STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165220	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Azria Health Prairie Ridge	608 Prairie Street Mediapolis, IA 52637

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, record review, staff interviews, and the facility policy, the facility failed to respect resident rights by not allowing residents to go out and smoke during the designated times for 3 of 4 residents reviewed for smoking (Resident #3, Resident #12 and Resident #13). The facility reported a census of 57 residents. Findings include: 1. The Brief Interview for Mental Status (BIMS) evaluation completed 5/5/26 at 4:31 PM revealed resident scored a 15 out of 15, which indicated cognition intact. Review of the Minimum Data Set (MDS) revealed Resident #12 admitted to the facility on [DATE]. The Care Plan revealed a focus area dated 5/5/26 for resident continued to enjoy smoking. Interventions dated 5/5/26, included: Instruct resident about the facility policy on smoking locations, times, and safety concerns and the resident requires supervision while smoking. During an interview on 5/12/26 at 9:45 AM, Resident #12 stated the facility allowed him to smoke three times a day except sometimes the staff didn't show up to allow the residents to smoke. Resident #12 stated yesterday and two days prior the residents were not allowed to go out and smoke at 7:30 PM. 2. The MDS assessment dated on 4/9/26 revealed Resident #13 scored a 15 out of 15 on the BIMS exam indicating intact cognition. The Care Plan revealed a focus area dated 1/9/26 for resident enjoyed smoking cigarettes. Interventions dated 9/25/25 included: Instruct resident about the smoking locations, times, and safety concerns and The resident requires supervision while smoking. Review of a Nurses Note dated 5/10/26 at 9:15 AM in the electronic health record (EHR), revealed resident was upset that staff was unable to take smokers out to smoke. Resident told other smokers to meet her at the front door and went to her room and retrieved a pack of cigarettes. Resident attempted to help smokers out of facility to smoke. Nurse and CNA (Certified Nurse Aide) notified residents that they are unable to leave the facility unassisted and staff is unable to take the smokers out. Residents became upset, redirection successful and resident went back to rooms. On call nurse notified of situation. 3. The MDS dated [DATE] revealed Resident #3 scored a 13 out of 15 on the BIMS exam, indicating intact cognition. The Care Plan revealed a focus are revised on 1/29/26 for resident continued to enjoy smoking. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions dated 8/9/25 included: Instruct resident about the facility policy on smoking locations, times, and safety concerns, and the resident requires supervision while smoking. Review of the Nurses Note dated 5/10/26 at 9:45 PM in the EHR, revealed nurse was alerted by CNA that resident wanted to speak to the nurse and resident was speaking to another resident. Upon entering the room with another CNA, the resident stated she was upset that she was unable to smoke and that she was dirty. Resident was informed that smoking is only to take place if staff is available and willing as the CNA/Nurse must volunteer to take the smokers out, resident was also informed that we were short staffed and unable to take the smokers out. During an interview on 5/13/26 at 3:33 PM, Staff G, Licensed Practical Nurse (LPN) queried on residents being able to go and smoke last weekend and Staff G stated no, the staff did not take the residents out for one of the smoking sessions. Staff G stated she didn't know if it was on Saturday or Sunday last weekend. Staff G stated the staff didn't have time to take the smokers out because the staff was shorthanded and they needed to take care of the residents. Staff G stated Resident #3 was very upset about not being able to go out and smoke. Staff G stated her understanding was staff had to volunteer to take the residents out to smoke. During an interview on 5/13/26 at 4:13 PM, Staff D, CNA stated she worked on Sunday and the residents didn't get their smoke break on second shift. Staff D stated the nurse said they didn't have enough staff to take off the floor. Per Administrator email on 5/14/26 at 11:22 AM, smoke times for residents was 9:30 AM, 1:30 PM, and 7:30 PM. Per email Resident #3, #12, and #13 were on the smoker's list. During an interview on 5/14/26 at 3:43 PM, the Director of Nursing (DON) queried about the residents not getting their smoke break on Sunday and the DON stated the facility spoke to the nurse on duty who was not an employee of the facility and let her know the residents need to be able to go out and smoke. The DON stated they were a smoking facility and had smoking times in place, and it was the facility policy to allow the resident smoke breaks. During an interview on 5/11/26 at 3:53 PM, Resident #3 reported the facility designated smoking times were 9:30 AM, 1:30 PM and 7:30 PM. Resident #3 voiced being upset due to not being able to smoke on 5/10/26 at 7:30 PM. She reported the resident's that smoke had been told that there wasn't enough staff available for them to smoke. Review of the facility policy titled Resident Rights Policy dated October 2022, revealed employees shall treat all residents with kindness, respect, and dignity.These rights include resident's right to exercise his or her rights as a resident of the facility.; be supported by the facility in exercising his or her rights. Review of the facility policy titled Smoking Policy -Residents dated August 2022 revealed in part: Any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member, family member, visitor or volunteer worker at all times while smoking.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy review, resident and staff interviews, the facility failed to follow up after a report of food purchased by a resident was missing for 1 of 4 residents (Resident #12) reviewed for personal possessions. The facility reported a census of 57 residents. Findings include: Review of the electronic health record (EHR) revealed Resident #12 admitted to the facility on [DATE].The Brief Interview for Mental Status (BIMS) completed 5/5/26, indicated intact cognition based on a score of 15 out of 15. During an interview on 5/12/26 at 9:50 AM, Resident #12 stated he bought some lunchables (a pre-packaged make it yourself meal kit) because he gets sick every time he eats. He explained he bought some lunchables because he doesn't eat dinner, and an employee needed them more than I did and he took them. Resident #12 stated he asked the CNA (Certified Nurse Aide) to go and get him one and they came back and said he didn't have any. Resident #12 stated he told a manager and they said they would replace them, adding they took 3 of them. Resident #12 stated he is not upset about the money; he is upset about the lunchables. Resident #12 stated the lunchables were kept in a refrigerator in the hall and he did not know if the staff labeled the food. Resident #12 stated he is leaving tomorrow [5/13/26] for an appointment with another place. During an interview on 5/13/26 at 9:59 AM, Resident #12 stated a facility staff had not followed up with him about his missing lunchables.During an interview on 5/14/26 at 12:06 PM, Staff E, CNA queried on Resident #12 lunchables and Staff E stated she worked the day Resident #12 got the lunchables and recalled it was Mother's Day [5/10/26]. Staff E stated a lady also brought him in ice cream. Staff E stated she didn't put the food in the fridge when Resident #12 got it, but when Resident #12 asked for the lunchables, she couldn't find them in the fridge. Staff E stated when resident receive food items, the staff put the resident's name on them and places them in the fridge.During an interview on 5/14/26 at 1:16 PM, Staff B, Licensed Practical Nurse (LPN)/Unit Manager queried on Resident #12 lunchables and Staff B stated Resident #12 just reported the missing lunchables the day he left and Staff B would follow up with the Administrator. Staff B stated the Administrator would want staff to write up a grievance. Staff B stated he had not talked to the Administrator about Resident #12 lunchables yet. Staff B queried if he thought staff took them and Staff B stated no, and recently the lock on the beautician door where the resident refrigerator was located was broke and they recently changed the lock on it. Staff B stated the facility did not inventory the resident's food items; they just mark the resident's name on the items.During an interview on 5/14/26 at 4:20 PM, the Administrator queried on Resident #12 lunchables and the Administrator stated it was the first time she heard about them missing. The Administrator asked the process on missing items and the Administrator stated generally the facility replaced missed items. The Administrator stated Resident #12 lunchables should have been taken care of within that day it was reported.During an observation 5/18/26 at 8:55 AM, the resident refrigerator noted to have multiple food items labeled with resident names. The freezer contained an ice cream container labeled with Resident #12's name. No lunchables found in the refrigerator. Review of the facility policy titled Personal Property Policy dated October 2022 revealed:a. Resident belongings are treated with respect by facility staff, regardless of perceived value.b. The facility promptly investigates any complaints of misappropriation or mistreatment of resident property.Review of the undated facility titled Foods Brought by Family/Visitors Policy revealed:a. Foods brought by family/visitors for individual residents may not be shared with or distributed to other residents.b. Food brought by family/visitors that is left with the resident to consume later will labeled and stored in a manner that it is clearly distinguishable from facility-prepared food.c. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the use by date.

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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 observation, clinical record review, facility policy review, resident and staff interview, the facility failed to ensure staff consistently used and re-ordered the appropriate size bariatric incontinence brief for resident comfort, and to ensure a bathroom faucet and closet were accessible for 2 of 4 residents (Resident #18 and Resident #3) reviewed for accommodations. The facility reported a census of 57 residents.Findings included:1. The Minimum Data Set (MDS) assessment for Resident #18 dated 4/9/26, revealed an admission date of 10/8/25. The Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicated intact cognition. The list of diagnoses included morbid obesity, incontinence without sensory awareness and need for assistance with personal care. The MDS identified: the use of a wheelchair; the resident required substantial/maximum assistance with toileting hygiene and bed mobility; dependent for lower body dressing, transfers and moving from sitting to lying and standing; and the resident always incontinent of bowel and urine.During an interview on 5/11/26 at 3:53 PM, Resident #3 stated the facility did not have enough size 5XL (extra-large) incontinent briefs for her roommate [Resident #18] and staff frequently used a smaller size brief. On 5/12/26 at 10:45 AM, during an interview, Staff O, Certified Nursing Assistant (CNA) stated Resident #18 wore a size 5XL incontinent brief. Staff O reported the facility did order 5XL briefs, but the briefs would get put on back order, and sometimes the resident had to wear size 4XL briefs. Staff O reported the size 4XL were too tight for the resident and caused rubbing sores on her inner thighs were the brief sat against the resident's skin. During an interview on 5/13/26 at 9:14 AM, during an interview, Resident #18 reported sometimes the facility had problems with running out the right size brief for her. She reported using a size 5XL brief. Resident #18 reported facility staff changed her brief every 2 to 3 hours. Resident #18 reported two wounds, one on her left thigh and a sore on her bottom. She thought the wound on left thigh was getting better, and reported sometimes it was closed and sometimes the wound was open. Resident #18 thought both wounds were from wearing the smaller size incontinent briefs and the briefs rubbing against her skin. Resident #18 explained the facility did not order the right size brief in a previous order. Until the next truck came in a week later, the resident reported she had to wear a smaller size brief. Resident #18 thought they had plenty of size 5XL briefs now. Review of a Nurses Note in the electronic health record (EHR) dated 10/8/25 revealed the following, in part: 3 skin issues upon admit.1) left inner thigh shearing of skin from incontinent brief measures 2 cm (centimeters) L (length) x 1cm W (width). 2) Right intragluteal cleft has MASD from incontinence measuring 1.5cm L x 1.5cm W. 3) Right hip has an abrasion circular in circumference measuring 1.5cm L x 1.5cm W.During an observation on 5/13/26 at 10:03 AM, Staff I, CNA prepared to complete incontinence care for Resident #18. Staff I, CNA reported the facility staff kept Resident #18's incontinent briefs locked in the medication room. Staff H, CNA, brought in several briefs into the room and put them in the drawer of the resident's dresser. Staff H reported they only had size 4XL briefs, and no 5XL available. Resident #18 visibly upset and expressed getting really angry about having to wear the smaller briefs. Staff I, CNA reported this had happened before. Staff I explained she had reported repeatedly to facility management about having the wrong size brief for Resident #18. Staff I stated management explained the 5XL brief was out of stock, they could not get the right size for the resident, it cost too much money, and at one point, they talked about making the resident buy her own briefs. During an interview on 5/13/26 at 1:10 PM, Staff M, CNA, reported she last provided incontinence cares to Resident #18 on 5/12/26 and there had been size 5XL incontinent briefs available. Staff M reported they were supposed to have a size 5XL for the resident and the kept the briefs in the nurse's office. Staff M reported there had been issues with the facility having the correct size incontinent brief. Staff M reported there were times when staff had to use a smaller brief when they were laying the resident down, because there weren't enough 5XL available. Staff M explained she had used size 3XL briefs on the resident, and the briefs did not fit. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Staff M reported the resident did get upset and complain when having to wear the smaller briefs. On 5/13/26 at 3:34 PM, during an interview, Staff G, LPN, reported she had provided wound treatment to Resident #18 in the last three weeks. Staff G reported the facility had ordered a smaller incontinent brief size for Resident #18, and she thought the smaller brief size was causing skin irritation in the upper thigh area.On 5/14/26 at 9:28 AM, during an interview, Staff N, Medical Records and Central Supplies, reported Resident #18 used a size 5XL. She explained the truck came every week, and there had been times that the facility ran out of the 5XL briefs. Staff N explained last week when she placed the order for Resident #18's briefs, the company they place their order from (Regional Purchasing Agent for the nursing home) wanted them to try size 4XL due to the price difference between 4XL and 5XL. Staff N was not sure who spoke with the resident to see if the resident was in agreement with wearing a smaller brief. Staff N explained Resident #18 did tell her that the 4XL briefs were not working. Staff N reported she got 5XL briefs overnighted to the facility, and reported they had 5XL briefs in the medication room. Observation during the interview revealed a total of 11 5XL incontinent briefs were located in the locked medication room.On 5/14/26 at 12:49 PM, during an interview, the Unit Manager and Infection Preventionist reported he had ordered 5XL incontinence briefs for Resident #18 from the time he started in the Central Supplies position. He explained the order for supplies might be place once per week, but the order could arrive over multiple days. The Unit Manager reported that there might have been a small gap in availability of 5XL briefs, depending on the number of incontinence episodes that Resident #18 had. The Unit Manager reported there had been times when the facility ran out of 5XL briefs for Resident #18. When the facility has ran out, the Unit Manger reported they usually had size 4XL available. He explained the 4XL briefs were big and fit the resident, but they were not comfortable for her. The Unit Manager explained that supply orders went through an umbrella company that owned the nursing home. The regional umbrella company had to approve or deny purchasing requests. The Unit Manager reported there were times when he was putting the order in that the umbrella company asked the facility to use a smaller size brief for Resident #18. The Unit Manager reported they could message. He explained there was one time, closer to the end of February 2026, that he did order 4XL for Resident #18, because the umbrella company asked him to do it. Resident #18 reported being uncomfortable and having a problem wearing the size 4XL briefs. The Unit Manager reported he switched back to ordering size 5XL incontinent briefs. He reported the size 5XL briefs came in bags, 8 briefs to a bag.Review of the facility purchasing orders, dated from 5/1/26 to 5/14/26, revealed the following: the facility ordered 3 bags of size 5XL incontinence briefs and received the order on 5/6/26.On 5/14/26 at 3:43 PM, during an interview, Resident #18 reported she could not use the size 4XL incontinent briefs, and stated, they rub on my wound. The resident denied anyone had asked her if it was okay to use size 4XL briefs instead size 5XL. 2. Review of the MDS assessment for Resident #3 dated 3/27/26, revealed an admission date of 8/6/25. The BIMS score of 13 out of 15, indicated intact cognition. The list of diagnoses included diabetes, heart failure, and need for assistance with personal care. The MDS indicated Resident #3 used a wheelchair for mobility; set up assistance for oral hygiene; substantial or maximum assistance for upper body dressing, bed mobility, transfers and personal hygiene, dependent for lower body dressing, toileting and putting on/taking off footwear.Review of the Care Plan for Resident #3 dated 5/10/26, identified that the resident wished to return home and had a Focus area to address increased risk for actual/potential limitation(s) in ability to perform ADLs (Activities of Daily Living) related to impaired mobility and activity intolerance. Interventions included: Encourage the resident to participate to the fullest extent possible with each interaction; Personal hygiene/Oral Care: Ax1 (assist of 1); Dressing: Ax1 as needed with catheter and getting feet into leg holes.Review of an Occupational Therapy (OT) Discharge summary, dated [DATE] to 1/12/26, revealed a goal for Resident #3 to improve upper and lower body dressing tasks with minimal assist using compensatory strategies with reduced risks for falls. OT staff educated the resident on use of assistive equipment (AE) including a reacher and compensatory strategies to improve independence (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and safety with dressing. During an interview on 5/11/26 at 3:53 PM, Resident #3 stated an inability to turn the water faucet on in her bathroom. The resident reported she had to wait for staff to turn it on for her. Observation revealed a pull-up type handle on the faucet that would not pull up with multiple attempts by the State Agency (SA). Resident #3 reported an inability to reach her clothes in her closet. Resident #3 reported she would be able to get her clothes out herself if she could reach them. She reported frustration with having to wait for staff or else break the hangers by pulling on the bottom of her clothing. Resident #3 reported breaking 8 out of her last 10 hangers by yanking on the bottom of her clothes to get them out of the closet. During an observation on 5/13/26 at 9:11 AM, Resident #3 demonstrated how she was unable to reach the clothes in her closet from her wheelchair. The closet had 2 lower drawers with double doors above the drawers which stored hanging clothes. Resident #3 was able to reach the bottom of the hanging clothing from her wheelchair. Resident #3 reported the CNAs were aware that she couldn't reach her clothes.During an interview on 5/13/26 at 9:31 AM, Staff H, CNA reported she had assisted Resident #3 with getting dressed. Staff H reported she asked the resident what she wanted to wear for the day and got the resident dressed before the resident got out of bed for the day. Staff H denied Resident #3 had ever complained to her about not being able to reach the clothes in her closet. Staff H reported she had seen the resident get in the closet by herself. During an interview on 5/13/26 at 10:03 AM, Staff I, CNA reported she asked Resident #3 for her clothing preference and got the resident's clothes out for her. Staff I reported the faucet in the resident's bathroom was hard to pull to turn on. Staff H, CNA also present demonstrated turning on the faucet. The faucet stuck when Staff H pulled on it and she had to use some force to turn the faucet on. On 5/13/26 at 1:10 PM, during an interview, Staff M, CNA, reported there were a few other resident rooms with faucets like Resident #3's faucet. Staff M reported had observed Resident #3 have a hard time turning the faucet on. Staff M explained Resident #3 complained about not being able to wash her hands, and Staff M would turn the faucet on for her. Staff M reported she reported the concern with the faucet to a nurse. She did not remember how long ago, or which nurse she had reported it to. During an interview on 5/13/26 at 3:24 PM, the Director of Nursing (DON) reported that the Therapy Department was responsible for accessing room accessibility for all new residents to the facility. During an interview on 5/14/26 at 11:28 AM, the Therapy Department Program Manager and the Physical Therapy (PT)Supervisor stated they did do an initial evaluation of each resident and their ability to access things in their room. The Department Manager reported she believed she did the initial evaluation on Resident #3, but accessibility of the resident's clothes closet and her dressing herself would have been Occupational Therapy's (OT) part of the assessment. She thought Resident #3's main focus was bathroom use and transfers and trying to get her as independent as possible. She explained therapy should have assessed and done a maintenance request to make the closet accessible and order a different handle for the faucet. The Department Manager reported therapy ended because there was no definite discharge plan for the resident, and therapy had assessed the resident needed 24/7 care and assistance with toileting and transfers. She reported the resident could stand at a grab bar, but needed lowered countertops.During an interview on 5/14/26 at 4:22 PM, the DON reported that she never heard Resident #3 complain about her closet. The DON reported staff encouraged the resident to be more independent and confirmed it would be hard for Resident #3 to be more independent if she could not reach her clothes.During an interview on 5/18/26 at 12:46 PM, Staff P, OT, reported she had been working with residents at the facility for 2 years. She reported almost every resident, depending on insurance, received an initial evaluation that included an assessment of their room accessibility with a goal for the resident to be as independent as possible. Staff P reported she completed the initial OT evaluation on Resident #3, worked with her during her treatment and discharged the resident from OT services about 4 months ago (1/12/26). Staff P reported she assessed the closet accessibility for Resident #3, but closet accessibility was not a formal goal due to the resident wanting to discharge to home. Staff P explained they did work with the resident on dressing and being more independent, but they focused more on the resident (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting on the edge of bed to get dressed with use of the reacher. Staff P reported another option would have been for Maintenance to lower the clothing bar. Review of the facility's policy, titled Accommodation of Needs, dated 3/2021, revealed, in part, . the resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis .In order to accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom and bathroom, as well as the common areas in the facility .In order to accommodate individual needs and preferences, staff attitudes and behaviors are directed towards assisting the residents in maintaining independence, dignity and well-being to the extent possible and in accordance with the residents' wishes.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review and staff interviews, the facility failed to notify a family of a missed medication in a timely manner for 1 of 1 resident (Resident #12) reviewed for family notification. The facility reported a census of 57 residents. Findings include: Review of the Minimum Data Set, dated [DATE], revealed Resident #12 admitted to the facility on [DATE]. The Brief Interview for Mental Status (BIMS) score of 15 out of 15 indicated intact cognition. Review of a Orders Administration Note entered into the electronic health record (EHR) on 5/2/26 at 4:34 PM, revealed an order for: famotidine oral tablet 20 milligram (MG)- Give 1 tablet by mouth two times a day related to gastro-esophageal reflux disease without esophagitis. Comments: on orderReview of a Nurses Notes dated 5/7/26 at 1:10 PM, revealed PCP (Primary Care Provider), POA (Power of Attorney) notified and acknowledged missed dose of famotidine upon admission on [DATE] due to not having medication available. No issues was noted from missed dose.During an interview on 5/13/26 at 3:33 PM, Staff G, Licensed Practical Nurse (LPN) confirmed she would notify the family when a medication is not available. Staff G stated she would try and call the family within 45 minutes to an hour.During an interview on 5/14/26 at 1:16 PM, Staff B, LPN/Unit Manager asked when the family notified and Staff B stated for pretty much everything and an example was when a medication not available. Staff B queried in what time frame the family would be notified and Staff B stated within 24 hours.During an interview on 5/14/26 at 3:43 PM, the Director of Nursing (DON) queried on when the facility notified the family and the DON named multiple examples to include medications not available. When asked if notifying the family 5 days later is appropriate, the DON stated no and it was an ongoing issue the DON was working to fix.Review of an undated facility policy titled Facility Change in a Resident's Condition or Status Policy revealed:a. Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.).1. Except in medical emergencies, notifications will be made within twenty-four (24) hours of a change occurring in the resident's medical/mental condition or status.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 observation, clinical record review, facility policy review, resident and staff interview, the facility failed to maintain a clean, odor free, comfortable and homelike environment in 31 of 32 resident rooms, 2 of 2 shower rooms, and 2 of 3 hallways throughout the facility. The facility reported a census of 57 residents.Findings included: 1. During a continuous observation from 8:26 AM to 12:30 PM on 5/11/26 a walk through completed for all resident rooms. The facility had a total of 32 resident rooms, with 16 rooms on the 100 Hall (East); 15 rooms on the 200 Hall (South) and one room on the 300 Hall (West). During the observation the following noted: a. Room entrances missing a transition strip, discolored yellow, brown and black with dirt particles embedded in rooms: 101,102, 103, 106, 107, 108, 109, 111, 112, 114, 117, 119, 202, 204, 205, 206, 207, 210, 211, 212, 214, 215 and 217. b. Black marks on and/or across the lower part of the resident room doors and frames in rooms: 104, 106, 107, 109, 111, 112, 115, 116, 117, 119, 201, 202, 204, 206, 210, 211, 214 c. Walls with scrap marks into the dry wall behind resident beds and/or chairs in rooms: 101, 102, 104, 105, 106, 107, 109, 111, 112, 114, 116, 119, 201, 204, 206, 208, 209, 215, 217 d. Stained and discolored flooring tiles in the resident rooms and bathrooms in rooms: 101, 103, 109, 111, 112, 115, 116, 119, 209, 210, 212, 215 e. Yellow, brown and black ring around the base of the toilet in rooms: 101, 103, 104, 105, 109, 111, 112, 115, 201, 202, 204, 207, 208, 210, 212, 214, 217 f. Missing basecoat (the foundational first layer of a coating system applied to seal the floor surface) on strip of flooring along the wall under the window leaving a dirt build up on the strip in rooms: 101, 102, 103, 104, 105, 106, 107, 109, 111, 112, 114, 115, 116, 117, 119, 202, 204, 206, 207, 208, 209, 210, 212, 215, 217 g. Dirt particles and particles of other unknown substances on floors in resident rooms, pieces of paper and/or tissue, and other trash items, and/or spiders/spider webs in rooms: 101, 102, 103, 104, 105, 106, 107, 108, 109, 111, 112, 119, 201, 204, 209, 214, 217 h. Persistent urine odors in the bathrooms of rooms: 202, 204, 207, 208, 212, 217; and in the 200-hall shower room. i. Dirt build up in corners of room and/or bathroom in rooms 101, 105, 107, 106, 109, 112, 117, 119, 202, 204, 206, 207, 208, 212, 214, 215, 217 j. Missing piece of floor tile in rooms: 101, 103, 104, 208 (bathroom), 212, 214, 215, 217 k. Holes in resident doors or in rooms: (bathroom door), 215 l. Broken dry wall on ceiling in rooms: 208, 210 (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	m. Leaking/running toilets or faucets in bathrooms of rooms: 101, 109, 112, 114, 207 n. Conduit box hanging loosely and not secured in resident's wall in rooms: 109, 114, 217 o. Pieces of anti-slip strips peeling and missing in rooms: 101, 106, 112, 117, 204, 208, 212, 217 In addition, the 100 and 200 hallways noted to have multiple scraps and black marks above and below the handrails. The shower room in the 100 Hall had dirt and dust build up with a hair ball on floor near the entrance to the shower room and multiple stained/discolored tiles on the shower