STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165186	A. Building B. Wing	05/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Good Samaritan - Indianola	708 South Jefferson Indianola, IA 50125

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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 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Deficiency Text Not Available

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, and staff and resident interviews, the facility failed to ensure hot foods were held at minimum required temperatures for 1 of 1 meals observed and for 2 of 18 interviewable residents reviewed for food(Residents #50 and #47). The facility reported a census of 80 residents.Findings included: 1. On 5/13/26 at 12:22 p.m., Staff A [NAME] prepared a test tray and placed it on a food cart in the kitchen. Staff A continued to plate meals and place them on the cart. At 12:28 p.m. Staff D [NAME] brought the cart out of the kitchen and took it to the nursing station. Staff started passing room trays at 12:30 p.m. and Staff E Certified Medication Assistant(CMA) distributed the last resident tray at 12:34 p.m. The surveyor immediately obtained the following temperatures from the test tray utilizing a facility-provided thermometer:Mashed potatoes: 126 degrees FahrenheitCarrots: 131 degrees Fahrenheit The surveyor tasted the above foods and they were warm but not hot. On 5/13/26 at 3:29 p.m. the Nutrition and Food Manager stated food should be held at a minimum of 135 degrees Fahrenheit but stated they wanted it to be above this. The facility policy Food Temperature Monitoring, reviewed 3/23/26, higher than 135. 2. Review of the clinical record for Resident #50 revealed he scored 13 on his Brief Interview for Mental Status, indicating intact cognition. In an interview on 5/11/26 at 1:25 PM Resident #50 stated he gets his food last an it's not always warm. They also don't always use a cloche to cover the food when they bring it. 3. The MDS assessment dated [DATE] revealed Resident #47 had a Brief Interview for Mental Status score of 15, indicating intact cognition. In an interview on 5/11/26 at 2:51 PM, Resident #47 reported the food was often cold and tasteless. Resident #47 stated she did not look forward to the meals that were served at the facility.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident and staff interview and policy review the facility failed to ensure the call light was within reach for 2 of 20 residents sampled (Resident #63 and #72). The facility reported a census of 80 residents.Findings include:1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had a Brief Interview for Mental Status (BIMS) score of 13 out of 15, indicating intact cognition. The MDS recorded the resident had dependence on staff for bed mobility and transfers, and had impaired range of motion to the upper extremity on one side. The Care Plan revised 1/22/26 revealed Resident #63 had a performance deficit in activities of daily living (ADL's) related to extremity weakness and paralysis, and at risk for falls. The Care Plan directed staff to modify the environment to maximize safety. During observation on 5/11/26 at 12:40 PM, observed the call light cord wrapped on the bed handrail. Resident #63 reported he had trouble reaching the call light. Resident #63 had contractures to his hand and fingers. On 5/13/26 at 1:25 PM, observed Resident #63 lying in bed on his back. The call light was lying on the floor by the bed. In an interview on 5/14/26 at 12:30 PM, Staff C, Clinical Care Lead, reported he expected the call light kept in reach for the resident. Staff C reported he planned to check with maintenance about getting a touch pad call light for Resident #63. 2. The MDS dated [DATE] indicated that Resident #72 had diagnoses of paraplegia, multiple sclerosis, muscle weakness and lack of coordination. It also indicated that she was dependent on staff for toilet hygiene, personal hygiene, toilet transfer, sit to stand and chair/bed-to-chair transfers. She also needed partial/moderate assist to roll left and right in her bed. She had a Brief Interview for Mental Status (BIMS) score of 14 indicating she was cognitively intact. The Care Plan initiated on 11/14/24 lacked documentation of call light use or being in reach of Resident #72. During an observation on 5/11/26 at 1:01 PM observed Resident #72 in her bed and did not have her call light within reach and actually waved to the surveyor to come into the room. Observed her call light lying over the side of the bed in the railing. Her roommate handed it to her. During an observation on 5/12/26 at 2:30 PM observed Resident #72 in her bed and waved at the surveyor to come into the room. She wanted her TV adjusted but her call light was noted to be lying over the bed railing and touching the floor. Her roommate handed it to her. During an observation on 5/14/26 at 9:25 AM observed Resident #72 in her wheelchair next to her bed. Her call light was not in reach and was actually on the bed railing behind her. In an interview on 5/11/26 at 1:01 PM Resident #72 stated she could not reach her call light. In an interview on 5/12/26 at 2:30 PM Resident #72 stated she needed her TV adjusted. The surveyor asked her to put on her call light. She stated that she could not reach it. