

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165350	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/03/2026
NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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 observations, clinical record review, resident and staff interviews, the facility failed to respect a resident's dignity throughout all care provided and talk to resident with dignity and respect for 1 of 6 residents reviewed (Resident #25). The facility reported a census of 81 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #25 revealed diagnoses of heart attack, stroke, CHF, pulmonary disease. The Brief Interview for Mental Status (BIMS) score was 14 that suggested an intact cognition. The MDS revealed that Resident #25 was dependent upon staff for toileting and total assistance of two staff to transfer from bed-to-chair transfer. Incident Summary: On 4/13/26: Staff FFF, Licensed Practical Nurse (LPN) asked Staff EEE, Certified Nursing Assistant (CNA) to assist Resident #25 to go to the restroom. Staff EEE responded, shut Resident #25's call light off, shrugged her shoulders to the resident who asked to be taken to the restroom and walked out of Resident #25's room without assisting and refused to acknowledge the nurse requesting assistance. On 4/16/26, The Director of Nursing (DON) completed an internal investigation and the determination of the facility to terminate Staff EEE, CNA for failure to provide resident care. During an interview on 5/19/2026 at 1:22 pm, Resident #25 stated he had discharged to home. Resident #25 stated during his stay at the facility (identified facility) he had told the nurse, as she was administering his medication, that he needed to use the bathroom. Resident #25 stated the nurse told him she would get someone and the nurse left his room without returning. Resident #25 stated a CNA came in, turned the call light off and left him because she had to get someone else. Resident #25 stated he waited for over 2 hours to have a bowel movement. Resident #25 stated a therapist entered his room to answer his call light and helped him. Resident #25 stated he felt abandoned due to the shortness of staff. Resident #25 stated at this facility, it was hurry up and wait, and wait, and wait. Resident #25 stated he felt that he was to learn patience, a lesson in patience due to not enough staff to provide proper care for him. A document titled Statement Form revealed: On 4/13/26 at 6:30 am, Resident #25 was assessed by Staff FFF, Licensed Practical Nurse (LPN) during medication pass. Resident #25 requested to be assisted to the toilet. Staff FFF left to find additional staff. At 8:00 am Resident #25's call light was on. Staff FFF observed Staff EEE, CNA exiting Resident #25's room. Staff FFF responded and asked Resident #25 what she could do to help. Resident #25 said Staff EEE, CNA came into answer the call light and when Resident #25 requested to go to the toilet, Staff EEE shrugged her shoulders and walked out. At 9:30 am Resident #25's son was present and requested to talk to administrative staff. The son expressed concern about the quality of care. At 10:15 am the Director of Nursing (DON) and Staff F, MDS coordinator responded. At 11:30 am the Administrator spoke with Resident #25 and his family. The document was signed by Staff FFF, LPN. The Grievance Form dated 4/13/26 signed by the Administrator as resolved on 4/13/26 recorded Resident #25 reported a concern he had to have a bowel movement at 6:30 AM, he put on his call light, a girl walked in at 8:00 AM, shrugged her shoulders and walked out. The Grievance Official Follow-Up section documented the Administrator spoke with Resident #25 and he reported the CNA went into his room, turned off his light and walked out, and the Administrator let the resident know that they would follow (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	up on his complaint; an investigation started. The form lacked any documentation of further follow up or interview with the resident. The form contained no information on whether the grievance was confirmed or not confirmed. The Progress Note dated 4/13/26 at 8:30 am revealed Staff O, Rehabilitation Director answered Resident #25's call light. Resident #25 said what's so good about it, had to have BM since 6:30 am. Resident #25 reported he activated the call light, some one answered it at 8am, she turned the call light off, shrugged her shoulders and walked out of his room. Staff O found a CNA immediately to assist then reported the incident to Staff FFF, LPN who stated she had requested Staff EEE, CNA to answer his call light during morning medication pass. A Grievance form was completed. The Progress Note dated 4/13/26 at 1:20 pm revealed Resident #25 and family were requesting a referral to two different facilities. The Progress Note dated 5/7/26 at 8:05 am Resident #25 was discharged . On 5/19/26 at 10:35 AM, Staff BB, LPN, responded to questions about staffing, stating there are days when nursing assignments are very overwhelming. The other day was very stressful, being the only nurse on multiple halls and having two resident falls, resulting in having to be sent to the ER, it was just a lot. Staff BB, continued stating help is not often received from the management team, they're rarely even seen on the floor. There is not enough help for the CNA on 300 hall, there is a float that comes to help on 300 but that CNA may not always be available or sometimes the CNAs just can't work well together.		

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident interview, observation, and staff interview, the facility failed to honor a resident's choice of bathing time for 1 of 1 residents reviewed for choices (Resident #81). The facility reported a census of 81 residents. Findings include: The annual Minimum Data Set (MDS) assessment dated [DATE] for Resident #81 coded the resident's daily preferences and marked the resident's response that it was very important for him to choose between a tub bath, shower, bed bath, or sponge bath. The quarterly MDS assessment dated [DATE] for Resident #81 identified a Brief Interview for Mental Status (BIMS) score of 15 which indicated intact cognition. The MDS coded the resident's functional abilities with mobility and showering self as dependent upon a helper for all effort. The MDS documented diagnoses that included debility (physical weakness) and cardiorespiratory conditions (heart and lung conditions). The Care Plan dated 5/3/26 documented a focus area revised 1/9/25 identifying the resident was still adjusting to his new surroundings, would adapt at his own pace, and he preferred doing self led activities. The interventions included to help the resident maintain his preferences in his daily living. The care plan focus area revised 1/8/26 identified the resident needed assistance with ADL (Activities of Daily Living) care related to weakness and decreased mobility. The care plan lacked any identification of resident preference regarding bathing time or assistance level to be provided for showers. In an interview on Monday 5/11/26 at 3:00 PM, Resident #81 stated that Tuesdays were his shower days. Observation on Tuesday 5/12/26 at 7:03 AM revealed the 100 hall shower room door open with a shower curtain pulled around a shower stall. Staff EE, Certified Nurse Aide (CNA), spoke with Resident #81 in an argumentative manner and tone. Resident #81 stated his concern was that the staff were coming around earlier than usual for his shower. When asked his preference, Resident #81 responded he preferred to take a shower at 11:00 AM. As the resident answered, Staff EE interrupted Resident #81 and Staff EE said, no you do not, he does not. The surveyor intervened to instruct Staff EE the questions were for the resident and not her and respectfully to allow the conversation without interrupting the resident. When asked how the resident came to shower at the time versus 11:00 AM, Resident #81 responded staff told him it was time to wake up by then and take his shower. Resident #81 stated it was not really an issue since he was awake and in the shower room so he would proceed to take the shower. In an interview on 5/12/26 at 7:11 AM, Staff EE, CNA, responded she and Resident #81 had a good relationship and were friends. Staff EE made no further comments about the resident's statements of preferred bathing time. In an interview on 5/14/26 at 9:41 AM, Resident #81 responded he would not be told what to do and when to do it. Resident #81 confirmed the conversation with Staff EE during the observation the day before in the shower room was due to him being told to take the shower other than his normal time. Resident #81 responded he thought Staff EE provided his shower at 7:00 AM as Staff EE told him the State expected the shower to be done at that time.		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility grievance documents, clinical record review, observation, resident interview, staff interview, and facility policy review, the facility failed to prevent physical abuse for 1 of 2 residents reviewed for abuse (Resident #81). The facility failed to perform assistance with bed mobility and transfers in a manner to prevent the occurrence of physical harm as evidenced by bruising to Resident #81's right elbow and left wrist as a result of staff holding the resident's arms too hard. The facility failed to converse with Resident #81 in a manner to prevent potential intimidation as the resident expressed a desire to shower at a different time than staff wanted. The facility also failed to perform a thorough and accurate investigation with Resident #71, who after an ER visit due to complaints of pain, was found to have rib fractures of unknown cause, putting residents at risk for further injury, abuse, or neglect for not identifying cause of injury. Additionally, the facility failed to prevent patterned issues of neglect as evidenced by: failure to provide assistance with activities of daily living including grooming, oral care, repositioning, and incontinence care spanning an approximate 7.5 hour period for Resident #73. The facility reported a census of 81 residents. Findings include: 1. Review of the Resident Council Meeting Minutes revealed the following: On 3/6/26, the minutes recorded 18 residents attended. The residents reported call light wait times were improving but some wait times are longer. On 4/3/26, the minutes recorded 14 residents attended. The residents reported: they would like staff to check more often on residents who are out in the common areas throughout the evening and nights; residents felt the nursing staff should have a happier disposition when interacting with residents; and call light wait times were getting better, but some days were better than others. 2. Review of the monthly grievance forms revealed the following: The Grievance Form dated 1/14/26 signed by the Director of Nursing (DON) as resolved on 1/21/26 recorded Resident #8 did not like the way the nurse spoke to her and gave an example of the nurse just lifting the resident's foot without the nurse asking the resident to lift the foot. The Grievance Official Follow-Up section documented education was provided to staff on the 2pm to 10pm and 10pm to 6am shifts on professionalism, customer service, abuse neglect and exploitation, and code of conduct. The Grievance Form dated 1/15/26 signed by the Administrator recorded Resident #81 complained he was not getting checked and changed (providing assistance with incontinence care) on the overnight shift. The Grievance Official Follow-Up section documented education was provided to staff on the 10pm to 6 am shift to make sure they were checking and changing the residents every 2 hours. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #49 reported the aides were not friendly, aides did not get her ice water or answer her call light, and she was not getting a shower. The Grievance Official Follow-Up section documented education provided to staff regarding resident dignity and all things that could be considered hindering their dignity, reinforced it was the resident's home, and spoke to staff specifically about the resident's shower schedule. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #44's family (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	member reported the resident's rash treatment was not done, a CNA on the 6am to 2 pm shift went into the room, turned off the call light and then never came back. The Grievance Official Follow-Up section documented there was no treatment to complete for the resident and education completed with staff to leave call light on until the resident need could be completed. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #16 complained a CNA (Certified Nurse Aide) was being rude and called her a stupid bitch in the resident's room. The Grievance Official Follow-Up section documented the CNA was suspended and a report was made to the State Survey Agency. The Grievance Form dated 1/21/26 signed by the Administrator recorded a resident who formerly resided in room [ROOM NUMBER]-A reported Staff KK, Licensed Practical Nurse (LPN), would not give her pain meds when she requested the med when she had pain and Staff KK gave the wrong insulin medication. The Grievance Official Follow-Up section documented education provided to Staff KK that pain medication was to be administered as requested by any resident, the pain assessment should be documented in PCC (Point Click Care aka Electronic Medical Record) and would have a second person with Staff KK while interacting and providing care with the resident. The Grievance Form dated 1/21/26 signed by the Administrator recorded Resident #84 reported the CNA on the 6am to 2pm shift talked rudely to him. The Grievance Official Follow-Up section documented education provided to the CNA on professionalism/customer service, and the resident cares would be provided in pairs. The form documented that the CNA stated she was never rude to the resident, she didn't tell the resident she would come back to check and change them, and the resident didn't request any assistance nor ask for care. The Concern/Recommendation form dated 1/29/26 recorded a resident in room [ROOM NUMBER] reported his call light was not being answered timely and sometimes the light was on for more than an hour. The Staff Response section recorded an inservice with staff done 1/29/26, they would continue to monitor call lights and talk with residents. The Concern/Recommendation form dated 1/29/26 recorded Resident #72 reported her call light was not being answered timely and it usually took 30 minutes. The Staff Response section recorded an inservice with staff done 1/29/26, they would continue to talk with residents and monitor call lights. The Grievance Form dated 1/29/26 signed by the Administrator as resolved on 1/30/26 recorded Resident #8 reported she waited 45 minutes for assistance, she put her light on at 7:10 PM and was very upset and crying. The Grievance Official Follow-Up section documented an inservice done on 1/29/26 with staff, they would continue to monitor call lights. The Grievance Form dated 1/29/26 signed by the Administrator as resolved on 1/30/26 recorded Resident #43 reported the overnight CNAs do not change her brief overnight and she is a complete bed change when that happens. The resident said she already had skin issues and that two staff did a check and change. The Grievance Official Follow-Up section documented an inservice was done on 1/30/26 with staff and they would continue to monitor call lights. The Concern/Recommendation form signed by the DON on 1/29/26 and the Administrator on 1/30/26 recorded Resident #45 reported a concern with a call light not being answered and a nurse trying to give him insulin medication which he did not take. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	The Grievance Form dated 1/30/26 signed by the Administrator as resolved on 1/31/26 recorded Resident #45 complained of sitting in bowel movement/feces for 14 hours and he did not like it at the facility. The Grievance Official Follow-Up section documented the Administrator asked staff in that hall and they reported they had changed the resident. The form documented an all staff huddle conducted at 2:00 PM, staff were talked with about checking with residents to see if they needed assistance. On 1/31/26 a note was added of a report staff were slow, a bath offered, and the resident refused. A second page Statement Form dated 1/31/26 documented follow up with Resident #45 on the grievance. The resident reported staff taking care of him were slow. The form also recorded staff reported Resident #45 cussed them out and he was very rude and mean. The Grievance Form dated 1/31/26 signed by the Administrator as resolved on 1/31/26 recorded Resident #44 reported a concern with a dietary staff member placing a food tray on her lap and if she could have thrown it at the dietary aide she would have. The form documented the official follow up as the dietary staff member reported the resident requested the tray be placed on her lap, she cussed the staff member out, and education was provided to the staff member about the resident's behaviors. The Grievance Form dated 2/1/26 signed by the Administrator as resolved on 2/1/26 recorded Resident #78 reported a concern with CNAs telling him they could not toilet him because they didn't have an EZ stand (sit-to-stand mechanical lift). The Grievance Official Follow-Up section documented the CNA reported that the EZ stand was not available, she helped the resident to use a urinal, and she found an EZ stand to help him. The Grievance Form dated 2/2/26 signed by the Administrator recorded Resident #84's family member reported the resident stated the CNAs were not treating him well, they just threw things wherever they wanted, and their bedside manner was not good. The Grievance Official Follow-Up section documented the complaint that CNAs put the blankets and bed linens on the floor and the Administrator would talk about it in a huddle. The Grievance Form dated 2/3/26 signed by the Administrator as resolved on 2/7/26 recorded Resident #85's family member reported all the resident's new clothes were missing that included plain t-shirts (a variety of colors), gym shorts, his TV remote, and the family member was supposed to be doing his laundry; the family member wanted the CNAs to stop sending clothes to the laundry room. The Grievance Official Follow-Up section documented a basket was placed in the resident's room, a sign up that family do laundry, the remote was found, and staff informed. The form documented a phone call placed to the family member 2/7/26 but lacked any documentation of follow up to confirm if the clothes were found or if the issue remained resolved. The Grievance Form dated 2/4/26 signed by the Administrator as resolved on 2/4/26 recorded Resident #43 reported not getting checked and changed on the last 3 overnight shifts. The Grievance Official Follow-Up section documented the care need was placed on the TAR (Treatment Administration Record), they would place the resident to get woken up between 3 to 4 AM to be checked and changed. The Grievance Form dated 2/5/26 signed by the DON as resolved on 2/6/26 recorded Resident #88 reported being left in bed due to a broken chair and when she asked to speak to a nurse, the staff member was rude stating she could use the call light, the call light was not in reach at the time, the bed side table was also not in reach, and the nurse would not come to talk to the daughter. The daughter turned on the call light at 3:00 PM, noticed the chair was unplugged, and when staff came in they did not offer to help rearrange to plug in the chair and oxygen, so the daughter did it. Upon (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	leaving the room, the oxygen was not reapplied, the daughter asked the staff member to come back in and reapply the oxygen, and the staff member was rude about doing so. The concern was also reported on 1/19/26, upon return to the facility, EMTs (emergency medical technicians) had to wait 30 minutes for paperwork to be given. The nurse stated she would be back to do an assessment, came back to take vitals, said be back again and did not go back until 7:00 PM. The daughter reported the resident's side of the room not cleaned the entire time the resident was in the hospital and staff told the resident they did not have time to warm up her supper. The Grievance Form dated 2/6/26 signed by the DON as resolved on 2/6/26 recorded a family member of a resident who formerly resided in room [ROOM NUMBER]-A reported a concern that the resident turned on the call light at 6:10 PM while the family member was on the phone with the resident and on the phone until 6:45 PM and no one had been in to help the resident. The Grievance Form dated 2/11/26 signed by the Administrator as resolved on 2/11/26 recorded Resident #8 reported a concern the staff did not have incontinence briefs available for her on the overnight shift. The Grievance Official Follow-Up section documented the Administrator talked with the Staff GG, Certified Medication Aide (CMA), who ordered supplies reported they had large pull ups but extra large would be placed in central supply. The Grievance Form dated 2/15/26 signed by the Administrator as resolved on 2/15/26 recorded Resident #30 complained staff let another resident yell in the hallway while staff were laughing at him and he reported call lights taking an hour and a half on the 200 Hall. The Grievance Official Follow-Up section documented the staff were educated on 2/15/26 about call lights and residents yelling. The Grievance Form dated 2/15/26 signed by the Administrator as resolved on 2/15/26 and 2/16/26 recorded Resident #45 reported missing 4 pairs of blue pants. The Grievance Official Follow-Up section documented the Administrator spoke with laundry and they would find the resident some clothes as he came with no clothes. The form lacked any documentation of further follow up or interview with the resident to confirm resolution or whether the resident actually owned 4 pairs of pants that were missing. The Grievance Form dated 2/16/26 signed by the Administrator as resolved on 2/17/26 recorded Resident #16 reported a concern that Staff HH, CMA, made the comment that the resident better watch her back. The Grievance Official Follow-Up section documented the Administrator Spoke with the CMA and had her write a statement. The statement form dated 2/16/26 recorded the CMA had no knowledge of any conversation of any kind with staff or resident on any day of an abusive nature. The Grievance Form dated 2/16/26 signed by the Administrator as resolved on 2/18/26 recorded Staff II, LPN, reported a concern involving Resident #52. Staff II reported Resident #52 very upset upon return from hospital around 12:00 PM as Staff JJ, CNA, did not do any cares, no pericare (cleansing of perineal area after incontinence), no assistance with any activities of daily living, and the 2pm to 10pm shift called the nurse into the resident's room around 3:00 PM as the resident needed help. Resident #52 reported to Staff II that she had been asking for help since returning from the hospital, the resident still underneath all the hospital linens and draw sheet (transfer sheet), with a brief and all linen saturated with blood and urine from the mid back to mid thigh. The Grievance Official Follow-Up section documented the DON spoke with Staff JJ who would be retrained starting 2/18/26, the facility wanted Staff JJ to do better with her cares, and she would be monitored. The Grievance Form dated 2/24/26 signed by the Administrator as resolved on 2/25/26 recorded (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	Staff II, LPN, reported a concern involving Resident #36 and Resident #78's family member. Staff II reported Resident #36 sat by the med cart in the commons area by the dining room when Resident #78's family member walked by and said 'fuck you' to Resident #36 who became upset and said he wanted it turned in as every time the family member seen Resident #36 he cursed at him due to Resident #36 reporting the family member stealing. The Grievance Official Follow-Up section documented the Administrator spoke with the family member of Resident #78 about calling residents curse names. The family member responded that Resident #36 calls Resident #78 names. The Administrator followed up with Resident #36 about calling Resident #78 names which he acknowledged but stated he had not done for a couple of months. The Administrator documented both residents and the family member were educated about name calling. The Grievance Form dated 2/24/26 signed by the DON as resolved on 2/25/26 recorded Resident #3 reported Staff KK, LPN, stuck her insulin in like a dart, the nurse spoke to her rudely, and refused to push her in the wheelchair on 2/24/26. The form also recorded the resident in a different chair that day, complained to the resident about her hygiene in the hallway, and the resident felt like she was being bullied that day. The Grievance Official Follow-Up section documented the DON spoke with Staff KK regarding the grievance and that they would be making some changes to assignments. The Grievance Form dated 2/27/26 signed by the Administrator as resolved on 2/27/26 recorded Staff LL, Therapy, reported a concern involving a resident who formerly resided in room [ROOM NUMBER]-B. Staff LL reported the resident put his call light on at 6:00 AM, called the front desk twice, a staff member by first name only noted to take the call, and no one went to help the resident until 8:00 AM and the resident almost missed breakfast. The resident reported the staff never cleaned up the room, took laundry, he waited 30 minutes to an hour for the call light to be answered, staff leave call light on for an hour, and it had been recurring for weeks on the 6am to 2pm shift. The resident further reported numerous items including: being left on the toilet for up to one hour; no one empties the urinal; and coming on the wrong shower days. The Grievance Form dated 2/28/26 signed by the Administrator as resolved on 3/2/26 recorded Resident #59 complained call lights took 1 hour to answer, he had a bowel movement in his brief and not changed in a timely manner, and complained of pain meds. The form contained no further elaboration about the pain med concern. The Grievance Official Follow-Up section documented the Administrator educated staff on 2/28/26, spoke to the nurse about pain med, and hung a sign on the door to leave it open. The Concern/Recommendation form dated 3/3/26 signed by the Administrator recorded Resident #44 reported a concern that a resident called Resident #44 a racial slur and threw water on her. The Staff Response section documented staff stated the resident didn't want to go back in the room and explained that was why they had two staff with cares. The response failed to indicate which other resident was involved in the altercation and which needed two staff with care. The form lacked any documentation of further follow up or interview with Resident #44, any other resident or staff who may have witnessed the interaction, or whether an investigation was initiated for resident to resident potential abuse allegation. The Grievance Form dated 3/11/26 signed by the Administrator as resolved on 3/12/26 recorded Resident #5's family member reported a concern that the resident was missing a pink blanket, it went to the laundry and had not been returned, and when going to the bathroom it took a very long time. The Grievance Official Follow-Up section documented staff needed to help the resident in the bathroom and assist her with walking; staff educated at huddle at 2:00 PM on 3/12/26 and the pink blanket (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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F 0600 Level of Harm - Actual harm Residents Affected - Some	found in her closet. A second white page cut off at the top of the form documented for staff to help the resident get cleaned up and they stated, you can walk, that's why we leave you and the family member stated that was true, however, the resident was unable to clean herself after using the bathroom. The Grievance Form dated 3/12/26 signed by the Administrator as resolved on 3/12/26 recorded Resident #51 reported a concern to hospice that Resident #46 tried to pull her pants down and she got away and left the area. The Grievance Official Follow-Up section documented the Administrator spoke with Resident #46 who reported nothing happened and he was confused about the concern. The Administrator spoke with Resident #51 who reported when Resident #46 tried to pull her pants down, she left the area. The Administrator documented both residents educated not to be around each other. The form lacked any documentation of further follow up or interview with other residents, staff, or potential witnesses to the occurrence or whether an abuse investigation was initiated. The Grievance Form dated 3/13/26 signed by the Administrator as resolved on 3/14/26 recorded Resident #43 reported a concern that while attending activity on 3/12/26 Resident #15 threw a bean bag at her making contact with her arm. The Grievance Official Follow-Up section documented at the time of the incident staff told Resident #15 that was not appropriate and he left the area, then returned to activity and the residents were separated as neither wanted to leave. The form documented in the future, the residents would be kept opposite during the activity. On 3/13/26 the DON noted she spoke with Resident #43 whos reported Resident #15 did it on purpose, the DON looked at Resident #43's arm and there were no bruises or marks, and the resident encouraged to continue attending activities. The DON also noted she spoke with Resident #15 and he acted like he didn't know what the DON was talking about. The form lacked any documentation of further follow up or interview with other residents or potential witnesses to the occurrence or whether it was investigated as a potential allegation of abuse. The Grievance Form dated 3/26/26 signed by the Administrator recorded Resident #74 reported a concern that sometimes it took 30 minutes or more to get the call light answered. The Grievance Official Follow-Up section documented 3/27/26 staff educated that day at a huddle about answering call lights in a timely manner. The Grievance Form dated 3/29/26 signed by the Administrator as resolved on 3/31/26 recorded Resident #16 reported a concern that two CNAs helped her roommate, Resident #16 had her call light on needing help in the bathroom, and the staff left her so she did her own cares. The Grievance Official Follow-Up section documented 3/28/26 the resident was unable to tell the Administrator who the two CNAs were and she would educate staff at huddle and no other investigation documented on the form. The Grievance Form dated 3/29/26 signed by the Administrator as resolved on 3/29/26 recorded Resident #58 reported a concern with the way the CNA talked to her, the CNA had a tone, and the resident did not want the CNA back in her room. The Grievance Official Follow-Up section documented 3/29/26 the resident reported she had no other concerns, she still did not want the CNA, and Staff MM, CNA, educated not to go in Resident #58's room. The Grievance Form dated 4/1/26 signed by the Administrator as resolved on 4/1/26 recorded Resident #45 reported a concern that he didn't receive his dinner tray the previous night, he turned on the call light and no one would answer forever. The Grievance Official Follow-Up section documented the Administrator spoke with the resident with the DON and Dietary Manager present, the resident (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	was very rude, they asked the resident to come to the dining room for his meals, and they educated staff at huddle on 4/1/26. An additional note added in different color ink without a date that the CMA stated that no one complained they didn't receive dinner. The Grievance Form dated 4/8/26 signed by the Administrator as resolved on 4/9/26 recorded a hospice CNA reported a concern for Resident #51. The aide reported the resident asked the dietary aide for a peanut butter and jelly sandwich and a drink and the dietary aide informed Resident #51 she could only have so many sandwiches and drinks per day. The Grievance Form dated 4/9/26 signed by the Administrator as resolved on 4/10/26 recorded Resident #21 reported a concern that from 11:30 AM to 2:30 PM, no one answered his call light, he had a hard time getting anyone to change his oxygen tank, and it took 45 minutes at night to get his tray (food). The Grievance Official Follow-Up section documented staff educated at 2:00 PM huddle about answering call lights in a timely manner. The Grievance Form dated 4/13/26 signed by the Administrator as resolved on 4/13/26 recorded Resident #25 reported a concern he had to have a bowel movement at 6:30 AM, he put on his call light, a girl walked in at 8:00 AM, shrugged her shoulders and walked out. The Grievance Official Follow-Up section documented the Administrator spoke with Resident #25 and he reported the CNA went into his room, turned off his light and walked out, and the Administrator let the resident know that they would follow up on his complaint; an investigation was started. The Grievance Form dated 4/14/26 signed by the Administrator as resolved on 4/15/26 recorded Staff Y, Occupational Therapist (OT), reported Resident #64 agitated and yelled in the hallway when the therapist approached at 2:10 PM. Staff Y reported the resident stated he had a wet brief (incontinence) at lunch, he told a CNA who told him they would be right back, and the resident upset they never came back. Staff Y assisted the resident with care. The Grievance Form dated 4/17/26 signed by the Administrator as resolved on 4/17/26 recorded a friend of Resident #35's reported the call light 30 minutes, the room was dirty, changing clothes, and bath, and no other notes to detail the issues in the first section. The Grievance Form dated 4/16/26 signed by the DON as resolved on 4/17/26 recorded a resident who formerly resided in room [ROOM NUMBER] reported since 3:00 or 4:00 AM he had been asking for his PRN (as needed) pain medication and muscle relaxer but he kept getting told he could not/did not have any. The Grievance Official Follow-Up section documented the staff had been educated on the use of PRNs and giving them in a timely manner and explaining why, if they could not. The Grievance Form dated 4/30/26 signed by the Administrator as resolved on 5/1/26 recorded Resident #45 reported the hallway would be noisy, he could hear staff talking, he turned on his call light, and everything went quiet with no one helping him, and it took awhile for anyone to answer his call light. The Grievance Official Follow-Up section documented the Administrator educated (staff) at huddle that day at 2:00 PM. The Grievance Form dated 5/1/26 signed by the Administrator as resolved on 5/1/26 recorded Resident #81 reported a concern of having a bruise to his left wrist and right elbow that happened during care and rolling on 4/30/26, and he did not believe it was purposeful. The Grievance Official Follow-Up section documented the DON and Administrator educated staff verbally on hall to use proper hand placement and a sheet to roll the resident and educated (staff) at huddle on 5/1/26 at (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	2:00 PM. The form lacked any documentation to indicate an investigation initiated for potential abuse or interviews with staff about the incident. 