floor. The entrance to the beauty salon in the 200 Hall lacked a transition strip, and was discolored with yellow, brown and black stains and dirty in appearance. The shower room in the 200 Hall had scraps across the outside of the lower part of the door, several yellowish-brown discolored tiles, on the floor and around the lower edges of the shower, dirt particles on the floor near the entrance way, During an interview on 5/11/26 at 8:33 AM, Resident #13 reported housekeeping staff had only been cleaning the rooms once per week. She stated the facility had hired some new housekeeping staff, and she thought this was getting better and they were cleaning more often. The Minimum Data Set (MDS) assessment dated on 4/9/26 revealed Resident #13 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) indicating intact cognition. During an interview on 5/11/26 at 8:49 AM, the Housekeeping Manager reported she had been working at the facility for one month. She explained that she worked 5 days per week, every other weekend. She explained there were two housekeepers working now, but the first two weeks she worked at the facility, she had to clean the resident rooms in the 100 and 200 hallways by herself. During an interview on 5/11/26 at 11:40 AM, Resident #7 stated the ceiling above his bed had needed repaired for at least 8 months. Resident #7 explained the roof had leaked at the facility and caused the damage to the ceiling. The ceiling noted to have a 2 foot in length by 1 foot in width opening into the dry wall with a piece of the dry wall hanging over the resident's bed. The MDS dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. During an interview on 5/11/26 at 12:07 PM, during an interview, Resident #20 reported she had been missing a piece of flooring and there had been scraps on the wall behind the bed for as long as she had been in the room; she was unsure how long she had been in the same room. The MDS dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. During an observation on 5/11/26 at 2:24 PM revealed: a. room [ROOM NUMBER] – the basecoat (top layer) of the flooring missing on a strip under the air conditioning unit and along the window leaving a buildup of dirt; a ring of discoloration noted around the toilet base; and a strong urine odor in the bathroom. b. room [ROOM NUMBER] – transition strip missing, floor discolored and dirty in appearance; trim board near the entrance with dried gray water marks present; grout and floor tiles discolored; discolored ring around the base of the toilet; and yellow & brown stains in sink. c. room [ROOM NUMBER] - the basecoat missing from the flooring on a strip along the wall under the window leaving a dirt build up and discolored appearance; a discolored ring around the base of the toilet with the caulk between the toilet base and floor cracked with pieces missing; and a buildup of (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dirt in the corners of bathroom floor. During an observation on 5/12/26 starting at 12:27 PM: a. room [ROOM NUMBER] – cover to the call light missing. b. room [ROOM NUMBER] - floor discolored at entrance; black marks across the lower part of the room door; a strip of flooring missing along the wall under the air conditioner unit; and discolored black ring around the base of the toilet. During an interview on 5/12/26 at 2:50 PM, the Maintenance Director reported she had started at the facility in September of 2025. The Maintenance Director explained she entered all repairs needed at the facility in an electronic tracking system. The Maintenance Director reported answering to a Regional Maintenance Manager. Upon reviewing the strip of flooring missing the basecoat in room [ROOM NUMBER] with the Maintenance Director, she reported the flooring needed a deep cleaning and that she had been aware of the concern existing in several of the resident rooms. The Maintenance Director reported the transition strips had been missing from the room entrances when she started at the facility and they were waiting on the hardware to install the strips. She reported being unaware of the discolored, stained appearance around the base of many of the resident's toilets. The Maintenance Director stated she did not know if there were any plans to replace flooring in residents' rooms. She stated she did not know there were some electrical conduit boxes not mounted in resident rooms. When asked if the boxes should be mounted into the resident's wall, the Maintenance Director said that was a good question. She had found a couple conduit boxes not secured and did secure them. The Maintenance Director had noticed the black marks on the walls. She explained she cleaned what she could and did patching and painting. She reported she planned to do another audit and paint and clean. The Maintenance Manager reported she had done two quarterly resident room inspections since starting at the facility in September of 2025. She explained she had done painting and dry wall patching. She stated that when a resident discharged , she tried to go into the room to get repairs done. The Maintenance Director reported she had redone the Administrator's and Director of Nursing's offices. On 5/13/26 at 7:42 AM, during an interview, the Administrator reported they had been using a contract company for housekeeping services, but they had problems with staff not showing up. The Administrator reported she had hired housekeeping staff and a manager for housekeeping and laundry. During an interview on 5/13/26 at 7:52 AM, Staff T, Housekeeping, stated she worked 5 days a week and every other weekend. Staff T reported during the week, she cleaned one hall, and another staff cleaned the other hall. On the weekends, Staff T reported she had to clean the whole facility. Staff T felt this was impossible, and she had too skimp. Staff T explained she had to do a quicker job and did not do as much. On the weekends she cleaned the resident's bathrooms, emptied their trash, cleaned any messes on the floor or tray table. Staff T clarified that she tried to mop the resident's floors, but did not have time to do the floor in every resident's room. She reported one of the housekeeping staff tended to call in when she was scheduled to work on the weekend. Staff T stated when she comes into the facility after the worker had called in, the trash would be over full, the rooms messy and there would be spills on the hallway floor. Staff T reported the facility was still hiring housekeeping staff and had hired a new manager. Staff T identified three resident rooms that smelled strongly of urine – rooms 202, 204 and 215. Staff T reported the facility was out of the chemical enzyme spray that they used to remove the urine smell, and they had been out of the spray for about a month. Staff T reported the facility just implemented a new daily and weekly cleaning schedule; housekeeping (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	staff were supposed to start picking one room to deep clean daily. On 5/13/26 at 11:32 AM, during an interview, the Regional Maintenance Manager reported being in his position for about 3 years. He reported trying to make routine visits to the buildings, and had 9 buildings under his responsibility. He reported another Regional Maintenance person visited the facility about 3 weeks ago for him. The Regional Maintenance Manager reported being unaware of what had been identified as needed repairs and had not looked at the itemized list compiled by the facility's Maintenance Director. The Regional Maintenance Manager explained he had not done rounding for 6 months due to covering the maintenance position at one his buildings that did not currently have a Maintenance Director. On 5/18/26 at 4:00 PM, during an interview, the Administrator reported not having any control over when maintenance items would get replaced or fixed in the facility. During an observation on 5/12/26 at 8:35 AM, the 100 Hall and 200 Hall had a strong smell of urine. Housekeeping mopping floors in Hall 200 and housekeeping mopping the floor in a room on Hall 100. During an observation on 5/13/26 at 8:22 AM, walked the hallways (100 and 200) and the smell of urine strong to the point of taking one's breath away. During an observation on 5/13/26 at 12:56 PM, a strong urine smell in the 200 hallway between rooms 201 to 204. During an interview on 5/13/26 at 9:22 AM, a family member of Resident #6 stated the facility smelled of urine all the time. The family member stated she told the staff they were nose blind because they were at the facility all the time. She stated facility being dirty was her biggest concern and her mother's bathroom was always disgusting. During an interview on 5/13/26 at 1:06 PM, Staff J, Certified Nurse Aide (CNA) queried on the urine odor and Staff J stated some rooms it is worse like the bathroom in room [ROOM NUMBER]. Staff J stated she did notice the smell a lot. During an interview on 5/13/26 at 1:40 PM, Staff I, CNA asked if she noticed a urine odor and Staff I stated yes, it was a hit and miss and pretty much everywhere. Staff I asked what she thought caused the urine odor and Staff I stated not getting the facility cleaned very well. Staff I stated up until 2 weeks ago, the facility only had one housekeeper for the whole facility. During an interview on 5/13/26 at 2:04 PM, Staff H, CNA stated the urine odor was very bad and everywhere. Staff H stated certain rooms were worse, especially room [ROOM NUMBER] bathroom was really bad. During an interview on 5/14/26 at 9:48 AM, the Housekeeping Lead queried about the urine odors and she acknowledged the odor and stated when she mopped 200 Hall she took extra time so the smell was not so powerful. The Housekeeping Lead stated she also took extra time cleaning the floors and walls in 3 rooms on the 200 Hall. The Housekeeping Lead stated she cleaned the rooms daily and the aides would let her know if they needed cleaned again due to the smell being overpowering. The Housekeeping Lead acknowledged the smell got bad, but stated she can't stay in the rooms all day, and the staff tried their best. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility policy, titled Work Orders, Maintenance, dated 4/2010, revealed, in part, .Maintenance work orders shall be completed in order to establish a priority of maintenance service .Works order requests will be completed in a facility specific maintenance portal . Work orders will be prioritized and followed up as indicated .Emergency requests will be given priority in making necessary repairs.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on employee record review, facility policy review, and staff interviews, the facility failed to complete a thorough background check for 1 of 5 employees reviewed for background checks. The facility reported a census of 57 residents. Findings include: Review of the employee record for Staff A, Registered Nurse (RN) revealed a start date of 7/16/25. The Single Contact License & Background check (SING) dated 7/14/25. revealed: Child Abuse: Initiate record check evaluation process by completing form [PHONE NUMBER] and submitting to HHS (Health and Human Services) The employee file lacked documentation of any further documentation for the evaluation of child abuse. During an interview on 5/14/26 at 2:57 PM, the Business Office/Human Resource Manager queried on Staff A SING report and she stated she missed the child abuse section. She stated she reviewed the dependent abuse and sex offender sections. The Business Office/Human Resources stated the facility suspended Staff A and the facility submitted for the record evaluation and asked it to be expedited. The Business Office/Human Resource Manager stated she intended to review all staff SIGN to make sure nothing else missed. During an interview on 5/14/26 at 4:20 PM, the Administrator queried on Staff A SING and she stated she due to where the child abuse was located on the paper, her staff missed it, and the facility would go back and review all the staff files to make sure they didn't miss anyone else. Review of the undated policy titled Background Screening Investigations Policy revealed:a. The director of human resources, or designee, conducts background checks, reference checks and criminal conviction checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors. Background and criminal checks are initiated with offer of employment or contract agreement, and completed prior to employment.b. Should the background investigation disclose any misrepresentation on the application form or information indicating that the individual has been convicted of abuse, neglect, mistreatment of individuals, and/or misappropriation of property, the applicant is not employed or contracted.c. Any information (e.g., court actions) discovered through the course of the background investigation that indicates that the applicant is unfit for employment in a nursing home (for example, convictions involving child abuse, sexual assault, theft, assault with a deadly weapon, etc.) is reported to the individual's appropriate licensing boards.