

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

Printed: 10/09/2026
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 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 (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 seemed more antibiotic treatment. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 [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) (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 [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 (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 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 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. (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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] 8:59 AM - A Social Service note documented the writer followed up with the sending hospital (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 (continued on next page)		

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 pressureproducing 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: (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 vaccuum Resident Random#4 - toe with eschar Resident #7 - coccyx Resident #4 - buttock (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 periaarea/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 periaarea creases red and yeasty, right breast yeasty, abdominal folds red and yeasty 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 (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident #72 - small open area left abdominal fold Resident #41 - periarea 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 - periarea 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, 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 (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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: 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. (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 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 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 (continued on next page)		

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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. 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 (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	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 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 (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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 (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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. (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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 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. (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	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. b. Date 3/23/26 at 8:48 am pain rated as 6/10. c. Date 3/23/26 at 2:07 pm pain rated as 6/10. d. Date 3/23/26 at 7:55 pm through 3/24/26 at 7:16 am pain rated as 0 for numerical. A document dated 3/20/26 at 2:56 pm by Staff Y, Occupational Therapist (OT) as Resident #94's last day of services. Resident #94 had severe dependency on care givers to perform cares, required a mechanical lift for transfers. Resident #94 was alert and oriented during care provided with mild weight bearing to the right lower extremity. Resident #94 displayed increased behaviors that impacted engagement. No complaint of pain but displayed signs and symptoms as restlessness and increased agitation and the nurse was made aware. During an interview on 5/21/26 at 1pm, Staff Y, OT stated Resident #94 declined cognitively and became more agitated to the point that he was not following directives. Staff Y stated Resident #94 was good initially but was not eating. Staff Y stated Resident #94 pulled at the leg brace and the urinary catheter which could be indicators of discomfort. Staff Y stated therapy could not provide further effective treatment for Resident #94. During an interview on 5/21/26 at 11:32 am Staff O, Speech Therapist (ST) Rehabilitation Director stated Resident #94 was admitted to the facility from the hospital for therapy due to a repair of his leg. Staff O stated Resident #94 became agitated and confused during his stay. During an interview on 5/21/26 at 1:26 pm, Staff UU, Physical Therapy Assistant (PTA) stated Resident #94 was admitted for physical therapy. Staff UU stated Resident #94 was never 100% in thought, he required 1 step at a time directions then overtime he became more agitated and combative. Staff UU stated when she had asked Resident #94 if he had pain, he couldn't rate his pain but it was his body language, he rubbed and pulled at everything. Staff UU stated the nurses were aware of his discomfort. Staff UU stated the nurses were notified if a resident can or cannot participate in the therapy, and Resident #94 was to the point that he could not. Staff UU stated she did not remember helping with Resident #94 on 3/23/26. (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	During an interview on 5/21/26 at 12:24 pm, Staff BB, LPN stated at this facility, the certified medication aid (CMA) administers medication but she personally would conduct assessments of a resident if they have pain. Staff BB stated that would trigger a follow up in the computer for the nurse. Staff BB stated the CMA's do not conduct assessments, nurses have to, and there was an automatic order on every resident to assess pain every shift. Staff BB stated she provided care for Resident #94 on 3/23/26, asked if he had pain and used the PAINAD scale, but did not remember if he had pain. Staff BB stated she could not remember if she was notified Resident #94's recliner was tipped forward. Staff BB stated she was aware Resident #94 had a new abrasion on his arm, but unable to remember if she had assessed it. Staff BB stated she had assisted to transfer Resident #94 into the recliner with the mechanical lift. Staff BB stated Resident #94 was in a lot of pain but didn't think it was related to his surgical leg. Staff BB stated she could not remember if she had directed the CMA to administer something for pain. Staff BB stated she was working with the treatment cart and was certain she did not give a pain medication to Resident #94. Staff BB stated she was not aware that the Hospice nurse admitted Resident #94 and wrote an order for Morphine. During an interview on 5/21/2026 at 2:48 pm, Staff L, LPN stated she provided care for Resident #94 on 3/23/26 during the 2-10 pm shift. Staff L stated she was told Resident #94 was falling out of his 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 (continued on next page)		

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F 0697 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(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 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 (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	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 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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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. 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. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0600 Level of Harm - Actual harm Residents Affected - Some	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 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 hoier (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 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 (continued on next page)		

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

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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: 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: (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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. 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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 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). (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, family interview, resident interview, and staff interview, the facility failed to maintain an environment free of offensive odors, which were pervasive throughout the building during the majority of the survey period. The facility reported a census of 81 residents. Findings include: Observations and interviews on the following dates and times revealed: May 11, 2026: At 1:27 PM a strong, pungent, foul odor present in the breezeway connecting the back halls to the dining room and in the dining and activity areas on the facility's east end. Immediate observations across all hallways revealed multiple areas of noncompliance: a urine/ammonia smell on the 100 hallway, specifically outside Resident 81's room (118). a strong chemical smell outside rooms 106 (Resident #3 and Resident #43's room); this odor irritated surveyors' eyes and throat. construction occurring at the nurses station, where caution tape and orange cones marked the stripped flooring. a strong, pungent urine/ammonia odor outside rooms [ROOM NUMBERS]; the odor's strength irritated surveyor's throat and required them to plug their nose. a urine odor outside room [ROOM NUMBER] (Resident #83 and Resident #12's room). the urine odor continued down the hall outside rooms 306 (Resident #1 and Resident #16's room) and 307 (Resident #73 and Resident #52's room). At 2:13 PM the strong urine smell continued on the 300 hallway as the surveyor transitioned to the 200 hallway. A moderate aroma of ammonia present outside room [ROOM NUMBER] (Resident #72 and Resident #29's room). A strong urine ammonia odor was present outside room [ROOM NUMBER] (Resident #41 and Resident #26's room). The strong urine odor continued where the hallway turned 90 degrees to connect to the dining room. At 2:35 PM a strong urine odor present outside rooms [ROOM NUMBERS]. At 3:10 PM a strong, pungent body odor present throughout the dining room and activity rooms. At 4:36 PM the shower room door on the 100 hall wide open. A staff member transported a resident to the shower room and a very strong urine smell detected as the resident passed. May 12, 2026 At 10:45 AM in an interview, Resident #4's family member reported the staff fail to change the resident's incontinence brief often enough leaving the resident frequently wet, sitting in urine. At 12:08 PM a strong urine/ammonia odor present in Resident #73's room [ROOM NUMBER] while the resident was not present. At 12:13 PM a strong ammonia/urine odor identified in Resident #86's room, 308. At 2:23 PM in an interview, Resident #1 reported having to wait long periods of time after incontinence episodes for assistance to the bathroom. Observation revealed the presence of strong urine odor. May 13, 2026 At 4:30 AM Immediately upon entering the building, a strong ammonia/urine odor was identified. A half-full trash bag was attached to the outside of a 33 gallon soiled linen yellow barrel on hall 100. An unknown staff member exited room [ROOM NUMBER] with trash after providing care. At 4:35 AM two large trash bags rested on the carpeted floor just outside room [ROOM NUMBER] (Resident #93 and Resident #60's room) on the east end of hall 200; one bag contained trash and the other soiled incontinence linens. A staff member placed items in the bag, picked up both bags, and walked down the hall. A strong ammonia/urine odor present in hall 200 outside rooms [ROOM NUMBERS]. At 4:43 AM a strong ammonia/urine smell on hall 300 outside room [ROOM NUMBER] (Resident #83 and Resident #12's room). The odor continued down the hallway to room [ROOM NUMBER] (Resident #73 and Resident #52's room), where an open trash bag containing soiled incontinence briefs was open to the air. At 4:46 AM Staff A, Certified Nurse Aide (CNA), and Staff B, CNA, entered Resident #83's room. Staff performed incomplete incontinence care for Resident #83, who was heavily soiled with urine and feces. Staff A removed the soiled brief and left the room with the soiled bags of trash and linens, then (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	placed the trash in a bag on the floor in hall 300. Staff A placed the soiled linen bag in room [ROOM NUMBER] at the end of the hallway. The urine smell remained in the room after the staff provided incontinence care. At 5:06 AM a strong ammonia smell present throughout Resident #52's room. Staff B and Staff A performed incomplete incontinence care for Resident #52, whose brief was heavily soiled with urine and feces. Staff B left the room with a trash bag, returned, and stated she needed one more bag. At 5:18 AM, Staff B left the room with the soiled linen bag. The urine smell remained in the room after the staff provided incontinence care. At 5:20 AM Staff B took a trash bag into empty room [ROOM NUMBER], which staff used to place garbage bags and soiled linen bags on the tiled floor. Staff B responded during an interview that she noticed the urine odor throughout the building. Staff B acknowledged the smell was down the entire 300 hall and was present on the 100 hallway, speculating it came from the carpet. Staff B responded that she had told leadership about the terrible odor before, and that housekeeping cannot get the smell out. At 5:29 AM Staff C, Registered Nurse (RN), responded during an interview that he had not noticed a urine smell that night or previously, speculating the surveyor smelled it because CNAs had just completed incontinence care rounds or that he was just used to the smell. At 5:31 AM Staff A placed smaller bags of trash into the large bag of trash remaining on the floor of the 100 hallway, then removed it from the hallway. At 5:38 AM the vacant room [ROOM NUMBER] contained two large bags of trash tied shut but placed on the floor; a strong urine odor permeated the room. At 5:43 AM Staff D, CNA, exited room [ROOM NUMBER]. Staff D responded during an interview that she had not noticed an odor, speculating she was used to the building smell since she had worked there for three years. At 5:57 AM the Administrator entered the housekeeping room by the nurses station and told a staff member that a urine smell concern existed on hall 100 and she knew it was the carpet. At 5:58 AM Staff A responded during an interview that she had not really noticed a urine smell in the building, speculating the surveyor smelled it because staff had just completed rounds or that the smell occurred by housekeeping areas. Staff A stated she had never spoken to leadership about the odor. At 6:05 AM an unknown maintenance or housekeeping staff member observed running a carpet cleaner on the central breezeway hallway between the nurses station and the dining room. At 8:56 AM (Cluttered Environment) a pallet full of supplies delivered and dropped in the 300 hallway between rooms [ROOM NUMBERS]. Staff also placed a Hoyer (mechanical) lift on the opposite side of the hallway, reducing the width to less than the space a wheelchair requires to pass. The hallway also contained a nurses treatment cart, a medication cart, several three small drawer containers for Personal Protective Equipment (PPE), and the metal cart for room trays. May 14, 2026 At 7:00 AM immediately upon entering the facility a faint odor of ammonia/urine detected in the activity room area near the southeast entrance. At 7:31 AM a quarter of the way down the 300 hall, a strong overwhelming ammonia/urine odor present outside Resident #83's room (302) and continued to Resident #73's room (307). May 18, 2026 At 10:54 AM to 12:15 PM a strong pungent urine odor identified on the 300 hallway. No soiled linen bins available in the hallway. The strong odor caused surveyor a scratchy throat with burning sensation to the sinuses and eyes. At 12:50 PM (Sanitary Environment/Hazard) the 100 shower room door wide open, with no staff member present, with the sound of running water. Observation revealed the water trickling out of the shower hose because staff had not completely turned off the water. A single-blade shaving razor laid on the floor of the shower stall, approximately six inches from the drain. At 12:51 PM Staff E, CNA, transported a resident in a shower chair into the shower room. Staff E responded that she left the door open because housekeeping would be delivering items. Staff E donned a glove and picked up the razor after the surveyor pointed it out. At 2:12 PM the Director of Nursing (DON) responded during an interview that Resident #55, who was on a behavioral contract for inappropriate urination and (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	repeated housekeeping issues, likely caused the urine odor on the 300 hall. The DON responded she only occasionally smelled a urine odor on the 200 hallway and not on the 100 hall. The DON believed the maintenance person worked hard to keep up with cleaning the carpet. The DON responded she had not observed soiled linen or trash on the floor or in open garbage bags in hallways. The DON commented she had observed this practice when she started in September 2025, provided education, and expected staff to avoid placing soiled linen and trash bags directly on the floor. On 5/26/26 at 11:02 AM the Administrator responded that when she started in January 2026, she told staff to stop putting bags on the floor and to use the barrels. She procured large bags for staff to take dirty linens and trash back to the laundry in a timely manner, to remove the odor.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility grievance forms, resident interview, staff interview, and facility policy review, the facility failed to effectively resolve grievances and failed to document written outcomes on whether grievances were confirmed or not confirmed. The Monthly Grievance Logs from January through the beginning of May 2026 revealed a total of 75 grievances filed by 36 different residents, representatives, or staff (Resident #3, #5, #6, #8, #10, #15, #16, #20, #21, #22, #25, #30, #35, #36, #39, #43, #44, #45, #46, #49, #51, #52, #58, #59, #64, #66, #72, #73, #74, #78, #81, #83, #84, #85, #88, #92). The failure has the potential to impact all residents in the building, indicating a widespread issue. The facility reported a census of 81 residents. Findings include: Review of the monthly grievance forms revealed the following: The January 2026 Grievance Log form documented 31 grievances tracked for the month. The log contained a column titled Disposition of Grievance with an *. At the bottom of the form, it noted, * Disposition of Grievance: Confirmed/Not Confirmed, Resolved/Not Resolved. All but two of the entries recorded Resolved in the column and none of the rows indicated Confirmed or Not Confirmed. The Grievance Form dated 1/14/26 signed by the 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 form recorded no 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 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 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 form documented the issue resolved on 1/16/26 but lacked any documentation of follow up beyond 1/16/26 with the resident. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #44's family 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 form documented the issue resolved on 1/16/26 but lacked any documentation of follow up being conducted with the resident or whether the concern (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	regarding a rash treatment was confirmed. 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 form contained no information on whether the grievance was confirmed or not confirmed. 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 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 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 DON signed the issue as resolved on 1/21/26. The form lacked any documentation of further interview or follow up with the resident on resolution. The form contained no information on whether the grievance was confirmed or not confirmed. 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. On 1/30/26 the Administrator noted the resident reported the call light was better. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. 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. On 1/30/26 the Administrator noted the resident reported the call light was being answered. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. 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, and she talked with the resident who reported it was better on 1/30/26. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 1/29/26 signed by the Administrator as resolved on 1/30/26 recorded Resident #43 reported the overnight CNAs (Certified Nurse Aides) 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, they talked with the resident and she was happy with the staff response and the change. The form lacked documentation (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of any investigation done with specific staff regarding the lack of assistance on the overnight shift. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. The Concern/Recommendation form signed by the Director of Nursing (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. 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 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 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 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. 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 form lacked any documentation regarding interview or follow up with the resident who reported the concern on the outcome of the grievance and the line for notification of representative and whether it was documented left blank. The form contained no information on whether the grievance was confirmed or not confirmed. The February 2026 Grievance Log form documented 19 grievances tracked for the month. The log contained a column titled Disposition of Grievance with an *. At the bottom of the form, it noted, * Disposition of Grievance: Confirmed/Not Confirmed, Resolved/Not Resolved. All but two of the entries recorded Resolved in the column and none of the rows indicated 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 2/2/26 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 form lacked any documentation of further follow up or interview with the family member or resident regarding the concern of staff treatment and lacked a date of resolution. The form contained no information on whether the grievance was confirmed or not confirmed. 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 (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 form contained no information on whether the grievance was confirmed or not confirmed. The February 2026 Grievance Log documented the disposition of grievance received on 2/3/26 for Resident #85 as blank with a date of written decision blank. 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 February 2026 Grievance Log documented the disposition of grievance received on 2/4/26 for Resident #43 as resolved 2/4/26. 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 leaving the room, the oxygen was not reapplied, the daughter asked staff member to come back in and reapply the oxygen, and 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 Official Follow-Up section documented the Nurse Practitioner saw the resident on 1/19/26, the nurse and staff nurse listened to the concerns regarding the resident's health status, issues with the recliner and call light, and staff were educated with maintenance actively working on the recliner, labs and x-rays were ordered. The form lacked any documentation of further follow up or interview with the family member or resident to confirm resolution of the call light concern or whether the recliner and oxygen plugged in. 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 2/11/26 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. (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 form lacked any documentation of further follow up or interview with the resident regarding resolution. The form contained no information on whether the grievance was confirmed or not confirmed. 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 would like the staff to groom the resident better and would also like them to do a better job with keeping the room clean. The Grievance Official Follow-Up section documented the Administrator spoke with housekeeping to keep the room cleaned and to the CNAs to keep the resident groomed. The form lacked any documentation of further follow up or interview with the family member to ensure resolution or monitoring of cares to determine if needs met. 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. 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 form contained no information on whether the grievance was confirmed or not confirmed. 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, Certified Medication Aide (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 form lacked any documentation of further follow up or interview to investigate the concern or report back to the resident about resolution. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 2/16/26 signed by the Administrator as resolved on 2/18/26 recorded Staff II, Licensed Practical Nurse (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 form lacked any documentation of further follow up or interview with the resident regarding resolution or further investigation into the reason why the staff members did not provide care for such an extended period of time. The Grievance Form dated 2/19/26 signed by the Administrator as resolved (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	on 2/19/26 recorded Resident #6's family member reported a concern with the resident's hearing aides not being charged or batteries changed. Additionally the concern included that no one turned the volume up so the resident could hear. The Grievance Official Follow-Up section documented the hearing aides would be in the TARS (Treatment Administration Record) to be charged and batteries changed with staff to turn them on. The form lacked any documentation of further follow up or interview with the family member or resident regarding resolution. 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 did not get a nightly snack at bedtime, did not get a shower when she was supposed to, her bed was not being made, and the call light timing still took a while. The Grievance Official Follow-Up section documented only evening shift call light, snack to be brought to room, and shower given later that day. The form lacked any documentation of further follow up or interview with the resident regarding resolution. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 2/24/26 signed by the Administrator as resolved on 2/25/26 recorded 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 form lacked any documentation of further follow up or interview with any one to ensure no further allegations of verbal abuse were occurring. 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 form lacked any documentation of further follow up or interview with the resident, other residents, or staff members to rule out abuse or regarding resolution for the resident. The form contained no information on whether the grievance was confirmed or not confirmed. 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; coming on wrong shower days; pill left on floor did not know whose pill it was but nurse looked at pill and threw it in the trash so someone ended up missing a pill since it went into the trash; no one hanging clean laundry it is thrown on a chair and gets taken away; no one available to talk to since everyone reported being in training; roommate was needy and he felt like it was being taken out on him being (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ignored with his roommate; roommate watches TV 24/7 never turning it off at night and tells the tech to close the door at night as he does not feel safe but no one can hear calls for help with the door closed. The Grievance Official Follow-Up section documented the Administrator educated staff at huddle about the resident's concerns, educated the nurses and med aides, and would continue to follow up with the concerns. The form lacked any documentation of further follow up or interview with residents to verify resolution of their concerns. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 2/23/26 signed by the Administrator as resolved on 3/2/26 recorded Resident #92 complained Staff J, LPN, entered the resident's room to complete a dressing change without waking up the resident and the nurse didn't clean the wound with the hydro blue or cream, she just wrapped it. The Grievance Official Follow-Up section documented the Administrator would follow up with the nurse the next time she worked and she spoke to her on 3/22/26. Staff J did write a statement to document she went into the resident's room, told him she was there to do the treatment, she couldn't find the hydro blue in the treatment cart, so she asked the resident if he had any in his room. The resident indicated the hydroblue in his closet, the nurse let him know it was not enough to cover the wound bed, and the wound was cleansed with wound cleanser prior to applying the dressing. Staff J wrote she wondered if the resident was asleep how could he know that she didn't cleanse his wounds and she questioned if he was talking in his sleep with his eyes open when he told her where the hydro blue was. 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 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 March 2026 Grievance Log form documented 13 grievances tracked for the month. The log contained a column titled Disposition of Grievance with an *. At the bottom of the form, it noted, * Disposition of Grievance: Confirmed/Not Confirmed, Resolved/Not Resolved. All but one of the entries recorded Resolved in the column and none of the rows indicated Confirmed or Not Confirmed. 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 form contained no information on whether the grievance was confirmed or not confirmed. 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 found in her closet. A second white page cut off at the top of the (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 form lacked any documentation of further follow up or interview with the resident or family member on resolution. The form contained no information on whether the grievance was confirmed or not confirmed. 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 form contained no information on whether the grievance was confirmed or not confirmed. 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		