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 5/14/26 at 9:25 PM Resident #72 stated that she could not reach her call light or even see it as it was behind her. In an interview on 5/14/26 at 9:28 AM Staff O, CNA was informed that Resident #72 could not reach her call light. She stated she should have had it and gave it to her. A Call Light policy reviewed/revised 7/8/25 revealed the call light placed within easy reach of the resident when staff leave the room. An adaptive call light provided if applicable.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, grievance/concern forms, and policy review the facility failed to ensure a system for tracking and making an effort to follow up on the residents' concerns regarding missing belongings for 2 of 3 residents reviewed for personal property (Resident #6 and #47). The facility reported a census of 80 residents. Findings include: 1.The Annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #6 had diagnoses of cerebral vascular accident (CVA) (stroke), Post-Traumatic Stress Disorder (PTSD), and depression. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognition. The MDS documented the care of personal belongings was very important to the resident. In an interview on 5/12/26 at 9:37 AM, a family member reported the facility had lost so many of Resident #6's clothes, a pair of black shoes and a blue walker with a seat that folded up had been missing in the past year. The family member voiced concern related to staff turnover and she thought the belongings came up missing after the resident got moved to another room. The family member reported the missing belongings was brought up at a care conference but nothing ever came of it. The family member was unaware of any grievance form.Review of Resident Inventory of Personal Effects forms, provided by the facility to the surveyor during the survey week, revealed no inventory form for Resident #6.A Grievance Suggestion or Concern form dated 2/16/26 revealed the resident reported colored t-shirts with pockets, white t-shirts, and six to eight white jockey shorts missing. On 2/18/26, an Investigation revealed clothing sent to the laundry daily. Laundry staff reported the resident's laundry was delivered on 2/17/26. Ancillary staff and Administrator aware of concern and continue to look for the articles. Will continue to investigate. On 2/19/26, the resident's son was to have more clothing delivered on 2/18/26 to have more pants and t-shirts in the closet. In an interview on 5/13/26 at 10:10 AM, Staff J, Social Services (SS), reported she started in the SS role on 12/1/25 and also worked at the facility for 2 years as a nurse prior to working in the SS role. Staff J stated she was told that the inventory sheets for resident belongings were kept at the nurse's station in a file. She cleaned the nursing station area often and never came across any inventory sheets. Staff J stated she filled out a grievance form if a resident reported something missing. The form was given to SS, the Director of Nursing (DON) and the Administrator. They notified ancillary staff to look for the item. She also checked the lost and found to see if they could find the item but a lot of times things were not labeled. Staff J reported she kept the paper inventory form in a file in the SS office effective 1/2026. The family was provided the inventory form to fill out and sign when a resident admitted to the facility. Another inventory form was filled out when additional items had been brought in for a resident. The inventory form was given to SS. In an interview on 5/13/26 at 10:20 AM, Staff H, Activities Assistant, reported she checked the resident rooms and tried to look for missing items whenever a resident reported something missing. She filled out a grievance form if a resident reported to her that something was missing. Staff H reported she was unaware of Resident #6's walker but she thought a family member took the walker home.In an interview on 5/13/26 at 1:20 PM, Staff F, certified nursing assistant (CNA) reported she filled out a grievance form if a resident had a concern or reported something missing. Staff F stated she also checked laundry to see if she could find the missing item. In an interview on 5/13/26 at 1:30 PM, Staff G, CNA, reported she looked for the missing item, checked the lost and found, and let SS, the DON, and the Administrator know when someone reported a concern about a missing item. Staff G reported the inventory forms should be located