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	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 record review, staff interviews, and the facility policy, the facility failed to thorough document transfers to the hospital (Resident #2 and Resident #13); failed to provide the resident and/or the resident's representative a transfer notice, in writing, for 2 of 2 residents reviewed for hospitalization (Resident #1, Resident #11). The transfer notice also failed to include the resident appeal rights, the Ombudsman contact information, and the contact information for those agencies responsible for the protection of residents with intellectual, developmental, mental and related disabilities. This failure impacted all residents transferred to the hospital. The facility failed to notify the Ombudsman after resident sent to the hospital (Resident #10) for 5 of 5 residents reviewed for transfers. Findings include: 1. The Minimum Data Set assessment dated [DATE] revealed Resident #2 scored a 9 out 15 on the Brief Interview for Mental Status, which indicated a moderate cognitive impairment. The list of diagnoses included stroke, hemiplegia/hemiparesis, and diabetes mellitus.Review of the electronic health record (EHR) revealed the following:a. Orders Administration Note dated 12/7/225 at 5:43 PM: nitroglycerin tablet sublingual 0.4 MG (milligrams)- give 1 tablet sublingually every 5 minutes as needed for Chest Pain x 3 doses. If no relief, call MD (Medical Doctor). Resident c/o (complaints of) chest pain.b. Orders Administration Note 12/7/25 at 5:49 PM: . Administration was: Ineffectivec. eInteract Transfer Form V5 dated 12/7/25 at 5:52 PM, completed for transfer to hospital. The form lacked documentation of the change of condition and the forms sent with the resident.d. Nurses Note dated 12/7/25 at 9:22 PM: Resident returned from ED (emergency department) with no new orders. Arrived via wheel chair in a [company redacted] van. VSS Resident in a pleasant mood denies pain at this time. During an interview on 5/14/26 at 1:16 PM, Staff B, Licensed Practical Nurse (LPN)/Unit Manager asked what needed completed during a transfer and Staff B stated an eInteract Change of Condition if a change in a resident's behavior, contact the provider, get an order for transfer, put the order in and call 911. Staff B stated then the nurse started the transfer, and documents what time the provider called, family, and the ambulance. Staff B stated he printed the medication list, face sheet, transfer discharge sheet, and advanced directives. Staff B stated after the resident transported out of the facility, he notified the ED and gave report. Staff B stated the nurse could document in the eInteract Change of Condition or progress notes. Staff B queried on Resident #2 transfer on 12/7/26 and Staff B stated he might have missed doing the eInteract Change of Condition because he was PRN. Staff B confirmed he should have documented what he sent with the resident and what occurred prior to transport.2. The MDS assessment dated [DATE] revealed Resident #13 scored a 15 out of 15 on the BIMS exam, which indicated intact cognition. The MDS revealed medical diagnoses for depression and alcohol abuse, uncomplicated. The Care Plan revealed a focus area revised on 2/16/26 alteration in mood and behaviors aeb (as evidenced by) yelling/cursing at staff and refusing cares at times. Is often noncompliant with plan of care. Resident often goes out of the facility and returns appearing to be intoxicated. It is suspected that she hides alcohol in her belongings as well as she frequently returns with bags full of clothing and grocery items. The interventions dated 1/8/26 indicated if resident appeared to be intoxicated staff to monitor in order to keep her safe and keep other residents safe. Notify PCP (Primary Care Provider) and hold meds as needed. The interventions dated 2/16/26 noted over the previous weekend resident noted to have consumed alcohol. PCP notified and medications held as ordered. The interventions noted on 5/11/26 resident sent to ER (Emergency Room) for intoxication, MD (Medical Doctor) notified with orders to obtain a blood alcohol and to hold medications.An eInteract Transfer Form V5 dated 5/11/26 at 9:42 PM, revealed resident intoxicated and the last vital signs provided from 5/9/26. The transfer form lacked documentation of current vitals, events that occurred prior to transfer to hospital, and forms sent with the resident. The Nurses Note dated 5/11/26 at 5:15 PM (note put in by the Director of Nursing (DON) on 5/12/26 at (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	11:21 AM), revealed the resident was noticed to be stumbling while ambulating and slurred speech. able to move all extremities. Alcohol was smelled on residents' breath. MD was notified with orders to hold medications and send to ER (Emergency Room) for blood alcohol level. Ambulance was called, arrived and transferred resident to [name redacted] for treatment. resident was noncompliant with a full assessment and upset with staff due to sending her out for evaluation. During an interview on 5/14/26 at 3:43 PM, the DON queried on the process of a transfer and she stated nurses needed to do an assessment, vitals, call the provider, write down the times when called the ambulance, provider, and family. The DON stated a progress note needed completed with vitals and when the provider, ambulance, and family notified. The DON asked about her writing the progress note the following day after Resident #13 transferred out to the facility and the DON stated the situation with Resident #13 was a little messy and Resident #13 was intoxicated and Staff B called the DON and questioned if Resident #13 would go to the hospital, but it went pretty easily. The DON confirmed Staff B probably didn't document because Staff B was a new nurse and the DON was trying to get Staff B to put more progress notes in The DON confirmed a progress note needed completed with the change of condition and the forms sent with the resident. 3. The MDS assessment dated [DATE] revealed Resident #1 scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed diagnoses for non-Alzheimer's dementia and difficulty walking. The Nurses Note dated 5/8/26 at 1:09 PM, revealed resident was moving around dining room in her wheel chair. CNA found resident lying on her belly. NP (Nurse Practitioner) stated that she would like to get her evaluated as it was unclear if it could be an obstruction or a bladder infection. Resident's pain continued at a 10 and became diaphoretic (sweaty). Resident was then transferred to the gurney via (by) the EMTs (Emergency Medical Technicians.The Bed Hold Authorization dated 5/8/26 revealed Resident #1 transfer out of facility on 5/7/26. The Bed Hold requested the facility hold the bed and above signature revealed per phone call with Power of Attorney (POA) dated 5/8/26. The Nurses Note dated 5/13/26 at 8:00 AM, revealed resident presented this AM with URQ (upper right quadrant) pain. Order to send to ED for eval and treat for severe abdominal pain.The Bed Hold Authorization dated 5/14/26 revealed Resident #1 transfer out of facility on 5/13/26. The Bed Hold requested the facility hold the bed and above signature revealed per phone call with resident representative dated 5/14/26. 4. The MDS assessment dated [DATE] revealed Resident #11 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed medical diagnosis for unspecified dementia. The Nurses Note dated 4/14/26 at 3:56 PM, revealed received a call from facility staff transporting resident to cardiology appointment, stated the cardiologist suggested taking the resident to the ER for abnormal vital signs. Facility staff transported to ER without incident. Resident was seen in ER and admitted to the hospital.The Bed Hold Authorization dated 4/15/26 revealed Resident #11 transfer out of facility on 4/14/26. The Bed Hold requested the facility hold the bed and above signature revealed per phone call with resident representative dated 4/15/26.The transfer notices above lacked documentation to include the resident appeal rights, the Ombudsman contact information, and the contact information for those agencies responsible for the protection of residents with intellectual, developmental, mental and related disabilities.During an interview 5/14/26 at 2:57 PM, the Business Office/Human Resources queried on bed holds and she stated the bed holds are done over the phone with a family member and have another staff member sign the bed hold with her. The Business Office/Human Resources stated she didn't provide a copy to the family/resident. The Business Office/Human Resources was not aware resident could appeal bed holds. During an interview on 5/14/26 at 4:20 PM, the Administrator queried on the bed holds and the Administrator stated she occasionally helped with the bed holds. The Business Office/Human Resources notified the family about the bed holds and didn't know if the family received a copy of the bed hold. The Administrator confirmed the family should receive a copy of the bed hold. 5. The MDS assessment dated [DATE] revealed Resident #10 scored a 4 out of 15 on the BIMS exam, which indicated severely impaired cognition. The MDS revealed medical diagnosis for unspecified dementia, severe with anxiety.The Nurses Note dated (continued on next page)

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Some	4/25/26 at 11:27 PM, revealed at approximately 9:15 PM, CNA notified this nurse that resident was found on the floor. Upon entering the room resident was on the floor between her bed and wheelchair. Phoned [name redacted] on call number and they notified [name redacted. [name redacted] phoned back with verbal order to send to ED (Emergency Department) for evaluation.Phoned 911 at 9:41 PM, phoned report to [name redacted] ED at 9:37 PM. Resident left with EMS (Emergency Medical Staff) at 9:56 PM.The Notice of Transfer Form to Long Term Care Ombudsman for April 2026 lacked Resident #10 name for a transfer. During an interview on 5/14/26 at 4:20 PM, the Administrator queried on reporting hospital transfers to the Ombudsman and the Administrator stated she only reported if they discharged or were hospitalized and didn't know she needed to notify the Ombudsman if they went to the hospital and came back. Review of the facility policy, Transfer or Discharge, last revised 3/2025 revealed the following information: a. When the facility transfers or discharges a resident, the following information is documented in the medical record and appropriate information is communicated to the receiving health care institution or provider: The basis for the transfer or discharge;That an appropriate notice was provided to the resident and/or legal representative;The date and time of the transfer or discharge;The new location of the resident;The mode of transportation;A summary of the resident's overall medical, physical, and mental condition;Disposition of personal effects;Disposition of medications;b. Transfer or Discharge Appeals: Upon notice of transfer or discharge, the resident is provided with a statement of his or her right to appeal the transfer or discharge, including:The name, address, email, and telephone number of the entity which receives such requests;Information about how to obtain, complete, and submit an appeal form;How to get assistance completing the appeal process; andThe facility bed-hold policy.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to accurately assess and implement a physician order to prevent the worsening of a moisture associated skin damage (MASD) wound for 1 of 2 resident (Resident #18) with a history of MASD. The facility reported a census of 57 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #18, dated 10/14/25, identified an admission date of 10/8/25. The Brief Interview for Mental Status (BIMS) score of 12 out of 15, indicated a moderate cognitive impairment. The diagnoses list included diabetes, incontinence without sensory awareness and morbid obesity. The assessment identified the resident had moisture associated skin damage (MASD).The BIMS completed for the 4/9/26 MDS indicated intact cognition based on a score of 15 out of 15.Review of Resident #18 Care Plan dated 10/31/25, revealed a Focus area to address I have frequent redness irritant to skin folds that require antifungal treatment as needed. Interventions initiated on 10/31/25 included, in part: Treatments as ordered.A review of the October 2025 Treatment Administration Record (TAR) revealed the following: Weekly skin assessments Q (every) Wednesday every day shift. Order Date: 10/8/25.Review of the electronic health record (EHR) revealed Skin Check notes with assessments occurred on the following dates.a. 4/8/26 - N Adv-Skin Check note.#001: New skin issue. Location: Left lower quadrant midline.Issue type: Abrasion. Progress: New wound. Wound acquired in-house. Length (cm): 0.6 Width (cm): 0.4 Depth (cm): 0 Granulation: 100%. Cleansing solution: Generic wound cleanser. Other primary dressing: border gauze.1. Review of EHR revealed a Nurses Note dated 4/8/26 at 1:13 PM: Order to keep skin ABD abrasion clean, dry and open to air.b. 4/15/26 - N Adv-Skin Check note.No new skin issues identified. #001: Skin issue is resolved. Location: Left lower quadrant midline.1. Review of EHR revealed a [name of clinic redacted] Office/Clinic Notes dated 4/16/26 which documented, in part: .History of Present Illness.She [Resident #18] expresses concern about a wound with steroids left.Physical Exam.SKIN: Warm, perfused, and dry. LLQ (left lower quadrant) abrasion, left inner thigh wound, moist, fluid filled intact blisters. Assessment/Plan.5. Open wound of left thigh, inner.I reached out [doctor name redacted] for treatment options, current treatment is marathon wound dressing, area constantly moist d/t (due to) incontinence.2. Review of a Physician Order dated 4/16/26 revealed: Left inner thigh wound: Clean wound with wound cleanser daily and if soiled; d/c marathon dressing; Start using Triad Cream BID and PRN if soiled; Make sure she is being check and changed frequently d/t MASD. 3. Review of the April and May 2026 Medication and Treatment Administration Record (MAR/TAR) revealed no order for left inner thigh wound cleansing daily and if soiled, or use of Triad cream BID and PRN if soiled. Marathon order discontinued 4/1/26. c. 4/22/26 - N Adv-Skin Check note.No new skin issues identified.d. 5/6/26 - N Adv-Skin Check note.No new skin issues identified.d. 5/13/26 at 8:41 AM- N-Adv Skin Check note.No new skin issues identified.1. Review of the EHR revealed a Nurses Note dated 5/13/26 at 2:02 PM: Resident has open area associated with MASD to right buttock and has scratched and reopened previous area on inner left thigh. Buttock measures 0.3 cm x 0.4 cm. Inner thigh measures 1.9 cm x 0.6 cm. Cleaned with wound cleanser and applied house zinc.On 5/13/26 at 7:49 AM, during an interview, Staff C, Registered Nurse identified herself as the facility wound care nurse. She explained the floor nurses were responsible for the resident's weekly skin assessment if the resident did not have any wounds. Staff C reported Resident #18 did not currently have wounds, but the resident did have a thigh wound that would come and go. On 5/13/26 at 9:14 AM, during an interview, Resident #18 reported two wounds, one on her left thigh and a sore on her bottom. She thought the wound on left thigh was getting better, and reported sometimes it was closed and sometimes the wound was open. Resident #18 thought both the wound on her bottom and upper left thigh were from wearing the smaller size incontinent briefs and the briefs rubbing against her skin. Resident #18 explained the facility did not order the right size brief in a previous order. Resident #18 reported the nurse had not been in that morning to assess her wounds. On 5/13/26 at (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	9:27 AM, during an interview, Staff L, Licensed Practical Nurse (LPN) reported she was the floor nurse this day for Resident #18. She reported the resident was due for a skin assessment today and she would get the State Agency (SA) when it was time. Staff L reported the Certified Nursing Assistants (CNA) were good about letting her know if residents had any skin issues, and nothing had been reported to her yesterday when she worked with Resident #18.During an observation on 5/13/26 at 10:11 AM, Staff L, Licensed Practical Nurse (LPN), entered the room to assess Resident #18's skin and donned gloves. Staff L identified two wound areas. Staff L measured an open upper right coccyx wound at 0.3 centimeters (cm) in length and 0.4 cm in width and had shallow depth in appearance. Staff L described there is a scabbed area above the open wound on the coccyx. Staff L measured the open left inner thigh wound at 1.9 cm in length and 0.4 cm in width. The left inner thigh wound had a scabbed area similar in size above the open area. Staff L then sprayed the wounds with wounds cleanser and applied zinc oxide to each area.Review of May 2026 MAR/TAR revealed the following orders for skin and wound care:a. Miconazole Powder (Miconazole) Apply to effected area topically as needed for redness BID. Order Date: 10/29/26. Administered on 5/1/26 and 5/6/26.On 5/13/26 at 3:34 PM, during an interview, Staff G, LPN, reported she had worked at the facility for 3 weeks and had provided wound treatment to Resident #18 in the last three weeks. Staff G reported the CNAs had reported wound concerns more than once regarding Resident #18. Staff G reported she would check out the concerns every time. Staff G reported the resident had wound to her thigh area. The resident complained about the wound and about it hurting her a lot. The wound looked like an old wound with scabs and open areas. Staff G reported she only saw one wound on the left upper inner thigh, and did not see any weeping from the wound. Staff G reported she gave the resident Tylenol one time for pain related to the wound. Staff G reported she did try to document in the progress notes when she looked at wounds. Staff G reported she did not notify anyone else that the wound was open. Staff G explained there was already ongoing wound treatment.During an interview on 5/13/26 at 3:24 PM, the Director of Nursing (DON) explained floor nurses were responsible for completing skin assessments on residents every week. Residents with wounds were seen by Staff C, RN, every Wednesday. The DON reported she reviewed Staff C's notes and compared the notes to the previous week. The DON reported if see saw that a wound was stalled, she would fax the resident's physician. The DON added the facility's ARNP came to the facility and reviewed wound documentation every Thursday. On 5/14/26 at 8:05 AM, during an interview, Staff C, RN stated that she had been treating Resident #18 left inner thigh wound off and on. Staff C, RN stated the wound would heal, and the resident would scratch the area and it would reopen. Staff C explained seeing fingernail marks from where the resident had scratched the left inner thigh on occasion. Staff C, RN, reported she did not consider a scab over a wound as healed. Staff C explained when she assessed the thigh wound had healed, the skin might have been discolored, but the skin was intact. Staff C reported the last time she had assessed the resident's left inner thigh was when the resident was getting the Marathon treatment. Staff C explained if the treatment was discontinued, then the wound was healed. Review of the April MAR/TAR revealed Marathon order discontinued 4/1/26. During an interview on 5/14/26 at 11:05 AM, Staff V, ARNP (Nurse Practitioner), reported she was one of a group of three nurse practitioners for the facility. They all worked together to share responsibility of the residents. Staff V reported she wanted to be notified as soon as nursing staff found a wound. Staff V explained there was a process for the facility to send a fax to the provider group, and the group would send a fax back. Nursing staff could also call if the resident had concerns that needed to be addressed that day. If a resident had a new open wound, or a change with a current wound, the ARNPs would give a new treatment order. Staff V explained it was not okay for nursing staff to do a wound treatment without an order first. Staff V did think it would be okay to use a PRN order for Zinc Oxide or barrier cream if a resident had some excoriation from incontinence. Staff V stated she would assess Resident #18 today. At 11:35 AM after assessing Resident #18, Staff V, ARNP reported the resident left thigh wound looked worse compared to the assessment on 4/16/26 completed by another ARNP. Staff V stated the Zinc Oxide (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	treatment was not going to be effective. Staff V reviewed Resident #18 seen on 4/16/26 for a 60 day follow up visit and at that time was found to have one intact left inner thigh wound with fluid filled blisters. Staff V stated after the assessment the ARNP faxed a new order to the facility for: to discontinue the Marathon wound treatment, clean the wound with wound cleanser, apply Triad cream BID and PRN if soiled, and to make sure to check and change (resident's incontinent brief) due to maceration. Staff V reported she had not assessed the resident's coccyx wound on the visit today.Review of a document titled Final Report dated 5/14/26 revealed, in part: Chief Complaint: Acute Visit - Wound management. History of Present Illness: .The last wound treatment ordered on 4/16/26, which included cleaning the wound with wound cleanser daily and applying Triad twice a day. Upon assessment of the wound today, it was found to be larger with slough present. There was no redness or warmth noted in the area during today's assessment. I am changing the wound treatment orders to mupirocin and mometasone mixed 50-50 and applied to the wound bed covered with gauze and tape. Dressing to be done daily and as needed if soiled. On 5/14/26 at 11:52 AM, during an interview with the DON and Unit Manager, the Unit Manager reported they did receive the reports from the ARNP and physician visits via a fax system. The Unit Manager explained they usually received the reports the next day. The Unit Manager found the 4/16/26 visit note for Resident #18 in their electronic fax system. The visit and orders had not been pulled from the fax system.On 5/14/26 at 12:11 PM, during an interview, Staff C, RN, reported when she documented that she had assessed Resident #18 skin on 4/15/26, she would have done a full skin assessment and assessed the resident's left thigh. She explained the blisters could develop quickly and she did not see them on 4/15/26. Staff C did not remember doing the resident's skin assessment on 5/6/26. She explained that if she documented she did a skin assessment, then she did it. She then stated that she did the best that she could, and sometimes she could not see everything. On 5/14/26 at 4:22 PM, the DON reported she had been told by the wound nurse that Resident #18's left thigh wound had healed a couple days after the DON started to work at the facility, about six weeks ago. The DON reported she had only had access to the electronic faxes the last couple weeks, and the Unit Manager had showed her how to access them. Review of the facility policy, titled Medication and Treatment Orders dated July 2016 revealed a Policy Statement which declared: Orders for medications and treatments will be consistent with principles of safe and effective order writing. The Policy and Interpretation and Implementation section directed, in part:1. Medications and Treatments shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state.Following Orders - Physician orders shall be followed, if unable to follow physician orders, notify Director of Nursing Services/ Designee and physician as appropriate. Review of the facility policy titled Wound Care dated October 2010, revealed a Purpose Statement which declared: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The Preparation order directed:1. Verify that there is a physician's order for this procedure.2. Review the resident's care plan to assess for any special needs of the resident.a. For example, the resident may have PRN orders for pain medication to be administered prior to would care.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, record review, staff interviews, and the facility policy, the facility failed to ensure ongoing, personalized interventions for residents to address alcohol consumption by residents at the facility and to address alcohol being shared between residents at the facility for 4 of 4 residents reviewed (Resident #2, Resident #3, Resident #13, and Resident #19) for alcohol use; failed to keep a medication secured in a medication cart resulting in a resident accessing a topical pain relief medication with possible ingestion of the medication per facility staff for 1 of 4 residents reviewed for inadequate nursing supervision (Resident #10); and failed to conduct a smoking evaluation during admission for 1 of 4 residents reviewed for smoking (Resident #12). The facility reported a census of 57 residents. Findings include:1. The Minimum Data Set (MDS) assessment dated on 4/9/26 revealed Resident #13 scored a 15 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated resident independent with mobility. The MDS revealed medical diagnosis of depression, alcohol use unspecified, and revealed the resident took antidepressant medications. The Care Plan revealed a focus area revised on 2/16/26 revealed, in part, the following: The resident had alteration in mood and behaviors aeb (as evidenced by) yelling/cursing at staff and refusing cares at times. Is often noncompliant with plan of care. Resident often goes out of the facility and returns appearing to be intoxicated. It is suspected that she hides alcohol in her belongings as well as she frequently returns with bags full of clothing and grocery items.The Care Plan interventions dated 1/8/26 indicated if resident appeared to be intoxicated staff to monitor in order to keep her safe and keep other residents safe. Notify PCP (Primary Care Provider) and hold meds as needed. The interventions dated 2/16/26 revealed on 2/16/26 over the previous weekend resident noted to have consumed alcohol. PCP notified and medications held as ordered. The interventions dated 5/11/26 indicated resident sent to ER (Emergency Room) on 5/11/26 for treatment for being intoxicated, MD (Medical Doctor) notified with orders to obtain a blood alcohol and to hold medications. The Care Plan did not address interventions to try to prevent resident from drinking at the facility or bringing in alcohol. The Nurses Notes dated 2/16/26 at 12:02 PM revealed resident started drinking on Friday February 13th and continued to drink until Sunday February 15th. Medications were held throughout the weekend. Resident was stable and monitored over the weekend. No signs/symptoms (s/s) of distress. Was no disruptive with staff or peers. Sending this note over to PCP with copy of MAR (Medication Administration Record) to update with medications that were held.The Behavior Note dated 2/16/26 at 4:09 PM revealed writer met with Resident #13 today. She noted that she did consume alcohol over the weekend, and she did notify to nurse. MD (Medical Doctor) aware. She states that she does not want any other psychotherapeutic follow up. Re education provided, d/c (discharge) still in progress with [name redacted] regarding placement.The Nurses Note dated 3/12/26 at 2:54 PM revealed resident was observed pouring vodka into a drinking cup with red juice into it. This nurse explained to her we would be holding her medications while she would be drinking. Resident stated she thought she was still taking an antibiotic. This nurse stated if she was we would hold it and finish the antibiotic if that is what the provide wanted. Sending this note over to update provider on resident and current activities. Will re-start medications in AM if resident is no longer consuming alcohol.The Nurses Note dated 3/13/26 at 9:25 AM revealed medications held on 3/12 and 3/13. Nurse stated that he held her medications due to showing visible signs of being intoxicated. Resident denied drinking but was stumbling down hallways and being loud. Resident was laughing and her face was flushed. She was carrying around a cup he assumed to be a mixed drink. Resident is own POA (Power of Attorney). Sending fax to PCP. Nurse did say he called the PCP and notified. Just sending for follow up.The Nurses Note dated 5/11/26 at 5:15 PM revealed the resident was noticed to be stumbling while ambulating and slurred speech. able to move all (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	extremities. Alcohol was smelled on residents' breath. MD was notified with orders to hold medications and send to ER for blood alcohol level. Ambulance was called, arrived and transferred resident to [name redacted hospital] for treatment. resident was noncompliant with a full assessment and upset with staff due to sending her out for evaluation. 2.The MDS dated [DATE] revealed Resident #3 scored a 13 out of 15 on the BIMS exam, which indicated cognition intact. The MDS indicated medical diagnoses of Type II diabetes mellitus (DM), alcoholic cirrhosis of liver without ascites, alcohol use, anxiety disorder, depression, and post traumatic stress disorder (PTSD). The Care Plan revealed a focus area dated 8/29/25 which revealed the resident had alcoholic cirrhosis of the liver. The interventions dated 8/29/25 indicated encourage alcohol cessation. The Care Plan revealed a focus area dated 2/16/26 for alteration in mood and behaviors aeb resident sometimes drink alcohol when she had provider orders to drink only non-alcoholic beer. The intervention dated 2/16/26 indicated to notify PCP and hold medications as ordered when it is believed resident has consumed alcohol. The Nurses Note dated 2/15/26 at 5:10 PM, revealed at 8:50 AM, this AM while this nurse was taking the resident's blood sugar (BS), the resident stated, I did something bad. This nurse asked the resident what they meant. The resident stated, I was bad and I drank. The nurse asked the resident what she meant. The resident stated, I drank alcohol the other day. The nurse asked the resident if the alcohol was in the resident's room. The resident stated it wasn't in the room. This nurse asked where the resident had gotten the alcohol from and the resident stated, I can't tell you, I'm not a snitch. This nurse educated the resident on the poor outcome of these behaviors if continued with current health conditions/diagnoses and how the current medications could have adverse reactions with the use of alcohol.The Nurses Note dated 2/15/26 at 5:22 PM, revealed at 4:40 PM, this nurse was approached by a staff member that the resident was leaned over in the wheelchair observed to be sleeping at the dining room table. This nurse brought the resident out of the dining room to do a focused assessment. The resident was slurring their words, their cheeks were flushed, and the resident could not stay awake during the conversation. This nurse asked the resident if they had drank any alcohol to which the resident stated no. This nurse took vitals, BP (blood pressure) 116/72, HR (heart rate) 93, Temp (temperature) 98.2, O2 (oxygen) 98% RA (room air), respirs (respirations) 16, BS 310. On call provider, [name redacted], notified of situation. On call manager, [name redacted] notified.The Nurses Note dated 2/16/26 at 12:08 PM revealed resident had a peer supply her with alcohol on Friday February 13th and they continued to drink until Sunday February 15th off and on. Medications were held throughout the weekend. Resident was stable and monitored over the weekend. No s/s of distress. Was no disruptive with staff or peers. Sending this note over to PCP with copy of MAR to update with medications that were held.3. The MDS assessment dated [DATE] revealed Resident #2 scored a 9 out 15 on the BIMS exam, which indicated moderately impaired cognition. The MDS revealed medical diagnoses of stroke, hemiplegia/hemiparesis, and diabetes mellitus. Per the MDS, the resident took antidepressant and hypoglycemic medication.The Behavior Note dated 12/21/25 at 3:33 PM revealed at 3:30 PM this nurse watched resident [Resident #19] hand [Resident #2] a cup of amber liquid and look down the hall at me and turn around as [Resident #2] was taking a drink. This nurse headed up the hall and asked [Resident #19] if he gave [Resident #2] alcohol, [Resident #19] stated I dont know what he has. I held my had out to [Resident #2] and he placed the cup in my hand and it smelled of Alcohol, at that time I had the CMA (Certified Medication Aide) confirm that it smelled of alcohol and was disposed of in the sink and witnessed