STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165255	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Carlisle	680 Cole Street Carlisle, IA 50047

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 and staff interview, the facility failed to maintain a safe and clean environment throughout the facility's 3 of 3 carpeted hallways (100, 200, and 300 halls), and 1 of 1 residents reported issues of the dirty tiled floor in their rooms and broken sink (Resident #35). The facility reported a census of 78 residents. Findings include: 1.On 5/19/26 at 7:06 AM, a walkthrough of the facility revealed items stored on both sides of the 200 hallway. Two shower chairs sat on the left side when walking down from the dining room, and multiple wheelchairs, garbage cans, and resident transfer devices (lifts) lined the right side. On 5/20/26 at 12:01 PM, an observation of the 200 hallway revealed discoloration continued throughout the entire length of the carpeted flooring. On 5/21/26 at 12:39 PM, an interview and observation with the facility's Housekeeping and Laundry Supervisor (HLS) revealed she worked at the facility in her role since 2007, cleaned the 200 hallway carpet flooring every Tuesday, and confirmed staff last cleaned it on 5/19/26. While walking through the 200 hallway, the HLS confirmed black marks on the carpeted walls, a darker and different floor coloring on the perimeter of the hallway carpet, chipped paint on the metal door frames, and doors with scratches and rough wood exposed. On 5/20/26 at 2:00 PM, an interview with the facility Nurse Consultant, Director of Nursing, and Administrator revealed they redid so much, so they're working through it. They completed roof leak repairs, purchased a [NAME], laptops, a boiler, a washer and dryer, a mechanical transfer lift, and business office flooring. They haven't repaired the driveway or the call lights yet, but those projects are next on the list before they address the carpet. The carpet's on their radar, and they're just trying to finish up projects. 2. Observations on 5/17/26 at 11:35 a.m. revealed the 100 and 300 Hall carpets covered with multiple large dark and bleach-colored stains. 3. On 5/17/26 at 11:38 a.m., the sink in Resident #35's room had a large piece broken off in front. The edge of the broken piece was jagged. The floor around the resident's toilet was covered with black stains. The resident stated the floor was stained all around the toilet. On 5/20/26 at 11:06 a.m., the Administrator stated that resident furnishings should be in good working order. On 5/20/26 at 1:43 p.m. via email, the Administrator stated the facility did not have a policy related to a homelike environment.

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 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 document review, resident interview, staff interview, and policy review the facility failed to provide food at an appetizing temperature to 1 of 8 residents (Residents #41) reviewed. The facility reported a census of 78 residents.Findings include: Review of Resident #41's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15 indicating intact cognitive functioning. Interview 5/18/2026 at 10:25 AM with Resident #41 revealed that she eats in her room, and the food is often cold when brought to her. Observation 5/19/26 at 12:03 PM a sample tray was obtained with food temperatures for the creamy pork chop measuring 122.7 degrees, and the broccoli measuring 132.3 degrees. The facility policy Food Temperatures, dated 2021, stated hot food items should not fall below 135 degrees Fahrenheit after cooking. On 5/19/26 at 12:37 p.m., the Certified Dietary Manager(CDM) stated he expected hot foods held at 135 degrees Fahrenheit or above.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, policy review, and staff interview, the facility failed to prepare food under sanitary conditions for 2 of 2 kitchen observations. The facility reported a census of 78 residents.Findings included: 1. Observations during the initial kitchen tour on 5/17/26 at 10:38 a.m. revealed the following concerns:A. A thick debris and dust layer on the floor under the shelves containing cans and dry goods in the pantry. B. A thick black dust layer covering the ceiling vent above and diagonal to the clean side of the dish machine room.C. A thick crusty-looking white buildup on the outside of the dishwasher.D. Dust particles hung down on 2 spigots of the fire suppression system located above the stove burners.E. Heavy dust buildup on the wall slats behind the stove burners.F. Orange splatters between the bottom of the stove and the stove door.G. Heavy dust buildup on a shelf with multiple steam table pans sitting face down. H. Multiple pudding-like splatters on the right side floor of the Arctic Air #2 refrigerator.I Clear plastic bowls sat face down in crumbs on a red tray.J. A white plastic piece on the interior ceiling of the ice machine covered with a black substance. Water dripped from the black areas into the ice in the bottom of the machine. The Certified Dietary Manager(CDM) was present and stated it appeared to be water mold. He stated he would empty the ice and would not want residents to consume(this ice). 