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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 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 form documented the issue resolved on 1/16/26 but lacked any documentation of follow up beyond 1/16/26 with the resident. The form contained no information on whether the grievance was confirmed or not confirmed. The Grievance Form dated 1/16/26 signed by the Administrator recorded Resident #44's family 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 form documented the issue resolved on 1/16/26 but lacked any documentation of follow up being conducted with the resident or whether the concern regarding a rash treatment was confirmed. 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 in-service with staff done 1/29/26, they would continue to monitor call lights and talk with residents. On 1/30/26 the Administrator noted the resident reported the call light was better. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. 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 in-service with staff done 1/29/26, they would continue to talk with residents and monitor call lights. On 1/30/26 the Administrator noted the resident reported the call light was being answered. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. 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 in-service done on 1/29/26 with staff, they would continue to monitor call lights, and she talked with the resident who reported it was better on 1/30/26. The form recorded no other monitoring or follow up on 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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Grievance Form dated 1/29/26 signed by the Administrator as resolved on 1/30/26 recorded Resident #43 reported the overnight CNAs (Certified Nurse Aides) 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 in-service was done on 1/30/26 with staff and they would continue to monitor call lights, they talked with the resident and she was happy with the staff response and the change. The form lacked documentation of any investigation done with specific staff regarding the lack of assistance on the overnight shift. The form recorded no other monitoring or follow up on call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. The Concern/Recommendation form signed by the Director of Nursing (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. 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 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. The Grievance Form dated 2/16/26 signed by the Administrator as resolved on 2/18/26 recorded Staff II, Licensed Practical Nurse (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 peri care (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 form lacked any documentation of further follow up or interview with the resident regarding resolution or further investigation into the reason why the staff members did not provide care for such an extended period of time. 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 did not get a nightly snack at bedtime, did not get a shower when she was supposed to, her bed was not being made, and the call light timing still took a while. The Grievance Official Follow-Up section documented only evening shift call light, snack to be brought to room, and shower given later that day. The form lacked any documentation of further follow up or interview with the resident regarding resolution. The form contained no information on whether the grievance was confirmed or not confirmed. 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 (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident further reported numerous items including: being left on the toilet for up to one hour; no one empties the urinal; coming on wrong shower days; pill left on floor did not know whose pill it was but nurse looked at pill and threw it in the trash so someone ended up missing a pill since it went into the trash; no one hanging clean laundry it is thrown on a chair and gets taken away; no one available to talk to since everyone reported being in training; roommate was needy and he felt like it was being taken out on him being ignored with his roommate; roommate watches TV 24/7 never turning it off at night and tells the tech to close the door at night as he does not feel safe but no one can hear calls for help with the door closed. The Grievance Official Follow-Up section documented the Administrator educated staff at huddle about the resident's concerns, educated the nurses and med aides, and would continue to follow up with the concerns. The form lacked any documentation of further follow up or interview with residents to verify resolution of their concerns. The form contained no information on whether the grievance was confirmed or not confirmed. 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 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 form lacked any documentation of date of resolution or further follow up or interview with the resident about their concern. The form contained no information on whether the grievance was confirmed or not confirmed. The March 2026 Grievance Log documented the disposition of grievance as resolved with a date of written decision 3/27/26. 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 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 form lacked any documentation of further follow up regarding the lack of call light response or lengthy response time. The form contained no information on whether the grievance was confirmed or not confirmed. 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 form lacked any documentation of further follow up or (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	interview with the resident. The form contained no information on whether the grievance was confirmed or not confirmed. 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 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 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 Official Follow-Up section documented education at huddle done on 4/15/26 at 2:00 PM and the Administrator would follow up. 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 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 Official Follow-Up section documented the Administrator spoke with the resident and he reported baths were being given, clothes were being changed, and staff educated on the concerns at huddle that day at 2:00 PM. The form contained no information on whether the grievance was confirmed or not confirmed. 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 a while 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 form lacked any documentation of further follow up or interview with the resident or monitoring of call light response times. The form contained no information on whether the grievance was confirmed or not confirmed. 4. Resident #25's Minimum Data Set (MDS) dated [DATE] revealed diagnoses of heart attack, stroke (blood clot or bleed in the brain), congestive heart failure (CHF; heart pumping weakness), and pulmonary disease (lung disease). The Brief Interview for Mental Status (BIMS) score showed a score of 14, indicating intact cognition. Resident #25 depended on staff for toileting and required total assistance from two staff members for bed-to-chair transfers. The Incident Summary from 4/13/26 reflected a nurse asked Staff EEE, Certified Nursing Assistant (CNA), to help Resident #25 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, walked out of the (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room without assisting, and refused to acknowledge the nurse requesting assistance. On 5/19/26 at 1:22 PM, Resident #25 stated he'd discharged to home. Resident #25 stated during his stay at the facility he told the nurse, as she administered his medication, that he needed to use the bathroom. Resident #25 stated the nurse told him she'd get someone and 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 that at the facility, it was hurry up and wait, and wait, and wait. Resident #25 stated he felt that he was to learn a lesson in patience due to not enough staff to provide proper care for him. A document titled Statement Form signed by Staff FFF, Licensed Practical Nurse (LPN), revealed: On 4/13/26 at 6:30 AM, Staff FFF assessed Resident #25 during a medication pass. Resident #25 requested to be assisted to the toilet. Staff FFF left to find additional staff. On 4/13/26 at 8:00 AM, Resident #25's call light was on. Staff FFF observed Staff EEE exiting Resident #25's room. Staff FFF responded and asked Resident #25 what she could do to help. Resident #25 said Staff EEE came in to answer the call light and when Resident #25 requested to go to the toilet, Staff EEE shrugged her shoulders and walked out. On 4/13/26 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. On 4/13/26 at 10:15 AM, the Director of Nursing (DON) and Staff F, MDS Coordinator, responded. On 4/13/26 at 11:30 AM, the Administrator spoke with Resident #25 and his family. 5. 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 is due to how he voices his opinion. Resident #81 stated he won't be silenced about his concerns and the staff can't stand it. Resident #81 commented he'd spoken to the last several administrators who all say they're working on it but he still sees the same stuff over and over. Resident #81 stated there was a Resident Council, but he quit going to the meetings as they didn't see any changes. Resident #81 said he'd waited up to 2 hours before and he checked his phone to know the amount of time; that only happened one time, otherwise he frequently waits over a half hour on all 3 shifts for help. Resident #81 commented he felt the 3rd shift was lazy and didn't give a damn. Resident #81 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. 6. On 5/11/26 at 5:25 PM, Resident #21 responded he usually waited a half hour for his call light to be answered. 7. On 5/12/26 at 9:22 AM, a confidential family member reported concerns with staffing. The family (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	member stated they received so many different answers from different people, no one had a clue what was going on, and most times when they visited, they can't find anyone to talk to or determine who was assigned to work. They commented there needed to be more communication with families and someone available to talk to. 8. On 5/12/26 at 10:40 AM, Resident #72 responded the staff were very slow at answering call lights on all shifts and she felt the facility didn't have enough staff. 9. On 5/12/26 at 10:45 AM, Resident #4 responded it's hard to get a hold of anyone at the facility, the staff didn't come in often to change her incontinence (lack of bladder or bowel control) brief, and she frequently experienced being wet which led to sores on her bottom from sitting in her own urine and not being changed like she should be. Resident #4 reported she sat in her wheelchair one day with blood on her face and hands. She pushed the button for help, the staff came in, shut the light off, and didn't come back. 10. On 5/12/26 at 11:32 AM, Resident #9 stated the staff tell him to wait for help but no one ever comes. Resident #9 had a fall with a fracture that occurred in March 2026 from attempting to get to the restroom independently. 11. On 5/12/26 at 12:57 PM, Resident #13 stated trying to talk to staff can be difficult and he can never find anyone who knows what's going on. Resident #13 complained about having to wait on staff, he can't get up on his own, and he depended on staff. 12. On 5/12/26 at 2:16 PM, Resident #1 indicated there weren't enough staff on the 300 wing and there were times she sat waiting more than an hour. Resident #1 said the staff said they can't put her to bed as they've to find someone to help transfer her to the chair and it took forever to answer the call light to be put in the chair. Resident #1 stated she knew the facility was working on hiring staff. Resident #1 reported she'd pooped her pants one time, it was upsetting, and she waited for the staff but they didn't come right away. Resident #1 reported after supper was the worst time and hard to get someone to help due to the number of residents who were totally dependent for care. Resident #1 commented the facility was short staffed a lot on the weekends. Resident #1 responded she times the wait by the clock on her wall and the residents had brought their concerns up in Resident Council which is how she knew the facility was trying to hire more people. 13. On 5/12/26 at an unrecorded time, a resident's Family Member stated concerns related to staffing. The Family Member stated she'll get so many different answers from different nursing staff. No one has a clue what's going on and most times she's not able to find anyone to talk to and isn't able to determine who the nurses or CNAs are that are assigned to care for her loved one. The communication with family's needs to be better. Nurses are rude, when Family Member asked about a wound care recommendation for a wheelchair cushion, the nurse's response was sharp and rude saying I don't know why they tell people they need that. 14. On 5/13/26 at 9:11 AM when asked if Resident #73 didn't get up for breakfast it was because Resident #73 wouldn't get out of the bed, Staff H responded Resident #73 would get out of bed, but the staff took longer than usual that morning in other resident rooms providing care. Staff H reported (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	normally they had a float between 300 and 400 hall and she'd to wait for the second aide to come and help her. Staff H stated what made 300 hall difficult was that Resident #73 was an aspiration risk (danger of breathing foreign materials into the lungs) and needed to be supervised; the 100-hall aide got sent home the day before, and the 300 hall was heavier with residents who require assistance of 2 people. Staff H answered she'd worked for the facility for 2 months, she was a newer aide, and she'd mentioned to leadership that it was hard and they tried to get a float but census a factor. Staff H said mainly it was difficult getting people up as if she didn't have the residents up by 7:30 AM to get to the dining room and they had no float or running behind like that morning because Resident #83's care took a long time, then it was difficult to get those residents who required assistance of 2 and mechanical lift up out of bed. Staff H indicated Resident #83 and Resident #12 took the longest to assist as they were both heavy care; Resident #85 needed a Hoyer mechanical lift, and Resident #1 only one person assists but it can be harder at times as her ability fluctuates. Staff H voiced she felt bad because she'd to assist the nurse with wound care and it took an hour to do that. Staff H stated the nurses have to be available to supervise the dining room so if they do not take residents to the dining room before 7:30 AM, they need to eat in their rooms. On 5/13/26 at 9:20 AM, an observation revealed Resident #73 remained dressed in a hospital gown positioned in a semi-Fowler's position (head of bed raised 30-45 degrees) on her back. A continuous observation on 5/13/26 from 4:20 AM to 12:00 PM revealed staff failed to provide assistance with grooming, dressing, oral care, major position changes, or incontinence care for Resident #73. Staff H assigned to the 300 hall on 5/13/26 responded in an interview the reason she can't provide care for that timeframe was directly related to only having 1 ded		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on filed grievances, recertification survey outcomes, resident interviews, observations, family interview, and staff interviews, the facility failed to provide effective leadership and administration of resources to ensure a safe, clean environment, free from abuse and neglect, with quality of care services provided by sufficient and competent staff. This failure was a widespread systemic failure affecting all residents in the building. The facility reported a census of 81 residents. Findings include: Review of the monthly grievance forms: The Monthly Grievance Logs from January through the beginning of May 2026 revealed a total of 75 grievances filed by 36 different residents, representatives, or staff: The January 2026 Grievance Log form documented 31 grievances tracked. The February 2026 Grievance Log form documented 19 grievances tracked. The March 2026 Grievance Log form documented 13 grievances tracked. The April 2026 Grievance Log form documented 11 grievances tracked. The May 2026 Grievance Log form documented 1 grievances tracked. The logs contained a column titled Disposition of Grievance with an *. At the bottom of the form, it noted, * Disposition of Grievance: Confirmed/Not Confirmed, Resolved/Not Resolved. All but two of the entries recorded Resolved in the column and none of the rows indicated Confirmed or Not Confirmed. The individual grievance forms contained no information on whether the grievance was confirmed or not confirmed. Proof of repeat deficiencies and higher scopes and severities for survey ending 1/8/26 cited the following 12 tags: F550 - D level - Resident Rights/Exercise of Rights F656 - D level - Develop/Implement Comprehensive Care Plan F658 - D level - Services Provided Meet Professional Standards F689 - D level - Free of Accident Hazards/Supervision/Devices F725 - D level - Sufficient Nursing Staff F755 - E level - Pharmacy Svcs/Procedures/Pharmacist/Records F760 - D level - Residents are Free of Significant Med Errors F804 - E level - Nutritive Value/Appear, Palatable/Prefer Temp F842 - E level - Resident Records - Identifiable Information F880 - D level - Infection Prevention & Control F883 - D level - Influenza and Pneumococcal Immunizations F887 - D level - COVID Immunizations The current survey cited the follow 33 tags: F550 - D level - Resident Rights/Exercise of Rights F561 - D level - Self Determination F584 - F level Substandard Quality of Care (SQOC) - Safe/Clean Environment F585 - F level - Grievances F600 - H level SQOC - Freedom from Abuse/Neglect F609 - D level - Reporting of Alleged Violations F610 - D level - Investigate/Prevent/Correct Alleged Violation F627 - D level - Inappropriate Discharge F628 - E level - Discharge Process F641 - D level - Accuracy of Assessments F656 - D level - Develop/Implement Comprehensive Care Plan F657 - E level - Care Plan Timing and Revision F677 - E level - Activities of Daily Living Care Provided for Dependent Residents F684 - K level SQOC - Quality of Care (Nursing Assessment and Intervention) F686 - K level SQOC - Treatment/Services to Prevent/Heal Pressure Ulcer F688 - E level - Increase/Prevent Decrease in Range of Motion/Mobility F689 - H level SQOC - Free of Accident Hazards/Supervision/Devices F693 - D level - Tube Feeding Management/Restore Eating Skills F695 - D level - Respiratory/Tracheostomy Care and Suctioning F697 - J level SQOC - Pain Management F725 - F level - Sufficient Nursing Staff F726 - E level - Competent Nursing Staff F732 - C level - Posted Nurse Staffing Information F760 - D level - Residents are Free of Significant Med Errors F761 - D level - Label/Store Drugs and Biologicals F812 - E level - Food Procurement, Store/Prepare/Serve-Sanitary F835 - F level - Administration F838 - F level - Facility Assessment F842 - D level - Resident Records - Identifiable Information F865 - F level - QAPI, Disclosure/Good Faith Attempt F880 - F level - Infection Prevention & Control F908 - E level - Essential Equipment, Safe Operating Condition The facility had 7 repeat deficiencies that include: (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F550, F656, F760F725 and F880 at higher scopesF689 at a higher severity levelThe facility had 3 newly cited areas that rose to the level of immediate jeopardy: F684 lack of comprehensive nursing assessment and intervention for 7 residentsF686 lack of pressure sore interventions and care for 4 residentsF697 inadequate pain management for 1 resident. The current survey identified 6 deficient practices as SQOC. The facility should have been aware of the systemic concerns well before the current survey started. The survey outcomes point to the ineffective QAPI program. F561 Resident Choices and failure of leadership to follow up on concerns: The current survey cited issues under F561 as the facility failed to honor a resident's choice of bathing time for Resident #81.The quarterly 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. In an interview on Monday 05/11/2026 at 3:00 PM, Resident #81 stated the call lights take forever to be answered, the staff claim they are short staffed and when the staff come to assist him, they run in and right back out. Resident #81 stated he voices his opinion, he will not be silenced, and the staff cannot stand that. Resident #81 said he talked to the last several administrators about his concerns and they tell him they are working on it, but he still sees the same stuff over and over and he doesn't see any changes. Resident #81 commented he doesn't go to resident council as it is a joke and he doesn't see any changes being made when concerns are voiced. F584 Environmental concern with odors and leadership awareness:The current survey cited issues under F584 as the facility failed to maintain an environment free of offensive odors, which were pervasive throughout the building during the majority of the survey period. Observations on multiple dates and times revealed the presence of urine/ammonia odors throughout the building. On 5/11/26 between 1:27 PM and 4:36 PM, observation revealed an ammonia/urine odor present on 100, 200, and 300 hallways. On 5/12/26 from 2:13 PM to 3:10 PM, observation revealed odors present in the 200 hallway and dining room/activity room. On 5/13/26 from 4:30 AM to 5:58 AM, observation revealed odors present in the 100, 200, and 300 hallways. In an interview at 5:20 AM, Staff B, Certified Nurse Aide (CNA), Staff B acknowledged the smell was down the entire 300 hall and was present on the 100 hallway, speculating it came from the carpet. Staff B responded that she had told leadership about the terrible odor before, and that housekeeping cannot get the smell out. In an interview at 5:57 AM, the Administrator entered the housekeeping room by the nurses station and told a staff member that a urine smell concern existed on hall 100 and she knew it was the carpet.On 5/14/26 from 7:00 AM to 7:31 AM, observation revealed immediately upon entering the facility a faint odor of ammonia/urine detected in the activity room area near the southeast entrance. Later observation revealed a quarter of the way down the 300 hall, a strong overwhelming ammonia/urine odor present outside Resident #83's room (302) and continued to Resident #73's room (307).On 5/18/26 from 10:54 AM to 12:15 PM observation revealed a strong pungent urine odor identified on the 300 hallway. No soiled linen bins available in the hallway. The strong odor caused surveyor a scratchy throat with burning sensation to the sinuses and eyes. At 2:12 PM the Director of Nursing (DON) responded during an interview she had not observed soiled linen or trash on the floor or in open garbage bags in hallways, however, she had observed this practice when she started in September 2025. The Director of Nursing (DON) stated she provided education and expected staff to avoid placing soiled linen and trash bags directly on the floor.On 5/26/26 at 11:02 AM, the Administrator stated that when she started in January 2026, she told staff to stop putting bags on the floor and to use the barrels. She procured large bags for staff to take dirty linens and trash back to the laundry in a timely manner, to remove the odor.F600, F607, F609, F610 Freedom of Abuse / Neglect:The current survey cited issues under several abuse regulatory tags as the facility failed to prevent physical abuse in the form of bruises left during provision of cares for (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Resident #81; failed to identify and report the bruises on Resident #81 as potential abuse and to identify fractured ribs as injury of unknown origin for Resident #71 as potential abuse; failed to fully investigate both of those situations, and failed to ensure implementation of their abuse policies and procedures which covered the protocols on how to prevent, report, and investigate allegations of abuse. The failures were evidenced by leadership awareness of staff treatment to residents via 45 grievance forms submitted January thru May 2026 that reported dignity, respect, and lack of providing care when assistance requested. 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 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 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. Under Resident Description, Staff L wrote: It's when they roll me. They hold on too hard. 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 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. Resident #81 stated he wore incontinence briefs and call lights took forever with staff claiming they are short staffed. Resident #81 said the staff ran in then right back out and he thought it was personal because he voices his opinion, he will not be silenced, and the staff cannot stand that. Resident #81 reported he had talked to the last several administrators who responded they were working on it but he continued to see the same stuff over and over; he doesn't see changes. 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 and the facility failed to report the allegation of abuse to the State Survey Agency. Review of MDS dated [DATE] revealed Resident #71 BIMS of 15, indicating cognitively intact. Provider Encounter Note dated 3/17/26 documented for Resident #71, chief complaint: abdominal pain. Resident #71 seen and examined today for follow-up acute abdominal pains onset 3/14/26, status post ER (Emergency Room) visit and return to facility on 3/15/26 with diagnosis of right 11th rib fracture, UTI (Urinary Tract Infection), and right sided abdominal pains and given prescription for Cefdinier (antibiotic medication) 300mg (milligram) by mouth every 12 hours for 5 days. Today Resident #71 is resting in a wheelchair in room. Resident #71 complaints of 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. 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. F677 Assistance with Activities of Daily Living: The current survey cited issues under F584 as 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 failures were evidenced by leadership awareness of staff treatment to residents via 16 grievance forms submitted to leadership from January thru April 2026 which complained of concerns with staff not providing assistance with resident needs which included answering call lights, toileting assistance, incontinence care, and getting showers. Resident (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 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#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. 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. F838 Facility Assessment: The current survey cited issues under F584 as 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 identified 48 residents needed assistance with transfers and 53 assistance with toileting. 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. 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 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.		