3. Resident #81 The Minimum Data Set (MDS) assessment dated [DATE] for Resident #81 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented no signs or symptoms of delirium, verbal behaviors directed toward others occurred on 1 to 3 days of the 7-day look back period, and the resident did not refuse care. The MDS coded the resident's functional abilities with mobility and showering self as dependent upon a helper for all effort. The MDS documented diagnoses that included debility, cardiorespiratory conditions. The Care Plan dated 5/3/26 for Resident #81 documented a focus area for assistance needed for Activities of Daily Living (ADL) care related to weakness and decreased mobility. The care plan interventions directed staff to provide assistance of 1 person for bathing and dressing, check and change for toileting, and provide assistance of 2 persons and a hooyer (full body) mechanical lift for transfers. The Care Conference note dated 4/2/26 documented Resident #81 reported to the Director of Nursing and MDS Coordinator who were in attendance that it took a long time for his call light to be answered. The note also recorded Resident #81 felt that nursing staff did not listen to him. The Weekly Skin Review dated 4/24/26 at 5:16 PM recorded skin condition of redness, open area, and pre-existing; it did not check the box for bruises. The review documented description of the skin conditions present as: groin area with redness to folds with treatment in place and right gluteal fold open area with treatment in place. The Incident Report dated 4/30/26 at 9:00 PM documented an incident for Resident #81 recorded by Staff L, Licensed Practical Nurse (LPN). The report documented Staff L was called to the resident's room by Certified Nurse Aide (CNA) due to bruises on left wrist measuring 5 cm x 2 cm (centimeters length by width) and right elbow measuring 10 cm x 7 cm. Staff L wrote the bruises were deep purple, no warmth noted, and no reported pain. Staff L wrote Resident #81 alert, oriented, and reported he was not harmed intentionally. Staff L wrote the resident had limited bed mobility, obesity and use of 10 mg (milligrams) Eliquis (anticoagulant medication aka blood thinner) daily were contributing factors. Under Resident Description, Staff L wrote: It's when they roll me. They hold on too hard. Under Immediate Action Taken, Staff L wrote she reported to the Director of Nursing (DON) for further assessment, monitored CNAs on evening shift with no issues noted during bed mobility. Under Injury Type / Location the report documented bruise to the right antecubital and bruise to left hand palm. The report documented the resident's Mental Status as oriented to person, place, time, and situation. The Progress Notes dated 4/30/2026 at 9:48 PM linked to the Incident Report and recorded the same information. The Follow up Skin assessment dated [DATE] at 9:50 PM documented a skin condition of a bruise. The assessment recorded the right elbow with deep purple bruise measuring 10 cm by 7 cm; left hand palm with deep purple bruises measuring 5 cm by 2 cm. The facility submitted the photographic documentation of Resident #81's bruises which Staff L, LPN, took on 4/30/26 when she first reported them. The photographs depict two areas: 2 deep dark maroon (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	colored thick lines at the base of a hand located on a wrist area, the lines clearly delineated of different lengths that would line up with the length and width of finger marks; and a large area of an elbow region with deep dark maroon and greenish coloring spanning an area which would be greater than the size of a dollar bill. Only upclose pictures were taken so the whole area of the hand/wrist and whole arm was not depicted. The Weekly Skin Review dated 5/1/26 at 2:57 PM recorded skin condition of none, skin intact, despite the photographic evidence and skin assessment the facility had of bruises present on 4/30/26. On 05/11/2026 at 3:00 PM Resident #81 stated he had lived at the facility for about a year, he required a hoyer (full body) mechanical lift for transfers and the staff grab hold of him and yank when helping him. Resident #81 reported the staff grabbed a hold of his arms harshly leaving a bruise when they grabbed to move him. Observation during the interview revealed a fading bruise to the resi		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on grievance document, clinical record review, resident interview, staff interview, facility investigation review, and facility policy review, the facility failed to report allegations of abuse involving injuries of unknown origin (Resident #71) and bruising that occurred as a result of staff grabbing a resident too hard (Resident #81) to the Department of Inspections, Appeals, and Licensing (DIAL) in a timely manner for 2 of 2 residents reviewed for abuse reporting. The facility reported a census of 81 residents. Findings include: 1. Resident #71 Review of the Minimum Data Set (MDS) dated [DATE] revealed Resident #71 Brief Interview of Mental Status (BIMS) of 15, indicating cognitively intact and Diagnoses of UTI, multiple fractures of right-side ribs, COPD, cirrhosis of liver, anxiety, and depression. Review of Resident #71's Care Plan documented a focus requiring assistance with ADL (activities of daily living) functions initiated 8/21/25 with intervention of assistance of one for transfers. Nursing Progress Note dated 3/12/26 at 4:59 AM, Resident #71 complains of pain to the right upper side, stating current pain medication is not effective. Resident #71 is on scheduled tramadol, 50 mg every 6 hours. Vital Signs obtained within normal ranges. Will keep monitoring Resident #71. Nursing Progress Note dated 3/14/26 at 7:03 PM, Resident #71 had complaints of right-side abdomen pain that extended from the top to lower part of abdomen. Vital signs stable for this resident. Resident #71 was in too much pain to eat dinner. This nurse called the on-call provider who ordered Resident #71 be sent to the emergency room (ER) for KUB (abdominal imaging study to evaluate kidneys, ureters and bladder). This nurse called EMS to transport and called the ER to give a report. Resident #71 rates pain 8/10. Nursing Progress Note dated 3/15/26 at 3:57 AM, Resident #71 returned with discharge paperwork from hospital visit. Documentation indicated Resident #71 was evaluated for fracture of the right 11th rib, UTI, and right sided abdominal pain. Instructions included encouraging hydration and fluid intake. Resident #71 to wear lidocaine patch every day for pain. Other prescriptions provided; cefdinir (antibiotic) 300mg by mouth every 12 hours for UTI. Assessment and vitals completed and Resident #71 resting in bed at this time. Further review of Resident #71's Electronic Health Record (EHR) provided scanned copies of Emergency Department Notes dated 3/14/26. The ER Physician noted, Resident #71 presents to the ER via EMS with complaints of 2 weeks gradually worsening sharp right upper quadrant abdominal pain that radiates to the right lower quadrant. Her pain is constant and waxes and wanes (symptoms repeatedly get worse (wax) then improve or subside (wane) over time). Resident #71 denies any recent falls or injuries. She has been taking tramadol for pain but that is not helping her symptoms. Resident #71's pain has worsened and she now presents to the ER. CT Scan Report dated 3/14/26 documented results compared to previous CT scan on 6/18/25. Findings documented, age indeterminate, though presumably acute (examiner believes the fracture is a recent development) nondisplaced right posterior 11th rib fracture. New from the prior study. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of provided Facility Investigation revealed the following: Major Injury Determination Form, Resident #71 Date and time of the injury: On 3/14/26 Resident #71 complained of pain to right upper anterior abdomen/chest. Description of injury: Resident #71 sent to ER on [DATE] with pain 8/10. Returned to facility with medical diagnosis of UTI and 11th rib fracture. Circumstances of the incident causing the injury: Resident #71 is supervision/touching assistance to partial/moderate assistance for all cares. Signature/Name of facility representative completing form; completed and signed by Staff F, MDS coordinator To be completed by the physician. Patient's prognosis: (blank, no noted documentation) After reviewing the circumstances, injury and prognosis of the patient, I believe the injury sustained is not a major injury and, to the best of my knowledge, barring any complications, I believe the patient will return to his/her previous functional status. Signed and dated 3/15/26 by Physician. Resident #71 Investigation 3/14/26 Talked with Resident #71 today and asked her if she had falls while out on pass on 3/13/26, she reported no falls. She also reported no falls in her room. Talked with Physician about Resident #71's Xray report and Physician signed a non-major injury form on 3/15/26. Resident #71 also was treated for UTI and started on antibiotics. Resident #71 to follow up with Physician. Signed by Facility Administrator. In email communication dated 5/28/26, Facility's Regional Director of Operations, clarified Resident #71's rib fracture of unknown origin had not been reported by the Facility to the Regional Director of Operations or DIAL. 2. Resident #81 The Grievance Form dated 5/1/26 signed by the Administrator as resolved on 5/1/26 recorded Resident #81 reported a concern of having a bruise to his left wrist and right elbow that happened during care and rolling on 4/30/26, and he did not believe it was purposeful. The Grievance Official Follow-Up section documented the DON and Administrator educated staff verbally on hall to use proper hand placement and a sheet to roll the resident and educated (staff) at huddle on 5/1/26 at 2:00 PM. The form lacked any documentation to indicate an investigation initiated for potential abuse or interviews with staff about the incident. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #81 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented diagnoses that included debility, cardiorespiratory conditions. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Care Plan dated 5/3/26 for Resident #81 documented a focus area for assistance needed for Activities of Daily Living (ADL) care related to weakness and decreased mobility. The care plan interventions directed staff to provide assistance of 1 person for bathing and dressing, check and change for toileting, and provide assistance of 2 persons and a Hoyer (full body) mechanical lift for transfers. The Incident Report dated 4/30/26 at 9:00 PM documented an incident for Resident #81 recorded by Staff L, Licensed Practical Nurse (LPN). The report documented Staff L was called to the resident's room by Certified Nurse Aide (CNA) due to bruises on left wrist measuring 5 cm x 2 cm (centimeters length by width) and right elbow measuring 10 cm x 7 cm. Staff L wrote the bruises were deep purple, no warmth noted, and no reported pain. Staff L wrote Resident #81 alert, oriented, and reported he was not harmed intentionally. Staff L wrote the resident had limited bed mobility, obesity and use of 10 mg (milligrams) Eliquis (anticoagulant medication aka blood thinner) daily were contributing factors. Under Resident Description, Staff L wrote: It's when they roll me. They hold on too hard. Under Immediate Action Taken, Staff L wrote she reported to the Director of Nursing (DON) for further assessment, monitored CNAs on evening shift with no issues noted during bed mobility. Under Injury Type / Location the report documented bruise to the right antecubital and bruise to left hand palm. The report documented the resident's Mental Status as oriented to person, place, time, and situation. The facility submitted the photographic documentation of Resident #81's bruises which Staff L, LPN, took on 4/30/26 when she first reported them. The photographs depict two areas: 2 deep dark maroon-colored thick lines at the base of a hand located on a wrist area, the lines clearly delineated of different lengths that would line up with the length and width of finger marks; and a large area of an elbow region with deep dark maroon and greenish coloring spanning an area which would be greater than the size of a dollar bill. Only up-close pictures were taken so the whole area of the hand/wrist and whole arm was not depicted. On 5/11/26 at 3:00 PM Resident #81 stated he had lived at the facility for about a year, he required a Hoyer lift for transfers and the staff grab hold of him and yank when helping him. Resident #81 reported the staff grabbed a hold of his arms harshly leaving a bruise when they grabbed to move him. Observation during the interview revealed a fading bruise to the resident's left wrist and a large bruise located on the resident's right forearm near the elbow. Resident #81 voiced the staff know they cannot do that, they ignore him like he is an idiot, and bottom line it should not be going on. In a follow up interview on 5/13/26 at 4:10 PM, Resident #81 when asked about the fading bruise on his right outer forearm, he responded that was ridiculous too as the staff were too rough when they grabbed his arm to move him and reiterated that was how he got the bruise. Resident #81 said he kept telling the staff they were too rough when moving him, they did not listen, he did not know any staff names specifically that pulled him too hard because he was terrible with names, and he was not sure which shift. With consent given by Resident #81, photographic evidence taken on 5/14/26 of the resident's bruise that remained on his right inner elbow and upper forearm region. A series of 3 pictures taken, close, near, far that depicted a bruise in various stages of healing. The bruise located on the lateral side of the elbow and upper forearm region extending out posteriorly. The posterior edge of the bruise-colored deep purple and mottled look with the upper center portion faded yellow/reddish color and the bottom center portions greenish in color. The area appeared to be the size of the resident's entire hand which was captured in the photo of the entire arm. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/26 at 12:10 PM, the Administrator acknowledged awareness of the resident's arm bruises from 4/30/26. The Administrator stated it was charted by the nurse in the nurses' notes that the bruises were a result of turning the resident and staff were educated. The Administrator responded she did not treat it as an allegation of abuse as it was not unknown origin as Resident #81 knew the bruise was there. The Administrator confirmed the only documentation was the grievance form where she documented education to staff done about caring for the resident by proper hand placement and using a transfer sheet to move him. In a follow up interview on 5/19/26 at 1:57 PM, Resident #81 reported he didn't know who actually left the bruises, but it wasn't the hospital and the facility was assuming the hospital was the ones who did it. When asked if he thought the bruising was intentional, Resident #81 responded he wanted to say yes, but if he said yes, then something needs to be done about it. Resident #81 voiced he also wanted to say no because he was not 100% sure who did it and he didn't want to blame someone and to get someone in trouble. Resident #81 commented the staff do grab his arms sometimes to help turn him and they do not use a turning sheet to help turn him. On 5/20/26 at 2:35 PM, Staff L, LPN, responded she only had 1 incident report which involved bruises across the resident's wrist and the elbow that looked like finger prints but he said he was told it came from the hospital IV. Staff L stated she told him no, as she had completed his skin assessment after return from hospital and every night before noticed and Resident #81 did not have the bruises. Staff L commented she voiced to the resident he was a big [NAME] and the bruising looked like someone holding on to him. Staff L said the resident responded he would say something if someone hurt him intentionally. Staff L reported she sent the pictures to the DON immediately from her phone and she suggested the DON should do spot checks of resident care. Staff L described a round bruise on the right elbow, bruise on the left wrist was two lines, and the resident told her he did not know where they came from as he couldn't see that part of his arm. When asked about Staff L's entry on the incident report that the resident stated on 4/30/26 that staff grabbed him too harshly, Staff L responded is that what I put? then yeah he must have said that and I thought it was from turning and grabbing, because he is so heavy in general. Staff L clarified staff have to put hands on the resident's body, arms, and butt to get him rolled over and the resident also took Eliquis that could make bruises. When asked to talk more about the documentation that the resident said he was grabbed too harshly, Staff L denied the resident told her he had been grabbed too hard. Staff L reported the aides said they had not seen the bruises before Staff L identified them after one of the aides reported the bruises to her. On 5/20/26 at 10:06 AM, Staff HHH, Certified Medication Aide (CMA), stated she didn't do much care with Resident #81. Staff HHH stated that when he came back from the hospital, he had a bruise she thought to his right elbow and maybe his right upper arm, she didn't really remember. On 5/20/26 at 2:27 PM, Staff GGG, CMA, stated that she didn't remember if Resident #81 had bruising to his arms after his hospitalization. Staff GGG stated that she had a lot going on every day, she did remember that the nurse Staff L said something to her about the bruise to his arm, but she did not remember when it was. As of 6/1/26 at 7:34 AM no abuse investigation file was received related to the bruises on the right elbow and left wrist and the facility failed to report the allegation of abuse to the State Survey Agency. Policy Review (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy titled Abuse, Neglect and Exploitation revised 01/2026 included the following documentation: Definitions: Abuse, is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The facility policy lacked a definition for Injuries of Unknown Origin which the State Operations Manual Appendix PP defines as: Injuries of unknown source &ndash; An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. Reporting/Response (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility will have written procedures that include: Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury. Assuring that reporters are free from retaliation or reprisal; Promoting a culture of safety and open communication in the work environment prohibiting retaliation against any employee who reports a suspicion of a crime. This facility will post a conspicuous notice of employee rights, including the right to file a complaint with the State Survey Agency if the employee believes the facility has retaliated against him/her for reporting a suspected crime and how to file such a complaint. Reporting to the state nurse aide registry or licensing authorities any knowledge it has of any actions by a court of law which would indicate an employee is unfit for service; Taking all necessary actions as a result of the investigation, which may include, but are not limited to, the following: Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining how care provision will be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff competency after training is implemented; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and Identification of staff responsible for monitoring the implementation of the plan. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on grievance document, clinical record review, resident interview, observation, staff interview, facility investigation review, and facility policy review, the facility failed to conduct thorough investigations of allegations of abuse including bruising that occurred as a result of staff grabbing a resident too hard and allegation of intimidation/verbal abuse for 1 resident (Resident #81) and allegations of abuse involving injuries of unknown origin rib fractures for 1 resident (Resident #71), for 2 of 2 residents reviewed for comprehensive abuse investigations (Resident #81, #71). As a result, the facility could not ensure that allegations of abuse and injuries of unknown origin were fully investigated in accordance with facility policy and regulatory requirements. The facility reported a census of 81 residents. Findings include: 1. Resident #81 The Grievance Form dated 5/1/26 signed by the Administrator as resolved on 5/1/26 recorded Resident #81 reported a concern of having a bruise to his left wrist and right elbow that happened during care and rolling on 4/30/26, and he did not believe it was purposeful. The Grievance Official Follow-Up section documented the Director of Nursing (DON) and Administrator educated staff verbally on hall to use proper hand placement and a sheet to roll the resident and educated (staff) at huddle on 5/1/26 at 2:00 PM. The form lacked any documentation to indicate an investigation initiated for potential abuse or interviews with staff about the incident. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #81 identified a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented diagnoses that included debility, cardiorespiratory conditions. The Care Plan dated 5/3/26 for Resident #81 documented a focus area for assistance needed for Activities of Daily Living (ADL) care related to weakness and decreased mobility. The care plan interventions directed staff to provide assistance of 1 person for bathing and dressing, check and change for toileting, and provide assistance of 2 persons and a hoist (full body) mechanical lift for transfers. The Incident Report dated 4/30/26 at 9:00 PM documented an incident for Resident #81 recorded by Staff L, Licensed Practical Nurse (LPN). The report documented Staff L was called to the resident's room by Certified Nurse Aide (CNA) due to bruises on left wrist measuring 5 cm x 2 cm (centimeters length by width) and right elbow measuring 10 cm x 7 cm. Staff L wrote the bruises were deep purple, no warmth noted, and no reported pain. Staff L wrote Resident #81 alert, oriented, and reported he was not harmed intentionally. Staff L wrote the resident had limited bed mobility, obesity and use of 10 mg (milligrams) Eliquis (anticoagulant medication aka blood thinner) daily were contributing factors. Under Resident Description, Staff L wrote: It's when they roll me. They hold on too hard. Under Immediate Action Taken, Staff L wrote she reported to the DON for further assessment, monitored CNAs on evening shift with no issues noted during bed mobility. Under Injury Type / Location the report documented bruise to the right antecubital and bruise to left hand palm. The report documented the resident's Mental Status as oriented to person, place, time, and situation. The facility submitted the photographic documentation of Resident #81's bruises which Staff L, LPN, took on 4/30/26 when she first reported them. The photographs depict two areas: 2 deep dark maroon colored thick lines at the base of a hand located on a wrist area, the lines clearly delineated of (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	different lengths that would line up with the length and width of finger marks; and a large area of an elbow region with deep dark maroon and greenish coloring spanning an area which would be greater than the size of a dollar bill. Only upclose pictures were taken so the whole area of the hand/wrist and whole arm was not depicted. On 05/11/2026 at 3:00 PM Resident #81 stated he had lived at the facility for about a year, he required a hoier lift for transfers and the staff grab hold of him and yank when helping him. Resident #81 reported the staff grabbed a hold of his arms harshly leaving a bruise when they grabbed to move him. Observation during the interview revealed a fading bruise to the resident's left wrist and a large bruise located on the resident's right forearm near the elbow. Resident #81 voiced the staff know they cannot do that, they ignore him like he is an idiot, and bottom line it should not be going on. Observation on 05/12/2026 at 7:03 AM revealed conversation overheard in the 100 hall shower room. The shower room door was open and the shower current pulled. Observations revealed a male resident and female staff voice heard. The female voice stated, I am trying to take damn good care of you. I do everything for you, people deserve to be criticized but you need to call those names out, just not my name, talk about the good not just the bad. The male resident responded, I will let the State know, I will not give your name. The surveyor entered the shower room to intervene due to the tone of the female staff member and the rising volume of the resident's tone in response which sounded like an argument back and forth with the resident; sounded intimidating to the surveyor. The surveyor shut the door for privacy after asking the resident's permission to observe cares and introducing herself with Staff EE, CNA, and Resident #81 introducing themselves. Resident #81 responded he felt safe when asked. Resident #81 stated his concern was that the staff were coming around earlier than usual for his shower and he felt the staff were trying to pull the wool over the eyes of the State. When asked his preference, Resident #81 responded he preferred to take a shower at 11:00 AM and Staff EE interrupted Resident #81 and with a tone evidenced by a scowl on her face said, no you do not, he does not. The surveyor intervened to instruct Staff EE the questions were for the resident and not her and respectfully to allow the conversation without interrupting the resident. When asked how the resident came to shower at the time versus 11:00 AM, Resident #81 responded staff told him it was time to wake up by then and take his shower. Resident #81 stated it was not really an issue since he was awake now and in the shower room and said the surveyor did not hear the whole conversation. At 7:07 AM, Staff FF, CNA, entered and Resident #81 stated again he just felt that the staff were trying to pull the wool over the State's eyes which is why he spoke up. Resident #81 said he used to work in a nursing home and he knew how it could be. At 7:11 AM, Staff EE pulled into the hall and instructed by surveyor she could not speak to the resident in that manner of tone or impede the survey process by telling a resident what they could and could not say to the State whether good or bad. Staff EE responded she and Resident #81 had a good relationship and were friends. Staff EE said she wanted Resident #81 to tell about the bad ones indicating staff and to make sure to tell the State. Staff EE stated the resident did not give names of the bad staff and she was trying to get him to tell her the names. Staff EE said Resident #81 only said that the overnight staff were bad and that he had told her that previously as well. Observed Staff EE to have red face, tearful at end of conversation. On 05/12/2026 at 7:20 AM Staff J, LPN, received the surveyor's report of allegation of potential abuse, intimidation. The surveyor reported to nurse Staff J the observation, Staff EE's reaction, and that Staff EE walked down the hall rather than returning to the shower room to collect herself. Staff J responded that Staff EE was like that. When asked if Staff J meant emotional, Staff J said no, that Staff EE was very disrespectful, had a bad attitude, and she was rude to residents. Staff J responded that she previously spoke to Staff EE about that behavior and Staff EE's response was to state she worked at the facility longer than they had and shrugged her shoulders. Staff J repeatedly asked the (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	surveyor to keep the conversation confidential and not use her name. On 05/12/2026 at 7:28 AM, the DON was present in the hallway and asked Staff J where Staff EE was located. The surveyor asked to speak to DON to convey observations and interview to report an allegation of abuse, intimidation. On 05/12/2026 at 7:31 AM, the Administrator responded that nurse Staff J approached her to report she observed the surveyor pull Staff EE from the shower room to speak about the interactions. On 05/12/2026 at 8:24 AM, the Administrator reported she spoke with Resident #81 and he did not feel threatened. The Administrator said Resident #81 said Staff EE was his friend and he hoped Staff EE did not get in trouble. The Administrator commented she felt based on what Resident #81 told her, her investigation was good enough to determine she did not need to report it to the State, unless the surveyor wished to escalate it. The surveyor responded to be clear, the surveyor had reported an allegation of potential intimidation and that the Administrator should consider that Staff EE worked with other residents and a comprehensive investigation would include more than just interviews with the resident involved. The surveyor relayed that a staff member who wished to remain anonymous had reported that Staff EE was rude, disrespectful, and had a bad attitude with other residents too. The Administrator responded she would report it then. On 05/13/2026 at 9:11 AM, Resident #81 reported Staff EE and him got along very well and he felt the surveyor took the conversation in a whole other direction as Staff EE and him were not arguing; she wasn't rude or abusive. Resident #81 stated Staff EE came in and said the State wanted them to get his shower and others done earlier. Resident #81 said he knew the surveyor wanted to watch the transfer and the staff wouldn't listen to him. Resident #81 stated he knew it was a cover up. Resident #81 said he didn't know if it was just him or an attitude issue with people not caring how they treat people. Resident #81 commented he didn't do well with names and the staff do not wear their name tags. In a follow up interview on 05/13/2026 at 4:10 PM, Resident #81 expressed he didn't understand what was going on as he had shared his concerns with the surveyor about his bruise on his arm, how some of the staff members could care less and apparently the interaction with Staff EE in the shower room not heard correctly as they were not arguing, and Staff EE got in trouble and fired. Resident #81 stated Staff EE and him talk to each other like that and it really pissed him off that the State came in and supposed to be helping and instead now another good worker got in trouble for no reason. When asked about the fading bruise on his right outer forearm, he responded that was ridiculous too as the staff were too rough when they grabbed his arm to move him and reiterated that was how he got the bruise. Resident #81 stated there were staff who told him he got it from an IV (Intravenous therapy) but he told them he didn't have his IV in the right arm. Resident #81 said he kept telling the staff they were too rough when moving him, they did not listen, he did not know any staff names specifically that pulled him too hard because he was terrible with names, and he was not sure which shift. With consent given by Resident #81, photographic evidence taken on 05/14/2026 of the resident's bruise that remained on his right inner elbow and upper forearm region. A series of 3 pictures taken, close, near, far that depicted a bruise in various stages of healing. The bruise located on the lateral side of the elbow and upper forearm region extending out posteriorly. The posterior edge of the bruise colored deep purple and mottled look with the upper center portion faded yellow/reddish color and the bottom center portions greenish in color. The area appeared to be the size of the resident's entire hand which was captured in the photo of the entire arm. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In another follow up interview on 05/14/2026 at 9:05 AM, Resident #81 confirmed the conversation with Staff EE during the observation the day before in the shower room was due to him being told to take the shower other than his normal time. Resident #81 responded he did not feel that Staff EE caused the bruise to his arm or was ever rough with him. Resident #81 responded he felt Staff EE was making a general statement when she stated to him, I take damn good care of you. Resident #81 responded he thought Staff EE provided his shower at that time as Staff EE told him State expected the shower to be done at that time. On 05/19/2026 at 12:10 PM, the Administrator responded to being asked what steps she took to investigate the allegation of abuse involving Staff EE on 5/12/26 and a copy of the investigation file requested. The Administrator stated she spoke to the CNAs that worked down 100 hallway and talked to other residents. The Administrator acknowledged awareness of the resident's arm bruises from 4/30/26. The Administrator stated it was charted by the nurse in the nurses notes that the bruises were a result of turning the resident and staff were educated. The Administrator responded she did not treat it as an allegation of abuse as it was not unknown origin as Resident #81 knew the bruise was there. The Administrator confirmed the only documentation was the grievance form where she documented education to staff done about caring for the resident by proper hand placement and using a transfer sheet to move him. In a follow up interview on 05/19/2026 at 1:57 PM, Resident #81 reported he didn't know who actually left the bruises, but it wasn't the hospital and the facility was assuming the hospital was the ones who did it. Resident #81 stated he had IV's in his left upper bicep and left forearm. He stated that he did not have any IV's in his antecubital areas. When asked if he thought the bruising was intentional, Resident #81 responded he wanted to say yes, but if he said yes, then something needs to be done about it. Resident #81 voiced he also wanted to say no because he was not 100% sure who did it and he didn't want to blame someone and to get someone in trouble. Resident #81 commented the staff do grab his arms sometimes to help turn him and they do not use a turning sheet to help turn him. On 05/20/2026 at 2:35 PM, Staff L, LPN, responded she only had 1 incident report she had ever done on Resident #81. Staff L said the incident involved bruises across the resident's wrist and the elbow that looked like finger prints but he said he was told it came from the hospital IV. Staff L stated she told him no, as she had completed his skin assessment after return from hospital and every night before noticed and Resident #81 did not have the bruises. Staff L commented she voiced to the resident he was a big [NAME] and the bruising looked like someone holding on to him. Staff L said the resident responded he would say something if someone hurt him intentionally. Staff L reported she sent the pictures to the DON immediately from her phone and she suggested the DON should do spot checks of resident care. Staff L described a round bruise on the right elbow, bruise on the left wrist was two lines, and the resident told her he did not know where they came from as he couldn't see that part of his arm. When asked about Staff L's entry on the incident report that the resident stated on 4/30/26 that staff grabbed him too harshly, Staff L responded is that what I put? then yeah he must have said that and I thought it was from turning and grabbing, because he is so heavy in general. Staff L clarified staff have to put hands on the resident's body, arms, and butt to get him rolled over and the resident also took Eliquis that could make bruises. When asked to talk more about the documentation that the resident said he was grabbed too harshly, Staff L denied the resident told her he had been grabbed too hard. Staff L responded it took 2 aides to turn the resident and a nurse to complete the treatment. Staff L stated there would be no record of a turn sheet, but staff roll the resident with the bed pad to put his body up on side when changing out the pad and she tries to use her palm. When asked if anyone was educated, Staff L responded a huddle was conducted on one shift and she knew the staff on shift for the 100 hallway on 4/30/26 included the 3 aides assigned to (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the hall. Staff L reported the aides said they had not seen the bruises before Staff L identified them after one of the aides reported the bruises to her. Staff L responded that no one from leadership interviewed or educated her about the bruises. Staff L denied being educated about using a turn sheet or roll sheet during resident care. On 05/20/2026 at 10:06 AM, Staff HHH, Certified Medication Aide (CMA), stated she didn't do much care with Resident #81. Staff HHH stated that when he came back from the hospital he had a bruise she thought to his right elbow and maybe his right upper arm, she didn't really remember. Staff HHH stated that staff don't grab the resident's arms. When asked if the staff utilized a turning sheet, Staff HHH responded what is that? Staff HHH said she knew they utilized the bed pad in his bed to help with turning. On 05/20/2026 at 1:21 PM, Staff OO, CNA, acknowledged that she worked the day of the 23rd and 24th and she did see a purple bruise to Resident #81's right elbow area. She stated that when she turned him she grabbed a hold of the bed pad and not his arms. Staff OO stated that she tried to grab the back of his legs and hold on to his back and legs so the other CNA could continue with peri cares. Review of the investigation items provided by the facility regarding the allegation involving Staff E revealed the Administrator had initiated an investigation and supplied 7 pages. The 7 page document documented the following: Page 1 - Investigation On 100 Hall 5/12/26 Staff EE initials. Statements taken from staff and random residents interviewed, see attached documents. The Administrator signed the page. Page 2 - Interview with Resident #81. Talked with Resident #81 this morning about the incident that happened in the shower room with Staff EE, CNA. He reported that a surveyor came into the shower room and started asking him questions and asked Staff EE, CNA, to step out and have another CNA come in. Resident #81 reported that he