at the nursing station. At the time, Staff G checked the file cabinet and the nurse's station area on the 100/200 hall and found no inventory forms. On 5/13/26 at 1:40 PM, Staff J, SS, reported no any inventory forms found for Resident #6. In an interview on 5/14/26 at 12:30 PM, Staff C, Clinical Care Lead, reported Resident #6 had a pair of shoes but he thought the resident's wife took (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the shoes home. Staff C reported the inventory forms were filled out by SS, and the resident or family member signed the sign the form. A copy of the inventory form was placed on the back of the resident's room door. Staff updated the form whenever items were brought in or removed. Staff C reported the policy had not stuck. There had been a turnover in SS staff at the facility. 2. The annual MDS assessment dated [DATE] revealed Resident #47 had intact cognition. The MDS indicated the care of your personal belongings or things as very important to the resident. In an interview on 5/11/26 at 2:53 PM, Resident #47 reported her things went to the laundry but don't come back. The resident reported a dusty-rose colored pants with flowers on one pant leg had been missing for 6 months and she had many other clothing items lost. Resident #47 stated she let the facility staff know the items were missing but they never got replaced. Review of Resident Inventory of Personal Effects forms revealed no inventory form for Resident #47. In an interview on 5/13/26 at 10:20 AM, Staff H, Activities Assistant, reported Resident #47 misplaced items a lot. Staff H stated she often had to look for the things the resident reported missing. On 5/13/26 at 1:40 PM, Staff J, SS, reported no inventory form for Resident #47. A Grievance, Suggestions or Concerns policy reviewed/revised 12/15/25 revealed concerns are to be deemed high priority customer satisfaction issues. Facility staff will make prompt efforts to resolve a grievance and keep the resident/resident representative apprised of progress toward resolution. The admission Agreement revealed the facility is not liable for loss or damage of the resident's personal possessions unless such loss is the result of any negligent act or omission of the facility.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and family interviews, and policy review, the facility failed to provide documented evidence in the resident's medical record to support the basis to necessitate the resident's discharge and transfer to an affiliated facility. The facility also failed to provide the required 30-day advance notice of discharge to the resident's representative and the Long-Term Care State Ombudsman. The facility reported a census of 80 residents.Findings include:Resident #92's MDS assessment dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease, dementia with other behavioral disturbances, and diabetes mellitus. It revealed the resident required supervision with eating, required maximal assistance with oral hygiene, upper body dressing, bathing, and bed repositioning, and was dependent with all other ADLs and mobility.The Care Plan revised 5/17/23 included a focus which indicate the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. It also indicated the resident understood consistent, simple, direct sentences and directed staff to ask the resident yes/no questions to determine the resident's needs.A Health Status Progress Note dated 2/23/25 at 11:00 AM revealed the resident exhibited hypersexual behavior toward a female resident.An Incident Progress Note dated 2/23/25 at 12:58 PM revealed he was moved to a room closer to the nurses' station and by other male residents.A Health Status Progress Note dated 9/25/25 at 12:34 PM revealed the resident was no longer able to ambulate.The Progress Notes dated from 2/24/25 to 2/28/26 revealed the resident exhibited no sexual behaviors other than to staff. There is no progress note documentation that Resident #92 exhibited hypersexual behavior toward other residents.A Health Status Note Progress Note dated 10/06/25 3:11 PM revealed multiple medications, including the medication used to control the resident's hypersexual behaviors, were discontinued due to a decline in health.A Health Status Note Progress note dated 1/16/26 at 11:43 AM indicated the facility restarted the medication used to control the resident's hypersexual behavior.A SAFE Event-Incident Report - SPN Progress Note dated 2/28/26 at 1:32 PM indicated the resident was involved in a resident-to-resident, physical contact incident with another resident.A Communication/Visit with Physician Progress Note dated 3/03/26 at 2:28 PM revealed the medication used to control the resident's hypersexual behaviors was increased.A Hospice Progress Note dated 3/04/26 at 5:21 PM revealed the resident was on a 1:1 supervision with no sexual behaviors noted. There are no documented progress notes