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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 (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on previously imposed Directed Plan of Correction monitoring, filed grievances, current survey outcomes with repeat deficiencies and identification of 6 Substandard Quality of Care tags with 3 rising to the level of immediate jeopardy, staff interview, and facility policy review, the facility failed to effectively monitor and improve the quality of care residents received. The failure represented a systemic, widespread failure with potential to impact all residents who resided in the facility. The facility reported a census of 81 residents. Findings include: Previous Directed Plan of Correction (DPOC) Monitoring The facility operated under a DPOC (Directed Plan of Correction) with monthly reports received by the SSA (State Survey Agency) from the facility's consultant and biweekly calls conducted with the facility. On 1/26/26 at 7:40 AM, an email from the consultant provided the monthly review of the facility. Areas reviewed included accidents and supervision, active performance improvement plans through the facility's QAPI (Quality Assurance Performance Improvement) plan, and progress notes including key clinical systems. The report documented that the facility continued to identify root causes and appropriate interventions for falls. The report also documented a review of recent survey tags and a review of treatments and dressings with wound documentation supporting positive trending. On 2/17/26 during the biweekly call with facility management and the consultant, the facility reported overall improvement with wounds but could not identify the cause except for the use of consistent staffing and a highly involved wound nurse. The facility held citations for significant medication errors at its last three surveys. To address the issue, staff performed medication pass audits and medication cart audits and attended a biweekly pharmacy meeting. On 3/3/26 at 2:18 PM, an email from the consultant provided the monthly review of the facility. The report documented a decreased number of falls in February related to terminal agitation (restlessness before death). She encouraged the community to evaluate transfer training and the anticipation of needs. Fall trends remained higher than community goals. On the 3/3/26 biweekly call with facility management and the consultant, the facility reported that management and nurses performed rounds. Through tracking, they identified a trend of falls with new admissions and falls with terminal agitation. Since identifying these trends and implementing interventions, the number of falls decreased in those two areas but remained above the facility goal. Staff completed a facility-wide medication cart audit. Cycle medication refills were scheduled to begin on 3/27/26. The facility self-identified a concern for smoking as more residents smoked, and management thought the visibility of the smoking area and a higher incidence of residents with behaviors served as contributing factors. They considered moving the designated smoking area. The consultant reported that the nursing management team took more proactive measures with daily reviews, which decreased the need for the consultant to identify and correct issues. (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 3/25/26 at 9:53 PM, an email from the consultant provided the monthly review of the facility. The report documented that she encouraged more details in the IDT (Interdisciplinary Team) portion of the risk assessment to include painting a picture of everything the team evaluated during a fall. The report noted that nursing staff notes and risk management improved with details about what staff observed when entering the area of a fall. Nursing implemented immediate interventions. Wounds reviewed showed positive trends, and staff resolved some difficult wounds. On the 3/31/26 monthly call with facility management and the consultant, the facility reported plans to move the smoking area due to issues with residents who smoke and behaviors. Falls continued to trend but dropped lower than the previous month. The facility conducted a daily huddle at the change of shift to discuss falls and obtain details. Management reported no new issues when asked. On 4/26/26 at 10:22 PM, an email from the consultant provided the monthly report. She reported an overall decrease in the number of falls along with a decrease in the number of recommendations needed from the consultant. On the 4/28/26 monthly call with facility management and the consultant, management reported that the facility responded to issues and trends in a proactive way. The facility involved its aides in falls meetings to help identify root causes and implement interventions. Staff then brought the new interventions to the daily huddle at the 2:00 PM change of shift. The process helped show a 53% reduction in falls. Clinical staff across all shifts just completed the skills fair. Pressure ulcers (bedsores) remained low, but staff noted an increase in non-pressure wounds. The facility hired a new ARNP (Advanced Registered Nurse Practitioner) for wound management who visits weekly. On 5/28/26 at 5:25 PM, an email from the consultant provided the monthly report. She continued to review progress notes weekly to identify systemic concerns. The report documented that appropriate team members identified and addressed systemic concerns, with the team demonstrating consistency. The IDT team continued to embrace opportunities to support floor staff with education, identified needs, and process improvement. Staff completed a facility skin sweep during the survey presence, which identified several new areas. The facility and external consultant reported that fall incident occurrences decreased and that residents did not have pressure sores. The leadership failed to identify current issues with staffing levels, a lack of provision of cares such as repositioning, and a failure to ensure pressure sore interventions stayed in place to prevent Stage 3 and 4 pressure sores. Leadership also failed to ensure that staff performed pain assessments to avoid severe pain, lacked adequate incontinence care, and failed to maintain an environment free of urine odor. Based on the previous recertification survey having 12 deficiencies and the current survey identifying 33 deficient practices, the facility failed to provide effective Quality Assurance. Grievances Review of the monthly grievance forms The Monthly Grievance Logs from January through the beginning of May 2026 revealed a total of 75 (continued on next page)		