and Staff EE are friends and he did not want her to get in trouble. The surveyor asked Resident #81 if he felt safe and he said yes, the Administrator also asked him the same questions. He said he was more upset about getting his bath earlier than usual, Staff EE talked to him like she did, did not bother him or make him feel unsafe. He did not want her to get in trouble or get fired because she was his friend. The Administrator signed the page on 5/12/26. Page 3 - Handwritten notes dated 5/12/26 and signed by the Administrator. The top of the page documented Hall 100 - Residents Interviewed. The page recorded 5 resident names, Resident #71, #70, #7, #10, #35 with their respective room numbers and all documented 'no concerns' except Resident #10 responded 'sometimes rude'. The Statement Form lacked any identification of what questions were asked and the only other documentation on the form recorded, 'The other residents in this hall will voice their concerns if they have any.' Page 4 - A handwritten, untitled, undated, unsigned, and unidentified Statement Form documented: Started with my normal showers (initials of Resident #35 and #80) then me and Staff EE agreed on doing Resident #81. Staff EE said she would get him ready while I was doing (initials Resident #80). After finishing DW, I went to Resident #81's room and there was no one in the room and the bed was stripped. Assuming Resident #81 was in the shower room, I then went to the shower room and Resident #81, Staff EE, and a female surveyor were in the shower room. The surveyor was asking Resident #81 questions and Staff EE standing there. I got the shampoo, ready and then the surveyor said she was going to leave so I could do the shower. She left and then tried to come in again to say (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she wanted Staff EE to come out so she could talk to her. Staff EE left with the surveyor and I proceeded with my cares. Page 5 - The handwritten Statement Form dated 5/12/26 and signed by Staff TT, CNA, recorded the following: I came out of room [ROOM NUMBER] and overheard Staff EE talking harshly to a resident. I could not intervene because State was already standing outside the shower room. But I did overhear her verbally abusing a resident by telling him he wasn't allowed to do what he wanted to do. Page 6 - The undated, handwritten Statement Form signed by Staff J, LPN, recorded the following: The lady from the state (surveyor) told me that she heard Staff EE arguing with a resident. Surveyor said she's concerned. She (the surveyor) told me that she asked another CNA to give resident his care instead of Staff EE. I notified the Administrator. Page 7 - The handwritten Statement Form dated 5/12/26 and signed by Staff PP, CNA, recorded the following: I wasn't around when the incident happened with Staff EE. She's a good worker and she's always helping the residents with anything they need The document / investigation file lacked any other interviews and the Administrator failed to request a written statement from the surveyor who made the initial report of allegation of abuse involving Staff EE. A typed report signed by the Administrator on 5/16/26 contained a 4 page document titled 5-day Investigation Report for Resident #81; date of incident and report 5/12/26. The report lacked any mention or follow up on Staff PP's written statement that recorded she overheard Staff EE talking harshly to a resident and that what she overheard was verbal abuse. The investigation Summary/Conclusion documented the facility conducted a comprehensive investigation into the verbal altercation with staff member Staff EE and Resident #81 and the facility was compliant with CMS Ftag F600 Freedom from Abuse and Neglect, however, the conclusion left out any mention of Staff TT's statement of Staff EE speaking to the resident harshly. As of 06/01/2026 at 7:34 AM no abuse investigation file was received related to the bruises on the right elbow and left wrist. Policy Review The facility policy titled Abuse, Neglect and Exploitation revised 01/2026 included the following documentation: Definitions: Abuse, is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Alleged violation is a situation or occurrence that is observed or reported by staff, resident, relative, (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visitor, another health care provider, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Mental Abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation. Mental abuse also includes abuse that is facilitated or caused by nursing home staff taking or using photographs or recording in any manner that would demean or humiliate a resident(s). Neglect, means the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Willful, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. Physical Abuse includes, but is not limited to hitting, slapping, punching, biting, and kicking. It also includes controlling behavior through corporal punishment. Verbal Abuse means the use of oral, written or gestured communication or sounds that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance regardless of their age, ability to comprehend, or disability. The components of the facility abuse prohibition plan are discussed herein: III. Prevention of Abuse, Neglect and Exploitation The facility will implement policies and procedures to prevent and prohibit all types of abuse, neglect, misappropriation of resident property, and exploitation that achieves: Identifying, correcting and intervening in situations in which abuse, neglect, exploitation, and/or misappropriation of resident property is more likely to occur with the deployment of trained and qualified, reiterated, licensed, and certified staff on each shift in sufficient numbers to meet the needs of the residents, and assure that the staff assigned have knowledge of the individual residents' care needs and behavioral symptoms; Assuring an assessment of the resources needed to provide care and services to all residents is included in the facility assessment; Providing residents, representatives, and staff information on how and to whom they may report concerns, incidents and grievances without the fear of retribution; and providing feedback regarding the concerns that have been expressed; Assigning responsibility for the supervision of staff on all shifts for identifying inappropriate staff behaviors. IV. Identification of Abuse, Neglect and Exploitation The facility will have written procedures to assist staff in identifying the different types of abuse - mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. This includes staff to resident abuse and certain resident to resident altercations. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Possible indicators of abuse include, but are not limited to: Resident, staff or family report of abuse Physical marks such as bruises or patterned appearances such as a hand print, belt or ring mark on a resident's body Physical injury of a resident, of unknown source Resident reports of theft or property, or missing property Verbal abuse of a resident overheard Physical abuse of a resident observed Psychological abuse of a resident observed Failure to provide care needs such as comfort, safety, feeding, bathing, dressing, turning & positioning The facility policy lacked a definition for Injuries of Unknown Origin which the State Operations Manual Appendix PP defines as: Injuries of unknown source &ndash; An injury should be classified as an injury of unknown source when all of the following criteria are met: The source of the injury was not observed by any person; and The source of the injury could not be explained by the resident; and The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. 2. Resident #71 Review of MDS dated [DATE] revealed Resident #71 BIMS of 15, indicating cognitively intact and Diagnoses of UTI, multiple fractures of right side ribs, COPD, cirrhosis of liver, anxiety, and depression. Review of Resident #71's Care Plan documented a focus requiring assistance with ADL (activities of daily living) functions initiated 8/21/25 with intervention of assistance of one for transfers. Document titled Therapy to Nursing CNA Handoff- Maintenance Plan dated 1/22/26, document Resident #71's transfer as stand-pivot with stand by assistance and use of gait belt and wheelchair use for mobility. Nursing progress noted dated 3/14/26 at 7:03 PM, Resident #71 had complaints of right side abdomen pain that extended from the top to lower part of abdomen. Vital signs stable for this resident. Resident #71 was in too much pain to eat dinner. This nurse called the on call provider who ordered Resident (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	#71 be sent to the emergency room (ER) for KUB (abdominal imaging study to evaluate kidneys, ureters and bladder). This nurse called EMS to transport and called the ER to give a report. Resident #71 rates pain 8/10. Nursing progress noted dated 3/15/26 at 3:57 AM, Resident #71 returned with discharge paperwork from hospital visit. Documentation indicated Resident #71 was evaluated for fracture of the right 11th rib, UTI, and right sided abdominal pain. Instructions included encouraging hydration and fluid intake. Resident #71 to wear lidocaine patch every day for pain. Other prescriptions provided; cefdinir (antibiotic) 300mg by mouth every 12 hours for UTI. Assessment and vitals completed and Resident #71 resting in bed at this time. Provider Encounter Note dated 3/17/26,, chief complaint: abdominal pain. Resident #71 seen and examined today for follow-up acute abdominal pains onset 3/14/26, status post ER visit and return to facility on 3/15/26 with diagnosis of right 11th rib fracture, UTI, and right sided abdominal pains and given prescription for Cefdinir 300mg by mouth every 12 hours for 5 days. Today Resident #71 is resting in wheelchair in room. Resident #71 complains right sided rib and abdominal pains for 2 weeks. Resident #71 reports cracked right rib. Denies falling or recent injury, denies shortness of breath, dyspnea on exertion, cough, congestion, fever, chills, nausea, vomiting. Nursing progress noted dated 3/20/26 at 12:00 AM Resident #71 with increase in pain to fracture of the right 11th rib. Physician notified via phone and new orders for Acetaminophen 1000mg every 6 hours as needed. Review of provided Facility Investigation revealed the following: Major Injury Determination Form: a. Resident #71b. Date and time of the injury: On 3/14/26 Resident #71 complained of pain to right upper anterior abdomen/chest.c. Description of injury: Resident #71 sent to ER on [DATE] with pain 8/10. Returned to facility with medical diagnosis of UTI and 11th rib fracture. d. Circumstances of the incident causing the injury: Resident #71 is supervision/touching assistance to		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on grievance documents, clinical record review, resident interview, observation, and staff interview, the facility failed to provide timely and complete assistance to residents who needed help with toileting / incontinence care, grooming, oral care, and transferring for 6 residents reviewed for assistance with personal cares (Resident #81, #73, #83, #53, #85, #86) and 14 residents identified via grievance forms (Resident #81, #49, #43, #45, #78, #8, #83, #52, #22, #59, #25, #64, #66, formerly room [ROOM NUMBER]-B). The facility reported a census of 81 residents. Findings include: 1. The Grievance Form dated 1/15/26 signed by the Administrator recorded Resident #81 complained he wasn't getting checked and changed, providing assistance with incontinence care (care given for lack of bladder or bowel control), on the overnight shift. The Grievance Official Follow-Up section documented education went to staff on the 10:00 PM to 6:00 AM shift to ensure they checked and changed the residents every 2 hours. The form recorded no date of resolution but documented it would remain ongoing to check with Resident #81. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #49 reported the aides weren't friendly, didn't get her ice water, didn't answer her call light, and she didn't receive her scheduled shower. The Grievance Official Follow-Up section documented education went to staff regarding resident dignity and all things that could hinder their dignity, reinforced it represented the resident's home, and spoke to staff specifically about Resident #49's shower schedule. The Grievance Form dated 1/29/26 signed by the Administrator as resolved on 1/30/26 recorded Resident #43 reported the overnight Certified Nurse Aides (CNA; staff members who provide basic care) didn't change her brief overnight, which resulted in a complete bed change. Resident #43 stated she already had skin issues and that two staff completed a check and change. The Grievance Form dated 1/30/26 signed by the Administrator as resolved on 1/31/26 recorded Resident #45 complained of sitting in his own bowel movement/feces for 14 hours and he didn't like it at the facility. The Grievance Official Follow-Up section documented the Administrator asked staff on that hall and they reported they changed Resident #45. The form documented an all-staff huddle conducted at 2:00 PM where staff talked about checking with residents to see if they needed assistance. The Grievance Form dated 2/1/26 signed by the Administrator as resolved on 2/1/26 recorded Resident #78 reported a concern with CNAs telling him they couldn't toilet him because they didn't have an EZ stand (sit-to-stand mechanical lift). The Grievance Official Follow-Up section documented the CNA reported that the EZ stand wasn't available, she helped Resident #78 use a urinal, and she eventually found an EZ stand to help him. The Grievance Form dated 2/4/26 signed by the Administrator as resolved on 2/4/26 recorded Resident #43 reported not getting checked and changed on the last 3 overnight shifts. The Grievance Official Follow-Up section documented the care need went onto the Treatment Administration Record (TAR; medication and treatment record), and staff would wake Resident #43 between 3:00 AM to 4:00 AM to check and change her. The Grievance Form dated 2/11/26 signed by the Administrator as resolved on 2/11/26 recorded Resident #8 reported a concern the staff didn't have incontinence briefs available for her on the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	overnight shift. The Grievance Official Follow-Up section documented the Administrator talked with Staff GG, Certified Medication Aide (CMA; staff member trained to give medications), who ordered supplies and reported they had large pull-ups but extra-large would go into central supply. The Grievance Form dated 2/12/26 signed by the Administrator as resolved on 2/18/26 recorded Resident #83's family member reported they wanted the staff to groom Resident #83 better and keep the room clean. The Grievance Official Follow-Up section documented the Administrator spoke with housekeeping to keep the room clean and with the CNAs to keep Resident #83 groomed. The Grievance Form dated 2/16/26 signed by the Administrator as resolved on 2/18/26 recorded Staff II, Licensed Practical Nurse (LPN; staff member who provides basic nursing care), reported a concern involving Resident #52. Staff II reported Resident #52 felt very upset upon return from the hospital around 12:00 PM because Staff JJ, CNA, didn't provide any care, no pericare (cleansing of perineal area after incontinence), and no assistance with any activities of daily living. The 2:00 PM to 10:00 PM shift called the nurse into Resident #52's room around 3:00 PM because Resident #52 needed help. Resident #52 reported to Staff II that she'd asked for help since returning from the hospital, and she still lay underneath all the hospital linens and draw sheet (transfer sheet) with a brief and all linen saturated with blood and urine from her mid-back to mid-thigh. The Grievance Official Follow-Up section documented the Director of Nursing (DON; staff member in charge of nursing) spoke with Staff JJ, who would begin retraining on 2/18/26, and the facility wanted Staff JJ to improve her care and undergo monitoring. The Grievance Form dated 2/19/26 signed by the Administrator as resolved on 2/19/26 recorded Resident #22 reported a concern that she didn't get a nightly snack at bedtime, didn't get a shower when she was supposed to, her bed wasn't being made, and the call light timing still took a while. The Grievance Official Follow-Up section documented only evening shift call lights, a snack went to the room, and she received a shower later that day. The Grievance Form dated 2/27/26 signed by the Administrator as resolved on 2/27/26 recorded Staff LL, Therapist (staff member who helps improve skills for daily living), reported a concern involving a resident who formerly resided in room [ROOM NUMBER]-B. Staff LL reported the resident put his call light on at 6:00 AM and called the front desk twice. A staff member by first name only took the call, but no one went to help the resident until 8:00 AM, and the resident almost missed breakfast. The resident reported the staff never cleaned up the room, never took laundry, and he waited 30 minutes to an hour for the call light answers. He noted staff left the call light on for an hour, and it recurrently happened for weeks on the 6:00 AM to 2:00 PM shift. The resident further reported being left on the toilet for up to one hour, no one emptied his urinal, staff came on the wrong shower days, and no one hung his clean laundry because staff threw it on a chair. The Grievance Form dated 2/28/26 signed by the Administrator as resolved on 3/2/26 recorded Resident #59 complained call lights took 1 hour to answer, he had a bowel movement in his brief and staff didn't change him in a timely manner, and he complained about his pain medications. The Grievance Form dated 3/11/26 signed by the Administrator as resolved on 3/12/26 recorded Resident #5's family member reported that using the bathroom took a very long time. The Grievance Official Follow-Up section documented staff needed to help Resident #5 in the bathroom and assist her with walking, and staff received education at a huddle at 2:00 PM on 3/12/26. A second white page cut off at the top of the form documented that staff told Resident #5, you can walk, that's why we leave you. The family member stated that while Resident #5 could walk, she couldn't clean herself (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	after using the bathroom. The Grievance Form dated 4/13/26 signed by the Administrator as resolved on 4/13/26 recorded Resident #25 reported a concern he had to have a bowel movement at 6:30 AM, he put on his call light, and a girl walked in at 8:00 AM, shrugged her shoulders, and walked out. The Grievance Official Follow-Up section documented the Administrator spoke with Resident #25, who reported the CNA went into his room, turned off his light, and walked out. The Administrator let Resident #25 know they'd follow up on his complaint, and an investigation started. The form lacked any documentation of further follow-up or an interview with Resident #25, and it contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 4/14/26 signed by the Administrator as resolved on 4/15/26 recorded Staff Y, Occupational Therapist, reported Resident #64 grew agitated and yelled in the hallway when the therapist approached at 2:10 PM. Staff Y reported Resident #64 stated he had a wet brief at lunch, he told a CNA who told him they'd be right back, and Resident #64 felt upset because they never returned. Staff Y assisted Resident #64 with care. The Grievance Official Follow-Up section documented education at a huddle occurred on 4/15/26 at 2:00 PM and the Administrator would follow up. The Grievance Form dated 4/23/26 signed by the DON as resolved on 4/24/26 recorded Resident #66 reported being upset she wasn't getting up early on her Monday and Thursday shower days, and it happened again that morning. The Grievance Official Follow-Up section documented the Administrator educated staff at a huddle on 4/24/26. 2. Resident #81's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented no signs or symptoms of delirium (sudden severe confusion), verbal behaviors directed toward others occurred on 1 to 3 days of the 7-day look-back period, and Resident #81 didn't refuse care. The Care Plan dated 5/3/26 for Resident #81 documented a focus area for assistance needed for Activities of Daily Living (ADL; everyday self-care tasks) care related to weakness and decreased mobility. The care plan interventions directed staff to provide assistance with oral hygiene as needed, assistance of 1 person for bathing and dressing, check and change for toileting, and assistance of 2 persons and a Hoyer mechanical lift for transfers. Another focus area identified a history of urinary tract infections (UTI; infection in the urinary system) related to incontinence with poor hygiene. The care plan interventions directed staff to check at least every 2 to 3 hours for incontinence while awake and to wash, rinse, and dry soiled areas, and offer a urinal or bedpan if continent. On 5/11/26 at 3:00 PM Resident #81 stated the call lights take forever and the staff claim they're short-staffed. Resident #81 said when the staff do come in to help, they run in and right back out, which he believes happens due to how he voices his opinion. He stated he checked his phone and once waited up to 2 hours for help, and he frequently waits over a half-hour on all 3 shifts. Resident #81 commented he felt the 3rd shift was lazy and didn't give a damn. He reported he eats in his room because the staff leave him in his wheelchair for over an hour when they bring him back to his room. On 5/14/26 at 7:56 AM Resident #81 reported the staff hadn't yet assisted him with incontinence care because typically they didn't change him until around 11:00 AM. Resident #81 stated he knew it wasn't yet time to have staff assist him because it was breakfast time and they didn't have enough staff. Resident #81 reported he was currently wet with urine and had a bowel movement at the time of (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the interview, he hadn't undergone a change, and wouldn't until around 11:00 AM. Resident #81 voiced he felt okay with that because of the staffing concerns. 3. Resident #73's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 8, indicating moderately impaired cognition. The MDS documented Resident #73 didn't refuse care. The Self-Care Functional Abilities section identified Resident #73 required supervision or touching assistance for oral care, substantial to maximal assistance with upper and lower body dressing, and total dependency on staff for toileting and personal hygiene. The Mobility status section identified Resident #73 required substantial to maximal assistance in bed rolling left and right, moving from sitting to lying, and moving from lying to sitting on the side of the bed, and total dependency for sitting to standing, chair-to-bed-to-chair, toilet, and tub or shower transfers. The MDS documented Resident #73 experienced frequent urinary incontinence and constant bowel incontinence. The Care Plan dated 4/13/26 for Resident #73 included a focus area revised 1/5/26 that identified Resident #73 had bladder and bowel incontinence related to impaired mobility and loss of peritoneal tone (abdominal muscle tone). An intervention created 4/5/23 instructed staff to clean the perineal area with each incontinence episode, and an intervention created 9/2/25 instructed staff to encourage toileting and manage incontinence before and after meals, in the morning, at bedtime, and as needed. A focus area revised 1/5/26 identified an ADL self-care performance deficit related to fatigue and impaired balance. Interventions revised 9/4/25 instructed staff to encourage Resident #73 to sit in the wheelchair and go to the dining room for meals, utilize a wheelchair for mobility, complete transfers with an EZ stand mechanical lift and the assistance of 2 persons, and provide the assistance of 1 person for dressing, personal hygiene, and toilet use. A focus area revised 4/13/26 identified impaired cognitive function or impaired thought processes related to short-term memory loss, and an intervention created 4/3/25 instructed staff to cue, reorient, and supervise as needed. The Monthly Nursing Summary dated 5/6/26 documented Resident #73 required extensive 2-person physical assistance for transfers and dressing, total dependency on 2-person physical assistance for bed mobility and personal hygiene, and indicated toilet use didn't occur. The summary recorded Resident #73 constantly experienced bowel and bladder incontinence. On 5/13/26 from 4:15 AM to 11:41 AM staff failed to provide Resident #73 with any major position changes, incontinence care, grooming, or oral care during a continuous observation. At 11:41 AM staff finally assisted Resident #73 with morning care. The observation revealed the following: On 5/13/26 at 5:20 AM Staff B stated she last provided care for Resident #73 prior to 4:30 AM during the 4 o'clock rounds. Staff B stated Resident #73 only required the assistance of 1 person for incontinence care, so she performed the care herself. On 5/13/26 at 7:54 AM witnessed Resident #73 remained in bed lying on her back. On 5/13/26 at 9:10 AM saw Staff QQ, LPN, exited the room after sitting to watch Resident #73 eat breakfast while Resident #73 lay on her back in a semi-Fowler's position (head of bed raised 30 to 45 degrees) in bed. On 5/13/26 at 9:11 AM Staff H stated Resident #73 would get out of bed but staff took longer assisting others that morning. Staff H stated they normally had a float staff member between the 300 and 400 halls, but that day she had to wait for help from a second person. Staff H reported Resident #83 had to eat in his room that morning because she couldn't get him down to the dining room. She (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	noted nurses had to remain available to supervise the dining area, so she couldn't take residents there after 7:30 AM. On 5/13/26 at 9:20 AM Resident #73 didn't know how to answer questions regarding her preference for eating in her room versus the dining room or whether she preferred to sit up in her wheelchair for breakfast. Resident #73 remained dressed in a hospital gown positioned in a semi-Fowler's position on her back, and an air mattress pump ran with a green light. On 5/13/26 at 10:28 AM observed staff provide care for other residents on the 300 hall while Resident #73 wasn't moved. Resident #73 rested with her eyes closed, remained clothed in a hospital gown, and stayed positioned in a semi-Fowler's position without any major position changes. On 5/13/26 at 11:02 AM witnessed Resident #73 remained lying in bed on her back while Staff H passed by with Resident #1. On 5/13/26 at 11:25 AM observed Resident #73 remained lying in bed in the same semi-Fowler's position on her back, but she'd slid down in the bed, and the room smelled strongly of urine and ammonia. Staff H and Staff TT entered Resident #86's room. On 5/13/26 at 11:29 AM watched Staff II entered Resident #73's room with medications. On 5/13/26 at 11:41 AM observed a therapy staff member entered the room and asked Resident #73 if she wanted to get up for lunch, and Resident #73 responded yes. Staff H acknowledged the last time she provided care for Resident #73 occurred around 4:00 AM, and she commented that once you get behind in the day, everything just gets pushed back further. Staff H stated Resident #73 represented the last resident to get up for lunch. Staff H and Staff TT proceeded to assist Resident #73 with incontinence care, dressing, and transferring, but skipped oral care. Resident #73's blanket pulled back and revealed the incontinence brief indicator with solid blue lines in front, and a very strong ammonia smell filled the room. Staff H and Staff TT failed to clean all skin areas that came in contact with the heavily soiled brief, which held urine and feces. Staff opened a new brief and placed it on the foot of the bed, used the EZ stand lift to transfer Resident #73, assisted her to doff her hospital gown, don a shirt, and Staff TT combed her hair. On 5/13/26 at 12:14 PM Staff H re-confirmed that she didn't provide any incontinence care for Resident #73 when she positioned the head of the bed up for breakfast, and no major position change occurred since the overnight shift completed it. 4. Resident #83's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 2, indicating severe cognitive impairment. The MDS documented Resident #83 required substantial to maximal assistance with toileting hygiene and constantly experienced bowel and bladder incontinence. The MDS listed diagnoses of a wound infection, a Stage 3 pressure ulcer (full thickness skin loss) of the left hip, and recorded the presence of one unhealed Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle). The Care Plan dated 3/12/26 for Resident #83 documented a focus area for mixed bowel and bladder incontinence related to impaired mobility, and interventions directed staff to check and change the resident before and after meals, with morning and bedtime, as needed, and to clean the perineal area with each incontinence episode using a bolster between the legs. Another focus area identified a Stage 3 pressure sore to the left hip related to impaired mobility, wheelchair dependency, ADL (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dependency, incontinence, cognitive impairment, and impaired communication. Interventions directed staff to manage moisture by providing toileting at regular intervals, prompt incontinence care, and preventative skin care products. On 5/13/26 at 4:43 AM noted a strong ammonia and urine smell filled the 300 hall outside of room [ROOM NUMBER] where Resident #83 and Resident #12 resided. The odor continued down the hallway to the end outside of room [ROOM NUMBER] where an open trash bag held soiled briefs open to the air. On 5/13/26 at 4:46 AM observed Staff A and Staff B entered the room of Resident #83, whose brief showed a blue indicator line from front to back. Staff A donned gloves and helped roll the resident to the right side, while Staff B moved the brief in front and tucked it between his legs. Staff A provided the wipes and Staff B wiped in small areas, but Resident #83's legs proved difficult to separate and staff failed to cleanse all areas where feces remained present. Staff B changed gloves but failed to wash her hands, donned new gloves, and rolled the resident to the left side, but didn't roll him enough to reach all areas. Staff B continued to wipe the same area repeatedly as feces remained present and her gloves became visibly soiled with feces across the palm. Staff B changed gloves and continued without washing hands, and Staff A instructed her to pull the brief out. Staff B handled the brief heavily soiled with feces and continued to swipe the rectal area, and both of her gloves touched feces on the wipes and then touched the resident's right hip area to pull the brief out. Friction and shear could be heard audibly as Staff B pulled using moderate force to remove the brief, which made an 'eeking' sound with each pull against the skin. The brief was soiled and Staff A failed to help pull the resident over to provide access. Staff B again changed gloves and failed to wash or sanitize her hands, tucked the soiled bed pad under the resident, and placed a new brief. The resident then rolled to the right and revealed an intact bandage labeled 5/12 over the pressure sore area. Staff A removed the soiled bed pad and continued with the same pair of gloves while staff rolled the resident back. Staff failed to cleanse the full scrotal area, lower abdomen, either hip, the penis, the foreskin, or any areas of skin contaminated with urine or feces where the brief contacted the skin. 5. Resident #52's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 9, indicating moderate cognitive impairment. The MDS documented Resident #52 was totally dependent upon staff for toileting hygiene and constantly experienced bowel and bladder incontinence. The MDS documented diagnoses of debility (physical weakness), chronic kidney disease (gradual loss of kidney function), and an overactive bladder. The Care Plan dated 3/12/26 for Resident #52 documented a focus area for bowel and bladder incontinence, and interventions directed staff to check and change the resident before and after meals, with morning and bedtime, as needed, and to wash, rinse, and dry her perineal area with each incontinence episode. On 5/13/26 at 5:06 AM watched Staff B and Staff A washed their hands, donned gloves, and entered Resident #52's room where a strong ammonia smell filled the air. Staff B uncovered the resident, stood on her left side, undid the brief, and asked her to help open her legs. Staff B wiped the abdominal fold under the pannus (hanging flap of tissue) and barely down the middle between her legs, then stated, okay, we are done. Staff helped the resident roll to the right side, revealing a heavily soiled brief with feces present, and Staff B continued with contaminated gloves to wipe her rectal area. At that time, Resident #52 expressed she didn't want the care viewed, and the observation moved to the other side of the curtain. Staff failed to cleanse all areas on the front contaminated by the brief prior to the move out of view. Staff A and Staff B quickly came around the (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	curtain to place items in the trash, and Staff A stated they were going to change her gown. Both staff told Resident #52 they'd help pull her up in bed and asked about placing pillows, but the urine smell remained in the room after the incontinence care. 6. Resident #85's Minimum Data Set (MDS) assessment dated [DATE] identified a BIMS score of 4, indicating severe cognitive impairment. The MDS documented Resident #85 was totally dependent upon staff for toileting hygiene, utilized an indwelling catheter, and constantly experienced bowel incontinence. The MDS listed diagnoses of a neurogenic bladder (nerve-related bladder loss) and a stroke. The Care Plan dated 4/14/26 for Resident #85 documented a focus area for bowel incontinence due to a stroke, weakness, pain, and impaired mobility, and interventions directed staff to check and change him before and after meals, with morning and bedtime, as needed, and to provide care with each incontinence episode. On 5/13/26 at 9:36 AM witnessed Staff H and Staff TT prepare to help Resident #85 with personal care while he lay in bed on his back with a catheter present. With gloved hands, Staff H wiped the left then right side of his groin and penis with a different wipe, then wiped down the catheter tube 3 inches with a new wipe. Staff H rolled the resident to his right side and Staff TT wiped the rectal area front to back where feces lay present. Staff H removed the soiled brief containing feces and placed it directly on the bed where the clean wipes sat. Staff H continued to wipe and then, using the same contaminated gloves, grabbed a new clean brief and handed it to Staff TT, who handed her the stack of feces wipes and the soiled brief. Staff H grabbed the items, and both staff continued to place the new brief without changing their gloves. No wiping occurred across the areas in contact with the soiled brief, such as his hips or buttocks. Both staff then entered the bathroom, washed their hands, and donned new gloves; Staff TT emptied the catheter bag and Staff H helped the resident change his shirt. 7. Resident #86's Minimum Data Set (MDS) assessment dated [DATE] revealed diagnoses of a stroke, hemiplegia (paralysis on one side of the body), and heart failure. The MDS identified Resident #86 constantly experienced bowel and bladder incontinence, required maximal assistance to roll left to right, and stayed dependent for toileting hygiene, dressing, and electric wheelchair transfers. Her BIMS score was a score of 7, suggesting severe cognitive impairment, yet she usually understood others and had the ability to express her ideas or wants. The Care Plan Focus dated 10/14/25 indicated Resident #86 needed assistance with ADLS due to weakness and decreased mobility. The Interventions directed staff to provide incontinence care in the morning, at bedtime, check and change her before and after meals and as needed. On 5/14/26 at 9:00 AM saw staff provided breakfast to Resident #86 in her room while she lay in bed, and no activities of daily living care occurred. On 5/14/26 at 9:34 AM Resident #86 stated it'd been a good while since the staff checked and changed her, and she currently lay wet with urine. A document titled Point of Care (POC) History for Resident #86 revealed that on 5/14/26 her last toilet hygiene occurred at 12:49 AM, and the shower history between 5/18/26 and 5/27/26 revealed 9 days passed without a shower. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/14/26 at 9:54 AM Staff TT stated she checked Resident #86 when she brought breakfast in and planned to check with the shower aide to see if they were ready for Resident #86's shower; if not, she'd provide perineal care. On 5/14/26 at 10:00 AM Staff OO, CNA, stated she'd help the shower aide get Resident #86 immediately to the shower.		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 clinical record review, staff interview, observation, and facility policy review, the facility failed to conduct comprehensive, ongoing nursing assessment and interventions for 7 of 7 residents reviewed for significant changes of condition (Resident #2, #7, #93, #71, #41, #83, #94). Resident #2 fell out of bed on [DATE] striking his face on the floor sustaining injury. The resident was sent to the emergency room (ER) where a nose fracture was ruled out and he returned to the facility. The morning of [DATE] the resident complained of pain and transferred back to the ER returning with orders for 5 days of antibiotic medication to treat a diagnosed UTI (Urinary Tract Infection) with hematuria (blood in urine). The facility failed to conduct ongoing neurological nursing assessments following Resident #2's fall with only 1 full set of neurological checks done [DATE] and the last set of full vital sign measurements recorded by nurses ending on [DATE]. Despite staff interviews indicating the resident experienced a significant change in mental condition [DATE] through [DATE], the clinical record lacked any nursing progress note entries from [DATE] at 6:20 AM to [DATE] at 5:54 PM. The resident transferred back to the hospital on [DATE] where he was admitted to the Intensive Care Unit (ICU) due to diagnoses of hyperthermia (low body temperature) and altered mental status, unspecified type. The resident subsequently passed away at the hospital on [DATE] with the cause of death identified as sepsis (life-threatening body reaction to infection) due to possible meningitis infection/swelling of the brain/spinal cord) with other significant conditions of chronic osteomyelitis (bone infection), diabetes, chronic subdural hematoma (swelling in the brain), atrial fibrillation (irregular heart rate), acute kidney injury, and hypertension (high blood pressure). The facility failed to conduct comprehensive nursing assessment and intervention for Resident #7 over a 6 day period from [DATE] through [DATE] while the resident was being treated with an antibiotic for pneumonia. The facility failed to conduct comprehensive nursing assessment and intervention for Resident #93 who experienced nausea and vomiting on [DATE], treated two different times with anti-nausea medication over a 6 hour period that day, with no documented assessments prior to the resident subsequently experiencing cardiac arrest and initiation of CPR (cardiopulmonary resuscitation). The resident passed away. The facility failed to conduct comprehensive nursing assessment and intervention for Resident #71 prior to and after identification on [DATE] of rib fractures of unknown origin. The facility failed to conduct comprehensive nursing assessment and intervention for Resident #41 on [DATE] after the resident experienced a fall. The facility failed to conduct comprehensive nursing assessment and intervention for Resident #83 on [DATE] through [DATE] while the resident received antibiotic medication to treat pneumonia. The facility failed to conduct comprehensive nursing assessment and intervention for Resident #94 on [DATE] after the resident found falling from a chair and had the presence of a skin injury of unknown origin. The above failures rose to a level of immediate jeopardy and the facility was notified of IJ on [DATE] at 4:52 PM. The failure to conduct nursing assessments began with the first example of failure to assess residents [DATE] for Resident #7, but for Resident #2, the failure began on [DATE]. The facility removed the immediacy on [DATE] after the State Survey Agency (SSA) verified removal actions taken by the facility that included: Immediate Corrective Action for Affected Resident Because Resident #2 was no longer in the facility, no further direct corrective action could be completed for that resident. Identification of Other Residents at Risk All residents were considered at risk for lack of timely assessment and follow-up when there is a fall, hospital return, acute change in condition, mental status change, infection, pain, abnormal vital signs, or staff report of decline. On [DATE], the DON/designee initiated a 100% review of current residents to identify any resident with a fall in the last 7 days, return from hospital or ER in the last 7 days, change in mental status or increased confusion, new infection or antibiotic order, abnormal vital signs, or staff concern of decline/change from baseline. Any resident identified with a change in condition will receive immediate licensed (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	nurse assessment, vital signs, neuro checks if indicated, provider notification as needed, family/responsible party notification as needed, care plan update as needed, and a progress note before the end of the nurse's shift. Systemic Changes to Prevent Recurrence Effective immediately, the facility would use a Change in Condition / Fall Monitoring Checklist for any resident with a fall, ER/hospital return, new or worsening confusion, change from baseline, new infection or antibiotic order, abnormal vital signs, or staff report that something is not right. The licensed nurse would complete and document a full nursing assessment, vital signs, neuro checks when indicated, provider notification for change in condition/abnormal findings/continued decline, family notification, progress note each shift until stable or transferred, and care plan update within 24 hours. For any resident returning from ER/hospital, the licensed nurse would review discharge instructions and new orders before the end of shift and notify the provider of any concern or change. If the resident had a fall with head injury, unwitnessed fall, anticoagulant use, mental status change, or continued confusion, neuro checks would be completed per facility policy and provider direction. CNAs would immediately report any change in condition to the charge nurse, including confusion, lethargy, weakness, pain, abnormal behavior, refusal of meals/fluids, or residents not acting like usual. Staff Education On [DATE], the DON/designee began immediate education with all licensed nurses and CNAs working in the facility. Education included F684 Quality of Care expectations, change in condition reporting, fall follow-up requirements, neuro checks when indicated, vital sign monitoring, provider notification, family notification, required progress note documentation, CNA responsibility to report decline immediately, and nurse responsibility to assess, document, and follow up before end of shift. Any nurse or CNA who had not received education would be educated before working the next scheduled shift. Agency staff, if used, would receive the same education before working the floor. Monitoring / Auditing The DON/designee will audit all falls, ER returns, hospital returns, and change of condition events daily for 5 days per week for 4 weeks, then weekly for 8 weeks. The audit will review for nursing assessment, vital signs, neuro checks when indicated, provider notification when indicated, family/responsible party notification when indicated, progress notes each shift until stable, care plan update, and follow-up for abnormal findings. Any missing item will be corrected immediately when possible and the nurse will be re-educated. QAPI / Ongoing Compliance Audit results will be reviewed by the Administrator and DON weekly for 4 weeks, then monthly through QAPI for 3 months. The QAPI committee will review trends and determine if additional action is needed. The facility's goal is 100% compliance with change of condition assessment, monitoring, notification, documentation, and follow-up. Responsible Parties The DON is responsible for clinical implementation, staff education, resident review, and audits. The Administrator is responsible for oversight, ensuring completion of the IJ removal plan, and ensuring audit results are reviewed through QAPI. Date of Compliance The facility alleges immediate compliance as of [DATE] after initiation of resident review, staff education, and implementation of the Change in Condition / Fall Monitoring Checklist. The scope and severity of the failure lowered from a K level to an E level on [DATE] after the facility removed the immediacy of the health threat. The facility reported a census of 81 residents. Findings include: 1. Resident #2's quarterly Minimum Data Set (MDS) assessment dated [DATE] identified a readmission date of [DATE]. The MDS identified the resident had clear speech, usually made himself understood, and usually understood others. The MDS recorded a Brief Interview for Mental Status (BIMS) score of 09, indicating moderate cognitive impairment without signs or symptoms of delirium or acute change in mental status. The MDS documented the resident exhibited no physical, verbal, or other behavioral symptoms during the 7-day look-back assessment period. The MDS coded the resident's functional abilities with rolling left and right, sit to lying, and lying to sitting on the side of the bed as 01 Dependent, indicating a helper does all of the effort and the resident does none of the effort to complete the activity. The MDS listed diagnoses that included stroke, cancer, hypertension (high blood pressure), neurogenic bladder (loss of bladder control), obstructive uropathy (blockage in the urinary tract), diabetes, aphasia (difficulty speaking), hemiplegia or hemiparesis (paralysis of one (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	side), traumatic brain injury (TBI), cerebral edema (brain swelling), chronic atrial fibrillation (irregular heartbeat), generalized muscle weakness, difficulty in walking, cognitive communication deficit, and need for assistance with personal care. The MDS documented the resident had no falls since the prior MDS assessment. The Discharge Return Anticipated (DRA) MDS assessment dated [DATE] for Resident #2 identified the resident discharged on [DATE] to a short-term general hospital. The MDS documented the resident exhibited no physical, verbal, or other behavioral symptoms during the 7-day look-back assessment period. The MDS coded the resident's functional abilities with rolling left and right, sit to lying, and lying to sitting on the side of the bed as 02 Substantial/maximal assistance, indicating a helper does more than half the effort and lifts or holds the trunk or limbs. The MDS documented the resident had 2 falls with no injury and 1 fall with injury since the prior MDS assessment on [DATE]. The Care Plan focus area initiated [DATE] and revised [DATE] identified the resident at risk for decreased ability to perform ADLs (Activities of Daily Living) in bathing, grooming, dressing and mobility, bathing, transfer, locomotion, toileting related to impaired balance/dizziness. The care plan intervention initiated [DATE] directed staff to provide the resident assistance of 1 for transfers using a FWW (Front Wheeled Walker) and gait belt. The Care Plan focus area initiated [DATE] and revised [DATE] (after the resident discharged and passed away) identified the resident had an ADL self-care performance deficit related to fatigue, impaired balance, difficulty walking, unsteadiness on feet, need for assistance with personal care, muscle wasting, and atrophy. The care plan intervention created [DATE] gave conflicting direction on transfer assistance, instructing staff that the resident required the assistance of 2 persons for toileting and the assistance of 2 persons and the Hoyer (full-body mechanical lift) for transfers. The care plan did not address the resident's bed mobility status. The Care Plan focus area revised [DATE] identified the resident had an actual fall with poor communication, comprehension, and unsteady gait. The care plan recorded the resident had an unwitnessed fall with injury to the nose (nosebleed), and the intervention created [DATE] documented a work order placed to have maintenance assess the brakes on the bed. The care plan intervention created [DATE] identified the resident as a fall risk and directed staff to check toileting, position, pain, personal items in reach, call bell within reach, and proper footwear on. The care plan interventions included another conflicting entry about transfers, instructing on [DATE] to provide assistance of 2 persons for transfers until upgraded by therapy. The care plan intervention revised [DATE] instructed a fall mat added to the floor on the right side of the bed. The Monthly Nursing Summary dated [DATE] at 8:49 PM documented the resident as cognitive and required extensive assistance with 1 person for personal hygiene, total dependence with 1 person for toilet use, and total dependence with a 2-person physical assist for bed mobility and transfers. The summary recorded the resident had no behavior symptoms. The fall incident report on [DATE] at 4:30 PM, recorded by Staff L, Licensed Practical Nurse (LPN), documented she was called to Resident #2's room by a CNA (Certified Nurse Aide) who found the resident on the floor between the bed and the wall. Staff L documented the incident was not witnessed and the resident was unable to communicate what happened. Staff L wrote the resident was on his left side with blood under his head coming from his nose. The resident reported an 8 out of 10 pain to his nose and forehead. The resident was able to follow Staff L's range of motion commands, independently moving his neck, arms, and legs without acute pain in the extremities. Staff (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	L assessed an injury to the bridge of the nose measuring 1.5 centimeters (cm) by 1.0 cm with evident swelling, and the back of the left hand was swollen and discolored, measuring 5 cm by 4 cm. Staff L called the on-call provider, who ordered neurological checks be continued per protocol and a facial bone x-ray. Staff L assessed the resident's mental status as alert and oriented to person and situation, but not place or time. Staff L checked the predisposing environmental factors box for Other (Describe), however she failed to describe what the other factor was. The Neurological Check List with an effective date of [DATE] at 6:05 PM, signed by Staff L, LPN, documented vital sign measurements for Resident #2 of 96.2 Temperature (T), 61 Pulse (P), 18 Respirations (R), 158/90 Blood Pressure (BP), pain an 8 on a 10 pain scale on the bridge of the resident's nose, and no Pulse Ox (Pox) reading (blood oxygen level) taken. Staff L documented the resident was oriented to person and situation, but not oriented to place or time. Staff L assessed the resident's level of consciousness (LOC) as alert, lethargic, and he responded to simple commands appropriately. The Post Fall Skin assessment dated effective [DATE] at 5:52 PM recorded the resident had a swollen open area to the back of his left hand measuring 5 cm by 4 cm and a 1.5 cm by 1.0 cm abrasion to his face. The hospital Emergency Department (ED) note with a Date of Service of [DATE] at 6:18 PM documented the chief complaint of the resident as an unwitnessed fall between the bed and dresser, appeared to have hit his face, took a blood thinner, and had chronic neck and back pain at baseline. At 8:40 PM, the note recorded the resident remained stable through the course of the ED evaluation, the family expressed some concerns about the care that the resident received at the nursing facility that they would address with the facility, and recommended close outpatient follow-up for further evaluation and treatment; the resident was discharged back to the facility. The clinical impression was documented as: ground-level fall; closed head injury, initial encounter; abrasion of nose, initial encounter; and right arm pain. The Change in Condition Evaluation dated [DATE] at 11:46 AM documented the resident had experienced an altered mental status with behavioral symptoms (e.g., agitation, psychosis), a fall, and the change started in the morning. The vital sign section of the assessment was left blank. The nurse documented the resident with increased confusion, acute pain in the neck, and the nurse questioned if there was a possible concussion. The hospital ED note dated [DATE] documented the resident was admitted to the ED at 11:56 AM and discharged at 9:12 PM. The ED note documented the reason for the visit as an unwitnessed fall at the nursing home on [DATE], the resident was alert and oriented times 4 (to person, place, time, situation) but confusion began on [DATE], and the resident complained of right shoulder and neck pain. The ED note recorded diagnosis codes that included primary generalized weakness, anticoagulated, hematuria unspecified type, abrasion of nose without infection, initial encounter injury of head, neck pain, and initial encounter fall. The ED note recorded under the Subjective section that the resident presented after a fall on [DATE] and a chart review showed the resident fell, unwitnessed, between his bed and dresser and had abrasions to the bridge of his nose and his head. The resident reported neck and back pain; radiographs did not show any emergent bony pathology (bone injury). The note recorded the resident had a possible small chronic left subdural (old, type of bleeding inside the head) versus nonspecific dural thickening (swollen or inflamed outer lining) on a computed tomography (CT) of the head, and he (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	was discharged then sent back to the ED on [DATE] after he seemed more confused. The ED note documented under Medical Decision-Making final diagnoses of generalized weakness, anticoagulated, and hematuria (bloody urine) unspecified type. The section documented admission was considered but not pursued based on the ED evaluation. The evaluation did note the resident was given IV (intravenous) fluids, symptoms seemed to improve, and although the resident felt generally somewhat weak, no focal numbness or weakness was noted and symptoms overall were improving. The resident was given cephalexin (antibiotic medication) due to the presence of hematuria noted on the urinalysis for the possibility of a UTI contributing to his symptoms, and a urine culture was sent. The [DATE] Medication Administration Record (MAR) documented the resident received cephalexin 500 milligrams four times a day from [DATE] through [DATE]. The facility EHR for Resident #2 lacked any documentation prior to related to follow-up on the urine culture performed at the hospital on [DATE]. The clinical record reflected only one set of neurological checks was performed at the time of the original fall incident on [DATE] and nothing further, despite the evidence that the resident hit his head during the fall and had obvious injuries to his face. The record lacked comprehensive assessments of the resident post-fall and post-return from the ER on [DATE]. The record lacked assessments of urinary status or characteristics as the resident received the antibiotic treatment. The Vitals tab of the EHR recorded only the following vital sign measurements from [DATE] through [DATE]. No vital signs were recorded on [DATE], [DATE], [DATE], [DATE], or [DATE] except for pain ratings, two of which were assessed when the resident was already discharged. The pain ratings correlate to the same date and times of the April MAR, which asks for ratings per shift: Temperature [DATE] at 6:05 PM - 96.2 degrees F [DATE] at 12:07 PM - 97.3 degrees F [DATE] at 8:58 PM - 97.0 degrees F [DATE] at 5:20 PM - 96.6 degrees F Pulse [DATE] at 6:05 PM - 61 bpm (beats per minute) [DATE] at 12:06 PM - 76 bpm [DATE] at 8:53 PM - 64 bpm [DATE] at 5:20 PM - 51 bpm Respirations [DATE] at 6:06 PM - 18 breaths per minute (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] at 12:07 PM - 18 breaths per minute [DATE] at 8:57 PM - 18 breaths per minute [DATE] at 5:20 PM - 18 breaths per minute Blood Pressure [DATE] at 6:24 PM - 127/83 [DATE] at 12:06 PM - 116/63 [DATE] at 8:53 PM - 89/57 (low reading) [DATE] at 7:19 PM - 158/90 (high reading) Pulse Ox [DATE] at 12:07 PM - 95% oxygen level on room air (RA) [DATE] at 8:53 PM - 97% on RA [DATE] at 5:21 PM - 93% on RA Pain Assessment [DATE] at 5:51 PM - 8 [DATE] at 8:04 AM - 10 [DATE] at 8:01 AM - 0 [DATE] at 4:27 PM - 0 [DATE] at 7:35 AM - 0 [DATE] at 8:27 PM - 0 [DATE] at 1:37 AM - 0 [DATE] at 7:50 AM - 0 [DATE] at 6:21 PM - 0 [DATE] at 12:07 AM - 0 [DATE] at 8:11 AM - 0 [DATE] at 5:03 PM - 0 (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	[DATE] at 12:11 AM - 0 [DATE] at 1:06 PM - 0 [DATE] at 6:06 PM - 0 [DATE] at 11:15 PM - 0 [DATE] at 12:39 PM - 0 [DATE] at 9:38 PM - 0 [DATE] at 2:02 AM - 0 [DATE] at 8:02 AM - 0 [DATE] at 11:52 PM - 0 (Resident could not have been assessed due to being hospitalized) [DATE] at 10:50 PM - 0 (Resident could not have been assessed due to being hospitalized) Review of the clinical record on [DATE] at 7:38 AM revealed that only the following Progress Notes were recorded in the EHR between [DATE] and [DATE]: [DATE] 9:10 AM - A Medication Administration note recorded the resident was given acetaminophen (Tylenol) for neck pain. 2:23 PM - A note indicated the Tylenol was effective and the resident rated his pain as 0. 4:30 PM - An Incident Note documented the nurse was called to the resident's room by a CNA who found the resident on the floor between the bed and the wall. The progress note contained the same assessment information as noted on the fall incident report. The entry recorded the family was notified and a portable x-ray was set up for the morning. 5:16 PM - A Medication Administration note recorded the resident was given Tylenol. 5:51 PM - An Assessment note recorded a pain level of 8 for severe nose pain. The acute pain was described as pressure, with the resident unable to determine what makes it better or worse. The note documented the resident was not satisfied with the current pain level, with a goal of 2 (mild pain). 5:57 PM - An Assessment Note recorded the pain level at an 8 for severe nose pain. 6:00 PM - A communication with family note recorded the son was coming to visit and the nurse shared the neurological assessment results and that an x-ray was planned. The son expressed that he wanted the resident seen in the emergency room that night, an order was received to send the resident for evaluation, and the resident was sent at that time. 10:03 PM - A Nursing Note documented the resident returned from the hospital with a report of no (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	fractures. The resident was given his nighttime medications, the bed was put in the low position with the call light in reach, and the son was to visit the next afternoon. [DATE] 8:01 AM - A Medication Administration Note documented that staff needed to ask the resident if he needed toileting before and after meals as the resident allows, as the resident was staying in bed due to the fall. 8:04 AM - A Medication Administration note indicated Tylenol was given. 9:44 AM - An IDT (Interdisciplinary Team) Note recorded the team reviewed the resident's fall status. The entry documented the resident fell with no injury on [DATE], the IDT investigated the fall and an abrasion to the bridge of the nose with swelling, the back of the left hand was swollen and discolored, and the root cause of the fall was determined to be self-transferring. The IDT documented the current interventions prevented major injury and a new intervention was implemented for maintenance to service the brakes on the bed. 11:41 AM - A Health Status Note documented the resident was sent to the emergency room (ER) for a change of mental status and neck pain. 12:02 PM - A Transfer Note recorded the reason for the unplanned transfer as a fall and vital signs as BP 89/57, T 97.3, R 18, and pulse ox 95% on room air. 10:46 PM - A General Note recorded the resident had returned from the ER, an antibiotic was ordered for a possible UTI (Urinary Tract Infection), the resident denied pain or discomfort at that time, and he rested in bed. [DATE] 1:49 PM - A Nursing Note recorded the facility received the hospital ER paperwork. 12:00 AM - An encounter note was entered for the Date of Service of [DATE]. The entry documented it was a copy of a signed encounter note documented in another EHR system. The note covered a review of the resident's medication list and recorded vital signs of P: 64, BP: 116/63, O2 Sat: 97% RA, R: 18, and Pain Level: 0. The encounter documented the resident presented for evaluation after a fall out of bed onto his face resulting in a facial injury on [DATE]. The resident was sent to the ER for imaging and no abnormality was reported, with little information in the discharge summary. The resident was started on an antibiotic for 5 days, with the reason not indicated and no access to the lab result at that time. The resident denied pain, chest pain, shortness of breath, or difficulty breathing, and the resident reported he was doing well with no concerns. An examination was documented noting the resident had generalized weakness, sensation was intact, speech was fluent, and he was alert and oriented times 3. The note documented a Signed Date of [DATE] at 5:03 PM, an additional line noted it was e-signed by the Nurse Practitioner on [DATE] at 6:03 PM, and an addendum listing only diagnosis codes was created on [DATE] at 4:22 AM. [DATE] 1:36 AM - A Health Status Note documented the resident was on fall follow-up with neuro (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	(neurological assessments) and an antibiotic for a UTI with no rash or hives from treatment. The clinical record lacked evidence of the completion of a neurological assessment. 4:19 PM - An Activities Participation Note recorded the resident attended a karaoke activity. 8:26 PM - A Medication Administration note documented a question, Was a behavior observed?, and answered YES. No other description of the behavior was documented. Review of the [DATE] MAR revealed the entry linked to the monitoring of anti-depressant medication on the evening shift. The MAR directed to monitor for: behavior/mood/cognition changes; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; no voiding; constipation, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, weight loss, nausea/vomiting/diarrhea, dry mouth, dry eyes. Document: 'N' if monitored and none of the above observed. 'Y' if monitored and any of the above was observed, select the chart code 'Side Effects Observed' and document. No other documentation was located for the description of the behavior. [DATE] 6:20 AM - A note documented the resident remained on fall follow-up with VSS (vital signs stable), the resident denied pain or discomfort, and no injury at the time. The entry lacked documentation of the vital sign readings or any assessment information either for the fall, behaviors, urinary assessment, or antibiotic medication monitoring. [DATE] through [DATE] No entries were recorded for 3 full days. [DATE] 5:54 PM - A Nursing Note recorded the resident presented with a change in condition that evening with complaints of shortness of breath, breathing through his mouth, and a observed mental status change. The vital signs were recorded as T 96.6, P 51, R 18, BP 127/83, and Pox 93% on RA. The entry noted the resident was seen by the Nurse Practitioner who was in the building at the time, and a new order was received to send the resident out to the ER for evaluation and treatment related to a change in condition. The resident transferred out of the facility at 6:24 PM. 12:00 AM - An encounter note was entered for the Date of Service of [DATE]. The entry documented it was a copy of a signed encounter note documented in another EHR system. The entry indicated it as an acute/follow-up transition of care note, though no transition occurred. The note documented that staff reported the resident had an altered mental status and chest pain, and upon assessment, the resident complained of shortness of breath. The entry noted vital signs of BP 121/83, P 51, R 18, pulse ox 93% on RA, and advised to send the resident to the ER for further evaluation. The note documented a Signed Date of [DATE] at 6:00 PM and an additional line noted it was e-signed by the Nurse Practitioner on [DATE] at 7:00 PM. [DATE] (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	8:59 AM - A Social Service note documented the writer followed up with the sending hospital regarding the resident's transfer status, as the resident was transferred to another hospital to the Critical Care Unit. The entry recorded that the ED documentation was obtained and uploaded into the medical record. 10:25 AM - A Medication Administration note coded the resident as hospitalized . [DATE] to [DATE] One Medication Administration entry on [DATE], one on [DATE], and two on [DATE] all recorded the resident was hospitalized . One Medication Administration entry on [DATE] recorded the resident as hospitalized . This entry occurred after the resident's passing. No other entries were entered in the progress notes as of [DATE]. The hospital ED note for the Date of Service of [DATE] at 6:47 PM documented a clinical impression that the resident had an altered mental status, unspecified mental status type, and hypothermia, initial encounter. The ED note documented under the Chief Complaint that the resident presented with an altered mental status with the last known normal on Thursday ([DATE]); staff stated he had been altered, alert to self only, and took Eliquis (anticoagulant medication). The ED note documented a chest x-ray completed with the impression of patchy bilateral middle and lower lung zone opacities concerning for a multifocal infectious process (scattered cloudy areas in both lungs with inflammation in multiple areas). The ED note documented a CT (computed tomography) of the abdomen and pelvis with contrast done due to indications of altered mental status, sepsis (life-threatening body reaction to infection), and suspected abdominal infection. The ED Course and Medical Decision-Making section documented that the resident presented to the ED with an altered mental status and staff were unable to obtain a good history from the resident due to his clinical condition. The section documented the resident arrived hypothermic with a temperature of 91.4 degrees F and hypoxic (low oxygen level) with a pulse ox of 88% on room air. He was placed on oxygen with warm blankets applied, showing an improvement of his temperature to 96.1 degrees F. The resident was bradycardic (low heart rate) but not hypotensive (low blood pressure). The resident was noted to have a history of hypothyroidism concerning for myxedema coma (a condition where a low hormone level causes body regulations to slow down), and the Thyroid Stimulating Hormone (TSH) was noted to be within normal limits. The note assessed the resident's venous blood gas (VBG) level as acidotic, which appeared to be hypercapnic (high carbon dioxide level) suspected as a result of a decreased respiratory drive from the hypothermia. The note documented a concern for sepsis versus environmental hypothermia and the CT of the abdomen and pelvis was concerning for cystitis (bladder infection); an antibiotic was ordered. The ED planned to admit him to the hospital for an altered mental status and presumed infection when a recheck of his temperature resulted in 87 degrees F, and the resident was admitted to the ICU for further management. The hospital Critical Care History and Physical dated [DATE] at 9:15 PM documented the resident was admitted for evaluation and management of acute encephalopathy (malfunctioning of brain function due to chemicals, toxins, or systemic illness elsewhere in the body). The note documented that a nurse at the facility had seen the resident the past Thursday ([DATE]) and again on [DATE] and noted the resident was altered, which prompted the evaluation. The Assessment and Plan section included a problem list that featured sepsis with acute hypoxic respiratory failure, and leukopenia with a suspected source of infection being pneumonia or a urinary		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident interview, staff interview, and facility policy review, the facility failed to implement preventive measures for a resident at risk of developing pressure sores for 4 of 4 residents reviewed for pressure sore prevention and interventions (Resident #73, #83, #85, #94). The facility failed to utilize a pressure reducing wheelchair cushion until after Resident #73 developed an avoidable facility-acquired Stage 4 (full-thickness skin damage) pressure sore to the lower right posterior thigh (which presented with eschar [dead tissue] and treated with antibiotic), failed to maintain pressure relief to the area once developed, and failed to provide major reposition changes and incontinence care over a 7.5 hour period based on a continuous observation. The facility failed to prevent friction and shear when providing incontinence care for Resident #83 who had a facility-acquired Stage 4 Pressure sore to his left hip. The facility also failed to provide physician ordered interventions to prevent pressure ulcers and skin integrity by not providing protective prevalon boots to Resident #83's left foot as ordered. The facility failed to ensure all skin interventions implemented for Resident #83 and #85 who required protective prevalon boots to be worn to the bilateral lower extremities. The facility failed to provide proper care for Resident #94 who had a pressure sore to his left heel and failed to implement measures to prevent the pressure sore to the right heel. The above failures rose to a level of immediate jeopardy and the facility was notified of the immediacy on 5/19/26 at 2:30 PM. The immediacy began based on the first known identification of pressure sore identification for Resident #73 on 3/10/26. The facility removed the immediacy on 5/20/26 after the State Survey Agency (SSA) verified removal actions taken by the facility that included: 1. Immediately removed Resident #73 from any pressure-producing wheelchair surface. Placed resident on ordered pressure redistribution surface/cushion verified to be inflated, intact, and appropriately positioned. If no appropriate cushion was immediately available, the resident would remain off the wheelchair except for medically necessary transfers until safe equipment is obtained. 2. Complete head-to-toe skin assessment for Resident #73, validate wound stage/measurements, obtain wound provider/physician orders, assess for infection, pain, drainage, odor, undermining/tunneling, and update treatment record. 3. Implement individualized pressure-relief schedule for Resident #73: reposition at least every 2 hours in bed, pressure relief at least hourly while up or per wound provider order, offload affected area, float heels, and document each intervention in real time. 4. Provide incontinence care for Resident #73 on rounds and as needed; document toileting/incontinence checks and skin barrier use. 5. Conduct 100% skin sweep for all current residents to identify existing pressure injuries, device-related areas, moisture-associated skin damage, and residents at risk based on immobility, incontinence, nutrition, wound history, chair/bed positioning, and Braden or facility risk tool. 6. Inspect 100% of wheelchair cushions, seating surfaces, beds, mattresses, heel protectors, and offloading devices for residents at risk. Remove broken, deflated, contaminated, missing, or inappropriate equipment from service and replace/rent same day. 7. Complete and document a daily staffing level and staffing pattern assessment by hall, shift, resident census, resident acuity, and care needs. Assign staff for repositioning, incontinence rounds, pressure relief, transfers, meal assistance, wound/skin checks, and supervision by resident and hall. The assessment must determine whether existing staffing is sufficient for facility needs, not merely whether staff completed assigned tasks. If staffing is insufficient, the charge nurse must immediately escalate to DON/Administrator/designee for added staff, reassignment, management assistance, agency request, or other immediate correction. Staffing shortages or assignment imbalance are not acceptable reasons for missed pressure relief, incontinence care, transfers, or skin/wound monitoring. 8. Educate all licensed nurses, CNAs, therapy, activities, and maintenance on F686 expectations, pressure injury prevention, turning/repositioning, offloading, wheelchair cushion integrity, incontinence care, reporting equipment failures, and immediate escalation. 9. Initiate daily (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	leadership wound-risk huddle reviewing Resident #73 and all high-risk residents: wounds, turning compliance, incontinence care, equipment status, nutritional concerns, staffing barriers, physician/wound provider updates, and new skin concerns. 