which indicated the resident exhibited hypersexual behaviors toward other residents after 3/02/26.A Communication with Resident/Family Progress Note dated 3/11/26 at 11:57 AM revealed the resident representative was notified the resident was being transferred to an affiliated facility. The Progress Note also revealed the representative was not happy with this decision and informed the facility they should give the medication longer to work. The Social Worker advised the representative they would keep her informed of the date and time of the resident's move.A Communication with Resident/Family Progress Note dated 3/18/26 at 10:54 AM revealed the resident was being discharged to the affiliated facility on 3/18/26 at 11:00 AM and would be living there permanently. It also revealed the resident's representative verbalized understanding. The facility provided no other documentation that the resident, the resident's representative, or the Long-Term Care State Ombudsman (LTCSO) was given the required 30-day notification of transfer and/or discharge.On 5/13/26 at 10:41 AM, Staff M, Certified Medication Aide (CMA) stated Resident #92 was hypersexual and moved to another area in the facility and isolated from women the day of the incident on 2/28/26. She also stated he on line-of-sight supervision. She further stated the resident would sit along at a dining table separated from female residents. She stated the incident on 2/28/26 was the only time the resident exhibited hypersexual behaviors toward another resident since she started in [DATE].On 5/13/26 at 11:01 AM, (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff B, Licensed Practical Nurse (LPN) stated the resident was moved to the rehabilitation area for more direct oversight. His room was in a location where staff could have direct observation of him if he were in his room. She also stated his only prior resident-to-resident incident was in early 2025. She further stated the resident was placed on hospice care in 2025 and no longer exhibited a risk.On 5/13/26 at 12:54 PM, the resident's representative stated she visited Resident #92 at the new facility and his room was not located in a locked unit. She stated the facility Administrator told her Resident #92 would get 1:1 supervision at the new facility. She also stated she was informed of the resident's transfer to another facility two (2) days prior to the scheduled date but it was delayed by one (1) week.On 5/13/26 at 1:36 PM, the Social Worker (SW) stated the resident had behaviors sexually grabbing at staff and residents. The facility contacted corporate because he was taken off of the medication that controlled his hypersexual behaviors. She also stated he inappropriately touched a resident on her thigh but added it was the first one he did in a long time. She further stated when he came off of hospice, he touched other residents and staff, so the facility contacted corporate to get him transferred to another affiliated facility, primarily within the same corporation. She said they tried to locate a facility with all-male units but their corporate owned facilities do not have one. She also said a second option the facility considered was to get him into another affiliated facility with fewer residents with a locked unit. She indicated the receiving facility had a locked unit and thought he was admitted to a room in the locked unit but wasn't sure. She admitted on [DATE] the resident had cognitive impairment and wouldn't have been able to understand why he was being transferred. She stated she was not directly involved in this transfer.On 5/13/26 at 1:51 PM, the Administrator stated after the 2/28/26 incident, he made a referral to an all-male unit two (2) separate facilities. One was full and the other denied acceptance based on unmet resident criteria. He further stated after the transfer referrals were unsuccessful, he and the DON contacted the receiving facility's Administrator, the DON, and the Senior Director of Long-Term Care to discuss the transfer. The Administrator and Director of Nursing (DON) stated the resident's BIMS was a 04 (out of 15), so he was not cognitively intact to understand his transfer. The Administrator also stated he discussed the transfer with the resident's representative but admitted she did not have input in the transfer location.On 5/13/26 at 1:59 PM, the DON stated the resident was moved to a room in a separate part of the facility so he could eat in that area's lower populated dining room. She also stated the resident's behaviors were directed toward staff and not at other residents after he changed rooms.On 5/13/26 at 2:24 PM, the Regional Clinical Services Director clarified the resident was admitted directly into the receiving facility's regular unit but in a low-stimulation area room.On 5/13/26 at 4:02 PM, the Administrator stated the resident's representative was in understanding of the transfer