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

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	grievances filed by 26 different residents, representatives, or staff: The January 2026 Grievance Log form documented 31 grievances tracked. The February 2026 Grievance Log form documented 19 grievances tracked. The March 2026 Grievance Log form documented 13 grievances tracked. The April 2026 Grievance Log form documented 11 grievances tracked. The May 2026 Grievance Log form documented 1 grievance tracked. Survey Outcomes Survey ending 1/8/26 cited the following 12 tags: F550 - D level - Resident Rights/Exercise of Rights F656 - D level - Develop/Implement Comprehensive Care Plan F658 - D level - Services Provided Meet Professional Standards F689 - D level - Free of Accident Hazards/Supervision/Devices F725 - D level - Sufficient Nursing Staff F755 - E level - Pharmacy Svcs/Procedures/Pharmacist/Records F760 - D level - Residents are Free of Significant Med Errors F804 - E level - Nutritive Value/Appear, Palatable/Prefer Temp F842 - E level - Resident Records - Identifiable Information F880 - D level - Infection Prevention & Control F883 - D level - Influenza and Pneumococcal Immunizations F887 - D level - COVID Immunizations The current survey cited the follow 33 tags: F550 - D level - Resident Rights/Exercise of Rights F561 - D level - Self Determination (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F584 - F level Substandard Quality of Care (SQOC) - Safe/Clean Environment F585 - F level - Grievances F600 - H level SQOC - Freedom from Abuse/Neglect F609 - D level - Reporting of Alleged Violations F610 - D level - Investigate/Prevent/Correct Alleged Violation F627 - D level - Inappropriate Discharge F628 - E level - Discharge Process F641 - D level - Accuracy of Assessments F656 - D level - Develop/Implement Comprehensive Care Plan F657 - E level - Care Plan Timing and Revision F677 - D level - Activities of Daily Living Care Provided for Dependent Residents F684 - K level SQOC - Quality of Care (Nursing Assessment and Intervention) F686 - K level SQOC - Treatment/Services to Prevent/Heal Pressure Ulcer F688 - E level - Increase/Prevent Decrease in Range of Motion/Mobility F689 - H level SQOC - Free of Accident Hazards/Supervision/Devices F693 - D level - Tube Feeding Management/Restore Eating Skills F695 - D level - Respiratory/Tracheostomy Care and Suctioning F697 - J level SQOC - Pain Management F725 - F level - Sufficient Nursing Staff F726 - E level - Competent Nursing Staff F732 - C level - Posted Nurse Staffing Information F760 - D level - Residents are Free of Significant Med Errors F761 - D level - Label/Store Drugs and Biologicals (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	F812 - E level - Food Procurement, Store/Prepare/Serve-Sanitary F835 - F level - Administration F838 - F level - Facility Assessment F842 - D level - Resident Records - Identifiable Information F865 - F level - QAPI, Disclosure/Good Faith Attempt F880 - F level - Infection Prevention & Control F908 - E level - Essential Equipment, Safe Operating Condition The facility had 7 repeat deficiencies that include: F550, F656, F760, F842 F725 and F880 at higher scopes F689 at a higher severity level The facility had 3 newly cited areas that rose to the level of immediate jeopardy: F684 lack of comprehensive nursing assessment and intervention for 7 residents F686 lack of pressure sore interventions and care for 4 residents F697 inadequate pain management for 1 resident. The current survey identified 6 deficient practices as SQOC. An interview on 6/3/26 at 2:39 PM with the Administrator revealed the process of the grievance forms is that anyone can write up a grievance form, and depending on what the grievance is about determines who follows up with it. She stated if they relate to more nursing and staffing concerns, the Director of Nursing or the MDS (Minimum Data Set) Coordinator should address it. If the grievance relates to the kitchen, the kitchen manager should address it, just like if it relates to therapy, the director of rehab (rehabilitation) should address it. The Administrator stated that she likes to follow up with them and sometimes will call the family depending on what it is and if she feels the family needs involvement. The Administrator stated that she takes them to huddle and talks with the staff. The Administrator stated that if the grievance regards call lights or the way staff talk to residents, she always asks the resident what time of day it occurred, figures out who worked that day, and depending on the situation will educate that person with a witness. She stated they would do a whole group education with whoever works in the building. She noted if it is widespread, she'd send the staff person home and investigate the situation. She stated that she likes to follow up with the (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident within 24 hours. The Administrator also stated the reason they hadn't identified the problems with several residents identified as having MASD (Moisture Associated Skin Damage) and other residents with skin interventions not being used or not in place is because staff left, they had a change in leadership, and they are getting the right people into those positions. The Quality Assurance and Performance Improvement Plan policy dated April 2025 instructed that the program is designed to establish and maintain an organized facility-wide program that is data-driven and utilizes a proactive approach to improving quality of care and services throughout the facility. The policy noted this is a living document that'll continue to be refined and revisited, written in accordance with the facility's vision and mission statement. Objectives of the QAPI plan include: a. Establish a facility-wide process to identify opportunities for improvement through continuous attention to quality of care, quality of life, and resident safety. b. Address gaps in systems or processes. c. Ensure adequate provision of staffing, time, equipment, and technical training resources. d. Establish clear expectations around safety, quality, rights, choice, and respect. e. Continually improve the quality of care and services provided to their residents. The facility designed their QAPI program to be ongoing and comprehensive. The scope of services encompasses all systems of care and services provided (including complexities and unique care) that impact clinical care, quality of life, resident choice, and care transitions with participation from all departments. The aim is safety and high quality with all clinical interventions, while emphasizing autonomy and choice in daily life for residents or resident's agents. It utilizes the best available evidence (such as data, national benchmarks, published best practices, and clinical guidelines) to determine appropriate care and define and measure goals. The policy section named Administration instructed that staff conduct all business practices to ensure every resident receives individualized care, and work to support providers with the resources and equipment to meet the care goals of their residents. The policy section named Clinical Care instructed that the facility provides comprehensive clinical care to residents with acute and chronic diseases, rehabilitative needs, as well as end-of-life care. All care is resident-centered and focuses on choice and individualized plans of care. Staff strive to meet each resident's goals of care, including developing and executing a transitional plan for discharge back to the community. Staff monitor existing quality indicator and quality measure results, post-fall assessments, medication errors, pressure injuries, incident reports, and infection reports. The Quality Assurance and Assessment Committee meets monthly with the Medical Director and others to address any care concerns. The policy section named Person Center Care instructed that the facility provides person-centered care services that focus on resident choice, resident strengths and interests, physical ability, and (continued on next page)		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cognitive status. The policy section named Dietary instructed that the facility provides nutritious meals under the services of a registered dietitian and a certified dietary manager based on each resident's choices and preferences by providing options for meals. The policy section named Pharmacy Services instructed that the facility contracts with a licensed pharmacist to review medications monthly, participate in antipsychotic reduction efforts, and assist with monitoring and effectiveness to ensure therapeutic goals are maintained for each and every resident. The policy section named Housekeeping instructed that the facility provides housekeeping services to ensure an environment that meets the requirements of the Occupational Safety and Health Administration through regular cleaning, disinfection, and sanitation of all aspects of the facility. The policy section named Maintenance and Engineering instructed that the facility provides a comprehensive maintenance program that maintains building safety, conducts repairs when needed, and performs safety inspections in accordance with State and Federal regulations to ensure the safety and well-being of all residents, visitors, and staff members. The policy section named Quality of Life instructed that their purpose is to provide excellent quality care and services for their residents. Staff will monitor existing data available through, but not limited to, resident and family satisfaction surveys, concerns brought up at Resident or Family Council meetings, concerns brought up at care conferences, and individual discussions with residents and family members. The policy section named QAPI Methodology instructed that the facility uses a systematic approach to determine when in-depth analysis is needed to fully understand the problem, its causes, and implications of change. The facility uses a thorough and highly organized approach to determine the root cause of identified problems. The facility will utilize a variety of tools to describe the current process we use, and to identify any area of breakdown or weakness in the current process. Each Performance Improvement Project subcommittee will identify areas for improvement. Data will be collected during the process and then analyzed to determine the effectiveness of change. The PIP subcommittee will provide the QAA Committee with a summary report, analysis of activities, and recommendations. Root Cause Analysis is a method of problem solving used to break down the current process and identify areas in need of improvement. Tools available to identify the cause of the problem include: Five Whys, Fishbone Diagram, Flowcharting, and Failure Mode and Effect Analysis. The policy section named Governing Body instructed that the Governing Body and facility administration shall provide general oversight for QAPI activities related to resident care and services throughout the facility. The Governing Body is responsible and accountable for ensuring that an ongoing QAPI program is defined, implemented, maintained, and addresses identified priorities; policies are established to ensure the QAPI program is sustained during leadership transitions and staff turnover; the QAPI program is adequately resourced, including ensuring staff, time, equipment, (continued on next page)		