by [name redacted, Registered Nurse]. I discussed with [Resident #2] that he should not be drinking alcohol while he is here at the facility and he can discuss that with his family when he leaves in a few days, he verbalized understanding. Family was called and he asked to talk to family member. This nurse heard [Resident #2] say I don't know what was in the cup PCP notified.4. The MDS assessment dated [DATE] revealed Resident #19 scored a 15 out of 15 on the BIMS exam, which indicated cognition intact. The MDS revealed medical diagnoses for anxiety disorder, depression, alcohol dependence, and alcoholic cirrhosis of liver without ascites. Per the MDS, the resident took (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	antidepressant, antianxiety, and opioid medication. The Care Plan revealed a focus area dated 11/25/24 which revealed the following: There are days [resident] may become physically and/or verbally aggressive towards others secondary to: Poor impulse control. Non- compliant with alcohol policy. The Physician Orders revealed the following:The Physician Order started on 6/19/24 and discontinued on 4/14/26 revealed, NO alcohol consumption while resident is taking pain medication- every shift for monitoring.The Orders Administration Note dated 12/13/25 at 8:37 PM, revealed resident may have non alcoholic beers 2 beers daily one at noon and one at bedtime.resident did not ask for beer. The Administration Note dated 12/13/25 at 8:38 PM, revealed no alcohol consumption while resident taking pain medication- every shift for monitoring- resident seems to be intoxicated. Resident's breath smells of alcohol and pupils are approx. (approximately) 7-8mm (millimeters). DON notified, PCP faxed, medications held.The Nurses Note dated 12/13/25 at 8:42 PM, revealed resident seems to be intoxicated. Resident is slurring words, their breath smells of alcohol, pupils are approx 7-8mm. Only medications received this shift were PRN (as needed) promethazine, scheduled tylenol, and scheduled guaifenesin, all other medications held per nursing judgement. DON, [name redacted] notified, PCP notified.The Behavior Note dated 12/21/25 at 3:30 PM, revealed @1530 this nurse watched resident [Resident #19] hand [Resident #2] a cup of amber liquid and look down the hall at me and turn around as [Resident #2] was taking a drink. This nurse headed up the hall and asked [Resident #19] if he gave [Resident #2] alcohol, [Resident #19] stated I dont know what he has. I held my had out to [Resident #2], and he placed the cup in my hand and it smelled of Alcohol, at that time I had the CMA confirm that it smelled of alcohol and was disposed of in the sink and witnessed by [name redacted, Registered Nurse]. I discussed with [Resident #19] that he should not be drinking alcohol while he is staying at our facility to which he shrugged his shoulders. PCP notified, Hold meds.The Behavior Note dated 12/28/25 at 2:54 PM revealed resident upset because d/t (due to) weather residents can not go out to smoke. Resident said he would just call up one of his friends to bring him some alcohol since he cannot smoke because there is nothing we can do about it.The Nurses Note dated 1/3/26 at 9:40 AM revealed resident was yelling this AM in hallway about having to have a roommate. This nurse explained there is no other open room and he would have to find a way to get along. He continued to be upset and returned to his room. CMA x 2 could smell alcohol on him. PCP stated to hold his narcotics for 12 hours due to alcohol consumption, but ok to give HTN (hypertensive) medications. Resident is his own POA and aware.During an interview on 5/13/26 at 1:06 PM, Staff J, Certified Nurse Aide (CNA) queried on the alcohol policy and Staff J stated knew some residents could bring in things they wanted, and some had brought in alcohol. Staff J stated she knew the facility had non-alcoholic beer. Staff J stated she didn't know the rules but she would think the facility would keep in locked in the medication room. During an interview on 5/13/26 at 1:40 PM, Staff I, CNA queried about the alcohol policy and Staff I stated as far as Staff I knew, residents couldn't bring it in, but staff were not allowed to take it out of the resident's room. Staff I stated Resident #13 brought it in and shared it with others. Staff I asked if where the alcohol was located and Staff I stated sometimes it would be out in the open and other times hidden. Staff I stated Resident #13 gave the cup to the staff and when staff took the lid off, they could smell alcohol. Staff I stated there was nothing they could do about it except alert the nurse. During an interview on 5/13/26 at 3:33 PM, Staff G, Licensed Practical Nurse (LPN) stated she was not clear on the alcohol policy. Staff G stated Resident #3 and Resident #13 drink at the facility and Staff G was told Resident #13 left the facility and brought back alcohol. Staff G stated she never seen the residents drinking. During an interview on 5/14/26 at 12:23 PM, Staff F, LPN stated it was reported to her Resident #3 and Resident #13 drinking over the weekend in February. Staff F stated a CMA saw Resident #13 pour it. Staff F queried if resident could bring alcohol into the facility, and Staff F stated officially Staff F got different information. Staff F stated Resident #13 could bring it, but we always encouraged her to turn it over to the nursing staff and the previous Administrator had several conversations with Resident #13 on not bringing alcohol into the facility. Staff F stated when Resident #13 would leave (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the facility, staff would go into her room and clean up the dirty dishes and find plastic pitchers with red [brand name] juice and when they took off the lid, it smelled like vodka. Staff F stated the only concern she had with Resident #13 drinking was when other staff were on call and didn't notify the provider and hold her medications. During an interview on 5/14/26 at 1:16 PM, Staff B, LPN/Unit Manager stated the alcohol policy was to notify the doctor and tell the staff to hold the medications. Staff B stated there was a fine line between resident rights and taking it, hard to explain, in his opinion. Staff B stated the policy was that the facility is their home, and if the residents BIMS is 15 would monitor their behaviors and notify the PCP. Staff B stated the residents he knew who drank in the facility were Resident #3, Resident #13, and Resident #19. Staff B stated he hoped the residents care plan were updated. Staff B stated he didn't agree with the alcohol policy, but it was breaching resident rights to confiscate. During an interview on 5/14/26 at 3:43 PM, the Director of Nursing (DON) stated the alcohol policy was the facility received an order from the physician and the pharmacy needed notified on what meds needed to be held. The DON stated residents should not be drinking in the facility, and if residents were drinking, their medications should be held. The DON queried what if a cognitive impaired resident got ahold of the alcohol, and the DON stated she didn't know, they hadn't had that happen.During an interview on 5/14/26 at 4:20 PM, the Administrator queried about the alcohol policy and the Administrator stated the policy was for a physician order and the resident needed to purchase it. The Administrator stated they were providing information often and encouraged Resident #13 not to drink because of the interaction with her medications. The Administrator stated Resident #13 wouldn't allow the facility to go through Resident #13's things. The Facility Alcoholic Beverages Policy dated February 2023 revealed: A physician's order must be received before any alcoholic beverage may be administered to a resident.Alcoholic beverages must be paid for by the resident, his family, and/or the resident's representative (sponsor).The Nurse Supervisor receiving the alcoholic beverage must label the bottle.Should you have any doubt concerning the administration of the beverage to the resident, contact the Director of Nursing Services.5. The MDS assessment dated [DATE] revealed Resident #10 scored a 4 out of 15 on a BIMS exam, which indicated severely impaired cognition. The MDS indicated the resident used a wheelchair. The MDS revealed medical diagnosis for unspecified dementia, severe with anxiety. The Nurses Note dated 3/12/26 at 11:51 AM revealed called to staff. She reported that she saw resident take off the cart & squirt some ActiveIce (topical pain-relief product) in a cup and possibly put some in her mouth. When evaluated her, she smelled like ActivIce. Vitals signs stable. Call made to [name redacted] w/ (with) instructions to call poison control. I was then instructed by them to give her some water or milk to drink. May irritate her lips some but she will be okay. She was gave water right away. NM (Nurse Manager) [name redacted] & Daughter [name redacted] notified. Resident is unable to say if she took any. She was making funny faces.During an interview on 5/14/26 at 1:54 PM, Staff B, LPN/Unit Manager stated he heard about the situation with Resident #10 but didn't know what interventions they did for Resident #10. Staff B stated a risk management was opened on it and the ActiveIce should of not been on top of the cart, it should of been locked up in the bottom of the cart. During an interview on 5/14/26 at 3:43 PM, the DON confirmed the ActiveIce should have been locked in the treatment cart so Resident #10 couldn't have access to it. The Facility Storage of Medications Policy revised November 2020 revealed, Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer medications have access to locked medications.6. Review of Resident #12's Census information revealed the resident admitted to the facility on [DATE].The BIMS evaluation completed 5/5/26 at 4:31 PM revealed the resident scored a 15 out of 15, which indicated cognition intact. The Care Plan revealed a focus area dated 5/5/26 which revealed the resident continued to enjoy smoking. The intervention dated 5/5/26 indicated to instruct resident about the facility policy on smoking locations, times, and safety concerns. The Electronic Medical Record (EMR) Standard Evaluation page lacked documentation a Smoking Evaluation was completed. During an observation (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on 5/13/26 at 9:45 AM, Resident #12 went outside to smoke and took out his walker. Once he sat down, the portable oxygen concentrator turned off and the walker placed inside. During an observation on 5/13/26 at 9:57 AM, Resident #12 finished smoking and the CNA took off his apron and brought him his wheeled walker outside with his oxygen concentrator and turned it on as the resident walked back inside.Per Administrator email on 5/14/26 at 11:22 AM, Resident #12 was listed as a smoker. During an interview on 5/14/26 at 1:16 PM, Staff B queried on smoking evaluations and Staff B stated residents needed them done prior to going out to smoke for the first time. Staff B stated the MDS Coordinator was completing those and Resident #12 should have had one completed. During an interview on 5/14/26 at 2:16 PM, the MDS Coordinator queried on the smoking evaluation for Resident #12, the MDS Coordinator acknowledged Resident didn't have one completed, and should have. During an interview on 5/14/26 at 3:43 PM, the DON queried about Resident #12's smoking evaluation and she stated she didn't know until today he didn't have one. Resident #12 should have had one on admission. The Facility Smoking Policy-Residents revised on November 2022 revealed the following:a.Resident smoking status is evaluated upon admission. If a smoker, the evaluation includes: 1. Current level of tobacco consumption; 2. Method of tobacco consumption (traditional cigarettes; electronic cigarettes; vaping, pipe, smokeless tobacco etc.); 3. Desire to quit smoking; and4. Ability to smoke safely with or without supervision (per a completed Smoking Evaluation).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and the facility policy, the facility failed to keep urinary catheter tubing and collection bags off of the floor in an effort to prevent an urinary tract infection for 2 of 2 residents (Resident #3 and Resident #14) reviewed with a urinary catheter; and failed to start an antibiotic in a timely manner to treat an urinary tract infection for 1 of 2 residents (Resident #3) reviewed for urinary tract infections. The facility reported a census of 57 residents. Findings include:1. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #3 scored a 13 out of 15 on the Brief Interview for Mental Status (BIMS) exam, which indicated cognition intact. The MDS indicated resident dependent with toileting hygiene and utilized a urinary catheter. The MDS revealed medical diagnoses for neurogenic bladder, type II diabetes mellitus, and a urinary tract infection (UTI) in the last 30 days. The Care Plan revealed a focus area dated 8/29/25 indicated resident had impaired urinary elimination pattern due to urinary retention resultant with need for a catheter. The interventions included: monitor/record/report to MD (medical doctor) for s/sx (signs/symptoms) UTI: pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns. Date Initiated: 08/29/2025Review of the Bacteriology Report dated 5/7/26 at 7:49 PM revealed verified date/time of 5/9/26 at 12:43 PM greater than 100,000 cfu/ml (colony-forming units per milliliter) Escherichia coli extended spectrum Beta Lactamase (ESBL) type organism. Review of the electronic health record (EHR) revealed:a. Nurses Note dated 5/11/26 at 9:52 AM: culture results received and faxed to PCP (primary care provider)b. The Nurses Note dated 5/11/26 at 2:05 PM: [name redacted] noted urine culture grew multidrug resistant e. coli, with orders for fosfomycin (an antibiotic). Resident aware and order was sent to pharmacy by provider.During an observation on 5/12/26 at 10:02 AM, Resident #3 catheter tubing and bag dragging on the floor. Resident #3 asked staff if her catheter was still dragging, and the CNA (certified nursing assistant) stated they couldn't get it better. The CNA stated she tried to fix it when they were outside. As Resident #3 self-propelled down the hall with the catheter bag dragging on the floor. During an observation on 5/12/26 at 12:22 PM, Resident #3 wheeled herself from one dining room table to the next and the catheter tubing and catheter bag dragging on the floor. The Orders Administration Note dated 5/12/26 at 6:34 PM revealed Hot Charting: Monitor residents' behavior, s/s (signs/symptoms) of a UTI every shift for monitoring Behaviors until 05/15/26 at 11:59 PM- no S/SDuring an observation on 5/13/26 at 9:18 AM revealed Resident #3 sat in her wheelchair and the catheter bag and tubing was off the floor. During an observation on 5/13/26 at 10:06 AM, Resident #3 self-propelled down the hallway and her catheter bag touched the floor as she went into the shower room. During an observation on 5/13/26 at 12:53 PM, Resident #3 self-propelled out of the dining room and the catheter bag has a large amount of urine in the bag and as she propelled one side of the bag touched the floor. During an interview on 5/13/26 at 3:33 PM, Staff G, Licensed Practical Nurse (LPN) stated catheter tubing/bags could not drag on the floor. Staff