10. Residents with current pressure ulcers/injuries or wounds; immediate review and required intervention: Wound measurements, staging, treatment orders, infection signs, pain, care plan, treatment documentation Update care plan/orders; wound provider/physician notification; offloading; treatment audit; weekly wound review 11. Residents with limited mobility, bed/chair dependence, contractures, paralysis, or poor repositioning ability; immediate review and required intervention: Turning/repositioning orders and actual documentation; seating/bed surface At least every 2 hours bed repositioning or individualized order; pressure redistribution surface; chair pressure relief; staff assignment 12. Residents with incontinence or moisture risk; immediate review and required intervention: Incontinence care documentation; skin barrier orders; briefing/toileting schedule Scheduled and PRN incontinence care; barrier cream; moisture management; CNA assignment verification 13. Residents using wheelchairs, cushions, foot pedals, leg rests, splints, oxygen tubing, catheters, or other pressure-producing devices; immediate review and required intervention: Device fit, inflation, cleanliness, placement, skin contact points Remove/replace defective devices; therapy assessment; device padding/offloading; maintenance work order 14. Residents with nutritional risk, weight loss, low intake, dehydration risk, diabetes, vascular disease, or poor wound healing risk; immediate review and required intervention: Dietary assessment, labs if ordered, supplements, hydration, weights, intake RD consult; supplements/protein/hydration plan; physician notification as indicated The facility leadership team reviewed the current removal plan and added this staffing assessment component to address the concern that survey evidence may indicate insufficient staffing levels or staffing patterns, rather than staff simply failing to complete care-planned tasks. The facility will evaluate staffing based on census, hall location, resident acuity, resident-specific care needs, and the ability to complete required care in real time. Action: Resident #73 was assessed immediately; pressure-producing wheelchair seating was removed from use until safe pressure redistribution equipment was verified; wound provider/physician was notified; wound treatment, infection monitoring, pain assessment, pressure relief, repositioning, offloading, and incontinence interventions were implemented and care planned. All residents were reviewed through a 100% skin sweep and risk review for pressure injury, immobility, incontinence, wheelchair/bed device use, current wounds, nutritional risk, and ineffective/missing pressure relief devices. Any resident identified with risk or skin concern had interventions added to the care plan and orders updated as indicated. Implemented a Pressure Injury Prevention, Equipment Integrity, and Census/Acuity-Based Staffing Assessment process. The facility now completes daily review of staffing levels and patterns by hall, shift, census, and resident acuity to determine whether current staffing is sufficient to meet resident needs. The review includes repositioning, incontinence care, Hoyer and assist x2 transfers, pressure relief, skin/wound monitoring, meal assistance, supervision, hospice/skilled residents, behaviors, admissions/readmissions, equipment needs, and care-completion barriers. Staffing assignments are posted by hall and resident care needs, not merely by total staff count. When staffing is not sufficient, the charge nurse escalates immediately to the DON/Administrator/designee for adjustment, calling support, leadership assistance, agency request, or other immediate correction. Audits include: staffing levels and patterns compared to resident needs; hall assignment appropriateness; turning/repositioning documentation; incontinence care documentation; wound treatment completion; wheelchair cushion/pressure surface integrity; care plan/order match; resident observation for positioning/offloading; staffing escalation log; calllight response concerns; missed showers, meals, weights, treatments, or skin checks; agency use; call-ins; and interviews with CNAs/licensed nurses on assignment awareness. Audit findings, wound trends, new or worsened pressure injuries, equipment concerns, staffing levels/patterns, staffing barriers, census/acuity changes, call-ins, agency use, missed care, corrective actions, and education completion will be reported to QAPI. QAPI (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	will determine additional action, including re-education, counseling, process revision, equipment purchases, staffing pattern modification, schedule revision, recruitment focus, or additional monitoring. Staffing will be based on resident needs and care demands, not census alone. The facility will staff above a basic minimum model while Immediate Jeopardy correction is underway and while SFF-level oversight is required. Daily assignments will be posted by hall and resident care need so that staff accountability is clear and surveyors can validate that the staffing model matches resident needs. Staffing Assessment revealed: Hall 1 - 29 residents Strong support: hospice, transfer-assist, ADL, incontinence, and skin-risk needs. Assign by resident need; validate repositioning, incontinence care, transfers, pressure relief, hospice support, and skin checks each shift. Hall 2 - 36 residents Highest priority: high census/occupancy with multiple Hoyer, assist x2, high assist, incontinence, and skin-risk needs. Do not staff as a standard hall. Validate that staff can complete transfers, rounds, incontinence care, meals, repositioning, and pressure relief. Hall 3 - 14 residents Deceptively heavy: high ADL, transfer, continence, and skin-risk needs despite lower census. Do not treat it as a light assignment. Assign clear accountability and validate care completion and response times. Hall 4 - 3 residents Low census but still requires assigned rounding responsibility. May combine with Hall 5 only if assigned coverage is clear and rounds are validated. Hall 5 - 3 residents Low census but still requires assigned rounding responsibility. May combine with Hall 4 only if assigned coverage is clear and rounds are validated. Daily Staffing Level and Pattern Assessment Process DON/designee will complete a daily staffing assessment by hall and shift using census, resident acuity, transfer status, incontinence needs, wound/skin risk, hospice/skilled status, behaviors, admissions/readmissions, and care-completion trends. Scheduler/DON/designee will post assignments by hall, including assigned CNA, assigned nurse, high-risk residents, Hoyer/assist x2 transfers, repositioning and incontinence-round responsibilities, meal assistance, showers, skin checks, and supervision needs. Hall 2 will receive the heaviest staffing review. Hall 1 will receive a strong staffing review. Hall 3 will not be treated as a light hall solely because the census is lower. Hall 4 and Hall 5 may be combined only when assigned coverage is clear and rounds are validated. The facility will adjust staffing whenever census or acuity changes, including new admission, hospital return, significant change, new wound/skin concern, new hospice/skilled resident, increased falls/behaviors, increased Hoyer/assist x2 needs, increased incontinence care, call-light concerns, staff call-ins, agency use, or missed care concerns. If staffing is insufficient, the charge nurse must immediately notify DON/Administrator/designee. Corrective action may include adding staff, calling in staff, revising assignments, leadership assistance with resident care within scope, adjusting breaks, shifting staff between halls, or requesting agency support when internal staff are unavailable. Leadership will validate staffing effectiveness against falls, call-light response, showers, meal assistance, weights, wounds/skin checks, incontinence rounds, repositioning, Hoyer/assist x2 transfers, behaviors, admissions/readmissions, care refusals, agency use, and missed or delayed care. The scope and severity lowered from a 'K' level to an 'E' level upon verification the immediacy removed. The facility reported a census of 81 residents. Findings include: The Minimum Data Set (MDS) Resident Assessment Instrument (RAI) manual defines pressure sore stages as: Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured blister (continued on next page)		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Stage 3: Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling Stage 4: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling Unstageable - Non-removable dressing/device: Known but not stageable due to non-removable dressing/device Unstageable - Slough and/or eschar: Known but not stageable due to coverage of wound bed by slough and/or eschar Unstageable - Deep tissue injury Upon the start of the survey, the facility provided a Resident Matrix dated 5/11/26 which identified all residents who had a current pressure ulcer and the highest stage and if not present on admission to the facility. The list included: room [ROOM NUMBER]-B - Resident #10 - Stage 3 room [ROOM NUMBER]-B - Resident Random#1 - Stage 4 room [ROOM NUMBER]-B - Resident #35 - Stage 1 room [ROOM NUMBER]-A - Resident #36 - Stage 3 room [ROOM NUMBER]-A - Resident #56 - Suspected Deep Tissue Injury (SDTI) room [ROOM NUMBER]-A - Resident #59 - SDTI room [ROOM NUMBER]-B - Resident #62 - SDTI room [ROOM NUMBER]-A - Resident #73 - Stage 4 room [ROOM NUMBER]-B - Resident #81 - SDTI room [ROOM NUMBER]-A - Resident #83 - Stage 1, Stage 3 As a result of the facilities removal efforts, a list of residents identified with Pressure Ulcer Wounds after a skin inspection completed on all residents. The list documented: Resident #80 - left knee and right heel Resident #54 - right heel Resident #50 - right foot plantar Resident #70 - sacrum (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #10 - right heel and left heel, sacrum Resident #21 - right buttock Resident #13 - perineum Resident #56 - right knee medial, right knee 'medra asheet' Resident #19 - left heel and peri/open Resident Random#2 - left lateral calf, right shin right medial Resident #73 - left posterior thigh Resident #83 - left hip Resident #11 - left buttock Resident #58 - right lower extremity and right medial knee Resident Random#3 - right foot wound vacuum Resident Random#4 - toe with eschar Resident #7 - coccyx Resident #4 - buttock Resident #72 - left abdominal fold open The facility also conducted skin assessments on all residents on 5/19/26 and identified: Resident #73 - pressure ulcer posterior left knee, MASD (Moisture Associated Skin Damage) in periaerea/buttock region Resident #83 - chronic pressure ulcer left heel, pressure ulcer to left upper hip, scar from previous pressure ulcer right mid hip area, prevlon boot for left heel and skin prep treatment twice a day in place Resident #62 - previous pressure to lateral right ankle area Resident #21 - MASD to coccyx area Resident #13 - left and right armpits with redness, perineum Resident #56 - red testicles Resident #19 - pressure to right lateral ankle area followed by podiatry, small open area 0.2 cm by 0.2 cm in periaerea creases red and yeasty, right breast yeasty, abdominal folds red and yeasty (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident Random#2 - preexisting area to back of right calf, periaarea pink and yeasty Resident #11 - circled left buttock area, facility did not state what was there Resident #58 - dressing in place on right lower extremity Resident Random#3 - wound vac right foot, rashes to coccyx region Resident #4 - open area to coccyx measured 1.0 centimeters (cm) by 1.3 cm Resident Random#4 - black area on right toe Resident #32 - coccyx area pink Resident #8 - coccyx slightly pink Resident #6 - red coccyx area, redness left great toe Resident Random#5 - coccyx area slightly pink Resident #28 - red/yeast under right breast, right great toe pink Resident #29 - periaarea red and itchy, left toes pink Resident #72 - small open area left abdominal fold Resident #41 - periaarea red and yeasty, coccyx area MASD Resident #74 - abdominal (abd) folds slightly pink Resident #82 - abdominal fold red and yeasty, coccyx area red, left toe red/pink Resident #27 - right great toe pink Resident #15 - blanchable redness to coccyx region, MASD Resident #12 - coccyx area blanchable MASD with treatment in place Resident #16 - periaarea with MASD 1. The Quarterly MDS assessment dated [DATE] for Resident #73 identified a Brief Interview for Mental Status (BIMS) score of 04, which indicated severe cognitive impairment. The MDS documented the resident did not refuse care and used a wheelchair. The MDS identified the resident's functional self care abilities as requiring partial to moderate assistance with oral care, substantial to maximal assistance with upper/lower body dressing, and totally dependent for assistance with toileting hygiene and personal hygiene. The MDS identified the resident's mobility status as totally dependent for assistance with sit to lying, lying to sitting on side of bed, sit to stand, toilet transfer, and tub/shower transfer. The MDS documented the resident frequently incontinent of urine but always continent with bowels. The MDS listed diagnoses that included debility, cardiorespiratory conditions, (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	heart failure, renal insufficiency/failure, stroke, chronic lung disease and respiratory failure. The MDS recorded a weight of 272 pounds. The MDS recorded the resident at risk of pressure ulcers/injuries with one unhealed Stage 1 pressure injury and moisture associated skin damage (MASD). The Skin and Ulcer/Injury Treatments checked for a pressure reducing device for chair, pressure ulcer/injury care, and application of nonsurgical dressings and ointments/medications. The MDS recorded the resident received hospice care services. The Quarterly MDS assessment dated [DATE] for Resident #73 identified a BIMS score of 08, which indicated moderate cognitive impairment. The MDS documented the resident did not refuse care. The Self Care Functional Abilities identified the resident required supervision or touching assistance for oral care, substantial to maximal assistance with upper/lower body dressing, and totally dependent upon staff for toileting and personal hygiene. The Mobility status identified the resident required substantial to maximal assistance in bed rolling left and right, sit to lying, and lying to sitting on side of bed, and totally dependent for sit to stand, chair-to-bed-to-chair, toilet and tub/shower transfers. The MDS documented the resident frequently incontinent of urine and always incontinent with bowels, which was a major change from the previous assessment. The MDS recorded the resident at risk of pressure ulcers/injuries with one unhealed Stage 1 pressure injury, one new unhealed Stage 4 pressure injury, and moisture associated skin damage (MASD). The Skin and Ulcer/Injury Treatments checked for a pressure reducing device for chair, pressure ulcer/injury care, and application of nonsurgical dressings and ointments/medications. The MDS recorded the resident received hospice care services. The Care Plan dated 1/5/26 documented the following focus areas and care plan interventions: Focus area revised 9/4/25 for potential for skin breakdown related to edema in bilateral lower extremities with two fluid filled intact blistered areas: left lower leg measures 8 cm (centimeters, length) by 6.5 cm (width) and top of left foot 6.3 cm by 4.0 cm. The care plan interventions included on-going assessment of skin conditioning during routine care. a. The interventions lacked identification of interventions to provide pressure relief to the bilateral extremities. Focus area revised 1/5/26 identified a potential for pressure ulcer development related to incontinence and decrease in mobility with a goal to have intact skin, free of redness, blisters, or discoloration by the next review date. The interventions initiated 4/5/23 included education to the resident/family/caregivers as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition, and frequent repositioning. The care plan directed staff to follow facility policies/protocols for the prevention/treatment of skin breakdown and to teach resident/family the importance of changing positions for prevention of pressure ulcers with encouragement of small frequent position changes. The interventions lacked identification or instruction in the use of pressure relieving devices in chairs or beds and instructed staff to follow facility policies/protocols for the prevention and treatment of skin breakdown. The care plan dated 4/13/26 that included the following focus areas and care plan interventions: (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Focus area revised 1/5/26 identified the resident had bladder and bowel incontinence related to impaired mobility and loss of peritoneal tone. The intervention created 4/5/23 instructed staff to clean the peri-area with each incontinence episode. The intervention created 9/2/25 instructed staff to encourage toileting and manage incontinence before/after meals, at AM (morning) and HS (bedtime), and as needed. Focus area revised 1/5/26 identified an ADL (Activities of Daily Living) self-care performance deficit related to fatigue and impaired balance. The interventions revised 9/4/25 included: encourage the resident to be up in the wheelchair and in the dining room for meals; wheelchair for mobility; transfers with EZ (sit-to-stand) mechanical lift and assistance of 2 persons; and assist of 1 person for dressing, personal hygienic, and toilet use. Focus area revised 3/26/26 identified the resident had an actual skin impairment of a pressure ulcer to the back of her left thigh related to CHF (Congestive Heart Failure), morbid obesity and incontinence of bowel and bladder. The care plan documented on 3/11/26 a Stage 4 pressure sore present on the back of the left thigh. The interventions created 3/11/26 instructed: the use of a pressure reduction equipment and procedures as indicated for preventative measure equipment/procedure; turn and reposition; cushion to the wheelchair and specialty mattress on the bed; and encourage the resident to shift weight, if able, every 2 hours to assist with skin integrity and assist as needed. Focus area revised 3/30/26 identified a potential for pressure ulcer development related to incontinence and decrease in mobility with a note 3/10/26 Stage 4 pressure ulcer present on left rear thigh. Focus area revised 4/13/26 identified impaired cognitive function or impaired thought processes related to short term memory loss. The intervention created 4/3/25 instructed staff to cue, reorient and supervise as needed. The Progress Notes dated 12/30/25 documented a Nurse Practitioner (NP) Encounter visit documenting the resident seen that day for follow up of a new Stage 2 pressure ulcer to buttocks identified first on 12/24/25 and measured 0.5 cm (length) by 1.8 cm (width) by 0.1 cm (depth). The Progress Notes dated 12/31/25 at 2:26 PM documented a wound observation and noted the care plan was reviewed and the wound present after admission. The Progress Notes dated 12/31/25 at 4:33 PM documented an IDT (Interdisciplinary Team) note. The entry recorded the IDT met to review the resident's current Stage 2 pressure ulcer to the right buttock and the care plan updated. The Progress Notes dated 1/5/26 documented a Nurse Practitioner Encounter visit documenting the resident seen that day for follow up of the Stage 2 pressure ulcer to right buttock times 2 and indicated another pressure sore had appeared. The entry noted the resident under hospice care, had (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Alzheimer's dementia, morbidly obese which further complicated her care. The wounds measured: 1.5 cm by 0.1 cm by 0.1 cm Stage 2 to the right top buttock and 2.5 cm by 2.5 cm by 0.1 cm Stage 2 to the right bottom buttock. The entry documented staff to encourage offloading and turn frequently. The Progress Notes dated 1/7/26 at 3:43 PM documented the IDT met to review the resident's two Stage 2 pressure areas to the right buttock and the resident being followed weekly by the facility wound team and wound nurse. The entry documented a cushion provided by hospice and placed in the recliner and the care plan updated. The Progress Notes dated 1/13/26 documented a Nurse Practitioner Encounter visit documenting the resident seen that day for follow up of Stage 2 pressure ulcer to buttocks and that both ulcers had healed. The entry recorded it was signed by the NP on 1/23/26 at 10:01 AM with an addendum created 1/28/26 at 11:36 AM. The Progress Notes dated 1/13/26 at 8:26 AM documented a late entry noting the pressure ulcers resurfaced. At 4:05 PM, an entry documented the two right buttock wounds resolved. Review of the care plan history and resolved items revealed: RESOLVED focus area dated 1/13/26 of an actual skin breakdown related to edema in bilateral lower extremities and two fluid filled blisters resolved 9/3/25. The area also noted 12/30/25 a Stage 2 pressure ulcer to the right buttock and on 1/6/26 a Stage 2 pressure ulcer to the bottom of the right buttock. The intervention created on 1/7/26 directed the use of a cushion in place in the recliner and on 1/13/26 the intervention was resolved and removed from the active care plan. The Progress Notes dated 1/16/26 at 7:48 PM documented the IDT team reviewed the resident's pressure ulcers and all areas had resurfaced (opened). The entry recorded the IDT would revisit intervention needed from the Registered Dietician at the next risk meeting, the care plan updated, and they would continue to monitor. The Progress Notes dated 1/22/26 recorded an Encounter visit by the physician / Medical Director (MD). The entry lacked documentation pertaining to pressure sores and was signed on 2/3/26 at 12:52 PM. The Progress Notes dated 1/23/26 thru 3/9/26 lacked any documentation of pressure sores. The late entry Progress Notes dated 3/10/26 at 10:48 AM recorded a wound observation. The entry documented a Stage 4 pressure sore present after admission to the left rear thigh that measured 2.7 cm by 7.0 cm by 0.3 cm. The note documented eschar (dead tissue), slough (dead, non-viable tissue that accumulates), and drainage present in the wound bed without odor. The Weekly Wound assessment dated [DATE] recorded a wound summary. The summary documented a Stage 4 pressure sore to the left rear thigh measured 2.7 cm by 7.0 cm x 0.3 cm with 80% eschar, 20% slough, large amount of serosanguineous drainage without odor present, and resident's wound tender to the touch. Noted interventions included pressure reduction mattress, Wheelchair Cushion, Nutritional Supplements, Vitamin Supplements, but did not have Specific Turning/Repositioning Program, Positioning Devices, or Heal Boots marked. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Follow Up Skin assessment dated [DATE] at 2:58 PM documented the resident had an open Stage 4 pressure area to the left rear thigh due to wheelchair seat placement. The Progress Notes dated 3/10/26 at 2:52 PM documented an Incident note for a skin concern on the resident's leg. The entry recorded a wound measurement of 2.7 cm by 7.0 cm by 0.3 cm and that the wound lined up with the wheelchair seat. The entry noted immediate education occurred with staff working to remove the wheelchair cushion from the recliner and place it in the wheelchair when the resident seated. The Progress Notes dated 3/11/26 at 3:15 PM documented the IDT met to review the resident's pressure ulcer to the back of her left thigh. The entry recorded the pressure ulcer was a Stage 4 with large serosanguineous drainage (mixture of clear fluid and small amount of blood). The IDT initiated staff education regarding the recliner cushion being placed in her wheelchair when the recliner was not in use and vice versa and the care plan updated; they would continue to monitor. The Weekly Wound assessment dated [DATE] recorded a wound summary. The summary documented a Stage 4 pressure sore to the left rear thigh measured 5.5 cm by 10.1 cm x 0.1 cm with 50% eschar, 25% slough, 25% granulation, moderate amount of serosanguineous drainage with odor present, the wound surface area enlarged, and the resident reported a pain of 5 out of 10. Noted interventions included pressure reduction mattress, Nutritional Supplements, but did not have wheelchair cushion, Specific Turning/Repositioning Program, Positioning Devices, or Heal Boots marked. The Progress Notes dated 3/19/26 at 10:318 AM recorded a wound observation. The entry documented the Stage 4 pressure sore on the left rear thigh measured 5.5 cm by 10.1 cm by 0.1 cm with eschar, slough, drainage and granulation (formation of new tissue) present in the wound bed. The resident voiced pain present during the wound treatment, a wound odor observed, and the periwound condition fragile with the overall progress of the wound healing documented as declined. The Progress Notes dated 3/20/26 at 4:35 AM documented a new order received for an antibiotic medication to be taken for 7 days for the left thigh wound. The Progress Notes dated 3/20/26 at 4:37 PM documented the IDT team reviewed the resident's pressure ulcer to the back of her left thigh. The entry documented the Stage 4 wound with a large amount of serosanguineous drainage. The IDT educated staff regarding the recliner cushion being placed in the wheelchair when the recliner was not in use and vice versa and the care plan updated; would continue to monitor. The Progress Notes dated 3/24/26 at 5:04 PM documented a Health Status note that the resident was on an antibiotic for wound infection and supplement for wound healing. The Progress Notes dated 3/24/26 at 5:42 PM		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review, the facility failed to provide a restorative program to residents with mobility concerns for 4 of 4 residents reviewed (Resident #3, #71, #83, #85). The facility reported a census of 81. Findings include: 1. Resident #3's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS recorded active diagnoses that included heart failure, hypertension (high blood pressure), diabetes mellitus, anxiety, and depression. The MDS also documented that Resident #3 had an impairment on her lower extremity. Resident #3's Care Plan dated 5/3/26 lacked a restorative nursing program. On 5/12/26 at 12:41 PM Resident #3 stated that she didn't think a restorative program existed at the facility. Resident #3 stated that she didn't work with anyone, the facility only offered Tuesday group exercises, and she and her roommate planned to start doing exercises on television. Resident #3 noted that she broke her left leg back in September. At this time, Resident #3 self-propelled her wheelchair. On 5/14/26 at 2:02 PM Staff Y, Occupational Therapist (OT), stated that a restorative program didn't exist. Staff Y stated that therapy performs a recommendation and maintains a screening process. Staff Y noted that therapy executes a therapy-to-nursing Certified Nurse Aide (CNA) handoff maintenance plan for levels of function at discharge. Staff Y stated that the facility provides walk-to-dine programs, and if a resident has a contracture (permanent muscle tightening), therapy instructs CNAs how to apply the device. Staff Y stated that once they finish the form, they review it with nursing staff, obtain signatures, and return it to Staff O, Rehab (Rehabilitation) Director. Staff Y didn't know what Staff O did with the forms after that point. On 5/21/26 at 11:25 AM Staff O, Rehab Director, explained that staff utilized various methods to contact therapy. Staff O stated that the facility communicated care details to maintain strength and endurance through the care plan and the communication book at the nurse's station. Staff O stated that she participated in morning meetings to review progress notes, incidents, skin conditions, and falls. Staff O noted that the facility utilized staff huddles. Regarding Resident #3, Staff O didn't recall the last time therapy provided services to her. Staff O detailed that staff used a therapy-to-nursing CNA handoff maintenance plan, which involved both staff and residents if the resident understood the plan cognitively. Staff O stated that therapists held responsibility for training staff on these specific plans. Staff O noted that despite staff turnover, the communication book remained consistent and information stayed available on the Kardex (medical information system). Staff O stated that the facility offered Tuesday exercises through activities to encourage individual participation. On 5/27/26 at 11:31 AM Resident #3 stated she didn't remember if therapy discharged her on any individualized program. Resident #3 stated she wanted to get up and walk, and wanted to talk to therapy again about her walker. Resident #3 noted that she didn't see how staff managed to walk-to-dine her because they stayed so busy. Resident #3 stated that she felt left on her own to walk. Resident #3 noted that she could bear weight on her left leg and possessed the ability to walk to the bathroom or perform a pivot transfer to the toilet. On 6/3/26 at 1:44 PM Staff O stated she didn't think a policy existed. Staff O stated that the facility (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lacked a restorative program because therapy operated there all the time and maintained communication with the staff. Staff O stated that if residents had a hard time walking or experienced contractures, therapy picked them up right away. Staff O stated that the plans stayed individualized for the Home Exercise Program (HEP). Staff O noted that a therapist and the resident represented factors in making that decision. On 6/3/26 at 1:51 PM Staff O verified that no policy existed for therapy. 2. Resident #71's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS recorded active diagnoses that included a urinary tract infection (UTI), multiple fractures of right-side ribs, chronic obstructive pulmonary disease (COPD), cirrhosis of the liver, anxiety, and depression. The MDS documented no impairment to Resident #71's upper or lower extremities. The MDS recorded partial or moderate assistance to supervision or touching assistance for ambulation and mobility with the use of a wheelchair. The MDS documented that Resident #71 received restorative nursing programs on 0 of the past 7 days. Resident #71's Care Plan revealed a focus area for requiring assistance with Activities of Daily Living (ADLs) functions. An intervention initiated on 8/21/25 and resolved on 1/22/26 required mobility assistance of 1 person with a Front Wheeled [NAME] (FWW), and wheelchair use for mobility initiated on 1/22/26. Interventions initiated on 1/22/26 directed staff to encourage Resident #71 as much as possible and report any increased need for assistance, decline in mobility, falls, near falls, or increased fatigue and weakness to therapy. On 4/22/26, staff initiated an intervention for ambulation with the assistance of 1 person using an FWW and a wheelchair to follow. Resident #71's Therapy to Nursing CNA Handoff - Maintenance Plan dated 4/14/26 documented transfers as stand-pivot with standby assistance, the assistance of 1 person for ambulation with an FWW and a wheelchair to follow, and independence with wheelchair mobility. Further review of Resident #71's Care Plan showed it lacked a restorative nursing program. On 6/4/26 at 2:00 PM Staff J, CNA, stated that Resident #71 functioned independently in her room with her walker and used her wheelchair outside of her room. Staff J stated that Resident #71 required the assistance of 1 person and used a gait belt. Staff J stated that she never assisted Resident #71 while using her FWW and a wheelchair to follow. 3. Resident #83's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 2, indicating severely impaired cognition. The MDS recorded active diagnoses that included Down Syndrome, aftercare following a hip joint replacement, a wound infection, adult failure to thrive, and pressure ulcers. The MDS documented substantial or maximal assistance to dependence for ambulation assistance. The MDS recorded a walker and a wheelchair as mobility devices utilized in the past 7 days. The MDS documented that Resident #83 received restorative nursing programs on 0 of the past 7 days. Resident #83's Care Plan documented that Resident #83 required staff assistance with ADL functions, with interventions to encourage Resident #83 to do as much as possible, use a wheelchair for mobility, and require a mechanical lift with the assistance of 2 persons for transfers. Resident #83's Therapy to Nursing CNA Handoff - Maintenance Plan dated 4/21/26 documented that (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #83 required maximal assistance with the use of a mechanical lift and stayed dependent for assistance with mobility in his wheelchair. Further review of Resident #83's Care Plan showed it lacked a restorative nursing program. On 5/12/26 at 9:22 AM a confidential interview revealed that nurses and CNAs must respect Resident #83's wishes when he refuses care and cannot continue to push him. The interviewee stated that due to his cognitive status and Down Syndrome diagnosis, Resident #83 needed more encouragement, and without it, he might not have physically declined to his current status. The interviewee noted that Resident #83 entered the facility about a year ago after a hip fracture and hip replacement, walked at that time, and no longer possessed the ability to walk. The interviewee stated that Resident #83 stayed continent and could stand to use the bathroom on admission, but after his transfer to the 300 hall, this gradually stopped because he couldn't stand and became incontinent. 4. Resident #85's Minimum Data Set (MDS) assessment dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS recorded active diagnoses that included a neurogenic bladder (lack of bladder control) with a catheter, aphasia (difficulty speaking), a stroke, hemiparesis (one-sided paralysis), dysphagia (difficulty swallowing), a pressure ulcer, and a right-hand contracture. The MDS documented that Resident #85 stayed dependent for ambulation with a wheelchair. The MDS documented that Resident #85 received restorative nursing programs on 0 of the past 7 days. Resident #85's Care Plan documented a focus area initiated 4/14/26 for hemiparesis related to a stroke, with interventions for physical therapy (PT), occupational therapy (OT), and speech therapy (ST) to evaluate and treat as ordered. The Care Plan directed staff to provide range of motion (ROM), either active or passive, with morning and evening care daily, and to reposition or ambulate Resident #85 as tolerated at least every 2 hours. Further review of Resident #85's Care Plan showed it lacked a restorative nursing program. On 5/19/26 at 2:05 PM Staff H, CNA, stated that staffing improved that day, with 14 residents on the 300 hall. Staff H noted that 5 residents required an assistance of 2 persons, which created difficulty when only one CNA held an assignment to the hall. Staff H stated that the CNA from the 400 and 500 hall helped if a float did not exist, but more residents entered that hall through admissions, which hindered their ability to assist. Staff H expressed uncertainty if the increased staffing on the 300 hall represented an actual change or resulted from state surveyors being present. Staff H stated that the facility lacked a restorative program, and if physical therapy had time, they showed CNAs the ROM and recommended exercises for individual residents, but she lacked certainty on how all CNAs became aware of those details. Staff H stated that she never received training on recommended restorative therapies from the facility, only the basic ROM taught in CNA school. Staff H noted that residents on the 300 hall with ROM included Resident #83 and Resident #85, and she tried to complete the exercises when they lay down after breakfast or lunch but often failed due to a lack of help. On 5/19/26 at 2:05 PM Staff CC, CNA, stated that she also never received training on each resident's restorative therapies or exercises from the facility, only what she learned in CNA school. When asked how she knew which resident required ROM exercises completed, Staff CC responded that if staff had to sign off on it in the resident's record, then they supposed they should do it. On 5/27/26 at 3:57 PM the Director of Nursing (DON) stated in a brief and dismissive tone that CNAs (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	received education from therapy upon hire during their initial onboarding regarding what ROM and exercise activities applied to the individual resident. The DON stated that residents who required ROM or adaptive equipment stayed noted on their Kardex. The DON noted that all CNAs had been shown where to access the Kardex.		