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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 I/Wound 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 the door; one with trash and one with soiled linens. The staff member placed items in the bag, picked up both bags and walked down the hall. Observation on 05/13/2026 at 4:43 AM revealed the presence of strong ammonia / urine smell on hall 300 outside of room [ROOM NUMBER] where Resident #83 and Resident #12 resided. The odor continued down the hallway all the way to the end outside of room [ROOM NUMBER] where observation revealed an open trash bag with soiled briefs inside, open to air. Observation on 05/13/2026 at 4:46 AM revealed Staff A, CNA and Staff B, CNA, entered the room of Resident #83 without donning PPE. A sign on the outside of the door indicated Enhanced Barrier Precautions (EBP) in place. Staff B donned gloves then removed the gloves, went to place them in the oral pink container for toothbrushes in the bathroom, then stopped right before touching it and placed them in her uniform pocket. Staff B then washed hands after Staff A and donned new gloves. Resident #83 laid in bed with a thin floor mat in place and edge bolsters on the side of the bed. With gloved hands, Staff B removed the bolster from under the fitted sheet and rolled the bed pad in half beside the resident. Staff B then removed gloves, threw them away, then continued without washing hands to exit the room to obtain more wipes. Staff B returned and washed her hands. Resident #83's brief with the blue indicator line from front to back indicating a soiled brief. Staff A donned gloves and assisted to roll the resident to the right side. Staff B moved the brief in front and tucked between the legs. Staff A provided the wipes and Staff B wiped in small areas. Resident #83's legs were difficult to separate and staff failed to cleanse all areas. Staff B wiped and feces present. Staff B changed gloves and failed to wash hands. Staff B donned gloves and rolled the resident to the left side but not rolled enough to reach all areas. Staff B continued to wipe the same area repeatedly as feces remained present and her gloves visibly soiled with feces on all of the palm. Staff B changed gloves and continued without washing hands to wipe then Staff A instructed to pull the brief out. Staff B handled the brief heavily soiled with feces and continued to swipe the rectal area. Both gloves touched feces on wipes and then would touch the resident's right hip area to pull the brief out. Friction and shear heard audibly as Staff B pulled, pulled, pulled, and pulled using moderate force to remove the brief which made an 'eeking' sound with each pull related to the friction between the brief and the resident's skin. The brief soiled and Staff A failed to assist to pull resident over to provide access. Staff B again changed gloves and failed to wash or sanitize hands. Staff B tucked the soiled bed pad under the resident then placed a new brief. Then the resident rolled to the right and revealed an intact bandage labeled 5/12; the area of the pressure sore. Staff A removed the soiled bed pad and continued with the same pair of gloves. Staff rolled the resident back to get the brief to cover the resident. Staff failed to cleanse the full scrotal area, lower abdomen, either left or right hip, penis or foreskin area, or all areas of skin contaminated with urine or feces where the incontinent brief contacted skin. Both staff continued with the same pair of contaminated gloves, Staff A placed items (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	neither of which donned PPE during the care. 4. The MDS assessment dated [DATE] for Resident #52 identified a BIMS score of 09, which indicated moderate cognitive impairment. The MDS documented the resident totally dependent upon staff for toileting hygiene and always incontinent of bowel and bladder. The MDS documented diagnoses that included debility, chronic kidney disease, and overactive bladder. The Care Plan dated 3/12/26 documented a focus area identifying the resident as incontinent of bowel and bladder. The care plan interventions directed staff to check and change the resident before/after meals, with AM/HS (morning, bedtime), as needed, and to wash, rinse, dry peri-area as allowed or needed and clean peri-area with each incontinence episode. Observation on 05/13/2026 at 5:06 AM revealed staff entered Resident #52's room to provide personal care. A strong ammonia smell was observed throughout the room. Staff B, CNA, and Staff A, CNA, washed hands and donned gloves. Staff B uncovered the resident removing the blankets, then adjusted the bed and bed control fell to the floor. Staff B removed gloves and donned new gloves without washing hands. Staff A placed a new incontinence brief and bed pad on the bed with the box of gloves without a barrier. Staff B stood on the resident's left side, undid the brief and asked resident to assist to open her legs. Staff B wiped the abdominal fold under the pannus and barely down middle between the legs then stated okay, we are done. Staff B changed gloves but failed to wash or sanitize her hands. Staff assisted the resident to roll to the right side revealing a heavily soiled brief with feces present. Staff B continued with contaminated gloves to wipe the rectal area. At that time, the resident expressed she did not want the surveyor visualizing care and the surveyor stepped to the other side of the curtain. Staff failed to cleanse all areas on the front contaminated by the brief prior to the surveyor stepping out of view. The surveyor immediately heard gloves changed however observation had revealed no sanitizer present and the sink located in the bathroom. The staff continued care without ever washing or sanitizing hands. Staff A and B quickly came around the curtain to remove items and placed them in trash. Staff A stated they were going to change her gown. Both staff told the resident they were going to assist her to be pulled up in bed telling the resident this and asked about placing pillows. Staff failed to go to the bathroom to access hand sanitizer or wash hands and continued to handle trash bags and move items in the room. Staff B left the room with a trash bag then returned, then said needed one more bag. Staff B returned and washed her hands. Staff A remained on the other side of the curtain near the resident. At 5:18 AM Staff A went to the bathroom to wash hands while Staff B left the room with the soiled linen bag then returned to room and washed hands. The urine smell remained in the room after provision of incontinence care. 5. The MDS assessment dated [DATE] for Resident #85 identified a BIMS score of 04, which indicated severe cognitive impairment. The MDS documented the resident totally dependent upon staff for toileting hygiene, had an indwelling catheter, and always incontinent of bowel. The MDS listed diagnoses that included neurogenic bladder and stroke. The Care Plan dated 4/14/26 documented a focus area identifying the resident incontinent of bowel due to CVA (stroke) and weakness, pain, and impaired mobility. The care plan interventions directed staff to check and change before/after meals, with AM/HS (morning, bedtime), as needed, and to provide peri-area with each incontinence episode. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observation on 05/13/2026 at 9:36 AM revealed Staff H, CNA, and Staff TT, CNA, prepared to assist Resident #85 with personal care. Staff H and Staff TT donned gown and gloves prior to entering the room. Prior to entering the room, Staff H asked surveyor if she could tell her what all she needed to wear for PPE and for what activities required EBP; she commented she knew at least for the catheter care. Surveyor responded SSA (State Survey Agency) only there to observe and questioned Staff H on what training she received about EBP. Staff H answered she was a new CNA, this was her first job, worked for 2 months, she received training when in school from CNA program, but she had not received any training from the facility about EBP. Resident #85 laid in bed on his back with a catheter present. With gloved hands Staff H wiped on the left then right side of the 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 was present. Staff H removed the soiled brief which contained feces and placed it directly on bed where the clean wipes sat. Staff H continued to wipe and then with the same contaminated gloves, Staff H grabbed a new clean brief, handed it to Staff TT who handed her the stack of feces wipes and brief which Staff H grabbed, then both continued to place a new brief without changing gloves. No wiping occurred of all the areas in contact with the soiled brief such as the right and left hips, or right and left buttocks. Both staff entered the bathroom and washed hands and donned new gloves. Staff TT went to empty the catheter bag and Staff H continued to assist the resident with changing his shirt. A nurse entered the room and Staff H reported the resident had a securement in place for the catheter but the resident reported pulling it off during the night. Both staff assisted to roll the resident back and forth to dress the resident. Placed the sling for the lift under the resident so they could assist the resident up when needed. Staff TT removed her gown and gloves, bagged the trash and soiled linens. Staff H removed her gown and gloves but failed to wash hands, then touched the resident's soda bottle, removed the cap, and provided the resident with a drink. Staff H positioned the bed down to transfer height and stated she would be back with a nurse to provide GT (gastroonomy feeding tube) care. Leadership called Staff H over radio and stated she was needed right then in office. Staff H left the room without washing hands, to sign a form provided by leadership. On 6/3/26 at 11:29 AM an observation in Resident #85's room, the bedside table noted to be covered with multiple items, including an open unlabeled, undated irrigation kit with a bolus feeding syringe, sterile cap removed (indicating it had been used), and an unlabeled, undated, graduate with another bolus feeding syringe. 6. The 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 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nonsurgical dressings and ointments/medications. The MDS recorded the resident received hospice care services. The care plan dated 4/13/26 that included the following focus areas and care plan interventions: 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 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 Monthly Nursing Summary dated 5/6/26 documented the resident required: extensive 2 person physical assist for transfers and dressing; totally dependent upon 2 person physical assist for bed (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	mobility and personal hygiene; and indicated toilet use activity did not occur. The summary recorded the resident always incontinent of bowel and bladder. The Weekly Wound assessment dated [DATE] recorded a wound summary. The summary documented a Stage 4 pressure sore to the left rear thigh measured 2.84 cm by 2.03 cm by 0.1 cm with 100% granulation, moderate amount of serosanguineous drainage with odor present. 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 5/8/26 at 1:08 PM documented the IDT team reviewed the resident's pressure ulcer to the posterior left thigh. The entry documented the Stage 4 wound treatment was effective and wound improved with no signs/symptoms of infection. The IDT updated the care plan and would continue to monitor. Observation on 05/13/2026 at 11:41 AM revealed a staff member entered the Resident #73's room and announced 'therapy'. The staff asked the resident if she wanted to get up for lunch and the resident responded yes. Staff H entered and said she would be back with the EZ stand. Staff TT informed and redirected Staff H that Resident #73 was on EBP (Enhanced Barrier Precautions, indicating the required use of gown and gloves with high contact cares) and Staff H and TT donned PPE (Personal Protective Equipment). Staff H acknowledged the last time care provided for Resident #73 was around 4:00 AM. Staff H commented unfortunately, once you get behind in the day there isn't much you can do, everything just gets pushed back further and further. Staff H verbalized they had just provided cares for Resident #86 and got her out of bed. Staff H stated Resident #73 was the last resident to get up for lunch. Staff H left the room to obtain more periwipes while Staff TT started with donning pants on the resident. Staff H returned and reported to Staff TT the nurse did Resident #73's wound care first thing in the morning. Resident #73's blanket pulled back to reveal the incontinence brief indicator with solid blue lines in front and a very strong ammonia smell in the room. Staff H used a remote to raise the bed and adjusted the gripper socks. Resident #73's left leg marked with black line to outline the area of cellulitis. Resident #73 cried out a bit when the gripper sock moved. Staff H lowered the bed to move the bed away from the wall then raised back up. Staff TT grabbed and opened a new brief and placed it on the foot of bed. Staff TT removed tabs of incontinence brief while having peri-wipes in hand, cleansed right the side abdominal fold then left side with a new wipe each time, then down the center. Staff H rolled the resident to the left side, Staff TT pulled the brief, rolled and brief heavily soiled with urine and feces. Staff TT wiped from front to back rectal area and part of the left buttock. Bandage on the back of lower left thigh just above the back of the knee, marked with dressing. Staff rolled back, failed to change soiled gloves or sanitize hands prior to placing a new brief and failed to cleanse all areas where the brief was in contact with skin. Staff H finished pulling out the soiled brief then the new brief placed with the same soiled, contaminated gloves. Both staff then removed gloves and gathered the trash. Staff H washed hands and Staff TT sanitized and donned new gloves. Staff TT returned to the bedside to pull up the pants to thigh level then assisted with 2 to rotate in the bed to the edge of the bed to connect the EZ stand lift into place. Without washing hands, the oxygen tubing was removed and Staff TT rolled up and placed in a bag on the oxygen concentrator. Assisted resident to doff hospital gown and don a shirt. EZ stand sling placed on top of fitted sheet in the same location where the heavily soiled brief laid, therefore the area contaminated. Both staff connected the sling loops, selecting both the 3rd green and 2nd black loops. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Staff TT ran the controls and instructed the resident to stand nice and tall. Staff H unlocked while Staff TT and Staff H pulled up pants, moved to the wheelchair, and safety strap was around the resident. Staff H removed the sling, hung it over the machine, and both staff continued to touch items with contaminated gloved hands. Staff H put leg foot pedals on the wheelchair and stated the one pedal was broken so that was why they used the pillow to try to hold it in place. Staff H voiced not the best option, but they were working on ordering a new one. Staff F put a wedge type cushion in place under the resident's feet as feet approximately 6 inches from touching the pedals. Staff H stated the resident needed a new oxygen tank by the nurse. Staff TT combed the resident's hair. Staff H left the room with soiled trash and linens and said she would be back for the EZ stand. Staff H failed to wash her hands after removing her gloves or the EZ stand. Observation on 05/14/2026 at 7:34 AM revealed Staff VV, LPN and facility wound nurse, and the Nurse Practitioner (NP) stood outside of Resident #73's room with a treatment cart and prepared for wound care. The NP stated to Staff VV that the resident just finished antibiotics medication for cellulitis in the leg. They entered the room and Resident #73 laid in bed on her back. The NP removed the wound dressing to the lower left posterior thigh and measured 3.0 cm width and 2.5 cm length with 100% granulation tissue present with moderate serosanguinous drainage present after cleansing the wound. The NP and Staff VV commented the wound looked much better than before and the NP felt the cellulitis caused by the fungal infection from the knee but responded the antibiotic likely helped the pressure wound. Observation revealed the wheelchair seat without cushion and the NP indicated that normally the cushion was in the chair. The NP located the roho cushion on the floor between the bed and the bedside drawers/table. Observation on 05/14/2026 at 9:45 AM revealed Resident #73 sat in the recliner in a se[TRUNCATED]		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility policy review, the facility failed to notify the Long-Term Care Ombudsman of a transfer to a hospital, failed to obtain bed hold notifications, and failed to document disposition of resident belongings and discharge status, for 5 of 5 residents (Resident #1, #2, #7, #52, #93) reviewed for discharge processes. The facility reported a census of 81 residents. Findings include:1. Resident #1's Clinical Census printed 5/27/26 listed the following: 2/4/26: Hospital unpaid leave 2/16/26: Hospital unpaid leave The Notice of Transfer Form to Long Term Care Ombudsman dated February 2026 provided by the facility lacked documentation of Resident #1's hospitalizations. Resident #1's clinical record lacked documentation regarding a bed hold notification for the hospitalizations in February 2026. On 6/2/26 at 11:00 AM, Staff R, Regional Director of Admissions and Marketing, stated the previous social worker would've reported the discharge to the Ombudsman. She stated when she looked into it, the facility put the census information into the electronic health record (EHR) late, so when they pulled the report, they had the incorrect discharge date . She stated she'll be the one reporting now until the facility hires someone, and she'll recheck the list at the end of the month before sending it to the Ombudsman. An email on 5/27/26 at 2:59 PM from the Regional Director of Operations indicated the facility didn't have an Ombudsman policy. 2. Resident #2's MDS discharge return anticipated assessment dated [DATE] identified Resident #2 discharged [DATE] to a short-term general hospital. The Census tab of the EHR reflected Resident #2 transferred to the hospital on 4/19/26, 4/20/26, and 4/27/26. The Assessments tab of the EHR reflected only one transfer and discharge form recorded for 4/20/26. The clinical record lacked documentation of the required written orientation and transfer information completed and communicated on 4/19/26 and 4/27/26. The clinical record also lacked written bed hold notices for the transfers. The progress note dated 4/28/26 at 8:59 AM recorded a social service note. The entry recorded a follow-up done to sending Resident #2 to the hospital and noted Resident #2 stayed in the critical care unit. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/26/26 at 11:05 AM, Staff R, Social Service Designee, reported the bed hold notices that were being looked for regarding the residents triggered in the survey software for hospitalization weren't found and weren't done. This included Resident #1, Resident #2, Resident #7, Resident #52, and Resident #93. Staff R stated prior to her being designated, Staff NN stayed as the social service designee and she left around 4/24/26. Staff R said the copies of the written bed hold notices should be uploaded in the EHR under the documents tab. On 5/28/26 at 11:05 AM, the Director of Nursing (DON) responded she didn't know Resident #2's disposition or whether he passed away. The DON stated she hadn't looked at Resident #2's record recently and would need time to look it up. Review of the progress notes revealed they lacked any mention of Resident #2 passing away or the disposition of his belongings and medications. 3. The Census tab of the EHR reflected Resident #7 transferred to the hospital on 1/27/26, 2/23/26, and 3/16/26. Review of the clinical record for Resident #7 lacked documentation of a written bed hold notice or written orientation and transfer notification. 4. The Census tab of the EHR reflected Resident #52 transferred to the hospital on 2/15/26 and 2/19/26. Review of the clinical record for Resident #52 lacked documentation of any written bed hold notices. On 5/21/26 at 1:00 PM, Staff F, Minimum Data Set (MDS) Coordinator, reported Resident #52's son took Resident #52 out to the hospital in February 2026. Staff F recalled the son wanted to take her to the hospital and it wasn't uncommon for that to be the situation since he also took her to appointments. Staff F stated a transfer discharge note would be entered into the EHR. Staff F responded she didn't know what the staff were doing, but she'd send the Facesheet, transfer form, an order sheet, and call the hospital on why they sent Resident #52 to the emergency room. Staff F answered the process for a bed hold notice should've been to give it to the son when Resident #52 left for the hospital. The Director of Nursing (DON) responded she didn't know of any other documentation location other than the EHR under documents, progress notes, and user defined assessments where the bed hold notification would be found. The DON inquired if the facility was expected to notify the long-term care Ombudsman with transfers to the emergency room and received information that they were required to do so. An email confirmation from the Regional Director of Operations on 5/26/26 at 1:11 PM documented the facility couldn't locate any of the bed hold notices, which included Resident #1, Resident #2, Resident #7, Resident #52, and Resident #93. 5. The progress notes for Resident #93 dated 1/21/26 at 3:13 PM documented Resident #93 was transported to the hospital on 1/16/26 and returned to the facility on 1/19/26. (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the clinical record for Resident #93 revealed it lacked documentation of a bed hold notice. The Bed Hold Notice Upon Transfer policy revised March 2025 instructed at the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. Before a resident is transferred to the hospital or goes on therapeutic leave, the facility will provide to the resident and/or the resident representative written information that specifies the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility. The written information must specify the reserve bed payment policy in the state plan policy, if any, and the facility policies regarding bed-hold periods to include allowing a resident to return to the next available bed. The written notice must specify the conditions upon which the resident would return to the facility, including that the resident requires the services which the facility provides and is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. In the event of an emergency transfer of a resident, the facility will provide within 24 hours written notice of the facility's bed-hold policies, as stipulated in the State's plan. The facility will provide the receiving provider contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, advance directive information, and all special instructions or precautions for ongoing care, as appropriate. The facility will provide the receiving provider comprehensive care plan goals and all other necessary information, including a copy of the resident's discharge summary, as applicable, and any other documentation to ensure a safe and effective transition of care. The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **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 revise care plans to accurately reflect resident needs in a timely manner for 3 of 3 residents triggered for care plan revisions (Resident #1, #86, #52). The facility reported a census of 81 residents. Findings include: 1. The Notice of PASRR (Preadmission Screening and Resident Review) Level II outcome for Resident #1 dated 1/18/26 recorded a PASRR Determination for Resident #1 of Approved with Specialized Services. The census page of Resident #1's clinical record reflected the resident admitted on [DATE], transferred to the hospital on leave 2/4/26, readmitted on [DATE], transferred to the hospital on leave 2/16/26, and readmitted [DATE]. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 recorded a most recent admission date of 2/10/26. Section A1500 section PASRR coded as 1 which indicated the resident did have conditions related to ID/DD (Intellectual Disability/Developmental Disability). Section A1510 checked all boxes yes for serious mental illness, Intellectual Disability, or Other related conditions. The care plan dated 3/12/26 documented a newly created entry initiated on 3/10/26 for the PASRR Specialized Services the resident needed to achieve optimal functioning and recovery. The care plan recorded an intervention created on 3/10/26 documented the provider who would provide ongoing psychiatric medication management by a psychiatrist starting 2/10/26, with referral to be made 3/10/26. No indication in the document as to why there would be a 2/10/26 start date prior to the 3/10/26 referral date. The care plan recorded an intervention initiated 3/10/26 to identify a provider for individual therapy to start on 3/12/26. The care plan recorded an intervention initiated 3/10/26 for social services to provide supportive counseling starting 2/10/26 as well as activities to be encouraged by nursing facility staff starting 2/10/26. The care plan recorded an intervention initiated 3/10/26 for the facility to obtain the resident's archived psychiatric/behavioral health treatment records to clarify history and make past records available to all medical and behavioral health service providers. The intervention documented this activity as an important component in the delivery of effective behavioral health and overall health care services and must be implemented in order to see that the resident's mental health treatment records were complete and comprehensive and that they follow the resident to various behavioral health primary providers. The care plan lacked timely revision to update it to include the PASRR Specialized Services the resident required upon initial admission date of 1/19/26. 2. The MDS assessment dated [DATE] for Resident #86 recorded an admit date of 10/1/25. The MDS coded the resident weight as 143 pounds with no weight loss or weight gain triggered. The MDS assessment dated [DATE] coded the resident weight as 169 pounds with a weight gain of 5% or more in the last month or gain of 10% or more in the last 6 months. The MDS assessment dated [DATE] coded the resident weight as 164 pounds with a weight loss of 5% or more in the last month or loss of 10% or more in the last 6 months. The weights vitals page of Resident #86's clinical record revealed the following weight values: 10/1/25 at 5:08 PM 154.2 lbs. (pounds) by mechanical lift scale. This weight measurement struck out on 10/8/25 at 4:11 PM noting the strike out reason as technical error. 10/1/25 at 8:46 PM 154.2 lbs. by wheelchair scale. 10/3/25 at 10:52 AM 143.0 lbs. by mechanical lift scale. This weight measurement struck out on 12/17/25 at 8:47 PM noting the strike out reason as other. This entry was recorded by Staff G, Dietician. 10/4/25 at 8:21 AM 143.0 lbs. by mechanical lift scale. This weight measurement struck out on 12/17/25 at 8:47 PM noting the strike out reason as other. This entry was recorded by Staff G, Dietician. 10/9/25 at 2:20 PM 143.2 lbs. by sitting (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	scale. This weight measurement struck out on 12/17/25 at 8:47 PM noting the strike out reason as other. This entry was recorded by Staff G, Dietician. 10/16/25 at 8:47 AM 145.0 lbs. by wheelchair scale. This weight measurement struck out on 12/17/25 at 8:47 PM noting the strike out reason as other. This entry was recorded by Staff G, Dietician. 11/1/25 at 11:44 AM 166.0 lbs. by wheelchair scale. 12/1/25 at 1:39 PM 169.8 lbs. by wheelchair scale. 1/21/26 at 4:17 PM 177.6 lbs. by wheelchair scale. 1/21/26 at 7:18 PM 177.4 lbs. by wheelchair scale. 2/1/26 at 8:58 PM 150.2 lbs. by wheelchair scale. This weight measurement struck out on 2/18/26 at 4:40 PM noting the strike out reason as re-weighed. This entry was recorded by Staff G, Dietician. 2/18/26 at 4:40 PM 182.0 lbs. by wheelchair scale. 3/18/26 at 1:10 PM 164.4 lbs. by wheelchair scale. This weight measurement struck out on 5/7/26 at 2:20 PM noting the strike out reason as incorrect documentation. This entry was recorded by Staff G, Dietician. 5/7/26 at 2:20 PM 182.6 lbs. by wheelchair scale. On 10/1/25, the resident weighed 154.2 lbs. On 5/7/26, the resident weighed 182.6 lbs. which is a 18.42% Gain in 6 months. On 1/21/26, the resident weighed 177.6 lbs. On 5/7/26, the resident weighed 182.6 lbs. which is a 2.82% Gain in 3 months. The progress notes dated 12/17/25 at 8:48 PM documented a weight note for a weight gain with a current weight of 169.8 lbs. The entry recorded some questionable weights from the facility were discussed with the medical power of attorney and that the admit weight of 154.2 lbs. previously assumed to be in error was reentered in the weight record. The entry noted the weight gain was an FYI (for your information). The progress notes dated 1/23/26 at 8:02 PM documented a weight note for weight gain with current weight 177.4 lbs. The entry recorded a 15.0% weight gain since admit and the Dietician provided education on excess calorie intakes. The progress notes dated 4/3/26 at 10:25 PM recorded a nutrition note. The entry documented the March 26 weight likely in question as no changes with food consumption that would result in weight loss and no change with diuretic medication (helps rid body of excess fluid). The entry noted the facility would continue to follow up after the April weight obtained. The progress notes dated 4/10/26 at 12:36 PM recorded a mini nutritional assessment. The entry documented a weight of 164.4 lbs. on 3/18/26 and in the last 3 months, there had been a weight loss greater than 6.6 lbs. The care plan dated 5/12/26 recorded a focus area initiated 10/8/25 by Staff G, Dietician, that the resident was at risk for altered nutrition/hydration status. The goal section for this focus area revised 5/12/26 documented the resident would maintain a present weight of 148 lbs. plus or minus 4% (142-155 lbs.) by 7/1/26. The care plan lacked any documentation pertaining to a weight loss or a weight gain and it failed to have a revision to reflect the resident's weight of 182.6 lbs. as of 5/7/26. In an interview on 5/21/26 at 12:50 PM, Staff F, MDS/Care Plan Coordinator responded that the MDS information of a weight loss was accurate at the time of the completion as the weights used to calculate the loss were not struck out at the time of doing the MDS assessment. Staff F denied being aware of the discrepancies in the weight values and voiced the Dietician was responsible for completing the nutrition section of the MDS and care plan. 3. The MDS assessment dated [DATE] for Resident #52 identified a readmission date of 2/24/26. The MDS coded under the High-Risk Drug Classes: Use and Indication the resident took anticoagulant medication in the 7 days or less since admission and an indication was noted. The Care Plan dated 3/12/26 documented a focus area revised 8/4/25 that identified the resident was on anticoagulant therapy related to a history of DVT (Deep Vein Thrombosis) and PE (Pulmonary Embolism). The care plan intervention dated 8/19/25 directed staff to administer anticoagulant medications as ordered by physician and to monitor for side effects and effectiveness every shift. The Progress Note dated 4/29/26 at 12:00 AM recorded a Date of Service visit completed by the Nurse Practitioner and signed 4/29/26 at 6:38 PM. The entry documented the resident's vaginal bleeding resolved after inpatient treatment and the anticoagulation (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discontinued from the last hospitalization but still active on the patient's MAR and the patient refusing. The Xarelto discontinued as recommended. The Order Recap Report run on 5/21/26 at 11:25 AM identified Xarelto tab 20 mg 1 tablet by mouth daily with supper started on 10/2/25 and ended on 4/29/26. The care plan lacked revision to reflect the resident's anticoagulant medication Xarelto discontinued on 4/29/26. On 5/21/26 at 1:00 PM, Staff F, MDS Coordinator, responded she was just getting the facility on a revised schedule to have the care plans done quarterly and revised with the MDS assessments. Staff F stated prior to revision, the facility was updating care plans only with the IDT (Interdisciplinary Team) with falls, wounds, and behaviors. Staff F stated she had been working long enough to get back on a schedule. When asked what was previously getting completed, Staff F responded the baseline care plans done on admission, along with comprehensive and significant change assessments and care plans. When asked if anyone else updates care plans, Staff F responded anyone on IDT could do it but going forward she would. Staff F responded she was not aware the anticoagulant medication for Resident #52 was discontinued and the care plan should have been revised when the medication was discontinued. The facility policy titled Care Plan Revisions Upon Status Change revised January 2026 included the following documentation: Policy: The purpose of this procedure is to provide a consistent process for reviewing and revising the care plan for those residents experiencing a status change. Policy Explanation and Compliance Guidelines: 1. The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change. 2. Procedure for reviewing and revising the care plan when a resident experiences a status change: a. Upon identification of a change in status, the nurse will notify the MDS Coordinator, the physician, and the resident representative, if applicable. b. The MDS Coordinator and the Interdisciplinary Team will discuss the resident condition and collaborate on intervention options. c. The team meeting discussion will be documented in the nursing progress notes. d. The care plan will be updated with the new or modified interventions. e. Staff involved in the care of the resident will report resident response to new or modified interventions. f. Care plans will be modified as needed by the MDS Coordinator or other designated staff member. g. The Unit Manager or other designated staff member will communicate care plan interventions to all staff involved in the resident's care. h. The Unit Manager or other designated staff member will conduct an audit on all residents experiencing a change in status, at the time the change in status is identified, to ensure care plans have been updated to reflect current resident needs. 3. The MDS Coordinator will determine whether a Significant Change in Status Assessment is warranted. If so, the assessment will be completed according to established procedures.		

