy review the facility failed to follow infection control procedures to prevent potential cross contamination during a blood draw procedure performed on 1 of 6 residents (Resident #17) reviewed for infection control, when the specimen drawn was placed on a clean dining room table. The facility also failed to prevent potential cross contamination during the laundry process in 1 of 10 units observed, when clean personal linens were placed on potentially contaminated public seating surfaces. The facility reported a census of 141 residents. Findings include:1. During an observation on 6/16/26 at 8:41 AM, Resident #17 sat at a dining room table with 2 other residents, the 3 residents continued to have a plate of breakfast set on the table in front of them. Staff S, Registered Nurse (RN), approached Resident #17 at the dining room table and collected blood specimen from Resident #17's left forearm. Staff S completed the blood draw from Resident #17, then set the vial containing the blood specimen on top of the dining room table without a barrier in place to prevent contamination of the clean surface. During an interview on 6/16/26 at 12:25 PM, Staff S confirmed performing a blood draw on Resident #17 on 6/16/26 at 8:41 AM for a Keppra (levetiracetam) level (measures the concentration of the anti-epileptic medication within the blood) as ordered by the provider. Staff S reported that Resident #17 doesn't mind having medications given or anything else done in the dining room. During an interview on 6/18/26 at 12:05 PM, Staff U, Infection Preventionist Nurse, revealed the expectation of nursing staff to place a barrier between clean surface and blood draw supplies to prevent the potential of cross contamination. During an interview on 6/18/26 at 2:51 PM, the Director of Nursing (DON), revealed the expectation of nursing staff to complete resident blood draw procedures in private area or in the resident's room and not in the common area or at the dining room table due to concern for resident infection control and preserving resident dignity. The DON revealed the expectation of nursing staff to place a barrier between clean surface and blood draw supplies to prevent the potential of cross contamination. Review of the facility policy titled, Specimen Collection Procedure, not dated, revealed the following Principle statement: To ensure accurate and reliable laboratory results, specimen collection adheres to specific principles, including using the correct collection method, proper identification of patient, aseptic technique, proper labeling, timely transport of specimens, and appropriate storage to maintain specimen integrity. 2. During an observation on 6/15/26 at 1:31 PM, a Certified Nursing Assistant (CNA) staff placed a laundry basket with a cloth fabric covering on top of a couch in a common area, located in the hallway outside of the laundry room and near the common area. The CNA folded the clean resident clothing and with no clean barrier on the couch, stacked the clean linen directly on the seat and armrest before returning the clothing to the basket and proceeding to deliver the laundry to resident rooms. During an observation on 6/17/26 at 12:21 PM, staff placed resident clothing in a laundry basket on top of the couch. Staff also hung shirts on hangers directly on the seat of the couch without a clean barrier. During an interview on 6/17/26 at 10:00 AM, Staff P, CNA, stated that staff on each unit wash and dry the resident's laundry and fold or hang clean clothing near the common area at the couch or kitchenette counter to provide resident supervision. During an interview on 6/17/26 at 3:20 PM, Staff R, RN Unit Manager, stated clean resident clothing should either be folded in the laundry room or taken to the resident room to be folded, hung, and put away. During an interview on 6/18/26 at 12:05 PM, Staff U, Infection Preventionist Nurse, revealed the expectation that staff either fold clean resident clothing in the laundry room or on top of a clean surface and not on a public couch without a barrier, to prevent contamination of clean linen.During an interview on 6/18/26 at 2:51 PM, the Director of Nursing (DON) revealed the expectation of staff to fold clean resident clothing on top of a clean surface to prevent contamination of clean linens. Review of the facility policy titled, Laundry and Linens dated 7/2025, revealed a Purpose section which declared To identify the process for laundry and linen handling. The Section titled, Personal Clothing instructed, in part: 1. Each household has on-site laundry facilities to minimize risk of lost or damaged resident clothing. 2. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident clothing is washed with the facility provided and approved laundry agents. Resident laundry will be done in individual loads that are designated by baskets assigned to that room number. The basket will be placed on top or in front of the washer/dryer to designate that resident's laundry. For soiled clothing, the hopper may be used and the appropriate pretreatment laundering agents to remove visible debris. Staff should use good hand hygiene after handling soiled or dirty laundry. Staff should wear gloves and consider aprons or gowns when handling soiled or dirty laundry. Staff should use minimal agitation when handling soiled/dirty laundry to decrease contamination of the air. 3. Once laundry is thoroughly washed and dried it will be returned to the resident's room.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and the facility policy, the facility failed to have a resident's Iowa Physician Orders for Scope of Treatment (IPOST) and provider's orders on the electronic health record match for 1 of 2 residents reviewed for advanced directives (Resident #13). The facility reported a census of 141 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] revealed Resident #13 scored a 5 out of 15 on the Brief Interview for Mental Status (BIMS), which indicated cognition severely impaired. The MDS indicated medical diagnosis for vascular dementia, unspecified severity, with anxiety. The Review of the signed IPOST dated [DATE] indicated Cardiopulmonary Resuscitation (CPR). The Review of the electronic health record (EHR) for Physician Orders indicated Do Not Resuscitate dated [DATE]. During an interview on [DATE] at 8:20 AM, Staff F, Registered Nurse (RN) queried where advanced directives or IPOST were located and Staff F pulled down a binder in the nurse's station and could not locate a paper form for Resident #13. Staff F stated she would speak to the Unit Manager when the Unit Manager came in. During an interview on [DATE] at 1:45 PM, Staff G, RN asked where she looked for advanced directives and Staff G stated to click on the resident's picture in the EMR and demographics would come up and then Staff G could see the advanced directives. Staff G stated she tried to think if Resident #13 had an IPOST, but Staff G knew Resident #13 was a DNR. Staff G stated the previous EMR would indicate if Resident #13 had an IPOST and Staff G would have to look in the binder because the facility tried to make sure everyone had an IPOST. During an interview on [DATE] at 3:35 PM, Staff H, Unit Manager stated she didn't realize Resident #13 had an IPOST before coming to the facility and the family didn't provide the IPOST. Staff H stated the IPOST was scanned into Resident #13 record a year and half ago. Staff H queried on the process for IPOST and Staff H stated the facility usually asked the family if they wanted one and completing an IPOST was not something the facility automatically completed. Staff H stated Resident #13 admission documentation was where Staff H found Resident #13 was a DNR. During an interview on [DATE] at 4:07 PM, Staff I, RN queried where the resident's advanced directives were located and Staff I stated he was not really sure. Staff I stated some where located in the charting room. Staff I informed Resident #13 did not have advanced directives in the binder and Staff I stated he would speak to the family to see what they wanted. Staff I informed the IPOST in the EMR was CPR and the order indicated DNR and Staff I stated he would speak to the Unit Manager to make sure the orders matched. During an interview on [DATE] at 1:24 PM, Staff H stated looking for resident's IPOST was not something she would go looking for and Social Services would scan them in, if a resident had one. Staff H stated she just went through the papers given to her when a resident admitted . During an interview on [DATE] at 2:15 PM, the Director of Nursing (DON) queried on Resident #13 IPOST indicated CPR and Resident #13 orders indicated DNR and the DON stated a resident didn't have to have an IPOST and in this situation how the facility came to the order of a DNR and who had the conversation with the family about the advance directives. The Facility Advanced Directives Policy dated 10/2024 revealed: a. At the time of admission, the resident will be given written information regarding resident rights and Advance Directives. If there is an Advance Directive already in place, the resident will be requested to furnish the facility with a copy. 1. If the resident does not have an Advance Directive but wishes to make one Social Services will assist with the notarization process. 2. If the resident is unable to supply a copy of their Advance Directive, Social Services will follow-up with the family until a copy is obtained for the record.