on 3/18/26. He stated there was no documentation of any other communication with her other than what was already in the EHR.On 5/14/26 at 10:56 AM, the SW confirmed the resident's representative was unhappy of the transfer because she verbalized it to the SW during a phone conversation on 3/18/26. The SW stated the representative stated moving the resident to the affiliated facility would limit her visitation ability to once monthly because of the extra 1 1/2 hour drive to the new facility. The SW also stated the representative indicated the facility hadn't given the resumed medication enough time to work. The SW revealed the Administrator notified her the resident was going to move to the receiving facility on 3/18/26 and asked her to contact the representative. The SW also stated the representative didn't verbalize any complaints on 3/18/26 when she was told the resident was leaving at 11:00 AM.A policy titled Discharge And Transfer-Rehab/Skilled, Therapy & Rehab revised 1/15/26 indicated When a transfer or discharge occurs, the location must ensure that the transfer or discharge is documented in the medical record and appropriate information is communicated to the receiving healthcare center or provider. The location permits each resident to remain in the location and does not transfer or discharge the resident from the location unless:The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the location. Documentation in the resident's record must include the specific resident needs that cannot be met, the location's attempts (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and family interview and policy review the facility failed to provide bed hold information for 3 of 3 residents admitted to the hospital (Residents #11, #1, #6) and failed to notify the resident, the resident's representative, or the Long-Term Care State Ombudsman (LTCSO) of a discharge at least 30 days in advance for 1 of 1 residents discharged (Resident #92). The facility reported a census of 80 residents.Findings included:1. The Minimum Data Set (MDS) dated [DATE] for Resident #11 lacked a Brief Interview for Mental Status (BIMS) score and had diagnoses of multiple sclerosis, quadriplegia and neurogenic bladder. The Electronic Health Record (EHR) indicated that Resident #11 had a suprapubic catheter and a history of Urinary Tract Infections (UTIs). She was transferred to the hospital on 5/5/26 for verbal unresponsiveness from baseline, dilated pupil and possible sepsis. She was admitted to the hospital for a UTI and altered mental status. The documentation revealed that the family was notified but did not include that a bed hold was offered or discussed. On 5/13/26 at 10:15 AM., via email, the Administrator indicated that there was no bed hold on file for Resident #11 for 5/5/26. 2. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 10 out of 15 which indicated moderately impaired cognition. It included diagnoses diabetes mellitus and traumatic brain injury. It revealed the resident was independent with eating, bed repositioning, sit-to-lying, and lying-to-sitting, required setup assistance with oral hygiene, moderate assistance with sit-to-stand and transfer mobility, and maximal assistance with all other Activities of Daily Living (ADLs) and mobility. The Care Plan revised 5/10/24 included a focus which indicated the resident had impaired cognitive function/dementia or impaired thought processes due to traumatic brain injury. A Health Status Note Progress Note on 12/19/25 at 3:17 PM revealed the resident experienced a drop in oxygen level and was sent to the hospital. An eINTERACT SBAR Summary for Providers Progress Note dated 12/19/25 at 3:19 PM revealed the nurse contacted the resident's representative but did not include documentation a bed hold was offered or discussed. The Clinical Census information indicated the resident changed to a hospital leave admission status. On 5/13/26 at 7:58 AM, Staff L, Licensed Practical Nurse (LPN) stated bed holds are documented on paper. The Electronic Health Record (EHR) document list did not include a bed hold or representative notification of hospital transfer for 12/19/25. On 5/13/26 at 9:04 AM, the Administrator stated the facility did not have a bed hold or resident representative notification of transfer documentation for Resident #1. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. The MDS assessment dated [DATE] revealed Resident #6 readmitted to the facility on [DATE] from the hospital. The Progress Note dated 3/3/26 at 10:08 PM, revealed the resident's spouse called with a concern about the resident possibly having a stroke. Resident observed in the dining room. He was responsive, alert and oriented, and leaning to his left side while seated in the wheelchair. Spouse notified of assessment but spouse still unsettled. Spouse requested evaluation at the hospital. The on-call provider was notified and approved to send the resident to the hospital. Resident was sent to the hospital at 7:49 PM. The record lacked documentation that a bed hold was offered or discussed. On 5/13/26 at 7:58 AM, Staff L, LPN, stated bed holds are documented on paper. In an interview on 5/14/26 at 12:50 PM, Staff B, Clinical Care Lead, reported Resident #6 went to the hospital on 3/3/26 and returned to the facility on 3/6/26. Staff B reported an E-interact transfer form filled out and saved in the computer when a resident had a change in condition or transferred to the hospital. The staff normally called report to the hospital staff and a copy of the face sheet, IPOST (advanced directive) and medication list sent with the resident. Staff B reported she would look to see if she could find documentation about a bed hold for Resident #6. A Bed-Hold Policy reviewed/revised 12/23/25 revealed the facility will provide written information to the resident or resident's representative at the time of a transfer about the duration of the bed-hold policy, the reserve bed payment policy in the State plan, and the policy regarding the bed-hold period permitting a resident to return to the facility. The purpose of the bed hold was to ensure the resident was made aware of the bed hold policy and to determine if the resident/representative wanted to hold the bed. 4. Resident #92's MDS assessment dated [DATE] identified a BIMS score of 03 out of 15 which indicated severely impaired cognition. It included diagnoses of Alzheimer's disease, dementia with other behavioral disturbances, and diabetes mellitus. It revealed the resident required supervision with eating, required maximal assistance with oral hygiene, upper body dressing, bathing, and bed repositioning, and was dependent with all other ADLs and mobility. The Care Plan revised 5/17/23 included a focus which indicate the resident had impaired cognitive function/dementia or impaired thought processes related to dementia. It also indicated the resident understood consistent, simple, direct sentences and directed staff to ask the resident yes/no questions to determine the resident's needs. A SAFE Event-Incident Report – SPN Progress Note dated 2/28/26 at 1:32 PM indicated the resident was involved in a resident-to-resident, physical contact incident with another resident. A Communication/Visit with Physician Progress Note dated 3/03/26 at 2:28 PM revealed the medication used to control the resident's hypersexual behaviors was increased. A Hospice Progress Note dated 3/04/26 at 5:21 PM revealed the resident was on a 1:1 supervision with no sexual behaviors noted. There are no documented progress notes which indicated the resident exhibited hypersexual behaviors after 3/02/26. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Communication with Resident/Family Progress Note dated 3/11/26 at 11:57 AM revealed the resident representative was notified the resident was being transferred to another facility owned by the same company. The Progress Note also revealed the representative was not happy with this decision and informed the facility they should give the medication longer to work. The Social Worker advised the representative they would keep her informed of the date and time of the resident's move. A Communication with Resident/Family Progress Note dated 3/18/26 at 10:54 AM revealed the resident was being discharged to the other company owned facility on 3/18/26 at 11:00 AM and would be living there permanently. It also revealed the resident's representative verbalized understanding. The facility provided no other documentation that the resident, the resident's representative, or the Long-Term Care State Ombudsman (LTCSO) was notified of the discharge in writing and in a manner they understood at least 30 days in advance of the discharge. On 5/13/26 at 4:02 PM, the Administrator stated the facility had no other communication documentation about the resident's transfer other than what was in the EHR.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to accurately complete a Minimum Data Set (MDS) assessment and a comprehensive care plan for 2 of 4 residents (Residents #22 and #72) reviewed for Pre-admission Screening and Resident Review (PASRR). The facility reported a census of 80 residents.Findings include:1. The MDS dated [DATE] revealed that Resident #22 had diagnoses of depression, bipolar disorder, anxiety disorder and other hallucinations. Question A1500 indicated that she was not considered a Level II PASRR by the state Level II PASRR process. Question A1510 lacked documentation.The Care Plan initiated 1/25/21 lacked documentation concerning Level II PASRR status.The Notice of PASRR Level II Outcome dated 9/19/24 indicated Resident #22 was approved with specialized services. It further indicated diagnoses of Bipolar disorder, major depressive disorder and paranoid disorder. 