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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 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 recurringly 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 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/11/26 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 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: (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/13/26 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 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, (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 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 (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 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. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 #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, (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 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 (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 bathroom, stopped right before touching it, and placed them in her uniform pocket. Staff B then washed her hands after Staff A and donned new gloves. Resident #83 lay in bed with a thin floor mat in place and edge bolsters on the side of the bed. With gloved hands, Staff B removed the bolster from under the sheet and rolled the bed pad in half beside Resident #83. Staff B then removed her gloves, threw them away, and continued without washing hands to exit the room to get more wipes. Staff B returned and washed her hands. Resident #83's brief showed a blue indicator line from front to back, indicating a soiled brief. Staff A donned gloves and helped roll Resident #83 to his right side. Staff B moved the brief in front and tucked it between his legs. Staff A provided wipes and Staff B wiped in small areas, but Resident #83's legs were difficult to separate and staff failed to cleanse all areas where feces lay present. Staff B changed gloves but failed to wash her hands, donned new gloves, and rolled Resident #83 to his left side, though she 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 across the entire 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. Both of her gloves touched feces on the wipes and then touched Resident #83's right hip area to pull the brief out. Friction and shear could be heard audibly as Staff B pulled four times using moderate force to remove the brief, which made an 'eeking' sound against Resident #83's skin. The brief was soiled and Staff A failed to help pull Resident #83 over to provide access. Staff B again changed gloves and failed to wash or sanitize her hands, tucked a soiled bed pad under Resident #83, and placed a new brief. Resident #83 then rolled to the right, revealing an intact bandage labeled 5/12 over a pressure sore area. Staff A removed the soiled bed pad and continued with the same pair of gloves while staff rolled Resident #83 back. Staff failed to cleanse his scrotal area, lower abdomen, hips, penis, foreskin, or any areas contaminated with urine or feces where the brief contacted his skin. Both staff continued with the same pair of contaminated gloves, and Staff A placed items in trash bags, changed gloves without washing her hands, and adjusted the bed controls. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff B moved a glove box and wipes to the bedside tray table, covered Resident #83, and replaced the bolster. After items in the room were repositioned back to how they were found, Staff B moved a trash can. Staff A left the room with soiled bags of trash and linens and placed the trash in a bag on the floor in the hallway. Staff B then removed her gloves and washed her hands. Staff A placed the soiled linen bag in a room at the end of the hallway, sanitized her hands, and returned to the room to wash her hands. On 5/13/26 at 8:00 AM saw Staff TT, CNA, don a gown and gloves outside of room [ROOM NUMBER]. When asked how she knew whether the Enhanced Barrier Precautions notice on the wall indicated Resident #83 or Resident #12, Staff TT responded she was new to the facility but was told Resident #83 required precautions because he had a wound. Staff noted that during the incontinence care conducted earlier by Staff A and Staff B, neither aide donned personal protective equipment. On 5/13/26 at 9:33 AM Staff H asked if it could be clarified which care activities required gown protection. Staff H was questioned on what training she received about EBP and she responded that she hadn't received any specific training from the facility since her hire. Staff H commented she received training in a school program and was a brand-new aide who had worked at the facility for two months. 4. On 5/13/26 at 5:06 AM witnessed staff enter Resident #52's room to provide personal care while a strong ammonia smell filled the room. Staff B and Staff A washed their hands and donned gloves. Staff B uncovered Resident #52, adjusted the bed, and the bed control fell to the floor. Staff B removed her gloves and donned new gloves without washing her hands. Staff A placed a new brief and bed pad on the bed with a box of gloves without a barrier. Staff B stood on Resident #52's left side, undid her brief, and asked her to help open her legs. Staff B wiped her abdominal fold under the pannus (hanging flap of tissue) and barely down the middle between her legs, then stated, okay, we are done. Staff B changed her gloves but failed to wash or sanitize her hands. Staff helped roll Resident #52 to her right side, revealing a heavily soiled brief with feces present. 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 staff stepped 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 changed gloves, though no sanitizer lay present and the sink stood located in the bathroom. Staff continued care without washing or auditing their hands. Staff A and Staff B came around the curtain to place items in the trash, and Staff A stated they were going to change her gown. Both staff told Resident #52 they would help pull her up in bed and asked about placing pillows. Staff failed to go to the bathroom to access hand sanitizer or wash their hands and continued to handle trash bags and move items. Staff B left with a trash bag, returned, and stated she needed one more bag. Staff B returned and washed her hands, while Staff A remained on the other side of the curtain near Resident #52. At 5:18 AM Staff A went to the bathroom to wash her hands, while Staff B left the room with a soiled linen bag, returned, and washed her hands. 5. On 5/13/26 at 9:36 AM watched Staff H and Staff TT prepare to help Resident #85 with personal care after donning gowns and gloves. Prior to entering, Staff H asked what she needed to wear for personal protective equipment and what activities required precautions, commenting she knew at least for catheter care. Staff H was questioned on what training she received about EBP, and she (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	answered she was a new aide whose first job lasted two months and she received training in school but hadn't received any training from the facility. Resident #85 lay in bed on his back with a catheter present. Staff H wiped the left then right side of his groin and penis with a different wipe, then wiped down the catheter tube three inches with a new wipe. Staff H rolled Resident #85 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 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 a stack of feces wipes and a brief. Staff H grabbed the items, and both staff continued to place a new brief without changing their gloves. No wiping occurred across his hips or buttocks in contact with the soiled brief. Both staff then entered the bathroom, washed their hands, and donned new gloves; Staff TT emptied the catheter bag and Staff H helped Resident #85 change his shirt. A nurse entered the room and Staff H reported Resident #85 had a securement in place for the catheter but pulled it off during the night. Both staff helped roll Resident #85 back and forth to dress him and placed a transfer lift sling under him. Staff TT removed her gown and gloves, and bagged the trash and soiled linens. Staff H removed her gown and gloves but failed to wash her hands. Staff H then touched Resident #85's soda bottle, removed the cap, and provided him with a drink. Staff H positioned the bed down to transfer height and stated she would return with a nurse to provide gastrostomy feeding tube care. Leadership called Staff H over the radio and stated she was needed right then in the office, and Staff H left the room without washing her hands to sign a form. 6. On 5/13/26 at 11:41 AM witnessed a therapy staff member enter Resident #73's room and ask if she wanted to get up for lunch, and Resident #73 responded yes. Staff H entered and stated she would return with an EZ stand lift. Staff TT informed and redirected Staff H that Resident #73 lay on precautions, and Staff H and Staff TT donned personal protective equipment. Staff H acknowledged she last provided care for Resident #73 around 4:00 AM, and she commented that once you get behind in the day, everything just gets pushed back further. Staff H verbalized they just provided care for Resident #86 and got her out of bed, and she stated Resident #73 represented the last resident to get up for lunch. Staff H left the room to get more wipes, while Staff TT started donning pants on 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 (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews and policy review, the facility failed to label and date open food items in the refrigerator, and freezer. During the initial observation of the kitchen numerous food items were not stored in a safe manner that would prevent foodborne illness to the residents and several food cooking surfaces were in need of cleaning. The facility reported a census of 81 residents. Findings include: During the initial kitchen observation on 5/11/26 at 1:51 PM the walk through with the Dietary Director revealed the following: Dry Storage: An open, unlabeled, and undated bag of cheerios not taped shut. Cortonia noodles not labeled or dated. Cortonia Bowtie noodles not labeled or dated. Brown sugar container not labeled or dated. An open and uncovered butter container sitting on the counter with the butter knife sitting in it. Cooler: An open, unlabeled, and undated large bag of mozzarella cheese. The steam table had old food particles on it and had not been cleaned or sanitized after lunch. The top of the stove had not been cleaned and had food particles on it. On 5/11/26 at 2:30 PM the Dietary Director advised all food items should be labeled and dated if not in their original container. The items observed all should have been marked. Typically, on Mondays she checked all food items to ensure they are labeled and dated and she had not had a chance to do so that day. The Dietary Director advised she is short of staff but would get things cleaned as soon as possible. On 5/13/26 at 10:31 AM when queried, the head cook advised all open food items should be labeled and dated. The Sanitation Inspection policy dated March 2026 directed all food service areas shall be kept clean, sanitary, free from litter, rubbish and protected from rodents, roaches, flies and other insects. The department shall establish a sanitation program for food services based on applicable state and federal requirements. The sanitation program will provide for inspections to be conducted of the food service areas.		