2. A follow-up visit to the kitchen on 5/19/26 revealed that dust/debris remained on the shelves, ceiling vents, dishwasher, fire suppression spigots, and the wall slats behind the stove. On 5/19/26 at 12:37 p.m., the CDM stated he thought the sanitation in the kitchen was pretty good. He agreed that surfaces should be clean and without debris and that vents should be clean.The undated, untitled dietary cleaning schedule directed staff to clean items including: refrigerators, the pantry, the dishwasher, and dish racks.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. Based on observation and staff interviews the facility failed to complete and/or maintain documentation of routine bed rail inspections for 10 of 10 residents with side rails. The facility reported a census of 78 residents. Findings include:A record review of Resident #32's current care plan revealed the resident used a side rail (bilateral half rails) to aid in repositioning and safety due to frequent falls out of bed. The goal, initiated on 6/27/25, directed that Resident #32 will remain free of falls out of bed and will assist with repositioning through the review date. A care plan intervention, initiated on 6/27/25, instructed staff to assist in resident independence with repositioning. On 5/20/26 at 9:48 AM, an observation and interview with the facility Administrator of bed rails revealed a resident had both upper quarter-length rails. The Administrator informed that the Housekeeping and Laundry Supervisor (HLS) currently oversees maintenance due to a recent staff changeover in that department.On 5/20/26 at 11:52 AM, an observation and interview with the Maintenance Director and Maintenance Assistant from a local sister facility revealed they're in Resident #32's room evaluating her bed rails, and one of the bed rails's removed and on the floor. They showed empty maintenance inspection sheets and stated facility staff didn't provide them with any prior documentation of bed rail assessments, and corporate management called them in today to check all bed rails in the facility. They revealed they didn't see anything wrong with Resident #32's bed rails, but they aren't used to this type and aren't verifying that the entrapment zone measurements were correct.On 5/20/26 at 12:19 PM, an electronic mail (email) from the Administrator informed that staff follow the regulations for side rails.On 5/20/26 at 12:39 PM, an interview with the HLS revealed she started her role in 2007, denied she's in charge of the maintenance department, and stated the facility will hire someone new who won't be from this location.On 5/20/26 at 1:55 PM, an interview with the Administrator revealed she provided a list of Bed Entrapment Inspections for all residents with bed rails, stating corporate or sister facility staff completed them today. A record review of the undated document the Administrator provided titled Bed Entrapment Inspection revealed 10 resident beds passed the inspection, but the form did not show who completed the assessments.

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on employee personnel record review, staff interview and policy review, the facility failed to ensure a thorough background check had been completed before hire prior to working with dependent adults for 1 of 3 staff personnel files reviewed. The facility reported a census of 78 residents. Findings include: On 5/18/26 at 1:06 PM, the Administrator reported in an email that Staff A, Certified Nursing Assistant (CNA) had a start date of 9/9/25. Review of the Iowa Criminal History Record Check Request SING form dated 9/3/25 revealed Staff A had a history of criminal convictions. The SING form did not contain further research documentation to confirm whether or not Staff A could work at the facility. Review of facility policy updated 10/19/22 and titled, Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy, the facility will conduct an Iowa criminal record check and dependent adult/child abuse registry check on all prospective employees and other individuals engaged to provide services to residents, prior to hire, in the manner prescribed under 481 Iowa Administrative Code S58.11(3). The facility will conduct a criminal record check and dependent adult/child abuse registry check on all current employees and other individuals engaged to provide services to residents who have criminal convictions or founded abuse determinations after hire, or where the facility received credible information that an employee has had a criminal conviction or a founded abuse determination subsequent to hire. See Iowa Code S135C.33(7).On 5/20/26 at 2:15 PM the Administrator acknowledged the facility did not have a copy of Staff A's completed background check including the results that indicated whether or not further research was required. The Administrator had requested the results from the Iowa Department of Public Service on 4/10/26 however due to a system change, the results were not able to be obtained.