2. The MDS dated [DATE] revealed that Resident #72 had diagnoses of anxiety disorder and bipolar disorder. Question A1500 indicated that she was not considered a Level II PASRR by the state Level II PASRR process. Question A1510 lacked documentation.The Care Plan initiated 11/14/24 lacked documentation concerning Level II PASRR status.The Notice of PASRR Level II Outcome dated 11/11/24 indicated Resident #72 was approved with specialized services. It further indicated diagnoses of dementia, anxiety disorder and bipolar disorder.In an interview on 5/12/26 at 2:45 PM Staff J, Social Services Coordinator stated that Resident #22 and #72 are both Level II PASRR residents.In an interview on 5/14/26 at 10:02 AM Staff P, MDS Coordinator stated that she does not do the PASRR portion of the MDS or the Care Plan. Staff J, Social Services Coordinator does them. Stated she thought that Resident #22 was a Level II but was sure if Resident #72 was.In an interview on 5/14/26 at 10:15 Staff J, Social Services Coordinator stated that she took over for PASRR in December of 2025. She confirmed again that Resident #22 and #72 were both Level II PASRR residents. She realized recently that she incorrectly marked no to the MDS question A1500 when they should have been marked yes for several residents. She marked Resident #22 incorrectly as no. She did not do the MDS for Resident #72 but said that it should have been marked yes as well. She also does the Care Plan portion for PASRR. She stated she should have had PASRR documentation on the Care Plan for both Resident #22 and #72.The Notice of PASRR Level II Outcome for both residents indicated they have PASRR conditions and if they admit to a Medicaid-certified nursing facility, or if they are currently in a Medicaid-certified nursing facility, the facility should mark yes for question A1500 on the MDS and the specific condition should be checked in question A1510.In a policy titled Pre-admission Screening and Resident Review (PASARR)-Rehab/Skilled dated 12/29/25 it indicated that Preadmission Screening and Resident Review (PASARR) - A federal requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are not inappropriately placed in nursing homes for long term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for a serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings.In a policy titled MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument)-Rehab/Skilled & Therapy and Rehab dated 10/27/25 it indicated that a significant correction is an assessment that is completed when it is determined that a resident's prior comprehensive assessment contains a significant error. It also indicated that A significant error is an error in an assessment where: a. The resident's overall clinical status is not accurately represented (i.e., miscoded) on the erroneous assessment; and b. The error has not been corrected via submission of a more recent assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review the facility failed to submit a Preadmission Screening and Resident Review (PASRR) within a time-limited review timeframe for one of four residents reviewed for PASRR (Resident #63). The facility reported a census of 80 residents. Findings include: The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #63 had diagnoses of anxiety disorder and psychotic disorder. The MDS documented the resident not currently considered by the state level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. The MDS revealed the resident took an antipsychotic and antidepressant medication during the seven-day look-back period. A PASRR Level II determination date 10/22/24 revealed a short-term approval ended 2/19/25. In an interview on 5/13/26 at 1:40 PM, Staff J, Social Services (SS), reported she had worked in the SS role since 12/1/25. Staff J was not aware she needed to do PASRR's. She realized some PASRR's were only in effect for 120 or 180 days and then a PASRR needed to be resubmitted. Staff J reported she was in the process of setting up a schedule for when a PASRR would be due. On 5/14/26 at 9:50 AM, Staff J checked the computer for the PASRR's completed on Resident #63. Staff J reported Resident #63's PASRR was last completed on 10/22/24 and the PASRR had a recommendation for an onsite review. Staff J checked the PASRR vendor website to review the PASRR's completed. A Level II PASRR was completed on 2/19/25 with a time-limited follow up review needed. Staff J reported she completed Resident #63's PASRR on 4/17/26. A PASRR policy reviewed/ revised 12/29/25 revealed a PASRR ensured that individuals with a mental diagnoses or intellectual disability receive the care and services they need in the most appropriate setting. A Level II PASRR screening is conducted by the agency designated by the state. The facility should reference the state PASRR program requirements for specific procedures.