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

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation and staff interviews, the facility failed to maintain essential equipment to ensure safe operating condition. On inspection, 2 out of 2 commercial dryer lint filters were completely filled with lint that decreased airflow. The facility reported a census of 81 residents. Findings include: During an observation on 5/13/26 at 3:35 pm, the facility laundry room contained 2 washers, actively washing loads and 2 dryers, one actively drying a blanket. Upon inspection of the dryer that was off, when opened, the dryer lint filter was completely filled and a moderate amount of lint was present on the bottom of the compartment. Upon inspection of the second dryer, the filter and compartment contained a larger amount of lint. During an interview on 5/13/26 at 3:35 pm, when inquired how often the dryer filters are cleaned, Staff CCC, Laundry aide stated she did not clean them as maintenance cleans them in the morning. During an interview on 5/13/2026 at 3:38 pm, Staff Q, Maintenance Director stated the lint filters were cleaned one time a day by the maintenance staff. When inquired to see his daily cleaning log, Staff Q stated he did not have a log form for the cleaning of the lint filers but will have one made immediately. Staff Q stated he will clean both dryer filters before further use. Manufacture instructions of the commercial dryer was not available.		

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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 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 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, (continued on next page)		

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

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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
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Taking all necessary actions as a result if 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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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 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 hooyer (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. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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) (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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, 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: (continued on next page)		

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

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 #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 (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interview, and policy review, the facility failed to ensure complete discharge planning and documentation for an individual who chose to leave the facility against medical advice (AMA) for 1 of 1 residents reviewed (Resident #92). The facility reported a census of 81. Findings include: Resident #92's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included diagnoses of surgical amputation (surgical removal of a body part) of the right great toe, deep venous thrombosis (DVT - blood clot in a deep vein), heart failure (weak heart), and hypertension (high blood pressure). The No Type Specified Progress Note dated 1/19/26 at 7:09 PM identified Resident #92 admitted to the facility from the hospital due to status post right great toe amputation and gangrene (dead tissue caused by a lack of blood flow) on his left great toe. The Encounter Progress Note dated 2/3/26 stated Resident #92 still didn't wish to go home at that time. However, he met the qualifications for home health care (medical care provided in a patient's home). The Nursing Note dated 3/6/26 at 10:22 PM revealed Resident #92 left the facility against medical advice (AMA) and signed the facility AMA form. The physician (medical doctor) notified. Resident #92 left the facility via an Uber (similar to a Taxi) with all of his belongings. Review of the clinical record lacked discharge documentation, discharge instructions, follow-up appointments, medication reconciliation (the process of comparing medication lists to prevent errors), and follow-up phone calls. The Discharge Against Medical Advice form dated 3/6/26 at 10:00 PM signed by Resident #92 included documentation that certified they left at their own insistence and against the advice of the facility and my attending physician. The facility informed them of the risks and potential complications of leaving at the time. The risks and potential complications include potential for injuries, infection, up to and including death. On 5/26/26 at 3:45 PM, the Director of Nursing (DON) stated she educated Resident #92 on treatments and the amputation of his left toe. She stated he just wanted to go home to be with his significant other. The DON reported she didn't have knowledge that anything happened, he just wanted to go home. The DON stated she also called Adult Protective Services (APS) but noted she didn't document the call anywhere. The DON stated the social services staff usually performed the follow-up phone calls and typically documented them in the nurses' notes. The DON stated she documented the education on the AMA form. On 5/26/26 at 4:47 PM, Staff R, Director of Marketing and Sales, stated she wasn't the social worker and wouldn't have made any follow-up phone calls. She stated that would've been the previous social worker who no longer worked at the facility. The Transfer and Discharge (including AMA) policy revised February 2025 stated it is the policy of the facility to permit each resident to remain in the facility, and not transfer or discharge the resident from the facility, except in limited circumstances. The policy applied to all residents regardless of their payment source. Discharges for AMAs include: a. AMA only applied when a resident expressed their wishes to be discharged earlier than outlined in the care plan. These situations do not apply if the facility offered to discharge a resident to a location which does not meet their health and/or safety needs, and the resident agrees. b. The resident and family/legal representative should be informed of the risks involved, the benefits of staying at the facility, and the alternatives to both. Under no circumstances will the facility force, pressure, or intimidate a resident into leaving AMA. c. The physician should be notified of the intended AMA discharge and be encouraged to speak with the resident to encourage them to stay at the facility. d. Documentation of this notification should be (continued on next page)		

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entered in the nurses' notes by the nursing department. The social service designee should document any discussions held with the resident/family in the social service progress notes, if present.e. Notify Adult Protection Services, or other entities as appropriate, if self-neglect is suspected. Document accordingly.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and facility policy review, the facility failed to document under Section A of the MDS assessment, the presence of a PASRR (Preadmission Screening and Resident Review) Level II condition of a serious mental illness and/or intellectual disability or related condition for 2 of 4 residents reviewed for accurate MDS (Minimum Data Set) assessments (Resident #1, #16). The facility reported a census of 81 residents. Findings include: 1. The Minimum Data Set (MDS) assessment dated [DATE] for Resident #1 recorded an admission date of 1/19/26. Section A1500 PASRR coded a 0 which indicated the resident did not have any conditions related to ID/DD (Intellectual Disability/Developmental Disability). Section A1510 was left blank with no check mark in either serious mental illness, Intellectual Disability, or Other related conditions. The Notice of PASRR Level II outcome dated 1/18/26 recorded a PASRR Determination for Resident #1 of Approved with Specialized Services. The notice contained instructions that the facility would need to mark Yes for question A1500 on the MDS. It also indicated the specific PASRR conditions should be checked in question A1510. The MDS assessment dated [DATE] recorded a readmission date of 2/10/26. The assessment did accurately code A1500 as a Yes and A1510 marked all 3 boxes yes for PASRR related conditions. The care plan dated 3/12/26 documented a newly created entry initiated on 3/10/26 for the PASRR Specialized Services the resident needed to achieve optimal functioning and recovery. 2. The MDS assessment dated [DATE] for Resident #16 recorded an admission date of 6/25/25. Section A1500 PASRR coded a 0 which indicated the resident did not have any conditions related to ID/DD (Intellectual Disability/Developmental Disability). Section A1510 was left blank with no check mark in either serious mental illness, Intellectual Disability, or Other related conditions. The Notice of PASRR Level I Screen Outcome dated 10/25/25 recorded a PASRR Level I Determination for Resident #16 of Level I Positive, No Status Change with Suspected or Confirmed PASRR Conditions of Mental Health Disability and Intellectual Disability. The notice documented No PASRR Level II Required, however, since the evaluation determined the resident had a PASRR condition, the notice contained instructions that the facility would need to mark Yes for question A1500 on the MDS. It also indicated the specific PASRR conditions should be checked in question A1510. In an interview on 5/21/26 at 12:50 PM, Staff F, MDS Coordinator, responded she had been doing the MDS assessments for the facility since October 2025. Staff F stated she used a residents' face sheet from the hospital and the PASRR documents to determine the answers for PASRR in Section A of the MDS. For Resident #1, Staff F reviewed the MDS dated [DATE] and the PASRR level 2 dated 1/18/26. Staff F stated she did not have any idea what happened and acknowledged the MDS should have been coded for the PASRR level 2. Staff F commented after looking at Resident #1's medical record the resident had discharged and readmitted and she did code the PASRR outcome appropriately upon the resident's return. Staff F responded she saw that Resident #16's Section A should have been marked as yes and that Staff F usually goes into the medical record to look at the PASRR notices before completing section A of the MDS. Staff F stated she would need to amend the MDS for Resident #16. 3. The facility policy titled Conducting an Accurate Resident Assessment revised March 2026 included the following: Policy: The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas. Policy Explanation and Compliance Guidelines: . 2. Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs, strengths, and areas of decline. The assessment will be documented in the medical (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record. 3. The appropriate, qualified health professional will correctly document the resident's medical, functional, and psychosocial problems and identifies resident strengths to maintain or improve medical status, functional abilities, and psychosocial status. 7. A registered nurse will sign and certify that the assessment/correction request is completed. Each individual who completes a portion of the assessment will sign and certify the accuracy of that portion of the assessment. Whether the MDS assessments are manually completed, or computer-generated following data entry, each individual assessor is responsible for certifying the accuracy of responses relative to the resident's condition and discharge or entry status.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan to include high risk medications and smoking status for 2 of 2 residents reviewed (Residents #1 and Resident #71) for Care Plans. The facility reported a census of 81. Findings include: 1. Resident #1's Minimum Data Set (MDS) assessment dated [DATE] identified a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. The MDS included diagnoses of diabetes mellitus (high blood sugar), anxiety (nervousness), depression (persistent sadness), and bipolar disorder (mood swings). Resident #1's Medication Administration Record (MAR) for May 2026 listed the following orders: Insulin Lispro (fast acting insulin) Injection 100/Milliliters (ML), inject 50 units subcutaneous (under the skin) every morning with breakfast Insulin Lispro Injection 100/ML, inject 36 units subcutaneous twice daily after lunch and supper Lantus Solostar (long-acting insulin) Injection 100/ML, inject 44 units subcutaneous at bedtime Freestyle LB Kit 2/sensor (continuous glucose monitoring device), apply to arm topically in the evening every 14 days for glucose (blood sugar) monitoring. The Comprehensive Care Plan initiated 1/22/26 revealed the facility failed to develop care plan interventions for diabetes mellitus and a high-risk medication for Resident #1. 2. On 5/20/26 at 1:40 PM, observed Resident #71 sitting outside smoking in the designated smoking area. Resident #71's MDS assessment dated [DATE] identified a BIMS score of 15, indicating intact cognition. The MDS included diagnoses of metabolic encephalopathy (altered brain function), liver cirrhosis (liver scarring), chronic obstructive pulmonary disease (COPD - progressive lung disease), anxiety, and depression. The admission Progress Note dated 8/20/25 documented Resident #71 smoked tobacco. The Comprehensive Care Plan initiated 8/21/25 revealed the facility failed to develop care plan interventions for smoking status with offered smoking cessation (stopping smoking) and safety strategies for Resident #71. The Resident Smoking Policy dated January 2025 instructed staff to ask all residents about tobacco use during the admission process and during each quarterly or comprehensive MDS assessment process. The policy directed residents who smoke undergo further assessment using the Resident Safe Smoking Assessment to determine whether staff supervision is required or if the resident can (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	smoke independently. The policy required that residents deemed safe to smoke, with or without supervision, utilize designated smoking areas in accordance with the care plan. The policy mandated that staff document all safe smoking measures on each resident's care plan and communicate the information to all staff, visitors, and volunteers responsible for supervising residents while smoking. The Comprehensive Care Plans Policy dated May 2026 instructed the facility to develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet medical, nursing, and mental and psychosocial needs. The policy directed the interdisciplinary team (IDT) to review and revise the care plan after each comprehensive and quarterly MDS assessment. The policy required that the care plan include measurable objectives and timeframes to meet the needs identified in the comprehensive assessment, utilize the objectives to monitor progress, and document alternative interventions as needed.		