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to report an allegation of abuse in a timely manner for 1 of 2 residents reviewed for abuse allegations(Resident #34). The facility reported a census of 78 residents.Findings included: 1. A 5/14/26 Brief Interview for Mental Status(BIMS) Evaluation listed Resident #83's score as 15 out of 15, indicating intact cognition. On 5/17/26 at 11:54 a.m., Resident #83 stated last night(5/16/26) staff yelled at her roommate(Resident #34). Resident #83 stated 3 staff assisted the resident on the toilet and they yelled at the resident. She stated she couldn't tell exactly what they said but stated they said if Resident #34 didn't do something, they would leave her on the toilet. Resident #83 stated she didn't know why they were so irritated but they were angry with Resident#34. She stated this was around 9:00 p.m. Resident #83 stated she informed Staff B Certified Nursing Assistant(CNA) about this this morning(5/17/26).2. The Minimum Data Set(MDS) assessment tool, dated 4/30/26, listed diagnoses for Resident #34 which included hemiplegia(one-sided paralysis), anxiety, and diabetes. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition. The MDS documented that the resident required staff assistance with toilet transfers, chair/bed-to-chair transfer, and sit to stand.On 5/18/26 at 3:02 p.m., Resident #34 stated on Saturday night(5/16/26) staff were mean to her and screamed at her. A 5/17/26 Grievance Form, completed by Staff B, Certified Nurses Aide (CNA) stated Resident #83 reported to her that 3 staff members screamed at Resident #34 last night and were mean. Staff B wrote that Resident #34 also said they were being mean and did not want to take her to the bathroom. On 5/19/26 at 2:31 p.m., Staff B stated that she reported to the Assistant Director of Nursing(ADON) that Resident #34 reported to her that 3 girls that took care of her the night before were mean to her. Staff B stated she also filled out a grievance form. On 5/20/26 at 9:36 a.m., the Director of Nursing(DON) stated that she received a grievance related to Resident #34 on Monday(5/18/26). She stated the date on the grievance was 5/17/26. She stated she would want to know about something of this nature right away. On 5/20/26 at 9:42 a.m., the Assistant Director of Nursing(ADON) stated that she received a grievance on Sunday(5/17/26). She stated Staff B handed it to her but then took it back and stated she needed to add things to it. The ADON stated Staff B told her there was an issue with a resident but she didn't get any details. The ADON stated she probably should have determined whether it was a reportable situation. She stated Staff B placed the grievance in her mailbox and they talked about it on Monday(5/18/26). The facility lacked documentation they reported the allegation of abuse to the State Agency.On 5/20/26 at 11:06 a.m., the Administrator stated if a staff member heard that staff were mean, they should inform her or the DON right away. She stated if it was reportable, they should separate staff and complete an investigation. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/19/22 stated the facility would report all allegations of abuse to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation was made. The policy stated the facility would investigate the incident including witness statements.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on clinical record review, policy review, and staff and resident interviews, the facility failed to investigate an allegation of abuse in a timely manner for 1 of 2 residents reviewed for abuse allegations(Resident #34). The facility reported a census of 78 residents.Findings included: 1. A 5/14/26 Brief Interview for Mental Status(BIMS) Evaluation listed Resident #83's score as 15 out of 15, indicating intact cognition. On 5/17/26 at 11:54 a.m., Resident #83 stated last night(5/16/26) staff yelled at her roommate(Resident #34). Resident #83 stated 3 staff assisted the resident on the toilet and they yelled at the resident. She stated she couldn't tell exactly what they said but stated they said if Resident #34 didn't do something, they would leave her on the toilet. Resident #83 stated she didn't know why they were so irritated but they were angry with her. She stated this was around 9:00 p.m. Resident #83 stated she informed Staff B Certified Nursing Assistant(CNA) about this this morning(5/17/26).2. The Minimum Data Set(MDS) assessment tool, dated 4/20/26, listed diagnoses for Resident #34 which included hemiplegia(one-sided paralysis), anxiety, and diabetes. The MDS listed the resident's BIMS score as 15 out of 15, indicating intact cognition.On 5/18/26 at 3:02 