G queried if she was aware Resident #3 had a UTI and Staff G stated they send out for a urine analysis with a culture and sensitivity but didn't know the results and was not aware of an antibiotic order.Review of the EHR revealed a Nurses Note dated 5/13/26 at 4:16 PM: NOR (new order) from [name redacted] for one dose of fosfomycin 3G to be mixed with liquids and drink immediately DX (diagnosis): UTI. Resident awareReview of the EHR revealed an Orders Administration Note at 5/13/26 at 4:45 PM: orders for Fosfomycin Tromethamine Oral Packet 3 GM- Give 1 packet by mouth one time a day for Uti for 1 Day mix packet in 4-6oz of liquid and drink immediately- waiting on pharmacy to bring2. The MDS assessment dated [DATE] revealed Resident #14 scored a 15 out of 15 on the BIMS exam, which indicated intact cognition. The diagnoses list included: neurogenic bladder (nerve damage caused loss (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of bladder control). The MDS indicated resident independent with toileting hygiene and utilized an indwelling catheter.Review of Resident #14 Care Plan revealed Focus areas to address: a. I have impaired urinary elimination pattern d/t (due to) neuromuscular bladder dysfunction resulting in the need for a suprapubic catheter. Resident often has bladder spasms resulting in urine leaking around the catheter. Date Revised: 6/9/25.b. I have a Urinary Tract Infection. Dated Initiated: 5/11/26.During an observation on 5/12/26 at 11:07 AM, Resident #14 self-propelled down the hallway with the urinary catheter tubing dragging on the floor.During an observation on 5/12/26 at 12:44 PM, Resident #14 sat in her wheelchair in her room with the urinary catheter tubing resting on the floor under her wheelchair. During an observation on 5/13/26 at 9:44 AM, Resident #14 self-propelled out of the building to go to the smoking area with the urinary catheter tubing dragging on the floor. While in the smoking area, Resident #14 foot rested on top of the catheter tubing. Facility staff present. During an interview on 5/13/26 at 1:06 PM, Staff J, Certified Nurse Aide (CNA) stated urinary catheter tubing and the bag should not touch the floor. Staff J stated Resident #3 would slide down and usually drug on the floor and Resident #14 usually wore a leg bag but since coming back from the hospital used the large bag. Staff J asked why the catheter bag/tubing drug on the floor and Staff J stated she thought from the movement of the resident when in their wheelchairs. During an interview on 5/13/26 at 1:40 PM, Staff I, CNA stated the catheter bag/ tubing couldn't touch the floor for infection control. Staff I stated some of the wheelchairs sat low and didn't know if there was a way to avoid the catheter bag from touching the ground.During an interview on 5/14/26 at 3:43 PM, the Director of Nursing (DON) stated catheter bags/tubing should not touch the ground. The DON explained Resident #3's wheelchair was a little shorter. The DON stated they obviously needed to get Resident #3 a different chair and to make sure the bag is secured on the seat for Resident #14.The [NAME] stated Resident #3 antibiotic order had been faxed by the provider to the pharmacy and not the facility. She explained she talked to the providers and they were made aware of the need to inform the facility of the orders. Review of the facility policy titled Urinary Catheter Care, revised March 2023 directed: Be sure the catheter tubing and drainage bag are kept off the floor.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, clinical record review, facility policy review, and staff interview, the facility failed to ensure nursing staff locked an unattended medication treatment cart for 1 of 2 observations for medication storage. The facility reported a census of 57 residents. Findings included:Review of the Minimum Data Set (MDS) for Resident #22, dated 4/23/26, revealed a diagnosis of dementia; and Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated a moderate cognitive impairment. The resident utilized a walker to with supervision or touch assistance to ambulate. Review of the Care Plan for Resident #22, dated 2/19/26, revealed a Focus area to address elopement risk/wanderer related to the resident wandering aimlessly. On 5/12/26 at 3:18 PM, while on a walkthrough of the facility with the Maintenance Director, a 4 (four) drawer medication/treatment cart noted to be positioned across from the nurse's station by the medication room. The cart unattended by a facility staff and unlocked. Staff A, Registered Nurse (RN) at the nurse's station not watching the unlocked cart. Resident #22 sitting in a chair near the cart with his walker within reach. Staff Q, Certified Medication Aide (CMA) stationed at another medication cart next to the nurse's station with her back to the unlocked cart. At 3:19 PM, the Unit Manger/Infection Preventionist noted to be in the hall talking with another staff person. The Maintenance Director called the Unit Manger over and asked him to lock the cart.During an interview on 5/12/26 at 3:19 PM, Staff Q, CMA, reported the cart that had been unlocked was the insulin and wound treatment cart for the 200 hall. Staff A, RN, joined the interview and explained she had unlocked the cart to put some gloves in. She explained she went into the nurse's station to get a computer and forgot to the lock the cart. On 5/12/26 at 3:27 PM, Staff A, RN and the State Agency (SA) reviewed the contents of the unlocked cart. The following medications and supplies were in the unlocked cart: a. Top drawer of car contained: disposable needles, spare glucometers, 2 pairs of scissors and a package of empty syringes with needles. b. Second drawer from the top of the cart contained: 4-lispro insulin pens; 1-Ozempic pen; 7-lantus insulin pens; 2-novolog insulin pens; 1-Baqsimi Nasal Powder (medication used to treat low blood sugar); 1-glucagon pen of 1 mg per 0.2 ml; 1-glucagon pen of 1 mg per 1 ml.c. Third drawer from the top of the cart contained: 1-tube Proctomed cream; 1-tube Hydrocortisone cream 2.5%; 1-container Magic Butt Paste; 1-tube Mupirocin topical ointment (antibiotic); 2-tubes Zinc Oxide; 1-tube Santyl (type of wound treatment); 1-container of Mometasone Furoate cream 1%; 1-tube Ketoconazole cream 2%; 1-container of Fluorouracil 5% cream; 1-container Miconazole 2% powder; 2-containers Nystatin 100,000 units/gram powder; 1-tube of Triamcinolone ointment 0.1%; 1-bottle of Ketoconazole Shampoo 2%In addition the drawer included the following stock medications: 4 - Lidocaine 4% patches; 1-container antifungal powder; 1-16 oz (ounce) bottle Active Ice temporary pain relief spray; 1-container Diclofenac 1% topical gel; 1-container Nystatin 100,000 units/gram powder; 1-3 oz container VapoFreeze pain relief cream with menthol and camphor; 2 - tubes Triad Wound Dressing topical cream; 2 - tubes Triple Antibiotic Ointment; 2 - containers Zinc Oxide; 2 - containers Silicone cream; 1 - container Zeasorb powder; 1 - tube Hemorrhoidal ointment; 1 - 14 oz container Aquaphor healing ointment; 1 - 400-gram container Ascend Silver Sulfadiazine cream.d. The fourth drawer from the top of the cart contained the following stock medications: Lidocaine 5% patches; 1-16-oz bottle Active Ice temporary pain relief spray; 1-16-oz bottle Skin Integrity Wound Cleanser Wound Wash; 1-bottle mouthwash; 2-32-oz bottles Hydrogen Peroxide; 1-16-oz bottle Witch Hazel.During an interview on 5/14/26 at 12:49 PM, the Unit Manager/Infection Preventionist stated it was important to keep the treatment carts locked so someone did not ingest something or get a hold of sharps. Review of the facility policy, titled Storage of Medications, dated 11/2020, revealed, in part: .Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. Only persons authorized to prepare and administer (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications have access to locked medications .Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. Unlocked medication carts are not left unattended.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to serve a meal to meet the physician ordered dietary needs for 2 (Residents #9 and #16) out of 42 residents reviewed for diet orders during a breakfast service. The facility reported a census of 57.Findings included: 1. Review of the Minimum Data Set (MDS) assessment for Resident #9, dated 4/2/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. Diagnoses included hip fracture, left tibia (lower leg) fracture, other fractures, and anemia (low red blood cell count).Review of the Care Plan for Resident #9, dated 4/24/26, revealed a Focus area to address I am at nutritional risk due to hospitalization.MNA (Mini Nutritional Assessment): 9/0 (4/2) At Risk for Malnutrition. Interventions initiated on 4/24/26 included:a. Diet: Consistent Carbohydrate with Double Protein portions to provide additional ~ 60 gms (grams) protein per [clinic name redacted].b. Meal Enrichments/Planned Snacks: Double protein at all meals per Ortho clinic recommendations.c. Monitor Meal Intakes.d. Offer an alternate if dislikes food/fluids given/on menu and offer flavored beverages or water between meals within fluid restriction if resident is on fluid restriction.e. Weigh at least weekly X 1 month(F692) after admit or per facility protocol then at least monthly or as recommended if more frequent than monthlyReview of Clinical Physician Orders for Resident #9 revealed a diet order dated 3/31/26, for a CCHO (consistent carbohydrate), regular texture, thin consistency. With direction for double protein portions at meals. During an interview on 5/11/26 at 3:34 PM, Resident #9 reported he was not getting enough to eat. Resident #9 reported all of his meal tickets stated he was supposed to get double. He explained sometimes he got double and sometimes he didn't. He explained he was supposed to get extra protein.2. Review of the MDS assessment for Resident #16, dated 3/12/26, revealed a BIMS score of 15 out of 15, which indicated intact cognition. Diagnoses included low back pain, weakness and spinal stenosis. Review of the Care Plan for Resident #16, last revised 2/10/26, revealed a Focus area to address I am at nutritional risk due to h/o (history of) falls and recent fractures in March of 2023 and again May 2024. I have h/o Breast CA (cancer), hypothyroidism, Left hip fx (fracture), UTI (urinary tract infection), low backpain. Interventions included, in part: Meal Enrichments/Planned Snacks: Extra egg when eggs are on the menu. Chocolate milk all meals. Revised on 4/3/25.Review of Clinical Physician Orders for Resident #16 included an order, dated 1/30/26 for a mechanical soft texture general diet and for dietary to give the resident an extra egg when on the menu.During an observation on 5/12/26 at 7:55 AM, Staff R, Cook, started breakfast service. Staff R stated the breakfast menu included one fried egg, Cream of Wheat for hot cereal, hot super cereal, 2 pieces of bacon, a muffin and ground sausage for residents required to have mechanical altered meat. During the course of the meal service observation, Staff R, [NAME] served food onto a tray for Resident #9. Staff R served Resident #9 one egg, a bowl of cold cereal with milk, a bowl of hot cereal and 2 pieces of bacon. Review of the resident's ticket for the 5/12/26 breakfast meal revealed the resident identified he did not like bacon, and the bacon had a line drawn through it. The resident's ticket identified the resident was to received double portion of protein all meals. During the course of the meal service observation, Staff R, [NAME] served food onto a tray for Resident #16. Staff R served Resident #16 one egg, 2 ounces of mechanically ground sausage, a bowl of cold cereal with milk and a muffin. Review of resident's ticket for the 5/12/26 breakfast meal revealed the resident had requested extra eggs. During an interview on 5/12/26 at 2:40 PM, the Dietary Manager reported she had noticed Staff R, Cook, had missed giving double or extra portions during breakfast service for some of the residents that morning. The Dietary Manager explained staff needed to read the meal tickets better, and she was working on different strategies to make dietary needs and preferences stand out. Review of the facility policy, titled Therapeutic Diets, dated 10/2017, revealed, in part, .Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes. Diagnosis (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	alone will not determine whether the resident is prescribed a therapeutic diet .A ?therapeutic diet is considered a diet ordered by a physician, practitioner or dietitian as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review, resident and staff interview, the facility to ensure staff served food at a palatable temperature to residents who requested a room tray for 1 of 1 meal service observations. The facility reported a census of 57 residents. Findings included:Review of the Minimum Data Set (MDS) assessment for Resident #20 dated 3/19/26, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15, which indicated intact cognition. During an interview on 5/11/26 at 12:07 PM, Resident #20 stated the food at the facility was horrible. Resident #20 described the food as cold and not tasting good. Resident #20 explained they ate their food in their room and always requested a room tray.During an observation on 5/12/26 that started at 7:55 AM, Staff R, Cook, started breakfast service, while Staff S, Cook, assisted with getting drinks, silverware and other requested condiments for residents and then handing the trays off to Certified Nursing Assistants (CNAs) and other facility staff in the dining room. Staff R identified the breakfast menu included one fried egg, Cream of Wheat for hot cereal, hot super cereal, 2 pieces of bacon, a muffin and ground sausage for residents required to have mechanical altered meat. During the course of meal service, Staff R, [NAME] served residents in the dining room first and then served residents that requested room trays. Staff R and Staff S, [NAME] placed a total of 6 residents meal trays per open service cart, and when the cart was full, staff in the dining room would take the cart to the residents rooms. Dietary staff sent a total of 2 carts to the 200 hall (South hall), the first with 6 resident meals and the second cart had 5 resident meals. Dietary staff sent 1 full cart and one additional cart with one resident meal and a test tray to the 100 hall. All meal plates leaving the dining room were covered with a plate lid. Timing of filling a cart with 6 resident meals was 6 minutes from start to finish.At 8:51 AM, Staff R and S added the test tray to the last cart. The Dietary Manager pushed the cart out of the kitchen, dropped the meal off for a resident in room [ROOM NUMBER], and pushed the cart with the test tray to the Administrator's office/conference room located between rooms 108 and room [ROOM NUMBER]. At 8:53 AM, the Dietary Manager tested the food temperatures with the following results: Eggs - 107.8 Fahrenheit (F); mechanical ground sausage - 96.8F; Cream of Wheat - 137 F. The eggs and sausage on the State Agency (SA) test tray were cold to the touch and not palatable. The Cream of Wheat was hot to the touch and had a good flavor. The Dietary Manager reported the food temperatures were too cold for the egg and sausage, and agreed the food would not taste good at those temperatures. During an interview on 5/12/26 at 2:40 PM, the Dietary Manager stated the facility needed to come up with better method to ensure hot delivery of food to rooms. Review of the facility policy, titled Food Preparation and Service, dated 4/2019, revealed, in part, .Proper hot and cold temperatures are maintained during food service.