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F 0689 Level of Harm - 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 clinical record review, facility document review, observations, staff interviews and policy review, the facility failed to ensure each resident received Safe Smoking Assessments quarterly and/or with change in condition, adequate supervision for smoking and fall prevention safety, and interventions to prevent accidents when smoking and reduce risks for falls for 10 of 14 residents reviewed (Resident #7, #9, #46, #51, #56, #69, #71, #78, #80, #2). Resident #80 sustained injury of a thermal burn when the end of a cigarette fell into his shoe on 5/14/26. Resident #2 sustained facial injury with abrasion to the nose when a staff member moved the bed away from the wall on 4/19/26 leading to the resident landing on his face. The facility reported a census of 81 residents. Findings include: 1. Resident #7's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 6, indicating severe impaired cognition. The MDS listed Resident #7 as dependent (helper does all of the effort) for sitting to lying, lying to sit on one side of bed, chair/bed to chair transfers. The MDS also documented Resident #7 is usually understood (difficult communicating some words or finishing thoughts but is able if prompted or given time) and usually understands (misses some part/intent of message but comprehends most conversation). Resident #7's MDS included diagnoses of stroke, hypertension (high blood pressure), anxiety disorder, schizophrenia and respiratory failure. The facility Incident Reports (IR) revealed Resident #7 fell on 1/2/26, 2/4/26, 2/13/26, 2/22/26, 2/27/26, 2/27/26, 3/2/26, 3/10/26, 3/13/26, 3/16/26, 3/21/26, 3/21/26, 4/3/26. The Care Plan with a target date of 7/8/26 revealed Resident #7 was at risk for falls. The interventions directed the following: 1/1/26 Staff education to answer call lights within 15 minutes. 2/4/26 Encouraged to wear grip socks when in bed. 2/13/26 Dycem to seat of the wheelchair. 2/22/26 Occupational Therapy (OT) will evaluate for another wheelchair. 2/27/26 Physician or Nurse Practitioner will review the medication summary. 2/27/26 OT to review wheelchair positioning 2/4/26 Skid strips added to floor at bedside 3/2/26 Please put my bed in low position while I am in bed 3/9/26 Encourage Resident #7 to participate in activities 3/16/26 Send to the emergency room to be evaluated and treated. 3/21/26 Encourage Resident #7 to be out of room when not in bed (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	3/21/26 Referral to physical and occupational therapy re-admission and fall 4/3/26 Obtaining labs to rule out pneumonia and upper respiratory infection. An Incident Report (IR) dated 1/2/26 at 3:00 am identified an unwitnessed fall in his room. The IR indicated Resident #7 was found in his room on the floor. The IR stated resident crawled out of bed and scooted himself to the door for assistance. Resident #7 stated I just wanted to get out. Immediate action taken; staff placed a call don't fall sign posted visibly from his bed. An IR dated 2/4/26 at 7:45 pm identified an unwitnessed fall in his room. The IR indicated a certified nursing assistant (CNA) called nurse to Resident #7's room where Resident #7 was on the floor beside his bed sitting on his butt, prior to fall resident was sitting on the side of his bed. Resident #7 denied hitting head and acute pain. Resident #7 was assisted off floor with staff and use of a Hoyer. Resident #7 did not want to go back to bed and wanted to sit in his wheelchair. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 2/5/26 at 9:59 am named Interdisciplinary Team (IDT) reviewed fall on 2/4/26 and determined the root cause was self-transferring. New interventions implemented: skid strips beside bed. An IR dated 2/13/26 at 1:45 pm identified an unwitnessed fall in his room. The IR indicated a staff summoned writer to Resident #7's room, Resident #7 was sitting on the floor on his buttocks, and his wheelchair was in the back of him. The call light was off. Resident #7 voiced he slid off his wheelchair. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 2/16/26 at 9:35 am named IDT note reviewed fall on 2/13/26 and determined the root cause was sliding out of the wheelchair. New interventions implemented: Dycem to seat. An IR dated 2/22/26 at 10:30 am identified an unwitnessed fall in his room. The IR indicated a staff summoned writer to Resident #7's room. Resident #7 was laying, leaning on his left side and resting on his left arm/elbow. Resident #7 denied any pain/discomfort. Resident #7 received an abrasion to his right side of forehead. Resident #7 had one gripper sock on right foot and left foot was bare. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 2/23/26 at 9:31 am named IDT note reviewed fall on 2/22/26 and determined the root cause was self-transferring. New interventions implemented: Occupational Therapy to evaluate for a different wheelchair. An IR dated 2/27/26 at 1:45 am identified an unwitnessed fall in his room. The IR indicated Resident #7 slid out of bed and scooted himself to the door for assistance. Call light was in reach but was off. Resident #7 stated I'm in pain and I need to go to hospital Resident #7 stated pain was 10/10 and everywhere. Resident #7 stated I don't have to explain myself again. Assessment completed before transfer. Resident #7 refused as needed pain medication stated it doesn't work. Resident #7 noted medication he gets at emergency room works. On call physician notified and one time dose order for Hydrocodone 5/325 mg received. Pain medication administered. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 3/2/26 at 10:00 am named IDT note reviewed fall on (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	2/27/26 and determined the root cause was slid off of bed. New interventions implemented: Bed to be in lowest position. An IR dated 2/27/26 at 6:15 pm identified a witnessed fall in his room. This nurse noted Resident #7 slid off his wheelchair and onto his bottom when this nurse was going to his room to check on him due to a recent fall. Resident #7 assessed for pain and reported pain that he said he had for the last week. Assisted resident off the floor x 2 staff to his bed. Resident #7 educated call staff when he notices he is sitting at the edge of his wheelchair. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 3/2/26 at 10:23 am named IDT note reviewed fall on 2/27/26 and determined the root cause was slid out of wheelchair. New interventions implemented: OT to access. An IR dated 3/2/26 at 5:00 am identified an unwitnessed fall in his room. Resident #7 stated he slid off his bed and hit his head. No visible injuries noted, no redness, swelling, bruising, or open area observed to head or body. Also documented on the IR Resident #7 wanted to transfer to his wheelchair but forgot to call for help. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 3/2/26 at 9:50 am named IDT note reviewed fall on 3/2/26 and determined the root cause was slid off of bed. New interventions implemented: bed to be low position while in bed. An IR dated 3/10/26 at 10:15 am identified an unwitnessed fall in his room. Resident #7 found by CNA sitting on bedroom floor with his back against the bed. Prior to fall CNA stated resident #7 was sitting in his wheelchair in the room. Resident #7 stated I slid off the wheelchair and scooted myself by the bed. Denied hitting his head. No other acute injuries. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 3/11/26 at 9:26 am named IDT note reviewed fall on 3/10/26 and determined the root cause was self-transferring. New interventions implemented: encourage activity participation An IR dated 3/13/26 at 7:15 pm identified an unwitnessed fall in his room. The nurse went to the resident's room and found him sitting on the floor beside his bed. Resident #7 stated that he slid off his bed. Resident #7 assisted x 2 staff to his wheelchair. The IR failed to have an immediate intervention documented. An IR dated 3/16/26 at 10:00 am identified an unwitnessed fall in the hallway. Resident #7 was heard screaming for help in the hallway outside of his room. Resident #7's wheelchair was at the bedside locked with Hoyer pad in wheelchair. Resident #7 denied hitting head. Resident #7 has a skin tear to the right thumb. Resident #7 denied pain/discomfort. Resident #7 able to move extremities at baseline. Resident #7 assisted via Hoyer lift and 2 CNA's and this nurse back into wheelchair. Resident #7 placed visually where he could be monitored continually. Resident #7 stated that he doesn't know what happened or why he was out of the wheelchair. The IR also documented Resident #7 is wheelchair bound, attempting to walk on his own, fell in hall, in front of his room door. Review of the facility Progress Notes on 3/17/26 at 9:50 am named IDT note reviewed fall on 3/15/26 and determined the root cause was self-transferring. New interventions implemented: Send (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	to ER for evaluation. An IR dated 3/21/26 at 9:00 am identified an unwitnessed fall in his room. Resident #7 was found on the floor in front of his wheelchair. Resident #7 stated he slipped out of his wheelchair while watching TV. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes revealed the facility failed to document this fall. Review of the facility Progress Notes on 3/24/26 at 9:16 am noted IDT reviewed fall on 3/21/26 and determined the root cause was reaching. New interventions implemented: Order Physical and Occupational Therapy. An IR dated 3/21/26 at 8:00 pm identified an unwitnessed fall in his room. Resident #7 stated he about to self-transfer to bed when he fell and scooted self to the door for assistance. Call light was within reach but off. Resident #7 noted he doesn't need to transfer to bed. Resident transfers with Hoyer x 2 but refusing to call for assistance requesting in multiple falls recently. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 3/24/26 at 9:23 am named IDT note reviewed fall on 3/21/26 and determined the root cause was self-transferring. New interventions implemented: Encourage resident to be out of room when not in bed. An IR dated 4/3/26 at 7:40 am identified an unwitnessed fall in his room. Resident #7 was trying to get up and fell down. Resident #7 was assessed, vitals taken, got dressed, up and toileted with no injuries. The IR failed to have an immediate intervention documented. Review of the facility Progress Notes on 4/6/26 at 9:32 am named IDT note reviewed fall on 4/3/26 and determined the root cause was self-transferring. New interventions implemented: labs to be requested. Interview with Resident #7 on 6/1/26 at 3:00 pm stated he doesn't have his new wheelchair yet, he stated that he has been waiting for it and has never received it. Observation completed in Resident #7's room on 6/1/26 at 3:00 pm revealed the facility failed to have interventions in place, observed no skid strips on the floor in resident's room, no Dycem to seat of wheelchair, no call light sign stating call don't fall sign and no scoop mattress to his bed to help prevent falls from bed. 2. Resident #69's Minimum Data Set (MDS) dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 0, indicating severe impaired cognition. The MDS listed Resident #69 as dependent (helper does all of the effort) for roll left and right, sitting to lying, lying to sit on one side of bed, chair/bed to chair transfers. The MDS also documented Resident #69 sometimes understands (responds adequately to simple, direct communication only) and sometimes understood (ability is limited to making concrete requests). Resident #69's MDS included diagnoses of heart failure, hypertension (high blood pressure), aphasia (a neurological disorder caused by brain damage that impairs your ability to speak, write, and understand language), and non-Alzheimer's dementia. Observation completed on 5/12/26 at 8:41 am revealed Resident #69 was observed in his room in his wheelchair. Observed signs on the door to not leave Resident #69 unattended in his room in a (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	wheelchair. No staff were present in the room. The facility IR documented revealed Resident #69 documented a fall on 5/29/26. The Care Plan with a targeted date of 7/10/26 revealed Resident #69 was at high risk for falls related to paralysis, high risk for fracture-low vitamin D, bone density, gait/balance problems, incontinence. The interventions directed the following: 4/2/26 Supervision while in wheelchair. Please do not leave me unattended in my wheelchair. 5/29/26 Encourage Resident #69 to lay down after meals. An IR dated 5/29/26 at 10:15 am identified Resident #69 had an unwitnessed fall in his room. Resident #69 was found on the floor in his room by a hospice CNA. Resident #69 was lying on the floor in front of a wheel chair beside the bed. No skin injuries or head injuries noted. The IR also documented Resident #69 was transferring without assistance. The IR failed to have an immediate intervention documented. Interview with the Director of Nursing (DON) on 6/3/26 at 12:28 pm acknowledged that Resident #69 was in his room in the wheelchair when he fell. The DON also stated the expectation is to have the nurse place an immediate intervention in place after the fall. The DON stated they have a list of interventions they can use and then the Interdisciplinary Team will meet and review the fall and change the intervention if needed. Review of the facility policy named Fall Prevention Program with a revised date of 7/2023 revealed each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls. The facility utilizes a standardized risk assessment for determining a resident's fall risk. The risk assessment categorizes residents according to low, moderate, or high risk. For program identification purposes, the facility utilizes high risk and low/moderate risk, using the scoring method designated on the risk assessment. Upon admission, the nurse will complete a fall risk assessment along with the admission assessment to determine the resident's level of fall risk. The nurse will indicate on the care plan/Kardex the resident's fall risk and initiate interventions on the resident's baseline care plan, in accordance with the resident's level of risk. The nurse will refer to the facility's High Risk or Low/Moderate Risk protocols when determining primary interventions. Low/Moderate Risk Protocols: Implement universal environmental interventions that decrease the risk of resident falling, including, but not limited to: (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	A clear pathway to the bathroom and bedroom doors. Bed is locked and lowered to a level that allows the resident's feet to be flat on the floor when the resident is sitting on the edge of the bed. Call light and frequently used items are within reach. Adequate lighting. Wheelchairs and assistive devices are in good repair. Implement routine rounding schedule. Monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. Encourage residents to wear shoes or slippers with non-slip soles when ambulating. Ensure eye glasses, if applicable, are clean and the resident wears them when ambulating. Monitor vital signs in accordance with facility policy. Complete a fall risk assessment every 90 days and as indicated when the resident's condition changes. High Risk Protocols: The resident will be placed on the facility's Fall Prevention Program. Indicate fall risk on care plan. Place Fall Prevention Indicator on the Kardex Implement interventions from Low/Moderate Risk Protocols. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent change in functional status. Provide additional interventions as directed by the resident's assessment, including but not limited to: Assistive devices Increased frequency of rounds Sitter, if indicated Medication regimen review Low bed (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Alternate call system access Scheduled ambulation or toileting assistance Family/caregiver or resident education Therapy services referral When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program. 3. The Minimum Data Set (MDS) dated [DATE] revealed Resident #9's admitted to the facility on [DATE], scored 11 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. Diagnoses include cancer, history of stroke, impairment to one side upper extremity, need for substantial/maximal assistance (helper does more than half the effort), and use of wheelchair. Review of Resident #9's Care Plan documented, Resident #9 is a smoker and is not at risk for smoker related injury and may smoke independently per facility assessment. Interventions included complete smoking assessment quarterly and with change in condition. Resident #9 can smoke unsupervised. Review of Resident #9's Electronic Health Record (EHR) revealed most recent Safe Smoking Assessment Form dated 9/23/25 documenting Resident #9 to be safe with independent smoking. The clinical record lacked any other assessments after 9/23/25. 4. Review of the MDS dated [DATE] revealed Resident #46's facility admission on [DATE], BIMS of 11, indicating moderate cognitive impairment. Diagnoses include history of stroke, hemiplegia (paralysis) affecting right dominant side, diabetes mellitus, depression, and need for substantial/maximal assistance for transfers and supervision or touch assistance with use of walker or wheelchair for ambulation. Review of Resident #46's Care Plan documented a focus initiated 9/22/25, Resident #46 likes to smoke and has potential for injury. Resident #46 is to be supervised while smoking due to having burn marks on clothing and shoes. Interventions include assessing resident's ability to smoke independently/safely, close monitoring while smoking in the smoking area, ensure there is no lighter/cigarettes at bedside; staff will provide during smoking time in the smoking room, and observe clothing and skin for signs of cigarette burns. A focus initiated 1/14/25 documented, Resident #46 is supervised with smoking, he is assessed to smoke safely with supervision. Interventions included, encourage resident to wear a smoking apron. Review of Resident #46's most recent Safe Smoking Assessment Form dated 9/22/25, documented Resident #46 is not able to extinguish smoking materials completely in an appropriate receptacle and not able to dispose of ashes or another tobacco-related residue appropriately. Need for adaptive equipment failed to indicate the need for a smoking apron and/or cigarette holder. The Interdisciplinary Team Consultation (IDTC) safety notes stated IDTC reviewed Resident #46's cushion in wheelchair and there were noted cigarette burns to the cushion. There was also noted cigarette butts laying on ground next to Resident #46's wheelchair. Review of Facility provided Smoking: Accidents and Supervision Contract for Resident #46, dated 12/16/25, indicated a current safe smoking assessment had been completed. Resident #46's Care (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Plan addressed supervision, and protective gear not applicable. 5. Review of MDS dated [DATE] revealed Resident #51's facility admission on [DATE], BIMS of 8, indicating moderate cognitive impairment. Diagnoses include cancer, history of stroke, hemiplegia, heart failure, COPD and need for supervision or touching assistance for transfers with use of a wheelchair. Review of Resident #51's Care Plan initiated 9/9/25 documented, Resident #51 likes to smoke, a smoking assessment was completed and requires supervision for safety with interventions for close monitoring while smoking in the smoking area and encourage Resident #51 to utilize a smoking apron. Review of Resident #51's most recent Safe Smoking Assessment Form dated 9/9/25, documented Resident #51 is not able to light own cigarette safely and need for use of a smoking apron. IDTC safety notes stated, Resident #51 is unable to light her own cigarette and is legally blind. 6. Review of MDS dated [DATE] revealed Resident #56's admission to the facility on 7/18/25, BIMS of 14, indicating cognitively intact. Diagnoses include history of stroke, speech and language deficits following stroke, and muscle wasting requiring substantial/maximal assistance for ambulation with use of a wheelchair. Review of Resident #56's Care Plan initiated 8/11/25 documented, Resident #56 enjoys smoking, currently requiring supervision, and a smoking contract in place 12/16/25. Interventions included Resident #56 requires supervision with smoking. Review of Safe Smoking Assessment Form dated 11/3/25 revealed due to Resident #56's cognitive status, supervised smoking is required. Review of Facility provided Smoking: Accidents and Supervision Contract dated 12/16/25 indicated a current safe smoking assessment had been completed, Resident #56 requires supervision, and protective gear not applicable. 7. Review of MDS dated [DATE] revealed Resident #71's admission to facility on 8/20/25, BIMS of 15, indicating cognitively intact. Diagnoses of metabolic encephalopathy (altered brain function caused by underlying illness), liver cirrhosis (permanent scarring of the liver caused by chronic disease or injury), anxiety, depression, COPD, and partial/moderate transfer assistance with use of wheelchair. Review of Resident #71's Care Plan initiated 9/2/25 documented, Resident #71 has COPD related to smoking with an intervention of utilization of nicotine patch daily to assist with smoking cessation. Care Plan failed to identify Resident #71's current smoking status. Review of facility admission MDS dated [DATE] revealed Resident #71's BIMS of 13, indicating cognitively intact. Review of Resident #71's admission Progress Note dated 8/20/25 documented Resident #71 is a current smoker. Review of Resident #71's January 2026 Medication Administration Record (MAR) documented an order for Nicotine transdermal patch, place one patch to skin daily, removing old patch, had been administered 31 of 31 days. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Review of Resident #71's February 2026 MAR documented the Nicotine patch had been administered 23 of 28 days, Resident #71 refused the patch 5 days. Review of Resident #71's March 2026 MAR documented the Nicotine patch had been administered 16 of 31 days, Resident #71 refused the patch 15 days. Review of Resident #71's April 2026 MAR documented the Nicotine patch had been administered 1 of 30 days, Resident #71 refused the patch 29 days. Review of Resident #71's May 2026 MAR documented the Nicotine patch had been administered 2 of 31 days, Resident #71 refused the patch 29 days. Review of Resident #71's Electronic Health Record (EHR) failed to provide a Safe Smoking Assessment Form to indicate an assessment had been completed. On 5/26/26 a Safe Smoking Assessment was requested from Administrative Staff for Resident #71. Review of facility provided Safe Smoking assessment dated [DATE], indicated Resident #71 is able to smoke independently. 8. Review of MDS dated [DATE] revealed Resident #78's admission to the facility on [DATE], BIMS of 15, indicating cognitively intact. Diagnoses of stroke, diabetes mellitus, hemiplegia to left side, contractures of left hand, and dependent assistance for transfers and use of wheelchair for mobility. Review of Resident #78's Care Plan initiated 9/24/25 documented, Resident #78 has chosen to continue to smoke and will need to be supervised for smoking safety as evidence by recent smoking assessment with intervention of need to wear a smoker's apron when smoking due to safety concerns, need for supervision, assure Resident #78 can safely reach the ashtray, assistance to make sure cigarette is fully distinguished each time to prevent burns, and show Resident #78 where the designated smoking area is and assist with getting to and from smoking area during smoking times if assistance is needed. Review of Resident #78's most recent Safe Smoking Assessment Form dated 2/26/26, IDTC safety note documented Resident #79 requires supervision for safety. 9. Review of MDS dated [DATE] revealed Resident #80's admission to facility on 11/2/24, BIMS of 15, indicating cognitively intact. Diagnoses of cancer, heart failure, peripheral vascular disease (disorder of blood circulation), below the knee amputation of left lower leg, kidney failure, diabetes mellitus, Non-Alzheimer's Dementia, and independent with transfers and mobility with use of limb prosthesis and wheelchair. Review of Resident #80's Care Plan initiated 12/18/24 documented, Resident #80 has Peripheral Vascular Disease with interventions of education on the importance of proper foot care; including proper fitting shoes, wash and dry feet thoroughly, keep toenails cut, inspect feet daily, daily change of hosiery and socks. Keep skin on extremities well lubricated with lotion in order to prevent dry skin and cracking of the skin. Monitor extremities for signs and symptoms of injury, infection or ulcers. Monitor and document for excessive edema and encourage resident to elevate legs. Care Plan revealed on 5/14/26 a cancelled focus, initiated 9/30/24 Resident #80 is a smoker and is independent in smoking. A focus initiated 5/14/26 indicated Resident #80 like to smoke and has an actual injury (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	while smoking with interventions to assess Resident #80's ability to smoke independently and safely and provide close monitoring while smoking in the smoking area. A Wound Observation Progress Note dated 5/14/26 at 10:04 AM documented Resident #80 having a thermal burn to the right heel, 1cm L x 0.8cm W x 0.1 cm D with drainage. A Skin/Wound Progress Note Dated 5/14/26 at 10:15 AM documented, Resident #80 seen by wound care provider, orders received to apply Bacitracin to burn on right heel daily and cover with a band aid until healed. An Interdisciplinary Team (ADT) Note dated 5/15/26 at 7:49 AM documented, Resident #80 currently have thermal burns to the right heel. Current treatment order to cleanse right heel with cleanser of choice, apply bacitracin and cover with band aid until healed. Treatments are effective and wounds are improving, no signs or symptoms of infection and surrounding tissue intact. Review of Resident #80's Electronic Health Record (EHR) provided a Safe Smoking Assessment Form dated 9/29/25 indicating Resident #80 able to smoke independently. Safe Smoking assessment dated [DATE] documented Resident #80 has a burn wound to right foot due to a cigarette cherry falling into his shoe and burning his skin. In order for Resident #80 to be safe and injure himself he will need to be supervised during smoking sessions with use of a smoking apron. Review of Facility Provided Smoking Injury Incident report dated 5/14/26 at 10:15 AM documented Resident #80 seen today by wound care provider; treatment orders received for right heel. Resident #80 stated the cherry from his cigarette fell into his shoe. Review of Facility provided Smoking Times and Smokers document, received on 5/11/26 provided the following. Scheduled smoking times and designated department for supervision. 9:00 AM Dietary, 11:00 AM Housekeeping, 1:00 PM Activities, 3:00 PM 200 hall nursing, 7:00 PM 300 hall nursing CNA. Smoking Residents that must be Supervised: Resident #46 Resident #51 Resident #56 Resident #71 Resident #78 Independent Smokers: Resident #9 Resident #80 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	During continued observation on 5/20/26 at 12:59 PM to 1:47 PM the following was observed: 12:59 PM Designated smoking supervision staff member, Staff K, Recreation Aid, opens door for Resident #51 to exit into the designated smoking area and courtyard. Staff K assists Resident #51 light her cigarette and fails to provide a smoking apron for protection. Resident #80 observed exiting to the smoking area walking independently with front wheeled walker (FWW). 1:00 PM Staff K enters the building from the smoking area and courtyard, standing in the community room with his back to the exit door. At this time Resident #80 is observed sitting outside on a chair smoking a cigarette without the use of a smoking apron for protection. Staff K, remains in the community room talking with other residents. Resident #51 and Resident #80 continue to smoke outside unsupervised. 1:05 PM Resident #51 re-enters the building after smoking. 1:08 PM Staff K returns outside, with Resident #51 and Resident #56 following. Resident #56 observed smoking without wearing a smoking apron. 1:12 PM Staff K enters the building, talking with residents in the community room. 1:14 PM Resident #9 observed exiting to outside smoking area. 1:17 PM Staff K continues to be inside in community area, unable to supervise residents outside. Staff K paging for assistance via walkie for another staff member to supervise smoker Residents. Staff K asks Staff L, Licensed Practical Nurse (LPN) to supervise as he has to provide activities for other residents. Staff L, LPN responds to Staff K stating I would but I'm helping another resident. During this time Resident #51, Resident #80 and Resident #56, two of three residents require supervision and smoking apron (Resident #51 and Resident #80). 1:20 PM Staff K continues in community area, while Resident #9 attempts to enter facility independently, Resident #9's wheelchair gets caught in the door jam. Both Staff K and Staff L fail to respond and assist Resident #9's get through the door. 1:26 PM Staff M, Certified Nursing Assistant (CNA) responds to Staff K's request for assistance. Staff M, CNA assists Resident #78 outside and follows to the smoking area/courtyard to supervise smoking residents. Resident #78 observed lighting a cigarette and smoking. 1:32 PM Staff M, CNA enters building, leaving Resident #51 and Resident #78 outside, neither resident smoking at this time. 1:36 PM Resident #71 attempts to go ou		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility policy review, and record review, the facility failed to ensure staff followed a gastrostomy tube (G-tube) feeding order for 1 of 4 residents reviewed (Resident #85) reviewed for nutrition. The facility reported a census of 81 residents. Findings include: Review of Resident #85's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 4, indicating severely impaired cognition. The MDS recorded active diagnoses of a stroke, aphasia (difficulty speaking), hemiplegia (one-sided paralysis), dysphagia (difficulty swallowing), and a neurogenic bladder (loss of bladder control) with the need for a catheter. The MDS documented an impairment to one side of the upper extremities and an impairment to both sides of the lower extremities. The MDS coded Resident #85 as dependent on the assistance of two persons with the use of a mechanical lift and a wheelchair for ambulation. The MDS failed to document Resident #85's gastrostomy tube (G-tube) for feeding and nutrition. Review of Resident #85's Care Plan documented a focus area initiated 9/4/25 that identified Resident #85 ran a risk for altered nutrition and hydration status related to cognitive status, a post-stroke condition, a feeding tube, a foley catheter, and being bed or chair bound. Interventions included monitoring for signs and symptoms of intolerance with G-tube feedings. Another focus area initiated 7/29/25 noted Resident #85 required tube feeding related to dysphagia secondary to a stroke. Interventions specified that Resident #85 stayed dependent on tube feeding and water flushes, and directed staff to see physician orders for current feeding orders. Review of Resident #85's Nutrition Progress Note dated 5/6/26 at 6:09 PM showed Staff G, Registered Dietitian, documented a recommendation to hold G-tube feedings for six nights. Staff G planned to re-assess in one week. Staff G asked if the provider agreed to hold the G-tube feeding for six nights and complete weekly weights for four weeks, and noted a copy went to the physician for review. Review of Resident #85's Advanced Registered Nurse Practitioner (ARNP) visit Progress Note dated 5/12/26 and signed on 5/27/26 at 10:34 AM documented that Resident #85 remained G-tube dependent. The note recorded that the hospital admitted Resident #85 last week for a G-tube exchange, but otherwise he did well overall. The note listed his nutritional status as stable on night feeds via the G-tube and recorded that his gastrostomy status continued with the G-tube for nutritional support. The note mentioned continued discussion regarding the potential to reduce dependence on the G-tube pending swallow study results. A non-face-to-face chart review of hospital records occurred prior to the visit, and the remaining time went to a current facility chart review, communication with nursing staff for an observational history, medication reconciliation, face-to-face evaluation, and counseling. Review of Resident #85's Nursing Progress Note dated 5/12/26 at 4:16 PM documented a returned weight note signed by the ARNP that gave approval to follow the recommendations. Review of Resident #85's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for May 2026 revealed an order to connect the feeding tube from 9:00 PM to 3:00 AM for Osmolite 1.2 at 96 mL/hr. The order carried a start date of 4/25/25, a hold date starting 5/12/26, and a discontinued date of 5/15/26. The documentation indicated that nursing staff held the G-tube feeding as ordered on 5/12/26, 5/13/26, and 5/14/26. Review of Resident #85's Nutrition Progress Note dated 5/15/26 at 3:17 PM showed Staff G documented that Resident #85 stated he did well with the G-tube holds. The note recorded that his Osmolite 1.2 at 95 mL/hr, which started at 9:00 PM and ended at 3:00 AM, stayed on hold. The note featured a message asking to extend the hold for the G-tube feedings through 5/21/26, and Staff G provided the note for advisement. A Progress Order Note dated 5/15/26 at 4:49 PM showed Staff F, Minimum Data Set Coordinator, documented a new order to continue the hold for the G-tube feedings until 5/21/26 for Resident #85. The note recorded that Resident #85 stayed on a regular diet and ate three meals per day and snacks. Review of Resident #85's Electronic Health Record (EHR) revealed an order entered (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by Staff F on 5/15/26 at 3:46 PM. The order instructed staff to connect the feeding tube from 9:00 PM to 3:00 AM for Osmolite 1.2 at 95 mL/hr. The scheduling details specified that the order applied every day at bedtime, carried a start date of 5/15/26, and carried an end date of 5/21/26 at 11:59 PM. Review of Resident #85's May 2026 MAR/TAR indicated an order with a start date of 5/15/26 to connect the feeding tube from 9:00 PM to 3:00 AM for Osmolite 1.2 at 95 mL/hr at bedtime until 5/21/26. The documentation indicated that staff administered feeding via the G-tube on 5/15/26 and 5/16/26, held it on 5/17/26, 5/18/26, and 5/19/26, and administered it on 5/20/26 and 5/21/26. An order for a 60 mL water flush every hour via the G-tube from 9:00 PM to 3:00 AM carried a start date of 4/25/26, and the documentation indicated that staff completed the water flushes as ordered for 30 or 31 days. Review of Resident #85's Nutrition Progress Note dated 5/22/26 at 10:52 AM showed Staff G documented recommendations to discontinue the G-tube feedings and the hourly water flushes during feeding. The note asked if the provider agreed to discontinue the G-tube feedings and water flushes, and a copy of the note went to the physician for advisement. On 5/19/26 at 4:42 PM Staff U, Licensed Practical Nurse, confirmed he worked overnight shifts on 5/15/26 and 5/16/26. Staff U stated he connected and administered Resident #85's feeding on Friday 5/15/26 as the MAR indicated. On Saturday 5/16/26 Staff U stated he didn't administer the feeding as indicated on the MAR. He noted that during the shift change report, he learned that Resident #85's feeding required a hold, but he couldn't find an order in the EHR stating that the feeding stayed on hold or discontinued. On 5/21/26 at 11:17 AM an observation of Resident #85's room revealed a bottle of Osmolite with 400 mL remaining and a feeding bag with 500 mL of water hanging on a pole with tubing inserted through the feeding pump. Both the bottle of feeding and the bag of water lacked a date of use. A feeding syringe and a graduate sat on the bedside table labeled 5/20 PM. On 5/27/26 at 3:57 PM an interview occurred with the Director of Nursing (DON), Staff F, Facility Administrator, Staff O, Rehab Director, and Regional Director of Operations. The recommendations made by Staff G for Resident #85 underwent a review that highlighted concerns related to communication with the provider, the timing of communication, and the nursing process for completing orders. The DON provided brief responses in a dismissive tone, stating that Staff G makes recommendations and puts them in the provider's box for review, and once the provider reviews them, the nurse processes any changes. After questions about the timeframe for reviewing these recommendations, the DON stated that the provider came onsite every Thursday and reviewed them at that time. The DON didn't feel that the timeframe from when staff made recommendations to when the provider reviewed them and nurses processed the order represented a concern. During the interview, a lack of response from the Facility Administrator and the DON's tone and manner of communication suggested irritation, which affected the flow and depth of the interview. On 6/1/26 at 2:49 PM an observation showed that the feeding pump no longer stayed in Resident #85's room. On 6/3/26 at 11:30 AM a further review of Resident #85's EHR revealed it failed to indicate that Staff G's recommendations on 5/22/26 to discontinue the G-tube feedings and water flushes had been communicated to, reviewed by, or approved or declined by the physician. In a communication received via email on 6/9/26 at 11:50 AM the Regional Director of Operations stated that after reviewing Resident #85's record and the sequence of events, management agreed that the concern centered on the communication, transcription, and follow-up process related to the dietitian's recommendations and the G-tube feeding order. She noted that the provider reviewed Staff G's recommendation to hold the G-tube feeding on 5/12/26. The subsequent recommendation on 5/15/26 to extend the hold through 5/21/26 underwent review and received approval from the provider the same day. The hold was accurately reflected in the progress note; however, when staff entered the order onto the MAR, the wording didn't clearly reflect that the feeding had to remain on hold through 5/21/26. This created the potential for inconsistent interpretation by nursing staff. The facility recognized that after the hold period ended on 5/21/26, staff should have obtained clarification timely regarding whether the feeding had to resume, remain on hold, or be discontinued. Staff G re-evaluated the resident on 5/22/26 and recommended the (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinuation of the G-tube feedings and flushes. The provider has since reviewed the resident, including seeing the resident last week, and the facility has ensured that the current order status has been clarified and accurately reflected. She added that regarding the order review process, the nurse entering an order reviews it, and then another licensed nurse on the following shift reviews it as part of the facility's order verification process. A third level of review occurs through clinical oversight by a designee during a clinical review, a MAR review, or a morning clinical meeting to ensure that orders, progress notes, and provider recommendations stay consistent. The facility's expectation is that staff communicate provider recommendations related to nutrition, enteral feedings, or other resident-specific interventions to the provider timely and follow up on them until the provider gives direction. If an unclear order, discrepancy, or change in a stop date occurs, nursing staff are expected to contact the provider for clarification before continuing or discontinuing the intervention. The Care and Treatment of Feeding Tubes Policy dated March 2019 directed that feeding tubes will be utilized according to physician orders, which typically include the kind of feeding and its caloric value, volume, duration, mechanism of administration, and frequency of flush. The policy instructed that the facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs. The policy stated that the facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complication and risk factors.		