p.m., Resident #34 stated on Saturday night(5/16/26) staff were mean to her and screamed at her. A 5/17/26 Grievance Form, completed by Staff B, stated Resident #83 reported to her that 3 staff members screamed at Resident #34 last night and were mean. Staff B wrote that Resident #34 also said they were being mean and did not want to take her to the bathroom. On 5/19/26 at 2:31 p.m., Staff B, CNA stated that she reported to the Assistant Director of Nursing(ADON) that Resident #34 reported to her that 3 girls that took care of her the night before were mean to her. Staff B stated she also filled out a grievance form. On 5/20/26 at 9:36 a.m., the Director of Nursing(DON) stated that she received a grievance related to Resident #34 on Monday(5/18/26). She stated the date on the grievance was 5/17/26. She stated she would want to know about something of this nature right away. The DON stated she did not interview the resident's roommate because of the resident's high BIMS score. On 5/20/26 at 9:42 a.m., the Assistant Director of Nursing(ADON) stated that she received a grievance on Sunday(5/17/26). She stated Staff B handed it to her but then took it back and stated she needed to add things to it. The ADON stated Staff B told her there was an issue with a resident but she didn't get any details. The ADON stated she probably should have determined whether it was a reportable situation. She stated Staff B placed the grievance in her mailbox and they talked about it on Monday(5/18/26). The facility lacked documentation they completed an investigation into the alleged 5/16/26 incident prior to 5/18/26.On 5/20/26 at 11:06 a.m., the Administrator stated if a staff member heard that staff were mean, they should inform her or the DON right away. She stated if it was reportable, they should separate staff and complete an investigation. The Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy dated 10/19/22 stated the facility would report all allegations of abuse to the Iowa Department of Inspections and Appeals not later than two (2) hours after the allegation was made. The policy stated the facility would investigate the incident including witness statements.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Electronic Health Record (EHR) review, document review, policy review, and staff interview the facility failed to complete a discharge summary that included a recapitulation of the resident's stay, a final summary of the resident's status, and reconciliation of all pre- and post-discharge medications for 1 of 3 residents reviewed (Resident #82). The facility reported a census of 78 residents.Findings include:Review of Resident #82's Minimum Data Set (MDS) dated [DATE] indicated Resident #82 was admitted to the facility on [DATE] and discharged on 2/20/26.Review of Resident #82's EHR page titled, Progress Notes indicated on 2/17/26 that Resident #82 was expressing a want to move to another facility. Further review of the Progress Notes revealed an entry 2/20/26 indicating transportation was at the facility to take Resident #82 to a new facility. Review of Resident #82's EHR page titled, Clinical Assessment revealed a discharge planning review assessment that had not been completed as of 5/19/26. Interview 5/19/2026 at 9:12 AM with the Director of Nursing (DON) revealed that a recapitulation of stay should have been completed. The DON further revealed that the discharge assessment had been completed, but had not been locked out, but this should have been done since the resident had been discharged [DATE]. Review of a facility provided policy titled, Discharge Planning Process with an updated date of 2/23/25 indicated the evaluation of the resident's discharge needs and discharge plan will be completely documented on a timely basis in the clinical record.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to complete 1 of 4 residents discharge Minimum Data Set (MDS) assessments when they discharged home from the facility (Resident #50). The facility reported a census of 78 residents. 1.Review of Resident #50 Electronic Health Record (EHR) Census revealed she was admitted on [DATE] and discharged on 12/20/25. Review of Resident #50 Communication With family Note dated 12/17/25 at 11:30 AM documented she will discharge home on [DATE]. Review of Resident #50 Discharge Summary Note dated 12/20/25 at 10:41 AM documented she discharged from the facility on 12/20/25 at 8:30 AM. Review of Resident #50 EHR MDS log on 5/19/26 revealed the facility has completed an Entry MDS on 12/5/25 and admission MDS on 12/11/25, but has not completed a discharge MDS when she discharged on 12/20/25. On 5/20/26 at 11:59 AM, an interview with the facility Administrator and Nurse Consultant revealed staff follow the Resident Assessment Instrument (RAI) manual.