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, clinical record review, facility policy review, resident and staff interview, the facility failed to serve food based on resident preference for 1 out of 1 meals services observed (Residents #1, Resident #5 and Resident #7). The facility reported a census of 57.Findings included: 1. Review of the Minimum Data Set (MDS) assessment for Resident #1, dated 3/12/26, revealed a Brief Interview for Mental Status (BIMS) score of 13 out of 15, which indicated intact cognition. Diagnoses listed included diabetes, dementia, morbid obesity and abnormal weight loss.Review of the Care Plan for Resident #1, revised 6/19/25 revealed a Focus area to address I am at nutritional risk .MNA (Mini Nutritional Assessment): 10 (6/09): At Risk of Malnutrition. Interventions include, in part: Offer an alternate if dislikes food/fluids given/on menu and offer flavored beverages or water between meals within fluid restriction if resident is on fluid restriction. Date Initiated: 09/11/2024. 2. Review of the MDS assessment for Resident #5, dated 4/7/26, revealed a BIMS score of 15 out of 15, which indicated intact cognition. Diagnoses listed included diabetes, dysphagia (difficulty swallowing), and morbid obesity. The assessment identified the resident on a mechanically altered diet. Review of the Care Plan for Resident #5, revised 4/7/26, revealed a Focus area to address [name redacted, Resident #5] is at an increased nutrition risk r/t (related to) T2DM (diabetes), dysphagia, morbid obesity, constipation, lymphedema (fluid retention in lymphatic nodes), vit (vitamin) D deficiency, osteoarthritis, diverticulosis (pouches in the intestine), mixed HLD (hyperlipidemia), and age-related osteoporosis (bone loss). Interventions included, in part: Modify diet as appropriate according to Resident's food tolerances and preferences. Date Initiated: 2/6/26. Review of a Progress Note, titled Nutrition/Dietary Note, dated 5/10/26, revealed the following documentation: Note Text: Text: Significant Weight Loss noted of: (-) 5.1% X 1 mo (month) . RD/RDN (Registered Dietician) Observations: Wt (weight) - 169# (pounds) (5/02)[BMI = 29.9] (body mass index). Resident is on Consistent Carbohydrate Mechanical Soft and eats 75-80%. Furosemide (often called a water pill, used to treat fluid retention) 40 mgs (milligrams) was started on 3/14/26 and resident continues to use pneumatic compression pump to keep her leg swelling down. RD talked to resident on Thursday during noon meal and resident with no concerns expressed. Is eating well and intake should meet needs. Some weight loss due to the Furosemide started. RD wrote out fax for clinician to notify regarding significant weight change.Review of the Resident Matrix, dated 5/11/26, revealed the facility identified Resident #5 as an excessive weight loss.3. Review of the MDS assessment for Resident #7, dated 3/12/26, revealed a BIMS score of 15 out of 15, indicative of an intact cognition, and diagnoses of heart failure, diabetes, and dysphagia. The assessment identified the resident was on a mechanically altered diet. Review of the Care Plan for Resident #7, dated 5/8/26, revealed, in part, the following focus area and intervention: NUTRITION: I am at nutritional risk due past h/o dehydration prior to admit, CKD (chronic kidney disease), H/O CABG (coronary artery bypass graft), asthma, Type 2 DM, weakness, dysphagia(oropharyngeal), COPD (chronic obstructive pulmonary disease), spinal stenosis, Heart failure, GERD (gastroesophageal reflux disease), Depression, cognitive deficits; Offer an alternate if dislikes food/fluids given/on menu and offer flavored beverages or water between meals within fluid restriction if resident is on fluid restriction.On 5/11/26 at 11:40 AM, during an interview, Resident #7 reported concerns with not getting extra portions at meals when he requested it. During an observation on 5/12/26 starting at 7:55 AM, Staff R, Cook, started breakfast service. Staff R stated the breakfast menu included one fried egg, Cream of Wheat for hot cereal, hot super cereal, 2 pieces of bacon, a muffin and ground sausage for residents required to have mechanical altered meat. Staff R, [NAME] serviced the following trays:a. For Resident #1: One egg, a bowl of cold cereal with milk, and 2 pieces of bacon. Review of the resident's ticket for the 5/12/26 breakfast meal revealed a line drawn through the bacon and eggs, and identified the resident disliked eggs and bacon. The resident requested double portion of entree, cold cereal and a breakfast (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	muffin. b. For Resident #5: One egg, a bowl of cream of wheat, and a 2 ounce serving of mechanically ground sausage. Review of the resident's ticket for the 5/12/26 breakfast meal revealed a line crossed through the ground sausage with gravy, and identified the resident disliked sausage and sausage gravy. The resident requested an egg and a muffin.c. For Resident #7: One egg, two bowls of cream of wheat, and a 2 ounce serving of mechanically ground sausage with gravy, a muffin and toast. Review of the resident's ticket for the 5/12/26 breakfast meal revealed the resident asked for 3 portions of eggs, 2 pieces of toast, 2 bowls of hot cereal, a muffin, and ground sausage.During an interview on 5/12/26 at 2:40 PM, the Dietary Manager reported she had noticed Staff R, Cook, had missed giving double or extra portions during breakfast service for some of the residents that morning. The Dietary Manager explained staff needed to read the meal tickets better, and she was working on different strategies to make dietary needs and preferences stand out. Review of the facility policy, titled Therapeutic Diets, dated 10/2017, revealed, in part, .Diet will be determined in accordance with the resident's informed choices, preferences, treatment goals and wishes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, facility policy review and staff interview, the facility failed to ensure nursing staff followed enhanced barrier precautions to prevent the spread of multi-drug resistant organisms to residents during when personal care and wound care provided for 1 of 1 resident (Resident #18) reviewed for infection control. The facility reported a census of 57.Findings included:Review of Resident #18's Minimum Data Set (MDS) assessment dated [DATE], diagnoses listed included diabetes, incontinence without sensory awareness and morbid obesity. The assessment identified the resident had moisture associated skin damage (MASD). The MDS listed an admission date of 10/8/25. Review of electronic health record (EHR) revealed a Nurses Notes dated 10/8/25 which documented: 3 skin issues upon admit. All need the application of Triad cream (type of topical wound treatment) to areas: 1) left inner thigh shearing of skin from incontinent brief measures 2 cm (centimeters) L (length) x 1cm W (width). 2) Right intragluteal cleft has MASD from incontinence measuring 1.5cm L x 1.5cm W. 3) Right hip has an abrasion circular in circumference measuring 1.5cm L x 1.5cm W.The MDS dated [DATE], revealed a BIMS score of 15 out of 15, which indicated Resident #18 had intact cognition. The assessment indicated the resident used a wheelchair and required substantial/maximum assistance with toileting hygiene and bed mobility and was dependent on staff for lower body dressing, transfers and moving from sitting to lying and standing. The resident was always incontinent of bowel and urine.During an observation on 5/13/26 at 10;11 AM, Staff L, Licensed Practical Nurse (LPN) entered the room to assess and treat the resident's wounds. Staff H, Certified Nursing Assistant (CNA) and Staff I, CNA also present to assist. Staff L, LPN, gloved, used the disposable measuring tape to measure an open upper right coccyx wound and open left inner thigh wound. Staff L reported there was a scabbed area above the open wound on the coccyx. Staff L measured an open lower left inner thigh wound at 1.9 cm in length and 0.4 cm in width. After spraying the wounds with wound cleanser, Staff L, LPN, without a change of gloves used a piece of woven gauze to clean the upper coccyx wounds. Using the same piece of gauze, Staff L then cleaned the wounds on Resident #18's left lower thigh. Without a change of gloves, Staff L, LPN, used her right hand to get zinc oxide out of the container, and then applied it to the coccyx wounds. Staff L proceeded to use the same gloved hand to get zinc oxide out of the container and then applied it to the wounds on the lower left thigh. Staff L, LPN, Staff H, CNA, and Staff I, CNA did not wear gowns during this observation. During an interview on 5/18/26 at 8:31 AM, Staff L, LPN, reported EBP (enhanced barrier precautions) should be used when doing personal cares on someone with a wound or catheter. Staff L explained staff needed to wear a gown and gloves for PPE when doing personal or wound cares for resident with a wound.During an interview 5/18/26 at 1:12 PM, the Unit Manager reported he started his role as Infection Preventionist and just obtained his certification. The Unit Manager reported EBP should be put in place when a resident had a catheter, wounds, ostomy or gastric tube. He stated PPE included a gown and gloves at a minimum and signs should be posted identifying the resident was on EBP. The Unit Manager explained the reason it was important for staff to follow EBP was to prevent the spread of infection. Review of the facility policy, titled Enhanced Barrier Precautions, dated 8/2022, revealed, in part, the following: Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employ targeted gown and glove use during high contact resident care activities. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc. A peripheral intravenous line is not considered an indwelling medical device); and wound care (wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers).Review of the facility policy titled Wound Care dated October 2010, revealed a Purpose Statement which declared: The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. The Steps in the Procedure directed, in part: a. Establish clean field. Place all items to be used during procedure on the clean field. Arrange the supplies so they can be easily reached.b. Wash and dry your hands thoroughly.c. Put on gloves. Gowns will only be necessary if soiling of your skin or clothing with blood, urine, feces, or other body fluids is likely. Masks and eyewear will only be necessary if splashing of blood or other body fluids into your eyes or mouth is likely.d. Use no-touch technique. Use applicators to remove ointments and creams from their containers.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, facility policy review, resident and staff interview, the facility failed to maintain a safe and homelike environment by ensuring the metal guard was in place over the heating elements of a baseboard heater in the dining room and front sitting room located inside the main entrance of the facility and failed to ensure a the replacement of the molding trim at the base of a window in the dining room. The facility reported a census of 57 residents. Findings included: Review of the Minimum Data Set (MDS) assessment for Resident #7 dated 3/12/26, revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated intact cognition. During an interview on 5/11/26 at 12:07 PM, Resident #7 reported being upset about conditions in the dining room. Resident #7 explained that there was a piece of missing window trim molding for a window in the dining room and the guard was missing for the baseboard heater in the dining room. Per the resident, both items had been missing for more than a year. During an observation on 5/11/26 at 1:55 PM in the main dinging room, one window noted to missing the bottom piece of window trim molding. The outline from where the missing piece had been was visible. The baseboard heater located on the north dining room wall noted to be missing a metal guard and exposed heating elements. The baseboard heater located on the north wall in front main sitting area noted to have a bent metal guard which exposed the heating elements. The baseboard heaters were not operating during the observation.Review of the Work Orders, titled Open and in Progress Work Orders, dated 5/12/26, revealed no work orders related to the missing window trim in the dining room, or the missing metal guard on the baseboard heater in the north dining room, or the bent metal guard on the baseboard heater in the front entrance sitting area. During an interview on 5/12/26 at 2:50 PM, the Maintenance Director reported she had started at the facility in September of 2025. The Maintenance Director explained she entered all repairs needed at the facility in an electronic tracking system. She reported being unaware of the missing window molding trim in the dining room and missing metal guard for the baseboard heater in the dining room. The Maintenance Director reported the facility did use the baseboard heaters in the winter time and stated It's a safety risk to have the metal heating element exposed. She stated she had fixed the bent guard on the baseboard heater in the front sitting area in the past, but was unaware the guard was bent again. The Maintenance Director reported answering to a Regional Maintenance Manager.During an observation on 5/13/26 at 9:36 AM, the metal guard on the baseboard heater in the front sitting room baseboard heater bent back into place. The dining room baseboard heater had chairs, table and caution tape placed in front of the area with the missing metal guard for the baseboard heater.During an interview on 5/13/26 at 11:32 AM, the Regional Maintenance Manager reported being in his position for about 3 years. He reported trying to make routine visits to the buildings, and had 9 buildings under his responsibility. He reported another Regional Maintenance person visited the facility about 3 weeks ago. The Regional Maintenance Manager reported being unaware of what had been identified as needing repairs and had not looked at the itemized list compiled by the facility's Maintenance Director. The Regional Maintenance Manager explained he had not done rounding for 6 months due to covering the maintenance position at another one his buildings that did not currently have a Maintenance Director. During an interview on 5/18/26 at 4:00 PM, the Administrator reported not having any control over when maintenance items would get replaced or fixed in the facility.Review of the facility policy, titled Work Orders, Maintenance, dated 4/2010, revealed, in part, .Maintenance work orders shall be completed in order to establish a priority of maintenance service .Works order requests will be completed in a facility specific maintenance portal . Work orders will be prioritized and followed up as indicated .Emergency requests will be given priority in making necessary repairs.