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety 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 grievance forms, clinical record review, family interview, staff interview, and facility policy review, the facility failed to timely and effectively manage resident pain for 1 of 1 residents reviewed for pain management (Resident #94) and for 3 residents via grievance reports (room [ROOM NUMBER]-A, Resident #59, room [ROOM NUMBER]). The facility failed to assess and intervene upon the report of Resident #94 having acute pain and failed to initiate a new order for morphine pain medication in a timely manner on 3/23/26. The resident experienced severe, avoidable pain as evidenced by non-verbal pain indicators and family reports. The facility failed to successfully submit escripts for the acute pain medication to the pharmacy leading to a delay in obtaining and administering the medication. The above failure rose to a level of immediate jeopardy and the facility was notified of IJ on 5/21/26 at 3:35 PM. The failure began 3/23/26 for Resident #94. The facility removed the immediacy on 5/22/26 after the State Survey Agency (SSA) verified removal actions taken by the facility that included: PlanComplete immediate pain and comfort assessment on every current resident, including verbal and non-verbal indicators, hospice/palliative care status, recent falls, wounds, fractures, terminal decline, therapy-related pain, behaviors, anxiety/restlessness, and residents unable to self-report pain. For any resident with pain score 4 or higher, severe nonverbal pain indicators, new/worsening pain, or uncontrolled pain: notify provider/hospice immediately, implement ordered interventions, administer ordered medication timely, and document resident response. Review Resident #94's record for root cause analysis: pain assessment failures, order implementation failure, missed routine tramadol, hospice/provider notification gap, family concern response, near fall/abrasion response, and end-of-life comfort process breakdown. Audit 100% of residents with active pain medication orders, PRN opioids, routine analgesics, hospice comfort medications, recent new orders, and recent pharmacy/hospice recommendations to verify orders are transcribed, available, administered as ordered, and reassessed. Implement pain reassessment requirements: after PRN pain medication, non-pharmacologic intervention, new/worsening pain, fall/injury, therapy treatment, wound care, transfer, hospice symptom change, or resident/family complaint. Establish hospice/palliative care communication protocol: any uncontrolled pain, distress, restlessness, agitation, terminal change, medication issue, family concern, or need to alter the comfort plan requires immediate hospice and/or provider notification. Educate all licensed nurses and CNAs on F697, pain recognition, nonverbal pain signs, end-of-life comfort, timely implementation of new orders, PRN effectiveness documentation, escalation, provider/hospice notification, and family concern response. Implement a Pain Management High-Risk Huddle at least daily, reviewing residents with pain scores 4 or greater, hospice/comfort care, new pain orders, missed/refused pain medications, PRN use, ineffective interventions, family concerns, and provider/hospice follow-up. Add leadership escalation: unresolved severe pain, delayed medication availability, missed pain medication, inability to reach provider/hospice, or concern that staff cannot meet pain management needs must be escalated immediately to DON and Administrator. Action Resident #94 expired prior to the IJ notice. The facility completed an immediate leadership review of the clinical record and survey allegation, including pain assessment, hospice level-of-care transition, morphine order implementation, routine tramadol administration, provider/hospice communication, family concern response, near-fall/abrasion assessment, and overnight monitoring. Findings were used to implement facility-wide corrective action to prevent recurrence. All residents have the potential to be affected by failure to assess and manage pain. The facility completed a 100% pain risk sweep of current residents, prioritizing hospice/comfort care residents, residents with pain orders, residents unable to self-report, residents with recent falls/injuries/wounds, residents receiving therapy/wound care, residents with behaviors that may indicate pain, and residents with new or changed pain medication orders. Implemented Pain Management Immediate Response Process: pain assessment on (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	admission/readmission, change in condition, fall/injury, wound care, therapy concern, family complaint, hospice change, and resident report/nonverbal indicators; timely implementation of pain orders; MAR/order audit; PRN effectiveness reassessment; provider/hospice notification protocol; severe pain escalation; daily pain huddle; staff education and competency validation. Audits include pain assessments, pain score follow-up, nonverbal pain indicators, PRN effectiveness, routine analgesic administration, new-order implementation, hospice/provider notifications, family concern follow-up, MAR/order accuracy, medication availability, and care plan accuracy. Audit findings, pain trends, missed medications, uncontrolled pain episodes, hospice/provider notification concerns, medication availability concerns, staff competency results, and corrective actions will be reported to QAPI. QAPI will determine additional action, including re-education, counseling, pharmacy/provider process revision, hospice communication revision, and staffing/assignment changes if needed. The scope and severity of the failure lowered from a J level to an D level on 5/22/26 after the facility removed the immediacy of the health threat. The facility reported a census of 81 residents. Findings include: The MDS dated [DATE] for Resident #94 revealed diagnoses of fractures of the upper and lower right fibula, fall, chronic obstructive pulmonary disease, heart valve disorder and identified surgical repair of fractures. Resident #94 was dependent on staff for personal hygiene, dressing, and moderate assistance for transfers from bed to chair. Pain was identified that interfered with sleep and therapy. The MDS identified two Stage 1 pressure ulcers, skin tears, a surgical wound that required wound care, the application of dressings and an infection of the foot to include pressure ulcer care. The MDS identified the use of oxygen therapy, an intravenous access site, occupational therapy, physical therapy and speech therapy. The Care Plan for Resident #94 identified a risk for skin tears, bruising and directed staff to apply folded sheet or small pillow between bony surfaces and apply a leg brace. The nursing staff was directed to assess for pain level, effectiveness of the pain medication and inspect skin for bruising or bleeding daily. The Care Plan identified Resident #94 as a fall risk and directed staff to apply the appropriate foot wear when ambulating, utilize the mechanical lift with two staff for transfer, wheelchair for mobility and keep personal items within reach. Staff were to follow all facility protocols related to falls, fall report, investigation, interventions and to inform the physician. During an interview on 5/20/2026 at 9:52 am, Resident #94's wife stated on 3/23/26 she was present in the morning when the Hospice nurse arrived to assess her husband. The wife stated she had left the facility before noon and returned approximately at 2pm to see two staff chatting outside her husband's room and found her husband in a tipped recliner hanging on with fright as the recliner was so far over that his surgical foot and the foot rest was on the floor. She yelled for help and visualized a new wound to her husband's right arm. The nurse told her it was just hair that was removed from his arm. The wife stated, I believe he just was frightened to death as her husband's oxygen level dropped, breathing hard and did not talk much. The wife stated his arm hurt, looked as if the skin was ripped off and his pain was extraordinary. The wife stated she informed the staff and six hours passed with no nurse response. The wife stated, He was so fearful that he did not want me to leave him. The wife stated the two Certified Nurses Aid's (CNA) came in at 8 pm, used the mechanical lift to put him to bed and he curled up facing the wall, he never slept facing the wall. The wife stated he was in terrible pain and the nurse did not respond, assess him or administer pain medication. During an interview on 5/20/2026 at 10:42 am, Resident #94's grandson stated on 3/23/26 he had arrived to visit at approximately 3 pm. The grandson stated his grandfather had a new bruise on his right shoulder and a large area in the middle of his right forearm with no skin, the skin was off, pink (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	but not bleeding. The grandson stated his grandmother requested to speak to a nurse and the nurse did not respond. The grandson stated his grandfather repeatedly said he wanted to go home and asked his grandmother not leave him. The grandson stated his grandfather was in and out of consciousness and staff came in to give him a food tray with pizza that he could not eat it because it was too hard. The grandson stated he was there until 8 pm and only visualized one CNA. The Progress Notes for Resident #94 revealed: a. On 3/21/2026 at 9:47 am Resident #94 was to receive Hospice care. Resident #94 was alert and orientated to person, no change with neuro checks and denied having pain. Resident #94 required assistance with bed mobility, eating, transfers, toilet, and dressing. Resident #94 was incontinent of bowel and bladder. The medications were crushed or given in liquid form. Resident #94 had wounds, skin tears and a surgical wound. b. The assessment on 3/22/26 was not completed c. On 3/23/2026 at 3:19pm, Staff L, Licensed Practical Nurse (LPN) documented she was called to Resident #94's room by a family member. Resident #94 had shifted his weight forward in his chair and had tipped the foot rest to the floor. Resident #94 was still in his chair with his feet on the floor in front of the foot rest. There was no fall nor did the resident leave his seated position. This nurse and therapy assistant tipped the chair back in place and repositioned Resident #94 into the recliner. Resident #94 had been reaching for items on the tray table which was moved closer to the resident. Staff cleaned up the floor where items had spilled. The family members sat with Resident #94 through meal services and Resident #94 was settled, resting comfortably. Resident #94's assessment was completed with no concerns except his oxygen (O2) saturation which was at 88%. Resident #94's family was aware of poor O2 profusion while on 4 Liters of O2, however Resident #94 was converting to Hospice Care tomorrow and requested no additional intervention at this time. Resident #94 eat only a few bits of food and drank 100 milliliters of liquid during meal time. Resident #94 showed no signs or symptoms of shortness of breath. d. On 3/23/2026 at 9:37 pm, Staff L, LPN documented Resident #94 admitted to Hospice Care this date for severe aortic stenosis and severe protein-calorie malnutrition in addition to recent hip and tibial plateau fracture. The blood thinning injection was discontinued and morphine liquid was ordered for difficult breathing and severe pain. Resident #94's daughter was present and in agreement with the new orders. Resident #94 had no discomfort. e. The Progress Notes lacked a follow-up documentation over the night shift. f. On 3/24/2026 at 7:45 am documentation of a call to the wife to report Resident #94 was not doing well and was declining. Blood pressure was 88/42, heart rate 56 and respiration was shallow at 16, difficulty with obtaining an accurate O2 saturation, and there was no sign of discomfort. g. On 3/24/2026 at 7:54 am, Resident #94 expired at 7:50 am, no heart beat or pulse. A call was placed to the wife and reported the information. The wife requested that resident not be moved until her arrival. The hospice nurse was notified. Communication document dated 3/23/26 by Staff SS, Hospice Registered Nurse (RN) documented Resident #94 was admitted to Hospice for severe aortic stenosis, severe malnutrition and recent hip and leg fracture with a request to stop the blood thinner and initiate Morphine for difficult breathing or (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	severe pain. The document was noted by Staff L, Licensed Practical Nurse (LPN). The Hospice Care admission note on 3/23/26, Staff SS, RN documented Resident #94 cried out in pain, scored 8/10 on the PAINAD scale, displayed anxiety and increased agitation with any transfer or movement. Ate small bites of food, drank fluid with heavy assistance and encouragement. Pressure injuries to bilateral heels and was non-blanchable, and pinkness to the skin in the coccyx area. A healing skin tear to the left forearm that the family reported he got when he was combative during his hospitalization. Scattered bruising and scabbed abrasions to both arms. A surgical wound to his rt knee with a dressing and a knee brace. A urinary catheter with yellow urine and was incontinent of bowel. During an interview on 5/20/26 at 9:20 am, Staff SS, RN stated she was the admission nurse for Hospice on 3/23/26 and arrived to the facility around 8 am. The referral came in on Friday late afternoon 3/20/26 as Resident #94 was discontinued from skilled care. Staff SS stated she assessed Resident #94 at 9am with his wife and daughter present. Resident #94 was in bed and the daughter offered him a snack cake; he took a drink. Resident #94 was in pain 8/10 on the PAINAD scale so she ordered Morphine, wrote it on the paper physician's order form provided by Staff BB, LPN, the nurse on duty. Staff SS stated the nursing staff fax the orders to their own pharmacy. Staff SS stated she did not have morphine to give Resident #94 but the facility had an emergency box that contained narcotics and she communicated with Staff BB, LPN who was made aware Resident #94 was experiencing pain. Staff SS stated she would expect Resident #94's pain to be treated. Staff SS stated the booklet with the care plan had not been built yet as she would chart and then the booklet would be brought back by the Hospice RN. Staff SS stated she only did Hospice admissions and the case manager RN will follow up within 24-48 hours. The Medication Administration Record dated March 2026 for Resident #94 revealed: a. Pain level rated at 6/10. b. On 3/23/26 Celecoxib (anti-inflammatory) 200 milligrams (mg) daily administered.c. On 3/23/26 Tylenol 500 mg 2 tablets BID (two times daily) Administered morning and afternoon. d. On 3/23/26 Lidocaine 4% patch, apply to affected area in the morning was applied and removed at bedtime. e. On 3/23/36 Tramadol 50 mg TID (three times daily) was administered am, pm, and lacked documentation for the bedtime dose. Pain levels documented as an X each dose. f. Hydroxyzine (antihistamine) 25 mg take 1 tablet at bedtime as needed for anxiety. Ordered on 3/6/26. No documentation of administration. g. On 3/23/26 Morphine Sulfate Solution 20 mg per 5 milliliter (ml) administer 0.25 ml every 4 hours as needed for dyspnea (difficult breathing) and severe pain. No documentation of administration. A document titled Pain Level Summary for Resident #94 document by nursing staff three times daily. a. Dates 3/17/26 through 3/22/26 revealed 0 for numerical (Resident rates the pain) and 0 for PAINAD (observational tool used to evaluate pain) scale. (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	blue recliner. Staff L stated she found Resident #94 leaning forward with his feet and the recliner foot rest on the floor. Staff L stated she flipped the recliner back but could not recall which staff member assisted to reposition Resident #94 back up and into the recliner. Staff L stated she did not visualize an abrasion on Resident #94's arm. Staff L stated this could have been considered a near fall. Staff L stated she did not see the need to do an assessment. Staff L stated Resident #94 had family present and could not remember if the family reported if he was experiencing pain or if Resident #94 said he had pain. Staff L stated she did not administer pain medication to Resident #94 and could not remember further details. Staff L stated Resident #94 was to be admitted to Hospice care the next day. Staff L stated Resident #94 was only at the facility for a few days. During a follow-up interview on 6/01/2026 at 3:39 pm, Staff L, LPN stated she was informed by the previous nurse on 3/23/26 that the order for Resident #94's pain medication was not received from the Hospice nurse until 2 pm and that nurse (not identified) had looked in the Cubix system for Morphine and it was empty and it would be delivered at 7pm. Staff L stated the unidentified nurse reported the order was e-scripted by hospice and faxed in and the pharmacy entered it into the computer. Staff L stated she called the pharmacy, who said they had not received an e-script from hospice, it had to be entered and that took 15 minutes. Staff L stated she looked in the Cubix and Morphine wasn't in there, it was empty, as it was used the night before for someone who was dying. Staff L stated she called their pharmacy who said on its way out. Staff L stated she had checked on Resident #94 and he was okay. Staff L stated the delivery did not arrive, she called the pharmacy and when asked where the medication was, the pharmacy staff said they did not get a quantity and something was wrong with the script. Staff L stated she had to call the physician on call and stat out an order. Review of the monthly grievance forms revealed the following: The Grievance Form dated 1/21/26 signed by the Administrator recorded a resident who formerly resided in room [ROOM NUMBER]-A reported Staff KK, LPN, would not give her pain medications (meds) when she requested the med when she had pain and Staff KK gave the wrong insulin medication. The Grievance Official Follow-Up section documented education provided to Staff KK that pain medication was to be administered as requested by any resident, the pain assessment should be documented in PCC (Point Click Care aka Electronic Medical Record) and would have a second person with Staff KK while interacting and providing care with the resident. The form lacked any documentation of further interview or follow up with the resident on resolution or efforts to ensure pain managed appropriately and recorded date resolved as 1/23/26. The Grievance Form dated 2/28/26 signed by the Administrator as resolved on 3/2/26 recorded Resident #59 complained call lights took 1 hour to answer, he had a bowel movement in his brief and not changed in a timely manner, and complained of pain meds. The form contained no further elaboration about the pain med concern. The Grievance Official Follow-Up section documented the Administrator educated staff on 2/28/26, spoke to the nurse about pain med, and hung a sign on the door to leave it open. The form lacked any documentation of further follow up or interview with the resident to verify resolution. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 4/16/26 signed by the DON as resolved on 4/17/26 recorded a resident who formerly resided in room [ROOM NUMBER] reported since 3:00 or 4:00 AM he had been asking for his PRN (as needed) pain medication and muscle relaxer but he kept getting told he could not/did not have any. The Grievance Official Follow-Up section documented the staff had been educated on the (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	use of PRNs and giving them in a timely manner and explaining why, if they could not. The form lacked any documentation of further follow up or interview with the resident about his pain or availability of the medications. The form contained no information on whether the grievance was confirmed or not confirmed. Review of Facility provided Change In Resident Condition Policy revised September 2024 stated, our facility shall notify the resident and his or her attending physician of changes in the resident's condition.GUIDELINES: The nurse will notify the resident's attending physician and family when there has been: An accident or incident involving the resident A discovery of injuries of an unknown cause A change in medication/treatment or reaction to a medication A significant change in the resident's physical/emotional/mental condition A need to be seen by a physician for a non-emergent condition A need for a significant alteration in the resident's medical treatment Refusal of treatment or medication per physicians' orders or three consecutive times A need to transfer the resident to a hospital/treatment center A discharge without medical authority Notifications will be made after the nurse assesses the resident and when deemed necessary, except in emergencies, in which case notification will be made immediately. The nurse will inform the resident, or resident representative if indicated, of any changes in his/her medical care or nursing treatments. The nurse will document in the resident's medical record or SBAR in the resident's chart any changes in the resident's condition, who was notified (e.g., physician and family), and any new orders. The resident will be placed on the critical charting board for the next 72 hours after the assessment is completed. Review of Facility provided PRN Medications Policy revised July 2025 stated PRN (as needed) medications are administered by staff who are legally authorized to do so through certifications or licensure, in accordance with a physician's order. Documentation will be provided in the resident's medical record to show adequate indications for a medication's use and the diagnosed condition for which it was prescribed. Orders for medications to be given on an as needed basis shall have clear instructions about how and (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	when to administer them. Examples include, but are not limited to: The symptom or condition for which the medication is to be given (i.e. pain, nausea). When administering a PRN Medication Verify physician's order for the medication. Document the reason by the resident and or assessment findings that show why the resident needs the medication. Document the time of administration. Evaluate the effectiveness of the medication and document the findings.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the facility assessment, resident council meeting minutes, facility grievance forms, resident interview, observation, family interview, and staff interview, the facility failed to provide sufficient staffing to meet resident needs in a timely manner in regards to answering call lights, providing incontinence care, and overall assistance with activities of daily living. The evidence identifies staffing concerns reported by 2 resident council meetings that had 18 and 14 attendees respectively and 23 different residents affected (R#1, #4, #8, #9, #12, #13, #21, #22, #25, #30, #35, #43, #44, #45, #49, 52, #59, #64, #72, #73, #74, #78, #81, #85 and 3 discharged residents identified by room numbers 504, 504-A, 205-B), indicating a widespread issue. The facility reported a census of 81 residents. Findings include: 1. Review of the Facility Assessment The Facility assessment dated [DATE] documented it was last reviewed May 2026 with no changes needed. The assessment identified 48 residents needed assistance with transfers and 53 assistance with toileting. The assessment documented on page 18 under Administration subsection that staffing patterns were regularly reviewed and adjusted to align with changes in resident acuity and care plans. The assessment documented on page 19 under other subsection that staffing for all other departments and support staff - including maintenance, housekeeping, laundry, administration, and activities- was adequate as evidenced by the facility's ability to maintain a safe, clean, and well-functioning environment that supports resident quality of life and regulatory compliance. The facility provided a resident roster dated 5/18/26 denoting a census of 84 that day and recorded the level of assistance needed for each residents' transfers and whether they had incontinence. The roster documented a total of 64 residents requiring assistance with transfers with 9 requiring an EZ-stand (sit-to-stand mechanical) lift and 20 requiring a Hoyer (full body mechanical) lift. The roster documented 79 residents who had incontinence; only 6 of the 79 residents identified as mixed incontinence meaning sometimes continent, the other 73 marked as fully incontinent. The roster contained the following numbers per hallway: 100 Hall - 29 residents Transfers - 8 independent, 9 assist of 1 person for transfers, 2 assist of 2 persons, 3 EZ stand mechanical lift, 5 Hoyer full body mechanical lift with assist of 2 persons Incontinence - 25 residents incontinent and 4 continent. 200 Hall - 36 residents Transfers - 4 independent, 14 assist of 1 person for transfers, 4 assist of 2 persons, 4 EZ stand mechanical lift, 10 Hoyer full body mechanical lift with assist of 2 persons (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Incontinence - 25 residents incontinent and 4 continent. 300 Hall - 14 residents Transfers - 3 independent, 3 assist of 1 person for transfers, 2 assist of 2 persons, 2 EZ stand mechanical lift, 4 Hoyer full body mechanical lift with assist of 2 persons Incontinence - 8 residents incontinent, 6 residents mixed incontinence, and 0 continent. 400 Hall - 3 residents Transfers - 3 independent Incontinence - 2 residents incontinent and 1 continent. 500 Hall - 3 residents Transfers - 1 independent, 1 assist of 2 persons, 1 Hoyer full body mechanical lift with assist of 2 persons Incontinence - 3 residents incontinent and 0 continent. The facility assessment failed to reflect the current resident needs for May 2026 or how staffing patterns were reviewed to address the increase in resident care needs. 2. Review of the Resident Council Meeting Minutes revealed the following: On 3/6/26, the minutes recorded 18 residents attended. The residents reported call light wait times were improvising but some wait times are longer. On 4/3/26, the minutes recorded 14 residents attended. The residents reported: they would like staff to check more often on residents who are out in the common areas throughout the evening and nights; residents felt the nursing staff should have a happier disposition when interacting with residents; and call light wait times were getting better, but some days were better than others. 3. Review of the monthly grievance forms revealed the following: The Grievance Form dated 1/15/26 signed by the Administrator recorded Resident #81 complained he was not getting checked and changed (providing assistance with incontinence care) on the overnight shift. The Grievance Official Follow-Up section documented education was provided to staff on the 10pm to 6 am shift to make sure they were checking and changing the residents every 2 hours. The form recorded no date of resolution but documented it would be ongoing to check with the resident. The form lacked any other monitoring or follow up and the notification of the representative left blank. The form contained no information on whether the grievance was confirmed or not confirmed. The January 2026 Grievance Log documented the disposition of grievance received on 1/15/26 as blank with a date of written decision blank. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #49 reported the aides were not friendly, aides did not get her ice water or answer her call light, and she was not (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Pine Acres Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1501 Office Park Road West Des Moines, IA 50265	
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administrator on 1/30/26 recorded Resident #45 reported a concern with a call light not being answered and a nurse trying to give him insulin medication which he did not take. The staff response section lacked any investigation summary or action taken in regards to the call light concern. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 1/30/26 signed by the Administrator as resolved on 1/31/26 recorded Resident #45 complained of sitting bowel movement/feces for 14 hours and he did not like it at the facility. The Grievance Official Follow-Up section documented the Administrator asked staff in that hall and they reported they had changed the resident. The form documented an all-staff huddle conducted at 2:00 PM, staff were talked with about checking with residents to see if they needed assistance. On 1/31/26 a note was added of a report staff were slow, a bath offered, and the resident refused. A second page Statement Form dated 1/31/26 documented follow up with Resident #45 on the grievance. The resident reported staff taking care of him were slow. The form also recorded staff reported Resident #45 cursed them out and he was very rude and mean. The form lacked any documentation of further follow up or interview with the resident to determine if resolved or report what action was taken to actually resolve his concern. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 2/1/26 signed by the Administrator as resolved on 2/1/26 recorded Resident #78 reported a concern with CNAs telling him they could not toilet him because they didn't have an EZ stand (sit-to-stand mechanical lift). The Grievance Official Follow-Up section documented the CNA reported that the EZ stand was not available, she helped the resident to use a urinal, and she found an EZ stand to help him. The form lacked any documentation of further follow up or interview with the resident to confirm resolution. The Grievance Form dated 2/4/26 signed by the Administrator as resolved on 2/4/26 recorded Resident #43 reported not getting checked and changed on the last 3 overnight shifts. The Grievance Official Follow-Up section documented the care need was placed on the TAR (Treatment Administration Record), they would place the resident to get woken up between 3 to 4 AM to be checked and changed. The form lacked any documentation of further follow up or interview with the resident to confirm resolution. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 2/6/26 signed by the DON as resolved on 2/6/26 recorded a family member of a resident who formerly resided in room [ROOM NUMBER]-A reported a concern that the resident turned on the call light at 6:10 PM while the family member was on the phone with the resident and on the phone until 6:45 PM and no one had been in to help the resident. The Grievance Official Follow-Up section documented it was discussed during huddle the expectations of call lights. The form lacked any documentation of further follow up or interview with the resident, family member, or staff whether the call light response times were corrected. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 2/15/26 signed by the Administrator as resolved on 2/15/26 recorded Resident #30 complained staff let another resident yell in the hallway while staff were laughing at him and he reported call lights taking an hour and a half on the 200 Hall. The Grievance Official Follow-Up section documented the staff were educated on 2/15/26 about call lights and residents yelling. The form lacked any documentation of further follow up or interview with the resident or staff about the call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and facility policy review, the facility failed to ensure nursing staff demonstrated the competencies and skills necessary to provide nursing services that met residents' needs. This was evidenced by Certified Nursing Assistants (CNAs) failing to perform proper hand hygiene, provide appropriate incontinence care, and demonstrate knowledge and implementation of Enhanced Barrier Precautions (EBP) and other infection prevention and control practices for 4 residents whose care was observed (Resident #83, #85, #52, #73). The facility also failed to ensure licensed nursing staff possessed the knowledge and competencies necessary to assess, monitor, and provide individualized, person-centered care based on residents' clinical conditions. This was evidenced by a nurse's inability to accurately identify and communicate Resident #83's and Resident #85's baseline status, current condition, changes in condition, and coordination of care with healthcare providers. The facility reported a census of 81 Residents. Findings include: 1. Resident #83's Minimum Data Set (MDS) assessment dated [DATE] documented a score of 2, indicating severe cognitive impairment. The MDS recorded active diagnoses of Down syndrome (a genetic disorder causing developmental delays), a hip replacement, a wound infection, adult failure to thrive (unexplained physical decline), and pressure ulcers. The MDS also documented that Resident #83 required substantial to maximal assistance to total dependence for walking. Review of Resident #83's Care Plan documented a focus area initiated 10/31/25 for a communication deficit as evidenced by difficulty understanding others or difficulty being understood. Resident #83 required full staff assistance with dressing and incontinence care, and the assistance of two staff members with the use of a mechanical lift for transfers. Another focus area identified Resident #83's potential for impaired skin integrity related to incontinence, a cognitive communication deficit, and wheelchair dependence. Interventions directed staff to monitor and document the location, size, and treatment of skin injuries, report abnormalities or a failure to heal, and monitor for signs and symptoms of infection. Staff were also directed to utilize enhanced barrier precautions (EBP) related to pressure ulcers on both hips and buttocks. Review of Resident #83's Electronic Health Record (EHR) revealed documentation of erythema (superficial skin redness) to the left hip and thigh on 4/30/26. The record showed a provider evaluation and orders for an antihistamine to treat a rash for three days, along with instructions for continued monitoring and to report to the provider if no improvement occurred. On 5/1/26 Resident #83's EHR documented a provider encounter that noted a rash to the left lower extremity with no significant improvement. The area remained red, blotchy, and showed increased warmth. The provider diagnosed left leg cellulitis (a bacterial skin infection), ordered staff to stop the antihistamine, and directed them to start antibiotics twice daily for 10 days. A nursing progress note dated 5/2/26 at 10:18 AM documented Resident #83 had a temperature of 99.2 degrees Fahrenheit. Staff administered Tylenol with effectiveness and gave the antibiotic for the rash, noting the redness lessened since the prior day. On 5/2/26 at 8:14 PM a nursing progress note stated that after further assessment of Resident #83 and a discussion with Resident #83's Power of Attorney (POA), staff determined Resident #83 needed a transfer to the emergency room (ER) for further evaluation. The note recorded that Resident #83's left lower extremity rash didn't appear to improve and spread to the right lower extremity. Resident (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#83's vital signs showed a temperature of 99.2 degrees Fahrenheit, a blood pressure of 89/43, a heart rate of 101, and an oxygen level of 93% on room air. Resident #83 didn't eat supper but drank a full glass of chocolate milk. Review of ER notes dated 5/2/26 documented Resident #83 arrived via ambulance for a rash. Facility staff reported to emergency medical services (EMS) staff that the patient developed a rash and became hypotensive (having low blood pressure) a few days ago. Resident #83 presented with a right lower and left lower extremity rash that went up and down his legs, and his left calf appeared redder and more swollen. The facility reported his systolic blood pressure (top number of blood pressure) hadn't risen above 80 for the past two days, with no fevers or chills. The history obtained from the facility nursing staff indicated that two days ago Resident #83 developed a rash on the left side of his body, received a prescription for an antihistamine, and yesterday received a prescription for antibiotics. That morning the rash spread, his temperature reached 99 degrees Fahrenheit, his systolic blood pressure stayed in the 80s, and staff noticed increased lethargy and a lack of eating. Further review of Resident #83's ER documentation on 5/2/26 at 9:23 PM stated that Resident #83's sister called requesting an update. A registered nurse (RN) relayed that Resident #83 would undergo admission to the hospital for intravenous (IV) antibiotics. Resident #83's sister reported that she visited the facility yesterday and strongly encouraged that the patient goes to the hospital. The sister reported the facility told her they would start antibiotics and re-evaluate. Review of the hospital Discharge summary dated [DATE] stated Resident #83 underwent admission from his facility on 5/2/26 for sepsis (a life-threatening systemic response to infection) related to left lower extremity cellulitis. Resident #83 presented with a rash, swelling, and hypotension. Review of Resident #83's vital signs revealed the following documentation: 4/30/26 at 2:36 AM: temperature 98.4, blood pressure 117/60, pulse 81, oxygen 95% on room air; 5/1/26 at 3:16 AM: temperature 98.8, blood pressure 124/68, pulse 78, oxygen 94% on room air; 5/1/26 at 4:28 PM: temperature 101.3; 5/1/26 at 6:27 PM: temperature 98.8; 5/2/26 at 1:38 AM: temperature 98.4; 5/2/26 at 10:19 AM: temperature 99.2; 5/2/26 at 7:50 PM: temperature 99.2, blood pressure 89/43, pulse 101, oxygen 93% on room air. On 5/12/26 at 9:22 AM during a confidential interview, an interviewee stated that in regard to Resident #83's rash, hospital admission, cellulitis, and sepsis, the Director of Nursing (DON) stated, well, I probably would have recognized it if I had seen it. On 6/3/26 at 11:10 AM during an interview, an EMS provider stated that on 5/2/26 she helped transport Resident #83 from the facility to the ER for an evaluation of what staff called in as a rash. Once at the facility, the EMS provider saw that Resident #83's rash covered both legs all the way up to his waist. A facility nurse told the EMS provider that the rash developed over two days. The EMS provider noted that the nursing staff should've known medical interventions were required before they called for a transport, and she stated that staff had no idea what Resident #83's baseline function (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was. On 6/3/26 at 12:45 PM during an interview, a hospital Social Worker reported that when Resident #83 was seen in the ER and underwent admission to the hospital, the facility nurse reported Resident #83 developed a rash and became hypotensive a few days ago. The hospital Social Worker stated a facility nurse told her, I don't know much about this Resident. When the hospital Social Worker asked to speak with another staff member who knew Resident #83, the facility nurse informed her no one else worked who could give an update because it was the weekend. The hospital Social Worker stated Resident #83's sister requested that the facility send Resident #83 to the ER on [DATE], but the facility declined and stated they wanted to try antibiotics first. On arrival at the ER, EMS staff informed the hospital Social Worker and ER nurses that Resident #83's antibiotics were discontinued and the facility wasn't administering them. The transport staff also reported that no staff on duty at the facility could answer questions about Resident #83's baseline, current concerns, or the reason for the transfer. The hospital Social Worker also noted that Resident #83's incontinence brief was dry on arrival, but the transfer linens underneath him were saturated with urine, indicating the facility staff quickly changed Resident #83's brief before transport but didn't change the linens. 