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident and staff interviews and policy review, the facility failed to implement and follow interventions on the care plan to use an apron whenever the resident smoked for 1 of 1 resident reviewed for smoking (Resident #49). The facility reported a census of 80 residents.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #49 had a Brief Interview for Mental Status score of 13 out of 15, indicating cognition intact. The MDS indicated the resident used tobacco.The Care Plan revised 3/19/26 revealed Resident #49 used cigarettes. The Care Plan directed staff to put a smoking apron on the resident (initiated 4/4/26), store cigarettes and lighter at the nurse's station (initiated 4/4/26) and supervise the resident to smoke.A Tobacco Evaluation dated 3/18/26 revealed the resident required supervision for smoking. The evaluation lacked documentation about smoking apron use.During observation on 5/12/26 at 9:35 AM, Resident #49 held a lit cigarette in his hand and smoked as he sat in a motorized wheelchair on the outside patio. The resident did not have an apron on. A staff person was in attendance outside. During continuous observations of residents smoking outside on 5/13/26 at 1:03 PM to 1:18 PM, nine residents sat outside on the patio smoking with Staff K, Maintenance, in attendance. Aprons hung on the coat hooks inside the alcove by the exit door to the patio. None of the residents had an apron on as they smoked. Staff K lit a cigarette for the resident. In an interview on 5/13/26 at 9:30 AM, Resident #49 reported he smoked cigarettes. He kept a lighter in his pocket but he could not do anything with the lighter if he did not have a cigarette to light. Resident #49 reported sometimes staff put an apron on him but he did not know why. Resident #49 stated he has not burned himself. In an interview on 5/13/26 at 1:20 PM, Staff F, certified nursing assistant (CNA), reported she looked at the care plan to know what a resident needed to have done or if the resident had privileges to go out to smoke. She also looked at the care plan to know If a resident needed supervision or had to wear an apron when the resident went out to smoke. In an interview on 5/13/26 at 1:25 PM, Staff K, Maintenance, reported on 5/13/25 at 1:00 PM was the second time he took residents out to smoke. Staff Q, Maintenance, normally took the residents out at 1 PM to smoke but Staff Q was off. Staff K reported the residents' cigarettes and lighters were kept in a large box and locked in a room by the nurse's station. Staff K reported Resident #21 was the only resident that he knew had to wear a bib (apron) when he smoked.In an interview on 5/14/26 at 12:30 PM, Staff C, Clinical Care Lead, reported he expected the care plan to be followed. The resident should have an apron if the care plan indicated the resident needed to wear an apron while smoking. Staff C reported only Resident #49 and Resident #21 needed to wear an apron when they smoked. The Administrator had talked to a resident about wearing an apron when smoking and it was a safety concern.The facility's Smoking and Tobacco Policy revealed residents who need protective wear should wear the protective attire at all times when smoking.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, clinical record review, policy review, and staff interview, the facility failed to properly disinfect a glucometer (a machine which obtained blood sugar readings) for 2 of 3 residents observed during blood sugar checks (Residents #38 and #6). The facility reported a census of 80 residents. Findings included: 1. The Minimum Data Set (MDS) assessment tool, dated 4/2/26, listed a diagnosis of diabetes for Resident #38 and listed his Brief Interview for Mental Status (BIMS) score as 14 out of 15, indicating intact cognition.A 1/20/25 order directed staff to check the resident's blood sugar before meals and at bedtime. 2. The MDS assessment tool, dated 3/19/26, listed a diagnosis of diabetes for Resident #6 and listed his BIMS score as 11 out of 15, indicating moderately impaired cognition.A 1/10/26 order directed staff to check the resident's blood sugar before meals and at bedtime. On 5/14/26 at 10:03 a.m., Staff N Certified Medication Aide (CMA) obtained Resident #55's blood sugar and wiped off the glucometer with an alcohol pad. Staff N then obtained Resident #38's blood sugar and wiped off the glucometer with an alcohol pad. Staff N then obtained Resident #6's blood sugar. Following the blood sugar checks, Staff N stated she was supposed to wipe off the glucometers with a disinfectant wipe but did not have those on her cart.On 5/14/26 at 10:12 a.m., the Director of Nursing(DON) stated staff should utilize disinfectant wipes to sanitize glucometers and should let the wipes set for 5 minutes. The facility policy Blood Glucose Monitoring, Disinfecting and Cleaning, dated 9/30/26, directed staff to utilize a disinfectant or germicide wipe to sanitize a glucometer.