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on a record review and staff interviews, the facility failed to ensure all mental health diagnoses were on 1 of 3 residents' Preadmission Screening and Resident Review (PASRR) documents for (Resident #8). The facility reported a census of 78 residents. Findings include: 1. Review of a Resident #8 Medical Diagnoses in her Electronic Health Record (EHR) documented she received the diagnosis of Post-Traumatic Stress Disorder (PTSD; a mental health condition triggered by a terrifying event) on 6/8/2021. A record review of Resident #8's current PASRR dated 6/10/2025 lacked her diagnosis of PTSD. On 3/27/26, a record review of a visit titled Modified Progress Note documented Resident #8 was changing from weekly to biweekly visits for the next 3 months, and mental health professionals continued to see her for her diagnoses of post-traumatic stress disorder PTSD and major depression (persistent and severe sadness). On 5/20/26 at 12:19 PM, an electronic mail (email) from the facility Administrator informed that staff follow the regulations for PASRR documents. On 5/20/26 at 12:45 PM, an interview with the facility Administrator revealed that a different person in the facility completed the Preadmission Screening and Resident Review (PASRR) documents up until about a week and a half ago, and now staff complete them centrally. The Administrator then revealed she'd expect post-traumatic stress disorder (PTSD) and any qualifying diagnosis to be on the PASRR and updated if need be. On 5/20/26 at 2:00 PM, an interview with the facility Nurse Consultant, Director of Nursing, and Administrator revealed they hadn't submitted the PASRR for Resident #8 regarding her PTSD, but they'd do that today.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review the facility failed to develop a comprehensive care plan that included problems, goals, or interventions for 1 of 5 residents (Resident #2) reviewed for a resident with diuretic medication usage. The facility reported a census of 78. Findings include:Review of Resident #2's Minimum Data Set (MDS) dated [DATE] revealed Resident #2 utilized diuretic medications during the 7 day look back period. The MDS documented that the resident was admitted to the facility on [DATE].Review of Resident #2's Electronic Healthcare Record (EHR) page titled, Clinical Physician Orders revealed an order for Lasix (Diuretic medication) 40mg oral tablet to give 1 tablet twice a day with a start date of 8/26/25. Review of Resident #2's Care Plan with a revision date of 4/13/26 revealed no focus, goals, or interventions for diuretic use. Interview 5/20/26 at 12:42 PM with the Minimum Data Set (MDS) Coordinator revealed that Lasix should be in the care plan. The MDS Coordinator further confirmed Resident #2 had been on Lasix since August of 2025. Interview 5/20/26 at 12:44 PM with the Director of Nursing (DON) revealed that her expectation would be that the appropriate items are listed in the care plans.Review of a facility provided policy titled, Comprehensive Care Plans with an updated date of 12/3/25 indicated the comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and policy review the facility failed to to provide the necessary care and services to ensure a resident received appropriate clinical monitoring, timely medical provider notification, and consistent administration of prescribed treatments for a Urinary Tract Infection (UTI) for 1 of 1 residents reviewed for UTI (Resident #31). Specifically, facility staff failed to conduct nursing assessments across two separate antibiotic regimens, delayed follow-up with an unresponsive medical provider regarding a recurrence of symptoms, omitted a scheduled antibiotic dose without clinical justification, and failed to update the resident's care plan to reflect a suspected multidrug-resistant infection and use of antibitoics. The facility reported a census of 78 residents. Findings include: A review of all Progress Notes and clinical records from 4/1/26 to 5/20/26 established a timeline of Resident #31's antibiotic therapies for a urinary tract infection (UTI), which included an initial order for Macrobid 100 milligrams twice a day for seven days on 4/25/26, a subsequent change to Cefdinir 300 milligrams twice a day for seven days on 4/27/26, and a new course of Ciprofloxacin Hydrochloride (Cipro) 500 milligrams twice a day for seven days ordered on 5/15/26.Resident #31's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status score of 15, indicating intact cognition. The MDS revealed Resident #31 had functional limitations to both lower extremities, depended on staff for all transfers and to go from a sitting to a standing position, and staff did not attempt to walk him due to his medical condition. The MDS further documented Resident #31 was occasionally incontinent of urine, frequently incontinent of bowel movements, and was not on a toileting program. The MDS recorded diagnoses of cancer, diabetes (a chronic condition affecting blood sugar regulation), Parkinson's disease (a progressive nervous system disorder affecting movement), and depression.On 5/18/26 