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, staff interview, and clinical record review, the facility failed to provide Resident #17 with privacy during a blood draw when procedure was performed at dining room table during a meal with other residents present for 1 of 3 residents (Resident #17) reviewed for dignity. The facility reported a census of 141 residents.Findings include:Review of the Minimum Data Set (MDS) Assessment, dated 5/26/26, revealed Resident #17 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15 which indicated intact cognition. The list of diagnoses included cerebrovascular accident (stroke), seizure disorder, and anxiety disorder. Review of Resident #17's Active Order list, dated 6/18/26, revealed a laboratory order for routine levetiracetam (brand name Keppra) level (measures the concentration of the anti-epileptic medication within the blood to ensure at a therapeutic level), started on 6/05/26, with instructions for the nurse to collect blood specimen. During an observation on 6/16/26 at 8:41 AM, Resident #17 sat at a dining room table with 2 other residents, the 3 residents continued to have a plate of breakfast set on the table in front of them. Staff S, Registered Nurse (RN), approached Resident #17 at the dining room table and collected blood specimen from Resident #17's left forearm. Staff S completed the blood draw from Resident #17, then set the vial containing the blood specimen on top of the dining room table without a barrier in place to prevent contamination of the clean surface. During an interview on 6/16/26 at 12:25 PM, Staff S, RN stated she did perform a blood draw on Resident #17 on 6/16/26 at 8:41 AM for a Keppra level. Staff S reported that Resident #17 doesn't mind having medications given or anything else done in the dining room. During an interview on 6/17/26 at 9:42 AM, Staff T, RN, stated blood draws would be done in a resident's room for maintaining resident dignity. During an interview on 6/17/26 at 3:20 PM, Staff R, RN Unit Manager, stated that blood draw should not be completed at the dining room table during meals because no one would want to see that while they're eating. During an interview on 6/18/26 at 2:51 PM, the Director of Nursing (DON), revealed the expectation of nursing staff to complete resident blood draw procedures in private area or in the resident's room and not in the common area or at the dining room table due to concern for resident infection control and preserving resident dignity.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff interview, the facility failed to complete reviews for gradual dose reduction for residents prescribed psychotropic medications, failed to attempt non-pharmacological interventions prior to the administration of as needed anti-anxiety medication, and failed to ensure as needed psychotropic medication orders did not exceed 14 days without a physician review for 3 of 6 residents (Resident#5, Resident #13 and Resident #109) reviewed for unnecessary medications. The facility reported a census of 141 residents. Findings included: Based on clinical record review, policy review, and staff interview, the facility failed to complete reviews for gradual dose reduction for residents prescribed psychotropic medications, failed to attempt non-pharmacological interventions prior to the administration of as needed anti-anxiety medication, and failed to ensure as needed anti-anxiety medication orders did not exceed 14 days for 3 of 6 residents (Resident#5, Resident #13 and Resident #109) reviewed for unnecessary medications. The facility reported a census of 141 residents. Findings included: 1. The Minimum Data Set (MDS) assessment tool dated 4/29/26, list of diagnoses for Resident #5 included anxiety, depression, and delirium due to a known condition. The MDS listed the resident's Brief Interview for Mental Status (BIMS) score as 6 out of 15, indicating severely impaired cognition. The MDS documented Resident #5 prescribed medications in the following high risk drug classes: antipsychotic, antianxiety, and antidepressants. A 7/15/23 Care Plan entry stated the resident would not exhibit side effects resulting from psychotropic medication use. A 6/11/25 Family Practice Office/Clinic Note documented the resident took the following medications: lorazepam (an anti-anxiety medication) 0.5 milligrams (mg) twice daily and sertraline (an antidepressant) 50 mg daily. A 5/27/26 Behavioral Health Office/Clinic Note documented the resident continued to take lorazepam 0.5 mg twice daily and sertraline 50 mg daily. The facility lacked documentation of a gradual dose reduction (GDR, the tapering of the dose to determine if symptoms, conditions or risks can be managed by a lower dose or the medication possibility discontinued) carried out during the time period of 6/11/25 to 5/27/26 and lacked documentation of a clinical rationale as to why the GDR was contraindicated. On 6/17/26 at 10:40 a.m., Staff M, Registered Nurse (RN) Manager, stated the facility did not have GDR information because they increased the resident's medications. When queried regarding a GDR for the other psychotropic medications which did not have an increase, she stated the last one she located was from 2024. On 6/17/26 at 3:30 p.m. via email, the Administrator stated the facility did not have a policy related to GDRs. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The MDS assessment dated [DATE], revealed Resident #109 did not have a BIMS completed. The list of diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood, anxiety disorder. The MDS documented Resident #109 prescribed medications in the following high risk drug classes: antipsychotic and antidepressants. Review of Resident #109's Care Plan dated 5/4/26, revealed a Focus area for psychotropic use. Interventions included observing and monitor changes in mood, behavior, or mental status and document any problems; and provide medications as ordered and monitor their effectiveness. Resident #13's Active orders as of 6/18/26 included: quetiapine (brand name Seroquel) 25 mg – 1 tablet TID (three times a day) PRN (as needed) dated 5/19/26. No end dated indicated. The June 2026 Medication Administration Record (MAR) Seroquel PRN given on the following dates with no interventions documented under psychotropic medication behavior: 6/9 at 3:59 PM, 6/10 at 10:07 AM, 6/11 at 9:47 AM and 5:49 PM, 6/12 at 8:44 AM and 3:25 PM, 6/13 at 11:39 AM, 6/14 at 6:16 AM and 1:32 PM, 6/15 at 12:25 AM, 6/16 at 9:44 AM, and 6/17 at 12:00 PM During an interview on 6/18/26 at 1:04 PM, Staff G, Registered Nurse (RN) stated the facility did mood assessments twice daily and before a PRN administered, the nurse would document interventions. During an interview on 6/18/26 at 1:10 PM, Staff H, RN Unit Manager queried on the interventions prior to PRN medication use and Staff H stated the interventions needed documented either in the progress notes or under the flowsheets, and whether or not the staff were doing it was another story. During an interview on 6/18/26 at 1:30 PM, Staff F, RN queried about giving a PRN and Staff F stated she would document the interventions tried before administering the PRN medication under progress notes. Staff F stated staff should be using at least 3 interventions before giving a PRN and then documenting the interventions. During an interview on 6/18/26 at 2:11 PM, the Director of Nursing (DON) queried on GDRs and the DON stated the facility should have the pharmacy do reviews and the pharmacist should recommend GDRs to the provider and the provider needed to follow up on the request and document why they recommended the GDR or not. During an interview on 6/18/26 at 2:20 PM, the DON stated she didn't have any reason for the quetiapine to not be a 14-day order. The DON confirmed staff should document the interventions tried before giving a PRN medications. 3. Resident #13's MDS assessment dated [DATE], diagnoses list included vascular dementia, unspecified severity, with anxiety. The BIMS score of 5 out of 15 indicated a severe cognitive impairment. The MDS documented Resident #13 prescribed medications in the following high risk drug classes: antipsychotic, antianxiety, and antidepressants. The Care Plan revealed a Focus area dated 5/22/26 for psychotropic medication use. Review of Resident #13 Active Orders revealed order for amitriptyline 10 mg at bedtime dated 5/22/25. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility lacked documentation for any GDR for the amitriptyline. During an interview on 6/18/26 at 2:18 PM, the DON stated Resident #13 should have had a GDR completed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, resident and staff interviews, the facility to ensure only licensed nursing staff applied a prescribed topical medication for 1 of 1 resident (Resident #23) reviewed for professional standards. The facility reported a census of 141 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE], revealed Resident #23 with intact cognition based on a Brief Interview for Mental Status (BIMS) score of 15 out of 15. m, which indicated cognition intact. Review of the electronic health record (EHR) revealed an order for clotrimazole (lotrimin) 1% cream topical, 2 times daily- administration instructions: topically to groin and breast folds for redness ordered on 6/6/26 and discontinued on 6/17/26During an interview on 6/17/26 at 11:57 AM, Resident #23 stated the Certified Nurse Assistants (CNA) put a prescribed cream on her and then takes the cream back to the nurses to put back in the medication cart. During an interview on 6/18/26 at 9:55 AM, Staff J, CNA queried if they had ever applied prescribed cream to Resident #23 and Staff J stated yes. Staff J explained the nurse gave them a cup of cream and the Staff J had applied it under Resident #13 folds. Staff J stated they applied the cream in the mornings and also on the night shift. During an interview on 6/18/26 at 10:02 AM, Staff K, Registered Nurse queried if the CNA apply prescribed cream to the residents and Staff K stated are supposed to apply prescribed cream, but sometimes to get things done, CAN's occasionally helped with it. Staff K queried if Staff K ever asked a CNA to apply a prescribed cream and they confirmed they had. During an interview on 6/18/26 at 10:34 AM, Staff L, CNA queried if they ever applied a prescribed cream to Resident #23 and Staff