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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 (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, and staff interviews, the facility failed to administer oxygen in accordance with physician orders for 1 of 2 residents reviewed (Resident #6). The facility reported a census of 81 residents. Findings include: Resident #6's Minimum Data Set (MDS) assessment dated [DATE] revealed active diagnoses of chronic obstructive pulmonary disease (COPD; a chronic lung disease causing breathing difficulty) and respiratory failure (a condition where lungs cannot provide enough oxygen) with hypoxia (lack of oxygen). Resident #6 made herself understood and usually understood others. Resident #6 required maximal to total dependency on staff for care. Resident #6's Care Plan directed staff to monitor and report oxygen (O2) saturation (SpO2; blood oxygen level) levels via pulse oximetry (a device that measures oxygen levels in the blood) as ordered and as needed, observe for respiratory changes, note mental changes, and monitor oxygen settings via nasal cannula (a plastic tube that fits behind the ears and delivers oxygen into the nose) as ordered. The Clinical Physician Order printed 5/13/26 included an order dated 2/17/26 to check SpO2 and liters of oxygen every shift, call the doctor if the blood oxygen level dropped below 90%, and administer continuous oxygen at 2 to 4 liters. On 5/12/26 at 11:00 AM, an observation showed Resident #6 in a wheelchair with an O2 tube in her nose. The portable oxygen tank level indicator sat in the red, which indicated the tank had an inadequate to no supply of oxygen. Resident #6 didn't realize that the tank didn't administer oxygen. The oxygen concentrator (a machine that filters room air to provide pure oxygen), set at 4 liters, stood right behind her with the tubing laying on the floor under her bed. The tubing didn't have a label with a date, and no black infection control bag was connected to the concentrator. The room had a very warm temperature, but Resident #6 didn't experience respiratory issues. The call light wasn't in her reach. During the continuous observation at 11:20 AM, a Licensed Practical Nurse (LPN) entered the room to administer medication to Resident #6's roommate, then left without checking on Resident #6. Two Certified Nursing Assistants (CNAs) stood just outside Resident #6's door but didn't enter the room. Review of Resident #6's Treatment Administration Record (TAR) dated May 2026 revealed that staff changed the oxygen tubing on 5/9/26. The record on 5/11/26 documented an oxygen saturation of 93% on 2 liters of oxygen, and the record on 5/12/26 documented an oxygen saturation of 94% on 2 liters of oxygen. On 5/12/26 at 11:24 AM, Staff BBB, CNA, stated that the nurse sets up the oxygen from the concentrator to the tank, and she denied placing Resident #6 on the portable oxygen. On 5/12/26 at 11:25 AM, Staff II, LPN, stated that she didn't know who assisted Resident #6 to the wheelchair and placed her on the portable tank. Staff II then walked away to locate her SpO2 meter, returned after a few minutes, and measured Resident #6's SpO2 at 93% with the oxygen set at 4 liters. On 5/12/26 at 11:30 AM, Staff AAA, Registered Nurse (RN), stated that she didn't take Resident #6 off the O2 concentrator and connect the portable tank before breakfast. Staff AAA stated that Staff S, CNA, assisted Resident #6 up to the wheelchair and out to breakfast, then brought Resident #6 back to her room after breakfast. On 5/12/26 at 11:31 AM, Staff S, CNA, stated that Resident #6 stayed connected to the portable tank before she was assisted from her bed that morning. Staff S stated that she didn't switch to the portable O2 because she didn't have training to do so. Staff S stated that she looked at the meter before propelling Resident #6 to the dining room at 7:30 AM and found the level indicator just a little bit above the red. Staff S didn't inform the nurse, and different staff assisted Resident #6 back to her room. On 5/13/26 at 9:06 AM, an observation showed Resident #6 in a wheelchair with an O2 tube in her nose. The portable oxygen tank level indicator sat in the green, but the oxygen meter was set on 0, which (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident #6 didn't receive a supply of oxygen. On 5/13/26 at 9:06 AM, Staff ZZ, CNA, stated that she just put Resident #6 in the wheelchair for a shower, placed the tubing in her nose, and paged Staff AAA. Staff ZZ stated that she wasn't allowed to adjust the oxygen level. On 5/13/26 at 9:09 AM, an observation showed Staff AAA arrived, placed the meter on 2 liters, and checked Resident #6's SpO2, which measured 93%. Staff ZZ then assisted Resident #6 into the shower room. On 5/28/26 at 4:02 PM, the Director of Nursing (DON) stated that the expectation was for nurses to manage the oxygen flow to residents and maintain the portable oxygen levels. The CNAs were to notify the nurse if the oxygen level indicator sat near the red. The facility's oxygen policy was requested from the DON but wasn't provided.		

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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 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right time right documentation. 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 (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, staff interview, and policy review, the facility failed to ensure the medication cart was locked when the Certified Medication Aide (CMA) responsible for the cart was not in sight. The facility reported a census of 81 residents. Findings include: On 5/18/26 at 10:54 AM to 11:12 AM, observed a medication cart on 300 hall unlocked and unsupervised, while nurses, Certified Nursing Assistants (CNA), and residents pass by. During a continued observation on 5/18/26 at 11:13 AM to 11:31 AM, 6 times, Staff I, Certified Medication Aide (CMA), approached the medication cart, prepared medications, leaving the medication cart unlocked, and walked into resident's rooms to administer the prepared medications. At 11:31 AM Staff I, CMA, returned to the medication cart, took the computer, locked the medication cart, and walked away. On 5/21/26 at 11:10 AM to 11:28 AM, observed a medication cart on 300 hall unlocked and unsupervised, while residents, housekeeping, and CNAs pass by. At 11:28 Staff J, Licensed Practical Nurse (LPN), approached the medication cart and locked it. During an interview on 5/27/26 at 4:00 PM, notified Facility Administrator and Director of Nursing (DON) of observations of the unlocked medication carts. No verbal response regarding the observation was received. The DON appeared frustrated, shaking her head, and continued to look at her computer, while the Facility Administrator took notes while failing to acknowledge the concerns. The Medication Storage Policy revised March 2026 instructed to store all drugs and biologicals in locked compartments (i.e. medications carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. Only authorized personnel will have access to the keys to locked compartments. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview, the facility failed to maintain accurate medical records for 2 of 2 residents triggered directly for review of accurate records (Resident #86, #72). The facility failed to record accurate weight records and maintain a clinical record without discrepancies for Resident #86 as 7 weight values struck out months after the initial recording of the values and the different areas of the clinical record did not reflect the same information pertaining to either a weight loss or weight gain. The facility also failed to record accurate clinical record for Resident #72 as the nurse practitioner documented an in the facility visit and a complete assessment for Resident #72 who was in the hospital, not in the facility. The facility reported a census of 81 residents. Findings include: 1. Resident #86's Minimum Data Set (MDS) assessment dated [DATE] recorded an admission date of 10/1/25. The MDS coded Resident #86's weight as 143 pounds (lbs.) and didn't trigger a weight loss or weight gain alert. Resident #86's Minimum Data Set (MDS) assessment dated [DATE] coded Resident #86's weight as 169 lbs. with a weight gain of 5% or more in the last month or a gain of 10% or more in the last 6 months. Resident #86's Minimum Data Set (MDS) assessment dated [DATE] coded Resident #86's weight as 164 lbs. with a weight loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. Resident #86 triggered a weight loss alert in the Long Term Care Survey Process (LTCSP) computer system for the State Survey Agency (SSA). The initial pool process on 5/11/26 revealed discrepancies in the Clinical Record because the record didn't show an actual weight loss. The weights vitals page of Resident #86's Clinical Record revealed the following weight values: 10/1/25 at 5:08 PM: 154.2 lbs. by a mechanical lift scale. Staff G, Dietician, struck out this weight measurement on 10/8/25 at 4:11 PM, noting a technical error as the reason. 10/1/25 at 8:46 PM: 154.2 lbs. by a wheelchair scale. 10/3/25 at 10:52 AM: 143.0 lbs. by a mechanical lift scale. Staff G struck out this weight measurement on 12/17/25 at 8:47 PM, noting other as the reason. 10/4/25 at 8:21 AM: 143.0 lbs. by a mechanical lift scale. Staff G struck out this weight measurement on 12/17/25 at 8:47 PM, noting other as the reason. 10/9/25 at 2:20 PM: 143.2 lbs. by a sitting scale. Staff G struck out this weight measurement on 12/17/25 at 8:47 PM, noting other as the reason. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10/16/25 at 8:47 AM: 145.0 lbs. by a wheelchair scale. Staff G struck out this weight measurement on 12/17/25 at 8:47 PM, noting other as the reason. 11/1/25 at 11:44 AM: 166.0 lbs. by a wheelchair scale. 12/1/25 at 1:39 PM: 169.8 lbs. by a wheelchair scale. 1/21/26 at 4:17 PM: 177.6 lbs. by a wheelchair scale. 1/21/26 at 7:18 PM: 177.4 lbs. by a wheelchair scale. 2/1/26 at 8:58 PM: 150.2 lbs. by a wheelchair scale. Staff G struck out this weight measurement on 2/18/26 at 4:40 PM, noting re-weighed as the reason. 2/18/26 at 4:40 PM: 182.0 lbs. by a wheelchair scale. 3/18/26 at 1:10 PM: 164.4 lbs. by a wheelchair scale. Staff G struck out this weight measurement on 5/7/26 at 2:20 PM, noting incorrect documentation as the reason. 5/7/26 at 2:20 PM: 182.6 lbs. by a wheelchair scale. The Clinical Record documented several weights in the last six months that staff struck out and removed. Without those weights, Resident #86 actually experienced a weight gain and not a weight loss since admission. On 10/1/25, Resident #86 weighed 154.2 lbs. On 5/7/26, Resident #86 weighed 182.6 lbs., which equals an 18.42% gain in 6 months. On 1/21/26, Resident #86 weighed 177.6 lbs. On 5/7/26, Resident #86 weighed 182.6 lbs., which equals a 2.82% gain in 3 months. The Progress Notes entry dated 12/4/25 at 12:24 PM recorded a communication note with Resident #86 Representative. The entry documented a discussion with Resident #86 Representative regarding Resident #86's weights. The entry recorded that Resident #86 Representative thought the admission weight of 143 lbs. represented an error, as it matched a weight from last summer when Resident #86 stayed at a previous facility. The Progress Notes entry dated 12/17/25 at 8:48 PM documented a weight note for a weight gain with a current weight of 169.8 lbs. The entry recorded that staff discussed some questionable facility weights with Resident #86 Representative. Staff re-entered the admission weight of 154.2 lbs., which they previously assumed contained an error, into the weight record. The entry noted the weight gain served as a for your information (FYI) notice. The Progress Notes entry dated 1/7/26 at 2:33 PM recorded a Mini Nutritional Assessment. The entry documented a current weight of 168.8 lbs. on 12/1/25 and indicated that Resident #86 hadn't (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experienced a weight loss in the last 3 months. The entry didn't mention a weight gain despite the difference from the original 10/1/25 admission weight value of 154.2 lbs. The Progress Notes entry dated 1/11/26 at 9:13 PM recorded a nutrition note. The entry documented that Resident #86 possessed a history of significant weight increases. The Progress Notes entry dated 1/23/26 at 8:02 PM documented a weight note for weight gain with a current weight of 177.4 lbs. The entry recorded a 15.0% weight gain since admission, and Staff G provided education on excess calorie intakes. The Progress Notes entry dated 4/3/26 at 10:25 PM recorded a nutrition note. The entry documented that the March 2026 weight likely remained in question because Resident #86 made no changes to food consumption that would result in weight loss, and staff didn't change the diuretic medication (helps rid body of excess fluid). The entry noted that the facility would continue to follow up after staff obtained the April weight. The Progress Notes entry dated 4/10/26 at 12:36 PM recorded a Mini Nutritional Assessment. The entry documented a weight of 164.4 lbs. on 3/18/26 and indicated that Resident #86 lost more than 6.6 lbs. in the last 3 months. The Care Plan dated 5/12/26 recorded a focus area that Staff G initiated on 10/8/25, noting that Resident #86 faced a risk for altered nutrition or hydration status. The goal section for this focus area, which staff revised on 5/12/26, documented that Resident #86 would maintain a present weight of 148 lbs. plus or minus 4% (142-155 lbs.) by 7/1/26. The Care Plan lacked any documentation pertaining to a weight loss or a weight gain. On 5/21/26 at 12:50 PM, Staff F, Minimum Data Set (MDS)/Care Plan Coordinator, and the Director of Nursing (DON) stated that neither knew why staff struck out the weight values. They verbalized that the Dietician held responsibility for striking out the weights in the medical record. Staff F responded that the MDS information regarding a weight loss remained accurate at the time of completion because staff hadn't struck out the weights used to calculate the loss when performing the MDS assessment. Staff F denied knowing about the discrepancies in the weight values and voiced that the Dietician held responsibility for completing the nutrition section of the MDS. The DON commented that the Dietician maintained responsibility for reweighing residents herself. 2. Resident #72's Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition, and required staff supervision while eating. The Nursing Progress Note dated 2/19/26 at 3:48 PM revealed that Resident #72 vomited two times in her room. Her vital signs showed temperature of 97.2, [NAME] of 68, respirations of 18, blood pressure of 129/65, and 95% on 3 liters (L) via nasal cannula (NC). Resident #72 stated the corn she ate for lunch caused it. Staff notified Staff DDD, Advanced Registered Nurse Practitioner (ARNP), and received a new order for Zofran, an anti-nausea medication, to administer as needed (PRN). (continued on next page)		

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing Progress Note dated 2/22/26 at 7:24 AM revealed parameters required staff to keep Resident #72's oxygen saturation level in blood (SPO2) above 90%, but the measurement dropped into the high 70% range. The nurse elevated her oxygen from 2 L to 4 L and called the healthcare provider, who recommended sending Resident #72 to the hospital. Staff transferred Resident #72 to the hospital. The Provider Progress Note dated 2/23/26 at 2:24 PM revealed that Staff DDD documented she saw Resident #72 for a routine follow-up. Staff DDD documented that Resident #72 sat in her room in no acute distress, wore oxygen, and offered no complaints of a cough or shortness of breath. The assessment included clear lungs and showed a stable blood pressure with vital signs from 2/22/26 at 7:26 AM: Temperature 97.3, Pulse 59, Respirations 20, Blood Pressure 118/77, and SPO2 94%. The documentation included that Resident #72's general state remained cooperative, and she appeared frail without acute distress. Staff DDD documented a complete exam, and the total time spent for the face-to-face encounter lasted 46 minutes. Staff DDD added an Addendum on 2/25/26 at 5:26 PM for an additional diagnosis. The Progress Note dated 3/3/26 at 12:04 AM revealed that Resident #72 returned from the hospital after receiving treatment for an upper respiratory infection (common cold). Resident #72 had a peripherally inserted central catheter (PICC) line (a special IV placed in a vein for antibiotic therapy). On 5/20/26 at 3:28 PM, an inquiry informed the DON of the documented examination that Staff DDD completed for Resident #72. The DON responded, What do you want me to do about it? The inquiry requested further action, and the DON replied that Staff DDD had documented an addendum.		

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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.		