at 11:37 AM, an interview with Resident #31 revealed he denied issues with all care and had no concerns related to his UTI (an infection in any part of the urinary system).A review of Medical Diagnoses in the Electronic Health Record (EHR) documented a current diagnosis starting on 4/24/26 of a UTI, site not specified.The Progress Notes from 4/1/26 to 5/20/26 recorded the following chronological entries:A Progress Note dated 4/23/26 at 3:23 PM recorded that staff called the local laboratory to follow up on a urine sample collected and sent the previous Thursday. The laboratory reported they never received the specimen. Staff re-collected the sample on 4/23/26 to send via courier the following day.A Progress Note dated 4/25/26 at 2:03 AM recorded that staff received urinalysis results from the laboratory. Staff placed a call to the on-call medical provider to request antibiotic orders, and received a new order for Macrobid 100 milligrams by mouth twice a day for seven days. the note recorded staff would call when final culture and sensitivity results became available.A Progress Note dated 4/25/26 at 2:08 AM recorded that staff pulled the first dose of Macrobid from the facility's on-hand medication supply and administered it.A Progress Note dated 4/27/26 at 11:32 AM recorded that staff received the final culture and sensitivity laboratory results. Following the provider's review, a change of antibiotic was ordered to discontinue Macrobid and initiate Cefdinir 300 milligrams by mouth twice a day for seven days.A Progress Note dated 4/27/26 at 8:17 PM recorded that vital signs were blood pressure 151/91, pulse 68, and temperature 98.0 F. Staff noted the resident continued on Cefdinir 300 milligrams for a UTI, with no adverse side effects observed at the time of the assessment.Progress Notes from 4/27/26 to 5/20/26 revealed that staff charted clinical updates on 4/28/26, 4/29/26, 4/30/26, and 5/2/26 indicating the resident denied burning or discomfort and fluids were encouraged. However, the progress notes lacked required daily nursing assessments regarding Resident #31's UTI signs, symptoms, and antibiotic usage on 5/1/26, 5/3/26, 5/4/26, 5/5/26, and from 5/7/26 through 5/12/26.A Progress Note dated 5/5/26 at 2:05 AM recorded that the resident was seen by the medical provider on 5/4/26, with no new orders documented at that time.A Progress Note dated 5/6/26 at 4:09 PM recorded a late entry noting that staff transmitted a fax to the provider to notify (continued on next page)

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	165255	A. Building B. Wing	05/21/2026

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	them that the resident continued to experience symptoms of burning with urination and minimal urinary urgency.A Progress Note dated 5/8/26 at 2:11 PM recorded a late entry noting that staff received no response from the provider. Staff re-faxed the communication to let the provider know that Resident #31 continued with symptoms after completing the antibiotic treatment.A Progress Note dated 5/13/26 at 11:02 AM recorded that staff obtained a urinalysis as ordered in a clean urinal, and they sent the specimen to the local laboratory.A Progress Note dated 5/15/26 at 4:15 PM recorded that staff received the urinalysis results back after the provider reviewed them, resulting in a new order for ciprofloxacin hydrochloride (Cipro) 500 milligrams twice a day for seven days, which staff faxed to the pharmacy and entered into the MAR.A review of the Medication Administration Record (MAR) for May 2026 showed Resident #31 received all doses as ordered for Cefdinir 300 milligram oral capsule, with directions to give one capsule by mouth two times a day for a UTI for seven days, starting on 4/27/26 at 8:00 PM. The May 2026 MAR further revealed a new order for Cipro 500 milligrams twice a day to be started on 5/16/26 for seven days. Staff did not give the medication on 5/16/26, and the record noted to see the progress notes. A review of the progress notes for 5/16/26 revealed no entry explaining why staff did not give the medication.A review of the Care Plan dated 4/21/26 identified Resident #31 had bladder incontinence related to impaired mobility. The goal directed that Resident #31 would remain free from skin breakdown due to incontinence and brief use through the review date. Interventions instructed staff to clean the perineal area with each incontinence episode and monitor and document for signs and symptoms of a UTI, including pain, burning, blood-tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul-smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. Facility staff didn't revise the care plan to reflect Resident #31's recent antibiotic usage and recurrent UTI.A review of Assessments in the EHR from 4/1/26 to 5/20/26 revealed staff completed an Infection Screening Evaluation on 4/24/26, an Infection Screening Evaluation on 5/6/26, and an Antibiotic Time Out on 5/6/26. The EHR lacked