2. Resident #85's Minimum Data Set (MDS) assessment dated [DATE] revealed a score of 4, indicating severe cognitive impairment. The MDS recorded active diagnoses of a stroke, aphasia (a language disorder affecting speech and comprehension), hemiplegia (one-sided paralysis), dysphagia (difficulty swallowing), and a neurogenic bladder (a nerve-related loss of bladder control) requiring a catheter. The MDS documented a physical impairment to one side of the upper extremities and an impairment to both sides of the lower extremities. The MDS recorded Resident #85 as dependent on the assistance of two staff members with the use of a mechanical lift and a wheelchair for mobility. The MDS failed to document Resident #85's gastrostomy feeding tube (G-tube) for feeding and nutrition. Review of Resident #85's Care Plan documented a focus area initiated 9/4/25 that identified Resident #85 ran a risk for altered nutrition and hydration status related to cognitive status, a post-stroke condition, a feeding tube, a foley catheter, and being bed or chair bound. Interventions included monitoring for signs and symptoms of intolerance with G-tube feedings. A focus area initiated 7/29/25 noted Resident #85 required tube feeding related to dysphagia secondary to a stroke. Interventions specified that Resident #85 stayed dependent on tube feeding and water flushes, and directed staff to see physician orders for current feeding orders. Further review of the care plan documented a need for enhanced barrier precautions (EBP; clinical infection control practices) because Resident #85 utilized a G-tube and a foley catheter, and had a pressure ulcer. Review of Resident #85's EHR revealed that on 5/6/26 a Dietitian recommended that staff hold G-tube feedings for six nights. The Dietitian recorded that she would plan to re-assess in one week, and asked if the provider agreed to hold the feeding for six nights and complete weekly weights for four weeks, noting a copy went to the physician for review. Review of Resident #85's Nursing Progress Note dated 5/12/26 at 4:16 PM documented that a weight note came back signed by an Advanced Registered Nurse Practitioner (ARNP) with an order that stated it was okay to follow the recommendations. Review of Resident #85's May 2026 Medication Administration Record and Treatment Administration Record (MAR/TAR) revealed an order to connect the feeding tube from 9:00 PM to 3:00 AM for Osmolite 1.2 at 96 mL/hr. The order carried a start date of 4/25/25, a hold date starting 5/12/26, and (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a discontinued date of 5/15/26. The documentation indicated that nursing staff held the G-tube feeding as ordered on 5/12/26, 5/13/26, and 5/14/26. On 5/15/26 at 3:17 PM the Dietitian documented that Resident #85 stated he did well with the feeding holds. The note recorded that his Osmolite 1.2 at 95 mL/hr., which started at 9:00 PM and ended at 3:00 AM, stayed on hold. The note featured a message asking to extend the hold for the feedings through 5/21/26, and the Dietitian provided the note for advisement. On 5/15/26 at 4:49 PM an MDS Coordinator documented a new order to continue the hold for the G-tube feedings until 5/21/26 for Resident #85. The note recorded that Resident #85 stayed on a regular diet and ate three meals per day and snacks. Review of Resident #85's EHR revealed an order entered by the MDS coordinator on 5/15/26 at 3:46 PM. The order instructed staff to connect the feeding tube from 9:00 PM to 3:00 AM for Osmolite 1.2 at 95 mL/hr. The scheduling details specified that the order applied every day at bedtime, carried a start date of 5/15/26, and carried an end date of 5/21/26 at 11:59 PM. The May 2026 MAR/TAR indicated an order with a start date of 5/15/26 to connect the feeding tube from 9:00 PM to 3:00 AM for Osmolite 1.2 at 95 mL/hr. at bedtime until 5/21/26. The documentation indicated that staff administered feeding via the G-tube on 5/15/26 and 5/16/26, held it on 5/17/26, 5/18/26, and 5/19/26, and administered it on 5/20/26 and 5/21/26. An order for a 60 mL water flush every hour via the G-tube from 9:00 PM to 3:00 AM carried a start date of 4/25/26, and the documentation indicated that staff completed the water flushes as ordered for 30 or 31 days. On 5/22/26 at 10:52 AM the Dietitian documented recommendations to discontinue the G-tube feedings and the hourly water flushes during feeding. The note asked if the provider agreed to discontinue the feedings and flushes, and the Dietitian noted a copy went to the physician for advisement. On 5/19/26 at 4:42 PM during an interview, Staff U, LPN, confirmed he worked overnight shifts on 5/15/26 and 5/16/26. Staff U stated he connected and administered Resident #85's feeding on Friday 5/15/26 as the MAR indicated. On Saturday 5/16/26 Staff U stated he didn't administer the feeding as indicated on the MAR. He noted that during the shift change report, he learned that Resident #85's feeding required a hold, but he couldn't find an order in the Electronic Health Record stating that the feeding stayed on hold or discontinued. On 5/21/26 at 11:17 AM witnessed a bottle of Osmolite with 400 mL remaining and a feeding bag with 500 mL of water hung on a pole with tubing inserted through the feeding pump. Both the bottle of feeding and the bag of water lacked a date of use. A feeding syringe and a graduate sat on the bedside table labeled 5/20 PM. On 5/27/26 at 3:57 PM during an interview with the DON, the MDS Coordinator, the Facility Administrator, a Rehab Director, Staff O, Rehab, and a Regional Director of Operations, the recommendations made by Staff G, Dietitian, for Resident #85 underwent a review that highlighted concerns related to communication with the provider, the timing of communication, and the nursing process for completing orders. Staff answered several questions regarding the expectations for nursing communications with the physician, the procedure for processing orders, and nursing documentation to obtain clarification. The DON provided brief responses in a dismissive tone, stating that the Dietitian makes recommendations and puts them in the provider's box for review, and once (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the provider reviews them, the nurse processes any changes. After questioning about the timeframe for reviewing these recommendations, the DON stated that the provider came onsite every Thursday and reviewed them at that time. The DON didn't feel that the timeframe from when staff made recommendations to when the provider reviewed them and just processed the order represented a concern. During the interview, a lack of response from the Facility Administrator and the DON's tone and manner of communication suggested irritation, which affected the flow and depth of the interview. On 6/1/26 at 2:49 PM the feeding pump was no longer seen in Resident #58's room. On 6/3/26 at 11:30 AM further review of Resident #85's EHR failed to indicate that the Dietitian's recommendations on 5/22/26 to discontinue the G-tube feedings and water flushes had been communicated to, reviewed by, or approved or declined by the physician. In a communication received via email on 6/9/26 at 11:50 AM the facility's Regional Director of Operations stated that after reviewing Resident #85's record and the sequence of events, management agreed that the concern centered on the communication, transcription, and follow-up process related to the dietitian's recommendations and the G-tube feeding order. She noted that the provider reviewed Staff G's recommendation to hold the G-tube feeding on 5/12/26. The subsequent recommendation on 5/15/26 to extend the hold through 5/21/26 underwent review and received approval from the provider the same day. The hold was accurately reflected in the progress note; however, when staff entered the order onto the MAR, the wording didn't clearly reflect that the feeding had to remain on hold through 5/21/26. This created the potential for inconsistent interpretation by nursing staff. The facility recognized that after the hold period ended on 5/21/26, staff should've obtained clarification timely regarding whether the feeding had to resume, remain on hold, or be discontinued. The Dietitian re-evaluated the resident on 5/22/26 and recommended the discontinuation of the feedings and flushes. The provider has since reviewed the resident, including seeing the resident last week, and the facility has ensured that the current order status has been clarified and accurately reflected. She added that regarding the order review process, transcribed and processed orders are reviewed by the nurse entering the order, and then another licensed nurse on the following shift reviews it as part of the facility's order verification process. A third level of review occurs through clinical oversight by a designee during a clinical review, a record review, or a morning clinical meeting to ensure that orders, progress notes, and provider recommendations stay consistent. The facility's expectation is that staff communicate provider recommendations related to nutrition, enteral feedings (tube feedings), or other resident-specific interventions to the provider timely and follow up on them until the provider gives direction. If an unclear order, discrepancy, or change in a stop date occurs, nursing staff are expected to contact the provider for clarification before continuing or discontinuing the intervention. The facility provided Care and Treatment of Feeding Tubes Policy dated March 2019 directed that feeding tubes will be utilized according to physician orders, which typically include the kind of feeding and its caloric value, volume, and duration. The policy instructed that the facility will utilize the Registered Dietitian in estimating and calculating a resident's daily nutritional and hydration needs. The policy stated that the facility will notify and involve the physician or designated practitioner of any complications, and in evaluating and managing care to address the complication and risk factors. 3. On 5/13/26 at 4:46 AM watched Staff A, CNA, and Staff B, CNA, enter the room of Resident #83 without donning personal protective equipment (PPE). A sign on the outside of the door indicated EBP in place. Staff B donned gloves, removed them, went to place them in an oral container in the (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #73. Staff H returned and reported to Staff TT that the juices did Resident #73's wound care first thing in the morning. Resident #73's blanket pulled back to reveal the brief indicator with solid blue lines in front, and a very strong ammonia smell filled the room. Staff H used a remote to raise the bed and adjusted her gripper socks. Resident #73's left leg lay marked with a black line to outline an area of cellulitis, and she cried out a bit when the sock moved. Staff H lowered the bed to move it away from the wall, then raised it back up. Staff TT grabbed and opened a new brief and placed it on the foot of the bed. Staff TT removed the tabs of the brief while holding wipes, cleansed the right-side abdominal fold, then the left side with a new wipe, and then down the center. Staff H rolled Resident #73 to her left side, and Staff TT pulled the brief, which lay heavily soiled with urine and feces. Staff TT wiped from front to back across the rectal area and part of the left buttock. Staff saw a bandage marked with a dressing on the back of her lower left thigh just above the knee. Staff rolled her back and failed to change soiled gloves or sanitize their hands prior to placing a new brief, and failed to cleanse all areas where the brief contacted her skin. Staff H finished pulling out the soiled brief, and the new brief lay placed with the same soiled, contaminated gloves. Both staff then removed their gloves and gathered the trash. Staff H washed her hands and Staff TT sanitized her hands and donned new gloves. Staff TT returned to the bedside to pull up her pants to thigh level, then helped rotate her to the edge of the bed to connect the lift. Without washing hands, staff removed the oxygen tubing, and Staff TT rolled it up and placed it in a bag on the oxygen concentrator. Staff helped Resident #73 doff her hospital gown and don a shirt. The lift sling lay placed on top of the fitted sheet in the same location where the heavily soiled brief had been, which contaminated the area. Both staff connected the sling loops, selecting the third green and second black loops. Staff TT ran the controls and instructed the resident to stand up tall. Staff H unlocked the lift while Staff TT and Staff H pulled up her pants, moved her to the wheelchair, and placed a safety strap around her. Staff H removed the sling, hung it over the machine, and both staff continued to touch items with contaminated gloves. Staff H put leg foot pedals on the wheelchair and stated one pedal lay broken, which was why they used a pillow to hold it in place. Staff H voiced it wasn't the best option but they were working on ordering a new one. Staff F put a wedge cushion in place under the resident's feet because her feet sat approximately six inches from touching the pedals. Staff H stated Resident #73 needed a new oxygen tank set up by the nurse. Staff TT combed the resident's hair. Staff H left the room with soiled trash and linens and stated she would return for the lift. Staff H failed to wash her hands after removing her gloves or the lift machine.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and staff interviews, the facility failed to post the daily staffing report as required in a public location for residents and visitors to see on a daily basis. The facility reported a census of 81 residents. Findings include: Observation on 5/23/26 at 7:07 PM revealed the daily staffing report posted by the east entrance before the dining/activity room. The print was very small and hard to read from greater than 12 inches away and standing at an approximate height of 5 feet. The daily posting papers were kept in a page protector sleeve and several forms were in it. Further observation revealed the top page dated 5/20/26 and all other forms behind that page dated prior to 5/14/26, and no posting since 5/20/26 found in the facility anywhere else. On 5/23/26 at 7:18 PM, when asked about the daily staff posting and where it could be found in the facility, Staff J, Licensed Practical Nurse (LPN), responded that the current staffing schedule was in the staff breakroom. On 5/23/26 at 7:39 PM, Staff C, Registered Nurse (RN) responded he knew nothing about the daily staff posting. On 5/23/26 at 7:47 PM the Administrator was asked to provide a copy of the staffing assignments for Saturday through Monday from the breakroom, as the daily staff posting was not current. The Administrator provided the daily hall assignment sheets to indicate which staff were assigned to which hall, but it failed to contain the requirements of the staff posting as to the total number and actual hours worked by nursing staff and no public posting was done after the request. Observation on 6/1/26 at 3:20 PM revealed the daily staff posting pinned in a page protector sheet on a bulletin board near the east entrance to the building. Observation revealed the most current daily staff information dated 5/28/26 with several sheets behind that page starting with 5/20/26, then 5/14/26, 5/13/26, 5/11/26, 5/6/26, 5/5/26, 5/4/26, 1/13/26 with no other sheets in the stack. On 6/1/26 at 3:25 PM the Administrator responded she did not know why the daily staff posting only had 5/28/26 as the most recent posting. The Administrator stated the scheduler was responsible to post the daily staff schedule. When asked who would post the schedule on weekends when the scheduler was gone, the Administrator responded that it was a good question and provided no other answers.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility policy review, the facility failed to administer insulin medication as ordered for Resident #79 and failed to discontinue an anticoagulant (blood thinning) medication for Resident #52, for 2 of 2 residents reviewed for significant medication errors. The facility reported a census of 81 residents. 1. Resident #79's Minimum Data Set (MDS) assessment dated [DATE] showed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented active diagnoses of hypertension (high blood pressure), diabetes mellitus (chronic high blood sugar), anxiety (excessive persistent worry), and depression (persistent sad mood). Review of Resident #79's physician orders dated 4/16/26 revealed orders for Insulin Lispro injection 100/milliliters, with instructions to inject as directed three times daily after meals and within 30 minutes of meal completion. The ordered dosage depended on meal consumption: 3 units if 25% of the meal was consumed, 6 units if 50% was consumed, 9 units if 75% was consumed, and 12 units if 100% was consumed. The orders also included a mealtime correction factor to give 1 additional unit of insulin for every 50 points over 150: an additional 1 unit for blood sugar levels between 150-200, an additional 2 units for 200-250, an additional 3 units for 250-300, an additional 4 units for 300-350, an additional 5 units for 350-400, and an additional 6 units if the level rose over 400. Review of the May Medication Administration Record (MAR) revealed that staff did not administer the scheduled insulin to Resident #79 on May 2nd and May 12th, noting it as a duplicate order. On 5/14/26 at 4:04 PM, Staff J, Licensed Practical Nurse (LPN), stated she must've misread the order. She noted Resident #79 previously stayed on only the sliding scale insulin, and she acknowledged she didn't give the insulin on those days. On 5/14/26 at 4:42 PM, the Director of Nursing (DON) verified Resident #79 had two different insulin sliding scale orders and stated she'd have expected the nurse to verify and administer the insulin according to the order. The Medication Administration policy revised January 2025 directed that licensed nurses or other staff legally authorized in this state administer medications as ordered by the physician. It instructed staff to follow professional standards of practice to prevent contamination or infection and to ensure compliance with the six rights of medication administration: right resident right drug right dosage right route right time right documentation. (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The policy further directed staff to review the MAR to identify medications for administration and compare the medication source with the MAR to verify the resident's name, medication name, form, dose, route, and time. Consult reference materials if unfamiliar with a drug's mechanism or side effects, Administer doses within 60 minutes before or after the scheduled time unless otherwise ordered. 2. Resident #52's MDS assessment dated [DATE] identified a readmission date of 2/24/26. Under the High-Risk Drug Classes: Use and Indication section, the MDS recorded that Resident #52 took an anticoagulant medication (blood thinner) in the seven days or less since admission, and noted an indication for use. Review of Resident #52's Care Plan dated 3/12/26 documented a focus area revised 8/4/25 that identified Resident #52 stayed on anticoagulant therapy related to a history of deep vein thrombosis (DVT; blood clot in a deep vein) and pulmonary embolism (PE; blood clot in the lungs). A care plan intervention dated 8/19/25 directed staff to administer anticoagulant medications as ordered by the physician and to monitor for side effects and effectiveness every shift. The Summary of Hospitalization dated 2/24/26 recorded Resident #52 underwent admission on [DATE] and discharge on [DATE] for acute blood loss anemia (low red blood cells from bleeding) secondary to vaginal bleeding. The Hospital Course section documented that Resident #52 took Xarelto for a history of DVT and PE, required treatment with one unit of packed red blood cells, and that hospital staff held the Xarelto on admission, which resolved the vaginal bleeding. The summary recorded multiple discussions with Resident #52 and her family regarding her history, noting there stood no specific reason for chronic anticoagulation given her vaginal bleeding and multiple previous episodes of gastrointestinal (GI; stomach or intestines) bleeding. The document stated that hospital staff discontinued the anticoagulation. The discharge medication list under Medications to Continue didn't list Xarelto, and under Stopped Medications it recorded rivaroxaban 20 milligram tablets, commonly known as Xarelto. The Medication List at discharge on the final two pages didn't contain rivaroxaban or Xarelto. Review of the February, March, and April 2026 MARs revealed an entry for the administration of Xarelto 20 milligram tablets by mouth daily with supper. The records indicated Resident #52 received the medication on: 2/1 through 2/18, and 2/26 through 2/27 3/1, 3/7, 3/13, 3/15, 3/17, and 3/22 4/2, 4/4 through 4/6, 4/10, 4/12, 4/14, and 4/18 through 4/19, 4/21, and 4/26 The February, March, and April 2026 MARs recorded Resident #52 didn't receive the medication on the following dates due to refusals or hospitalization: 2/19 through 2/23 due to hospitalization, and 2/24, 2/25, and 2/28 due to refusals 3/2 through 3/6, 3/8 through 3/12, 3/14, 3/16, 3/18 through 3/21, and 3/23 through 3/31 due to refusals (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/1, 4/3, 4/7 through 4/9, 4/11, 4/13, 4/15 through 4/17, 4/20, 4/22 through 4/25, and 4/27 through 4/28 due to refusals A printed Progress Note dated 4/28/26 at 9:56 PM documented a communication with the physician written by Staff W, Registered Nurse (RN). Staff W reported Resident #52 refused her Xarelto for the past two months because it'd been discontinued during her hospitalization for vaginal bleeding. Staff W wrote that the facility didn't possess written orders to discontinue the medication, noted Resident #52 didn't plan to take it, and asked the physician to consider an order to discontinue it. The physician's handwritten response noted he spoke with the patient, who stated she didn't want to take the prescription anymore since hospital staff discontinued it during her last stay for vaginal bleeding. The physician wrote that review of the discharge summary confirmed the discontinuation, and he chose to follow that recommendation. A Progress Note dated 4/29/26 recorded a visit completed by the Nurse Practitioner (NP). The entry documented that Resident #52's vaginal bleeding resolved after inpatient treatment and noted the anticoagulation discontinued during the last hospitalization, yet it stayed active on the MAR and the patient refused it. The note recorded that the NP discontinued the Xarelto as recommended. Review of the Order Recap Report run on 5/21/26 at 11:25 AM identified that the order for Xarelto 20 milligram tablets daily with supper started on 10/2/25 and ended on 4/29/26. Review of the care plan revealed it lacked revision to reflect that Resident #52's anticoagulant medication was discontinued on 4/29/26. On 5/21/26 at 1:00 PM, Staff F, MDS Coordinator, stated she didn't know Resident #52's anticoagulant medication was discontinued and noted the care plan required revision when that occurred. Staff F stated that the pharmacy puts orders directly into the system from the hospital, and she noted the facility faxed over discharge orders so the medications can be delivered. Staff F stated that the hospital discharge summary is faxed to the pharmacy, which inputs the medication orders, while facility protocols and additional orders are transcribed by facility nurses. The DON stated that nurses must double-check the transcription of orders because they have other orders to enter, and she noted that nurses stay responsible for reviewing hospital discharge summaries. The DON stated that the process for frequent refusals should be for the charge nurse to notify the doctor.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, observation, staff interview, and facility policy review, the facility failed to revise the facility assessment as needed to identify the changes to the leadership team, the high number of residents who required assistance with transfers and incontinence care, and how those changes directly impacted the assessment and determination of how many staff were needed to meet resident needs. The facility assessment affects all residents in the building and the facility reported a census of 81 residents. Findings include: The Facility assessment dated [DATE] documented it was last reviewed May 2026 with no changes needed. The assessment failed to contain updates in recent leadership changes which included a new Director of Nursing (DON), MDS (Minimum Data Set) Coordinator, and Administrator in September 2025, October 2025, and January 2026 respectively. The assessment contained names of leaders no longer employed by the facility. The Facility Assessment identified 48 residents needed assistance with transfers and 53 assistance with toileting. The assessment documented on page 18 under Administration subsection that staffing patterns were regularly reviewed and adjusted to align with changes in resident acuity and care plans. The assessment documented on page 19 under other subsection that staffing for all other departments and support staff - including maintenance, housekeeping, laundry, administration, and activities- was adequate as evidenced by the facility's ability to maintain a safe, clean, and well-functioning environment that supports resident quality of life and regulatory compliance. The facility assessment documented on page 8 under Diseases/Conditions & Physical/Cognitive Disabilities for Which We Provide Care, the Infectious Disease row in the table identified 11 residents who were on EBP (Enhanced Barrier Precautions) and 1 acute infection. Observation and initial tour of the facility on 5/11/26 at 1:50 PM revealed 19 rooms had signs outside the doorways identifying a resident in the room required Enhanced Barrier Precautions. The signs did not contain which side of the room impacted, if one or both residents were on precautions. The facility provided a resident roster dated 5/18/26 denoting a census of 84 that day and recorded each residents' level of assistance needed for transfers and whether they had incontinence. The roster documented a total of 64 residents requiring assistance with transfers and 9 required an EZ sit-to-stand mechanical lift and 20 required a Hoyer full body mechanical lift. The roster documented 79 residents had experienced incontinence; only 6 of the 79 residents identified as mixed incontinence meaning sometimes continent, the other 73 marked as fully incontinent. The roster contained the following numbers per hallway: 100 Hall - 29 residentsTransfers - 8 independent, 9 assist of 1 person for transfers, 2 assist of 2 persons, 3 EZ stand mechanical lift, 5 Hoyer full body mechanical lift with assist of 2 personsIncontinence - 25 residents incontinent and 4 continent.200 Hall - 36 residentsTransfers - 4 independent, 14 assist of 1 person for transfers, 4 assist of 2 persons, 4 EZ stand mechanical lift, 10 Hoyer full body mechanical lift with assist of 2 personsIncontinence - 25 residents incontinent and 4 continent.300 Hall - 14 residentsTransfers - 3 independent, 3 assist of 1 person for transfers, 2 assist of 2 persons, 2 EZ stand mechanical lift, 4 Hoyer full body mechanical lift with assist of 2 personsIncontinence - 8 residents incontinent, 6 residents mixed incontinence, and 0 continent.400 Hall - 3 residentsTransfers - 3 independentIncontinence - 2 residents incontinent and 1 continent.500 Hall - 3 residentsTransfers - 1 independent, 1 assist of 2 persons, 1 Hoyer full body mechanical lift with assist of 2 personsIncontinence - 3 residents incontinent and 0 continent. The facility assessment failed to reflect the current resident needs for May 2026 or how staffing patterns were reviewed to address the increase in resident care needs. The current survey identified F725 failure to have sufficient nursing staff to provide for resident needs. On 6/1/26 at 3:25 PM the Administrator confirmed she signed the May 2026 review and that the Facility Assessment needed no changes. After reviewing the (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	failure of the Facility Assessment to reflect the recent leadership changes, inaccurately reflect the vast number of residents who required transfer and toileting assistance, and the high number of residents on Enhanced Barrier Precautions, the Administrator was asked to respond to why the assessment was signed as needing no changes. The Administrator responded she would need to find the assessment to look at it before answering. The Administrator failed to provide any further response during the survey. The facility policy titled Facility Assessment revised July 2025 included the following documentation: Policy: This facility conducts and documents a facility-wide assessment to determine what resources are necessary to care for our residents competently during both day-to-day operations (including nights and weekends) and emergencies. The purpose of this policy is to establish responsibilities and procedures for the facility assessment process. Policy Explanation and Compliance Guidelines: .3. The facility will use the facility assessment to: a. Inform staffing decisions to ensure that there are a sufficient number of staff with the appropriate competencies and skill sets necessary to care for its residents' needs as identified through resident assessments and plans of care. b. Consider specific staffing needs for each resident unit in the facility and adjust as necessary based on changes to its resident population. c. Consider specific staffing needs for each shift, such as day, evening, night and adjust as necessary based on any changes to its resident population. d. Develop and maintain a plan to maximize recruitment and retention of direct care staff. e. Inform contingency planning for events that do not require activation of the facility's emergency plan, but do have the potential to affect resident care, such as, but not limited to, the availability of direct care nurse staffing or other resources needed for resident care. 4. The Administrator is responsible for ensuring the completion of the facility assessment and maintaining all documents that pertain to the assessment. The Administrator serves as the leader of the facility assessment process, or may designate someone to lead the process.8. Based on the assessment of resident characteristics, the facility will determine what care/services, staff competencies, and staffing needs are required to meet the needs of our residents. This will be compared to the specific care/services, including by contract, and training that we provide. Action plans will be implemented as necessary.10. The facility assessment will be reviewed and updated as necessary and at least annually, whenever there is, or the facility plans for, any change that would require a substantial modification to any part of the assessment. Additionally, the facility will consider specific staffing needs for each shift (e.g., day, evening, night, weekend shifts) and for each resident unit in the facility based on changes to resident population. Any changes to the assessment will be documented, along with a revision history.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, resident and staff interviews and policy review, the facility failed to implement and practice infection control policies and practice Enhanced Barrier Precautions (EBP) according to resident care plans for 6 of 6 residents reviewed (Residents #19, #6, #83, #52, #85, and #73). The facility failed to practice appropriate infection control measures with soiled laundry and the delivery of clean laundry. The facility failed to implement an effective infection control program due to the lack of tracking records for the entire facility and antibiotic stewardship program from January 2026 to June 2026. The facility reported a census of 81 residents. Findings include:1.The Minimum Data Set (MDS) dated [DATE] for Resident #19 revealed the diagnosis of a non-pressure chronic (long term) ulcer of the left foot and contained a Multidrug-Resistant Organism (MDRO) that required surgical wound care. The Brief Interview for Mental Status (BIMS) score was a 15 that suggested an intact cognition. The Care Plan for Resident #19 initiated on 4/15/25 directed staff to follow enhanced barrier precautions (EBP), physician treatment orders and complete weekly wound assessments. During an observation on 5/12/2026 at 12:34 pm, Resident #19 had a white dressing to her left leg. There was no evidence of personal protective equipment (PPE) at Resident #19's door and the lack of a sign to notify staff to EBP guidelines. During an interview on 5/12/2026 at 12:31 pm, Resident #19 stated she was admitted on [DATE] after she fell at home, found after she was on the floor for multiple days. Resident #19 stated she had been going to the wound clinic. Resident #19 stated in October 2025, she had to be treated at the hospital for sepsis from the skin infection in her lower left leg and in December 2025 she had a wound graft surgery with a wound vac in January 2026. Resident #19 stated it was improving and the concern was they only wear gloves when they change the dressing. When inquired about handwashing and a gown, Resident #19 stated no. Resident #19 stated the wound clinic ordered a new dressing and the pharmacy had not delivered it yet so the nurse put on gloves and wrapped it in the white dressing. The Physician Order for Resident #19 revealed: Start on 5/11/26, Left Foot- Cleanse leg with soap and water, apply Hydrofera Blue, cut to size of wound bed, and cover with an ABD pad or small super absorber, wrap from toes to knee with Colfax Calamine every Monday and Thursday for wound care. On 5/13/26 EBP was ordered. The Progress Notes for Resident #19 revealed:On 5/14/2026 at 12:42 the wound observation and care was completed.The Resident #19 denied pain during treatment.Care plan was reviewed and resident education was provided.Wound 1: Left heel - Pressure: Length = 0.9, Width = 1.8, Depth = 0.2, - Stage IVWound in unresolvedThe wound had drainage present without an odor.The overall progress of wound healing: Improved During an interview on 5/28/2026 at 4:02 pm, The Director of Nursing (DON) stated for Resident #19 the new treatment dressings were delivered before the next dressing change. The DON stated the initial application was completed by the wound clinic. The DON stated her expectation was that the nursing staff would follow EBP with treatment dressing changes. The DON stated the new Infection Preventionist (IP) had EBP set up immediately after the interview with the surveyor. 2. The MDS dated [DATE] for Resident #6 revealed a diagnosis of MDRO and identified a urinary (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	catheter. Resident #6 was able to make herself understood and usually understood others. Resident #6 required maximal to dependency on staff for care. The Care Plan revised on 12/12/24 for Resident #6 directed staff to follow EBP as it relates to urinary output, incontinence and history of ESBL (Extended-spectrum beta-lactamases (ESBLs) are enzymes produced by bacteria that make them resistant to many common antibiotics, including penicillin and cephalosporins. These resistant bacteria (commonly E. coli or Klebsiella) cause infections&mdash;often urinary tract infections&mdash;that are harder to treat and require specialized antibiotics. They are a significant global public health concern, particularly in hospitals, and require strict infection control). During an observation on 5/12/2026 at 11:00 am, Resident #6 was in her room, sitting in a wheelchair. Resident #6 had a urinary catheter tubing that led to a urinary bag that was placed into a dignity bag attached to her wheelchair. There was no evidence of PPE at her door and no sign to notify staff to EBP guidelines. During an interview on 5/13/2026 at 11:40 am, Staff YY, Registered Nurse (RN) Infection Control Nurse stated her employment began 5/12/26 and was reviewing the infection control history at this facility. Staff YY was unaware that Resident #6 had an MDRO. During an interview on 5/13/2026 at 11:47 am, Staff ZZ, Certified Nursing Assistant (CNA) stated she was made aware of infection control directions with a resident by the sign on the door and the personal protective equipment placed at the resident door. Staff ZZ stated the facility provided plenty of gloves and gowns. When inquired about access to the care plan, Staff ZZ stated yes, she had access to the care plans. Staff ZZ stated she was unaware that Resident #6 required EBP due to the urinary catheter as there was no sign on her door or PPE. During an interview on 5/13/2026 at 12:48, Staff AAA, RN stated she had worked on the unit with Resident #6 for a month and denied knowledge that she required EBP. During an interview on 5/14/2026 at 10:18 am, Staff BBB, CNA stated she wore a gown and gloves and gathered Resident #6's bedding into a clear bag and took it to the laundry room and dropped it into a yellow barrel. 3. The MDS assessment dated [DATE] for Resident #83 identified a BIMS score of 02, which indicated severe cognitive impairment. The MDS documented the resident required substantial to maximal assistance with toileting hygiene and was always incontinent of bowel and bladder. The MDS listed diagnoses that included wound infection and pressure ulcer of the left hip, Stage 3 (full thickness tissue loss). The MDS recorded the presence of one unhealed, Stage 4 (full thickness tissue loss with exposed bone, tendon or muscle) pressure ulcer. The Care Plan dated 3/12/26 documented a focus area identifying the resident experienced mixed incontinence of bowel and bladder related to impaired mobility. The care plan interventions directed staff to check and change the resident before/after meals, with AM/HS (morning, bedtime), as needed, and to clean the peri-area with each incontinence episode. The interventions included staff should utilize a bolster to position between the legs to increase ease with cares due to forward flexion. Another focus area identified the resident had a pressure injury related to impaired mobility, dependent on wheelchair, dependent on staff for ADLs, incontinence, cognitive impairment, and impaired communication. The focus area identified 11/25/25 a Stage 3 pressure sore to the left hip. The care plan interventions directed staff to manage moisture by providing toileting at regular intervals, provide prompt incontinent care, and to utilize preventative skin care products. Observation on 05/13/2026 at 4:35 AM revealed upon entering the east end of 200 hall, a staff member exited room [ROOM NUMBER] and two large trash bags were placed on the floor just outside (continued on next page)		

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