L stated yes, an antifungal cream that the nurse provided. During an interview on 6/18/26 at 11:06 AM Staff V, Unit Manager queried if CNA can apply prescribed creams to the residents and Staff V stated no, the nurse should be applying prescribed creams. During an interview on 6/18/26 at 2:11, the Director of Nursing (DON) confirmed the CNAs should not be applying prescribed ointments on the resident. The DON stated the CNAs should notify the nurse when the resident was ready for the cream. Review of the facility CNA/Universal Worker Job Description revised on 02/20/26, revealed the essential function for personal care: Bathing and dressing residents as care planned and as needed ensuring that the residents are properly and comfortably clothed. Combs hair, shaves resident, trims nails, and assists with personal and dental hygiene.Review of the facility LPN (Licensed Practical Nurse) Job Description dated 01/06/25, revealed the following essential functions: Administer prescribed medications adhering to the six rights of medication administration, IV fluids, enteral feedings, monitoring their effectiveness, and addressing needs.Review of the facility RN Job Description dated 3/30/26, revealed the following essential functions: Administer prescribed medications adhering to the six rights of medication administration, IV fluids, enteral feedings, monitoring their effectiveness, and addressing needs.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review and staff interview, the facility failed to maintain an environment free from accident and hazards by ensuring staff safely pushed wheelchairs with footrests in place during the transport of 2 of 5 residents (Resident #10 and Resident #138) reviewed for safety. The facility reported a census of 141 residents. Findings include:1. Review of Resident #138's Minimum Data Set (MDS) assessment dated [DATE], revealed a Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicating a moderate cognitive impairment. The list of diagnoses included Parkinson's disease, anxiety disorder, depression, and chronic pain syndrome. The MDS indicated Resident #138 had one side lower extremity impairment, utilized a walker and wheelchair for mobility and independently propelled the wheelchair. The MDS identified the resident had 2 or more falls without injury since the previous assessment.Review of Resident #138's Plan of Care initiated on 3/13/26, revealed a Plan for Falls with the Outcome of I will not sustain any bony injury from a fall. The Intervention directed Follow fall prevention interventions written on Care Plan and update PRN (as needed) after a fall.During an observation on 6/16/26 at 8:53 AM, Staff N, Certified Nursing Assistant (CNA) pushed Resident #138's in her wheelchair, with no foot pedals attached from the resident's room to the dining room, and then from the dining room into the common living area. Resident #138 walked her feet long the floor while being pushed. 2. Review of Resident #10's MDS assessment dated [DATE], revealed a BIMS score of 15 out of 15, indicating intact cognition. The list of diagnoses included osteoarthritis, general anxiety disorder, depression, and abnormalities of gait and mobility. The MDS indicated Resident #10 had impairment on both sides of upper and lower extremities, utilized a walker and wheelchair for mobility independently propelled the wheelchair. The MDS identified the resident had had no falls since the previous assessment.Review of Resident #10's Plan of Care, the Care Plan initiated on 2/13/24, revealed a Plan for Falls with the Outcome come of I will not sustain any bony injury from a fall. Intervention instructed staff to follow fall prevention interventions written on Care Plan and update PRN after a fall and to refer to mobility in fall intervention Care Plan.During an observation on 6/17/26 at 1:00 PM, Staff O, CNA, pushed Resident #10's wheelchair, without foot pedals applied, from the dining room area to Resident #10's room, while Resident #10 held her legs up above the ground. During an interview on 6/17/26 at 10:00 AM, Staff P, CNA, stated that staff are expected to apply foot pedals to wheelchairs and ensure a resident's feet are placed on the foot pedals prior to transporting residents in a wheelchair to prevent injuries.During an interview on 6/18/26 at 11:55 AM, Staff Q, CNA, stated that staff are expected to apply foot pedals to wheelchairs prior to pushing the chair because the resident could fall out.During an interview on 6/17/26 at 3:20 PM, Staff R, Registered Nurse (RN) Unit Manager, stated the expectation was for staff to ensure foot pedals are applied to wheelchairs and the resident's feet placed on foot pedals prior to transportation in a wheelchair.During an interview on 6/18/26 at 2:51 PM, the Director of Nursing (DON), revealed the expectation of staff to apply foot pedals to resident wheelchairs prior to transportation, and stated this should be done anytime a wheelchair is being pushed.