daily nursing assessments to monitor Resident #31's UTI signs, symptoms, and antibiotic usage.On 5/19/26 at 12:40 PM, an interview with the Infection Preventionist (IP) revealed that the EHR system completes the clinical criteria and creates an infection control case. The IP stated staff follow a protocol when completing UTI antibiotics, and she confirmed staff should document assessments or progress notes regarding side effects for UTIs. The IP further confirmed staff should chart more clearly and concisely.On 5/19/26 at 12:51 PM, an interview with the Director of Nursing (DON) revealed that staff follow McGreer's criteria (surveillance definitions for infections in long-term care facilities) through the EHR system. The DON stated staff should complete close monitoring and documentation for antibiotics the entire time a resident takes the medication. The DON further confirmed Resident #31 was a different case because a laboratory result came back showing a possible multidrug-resistant organism (bacteria resistant to multiple antibiotics), so management decided to continue the antibiotics to ensure they treated the infection completely.On 5/21/26 at 9:08 AM, an interview with Staff C, Certified Nursing Assistant (CNA), revealed she knew Resident #31 had a UTI during the past month and was on his second round of antibiotics. Staff C stated Resident #31 seemed to be doing okay and had no complaints of pain, burning, or urgency to her. Staff C recalled hearing during a nursing report that staff possibly caught the infection because he acted a little off.On 5/21/26 at 9:21 AM, an interview with Staff B, CNA, revealed she knew Resident #31 had a UTI and was on his second round of antibiotics. Staff B stated she asked him about it, and he reported he felt better and that the medications helped. Staff B reported Resident #31 had no complaints of pain, burning, or urgency to her, and he was doing well.On 5/21/26 at 9:48 AM, an interview with Staff D, Registered Nurse (RN), revealed she knew Resident #31 was on an antibiotic for a UTI diagnosed at the end of April. Staff D stated Resident #31 acted normal per his baseline, had no complaints of pain or burning, and was doing great. Staff D reported that when a resident has a UTI, staff must assess and document vital signs, urinary frequency, urgency, pain, and burning once every shift.A review of the facility's policy (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	titled Urinary Symptom Monitoring Protocol, dated 5/14/24, revealed that for residents exhibiting urinary symptoms, staff were required to notify the medical provider by phone, request orders for Vitamin C 1,000 milligrams (mg) daily, and initiate enhanced shift-by-shift tracking. The protocol strictly mandated that staff must document fluid intake in cubic centimeters (cc's) on the electronic Treatment Administration Record (eTAR) every shift, and utilize the facility's 24-hour sheet to document the resident's temperature, encouragement of fluids, and any observable symptoms every shift. The policy further directed that if at any time during the monitoring period the resident's condition appeared to be declining, staff were to notify the medical provider immediately.On 5/21/26 at 8:57 AM, an interview attempt was made to Resident #31's Doctor of Nursing Practice (DNP), but the provider didn't return the call.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, and policy review the facility failed to ensure that an effective pain management regimen was consistently implemented in accordance with professional standards of practice and the comprehensive plan of care for 1 of 1 resident reviewed for pain management (Resident #64). Specifically, the facility failed to administer prescribed pain medication as ordered, resulting in a failure to meet the resident's goals for care and preferences. The facility reported a census of 78 residents. Findings include: Resident #64's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status score of 13, indicating intact cognition. The MDS revealed staff admitted him to the facility on 4/21/26. The MDS revealed he uses a wheelchair, does not walk, and depends on staff for transfers. The MDS documented diagnoses of peripheral vascular disease (a circulatory condition where narrowed blood vessels reduce blood flow to the limbs), arthritis (joint inflammation causing pain and stiffness), malnutrition, asthma, and dislocation of the left hip. He occasionally experiences pain, and he rated his worst pain in the past five days as a seven out of 10.On 5/18/26 at 10:46 AM, an interview with Resident #64 revealed he had a lot of pain when getting in and out of bed.A review of the Medication Administration Record (MAR) for May 2026 revealed Resident #64 had an order starting on 5/7/26 at 8:00 PM for oxycodone hydrochloride (a strong opioid medication used to treat severe pain) five milligram capsule by mouth twice a day. Staff didn't manage the medication as ordered because:a. The staff missed both doses on 5/8/26 while Resident #64 rated his pain a two out of 10 each time.b. On 5/9/26, staff missed both doses while Resident #64 rated his pain a six out of 10 in the morning, and staff didn't assess his pain at bedtime.c. On 5/10/26, staff missed both doses while Resident #64 rated his pain a five out of 10 in the morning and a two out of 10 at bedtime.d. On 5/11/26, staff missed the morning dose, and Resident #64 rated his pain a six out of 10 when he finally received the medication on the night of 5/11/26.e. On 5/13/26, Resident #64 had worse pain with an eight out of 10 in the morning and a seven out of 10 in the evening.A review of the May 2026 MAR also showed that once the pharmacy filled the prescription, staff gave an as-needed dose on 5/11/26 at 2:47 PM for a pain rating of nine out of 10. The order directed staff to give oxycodone five milligram capsule every eight hours as needed for pain starting on 5/7/26. Resident #64 ran out of his scheduled twice-daily pain medications because the pharmacy didn't receive a written prescription after the doctor gave the order. The order remained on file, but the pharmacy couldn't fill it.A review of a Nurses Note dated May 2026 at 6:34 AM recorded that staff contacted the pharmacy because Resident #64 didn't receive his narcotic medication, and he continued to request a pain pill. A pharmacy technician stated Resident #64 didn't have a current prescription. The pharmacy technician reported they sent a refill prescription request on May 1st and still hadn't received a response. Staff couldn't pull the medication from the automated medication dispensing system because they didn't have a current prescription. Staff provided the on-call telephone number so the pharmacist could reach out to the on-call medical provider for a current prescription to deliver the medication.A review of a Nurses Note dated May 2026 at 1:26 PM recorded that staff awaited a three-day emergency prescription for Oxycodone before receiving a new prescription. Resident #64 showed continued pain to his left hip.A review of the Care Plan dated 4/21/26 identified Resident #64 had a potential for pain or actual pain related to chronic wounds and his disease process. The goal directed that Resident #64 would verbalize satisfaction with pain control over the next review period. Interventions instructed staff to assess for signs and symptoms of pain, give medications as ordered, and notify the physician of uncontrolled pain. Facility staff didn't follow the care plan interventions when they failed to provide the pain medications as ordered by the physician.On 5/20/26 at 9:20 AM, an interview with Resident #64 revealed his asthma (a respiratory condition causing breathing difficulties) is why he called emergency medical services (EMS) earlier in the month and wanted to see his local provider, it was not due to his pain.A review of (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an Administrator Email dated 5/20/26 at 12:30 PM recorded the facility did not have a policy for physician orders, and staff followed standards of practice.On 5/21/26 at 9:08 AM, an interview with Staff C, Certified Nursing Assistant (CNA), revealed Resident #64 complains about pain all the time. Staff C stated Resident #64 always complains about his hip and always complains about getting up. Staff C reported Resident #64 seems very uncomfortable a lot, and he always asks for pain pills.On 5/21/26 at 9:21 AM, an interview with Staff B, CNA, revealed Resident #64 complains about pain all the time, always wants pain medications, and always yells that he is in pain when staff change him. Staff B reported Resident #64 always complains about his hip.On 5/21/26 at 9:48 AM, an interview with Staff D, Registered Nurse (RN), revealed Resident #64 has complained about pain to her. Staff D reported Resident #64 has scheduled pain medications. Staff D stated if a resident had an order for pain medication but the pharmacy didn't receive a prescription, she would call the pharmacy and see if she could pull the medication from the emergency medication kit. Staff D reported she would try to call as soon as possible, would talk to the Director of Nursing, and then would call the doctor.On 5/21/26 at 8:57 AM, an interview attempt was made to Resident #64's Doctor of Nursing Practice (DNP), but the provider didn't return the call.The Pain Management Policy last revised on April 2025 directed staff to recognize when a resident is experiencing pain, manage or prevent pain consistent with the comprehensive assessment and plan of care, and develop, implement, monitor, and revise interventions to manage each individual resident's pain. The policy instructed staff to notify the practitioner if the resident's pain is not controlled by the current treatment regimen, and to revise the pain management regimen and plan of care if reassessment findings indicate pain is not adequately controlled.