STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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 0600 Level of Harm - Actual harm Residents Affected - Few	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 observations, interviews, and record review, the facility failed to ensure that a resident was treated with respect and dignity for 1 out of 3 residents reviewed (Resident #18). Resident #18 reported she had laid in urine for a delayed period of time without Staff X, Certified Nurse Aide (CNA), cleaning her up after asking this CNA to clean her up, causing her pain. This resident reported that she felt fearful that Staff X was going to hit her (Resident 18) and did not want Staff X to return to her room. The facility reported a census of 58 residents. Findings include:A Minimum Data Set, dated [DATE], documented that Resident #18's diagnoses included acute respiratory failure with hypoxia and cardiorespiratory conditions. A Brief Interview for Mental Status revealed a score of 13 out of 15, which revealed her cognition was intact. This resident was always incontinent of urine and bowel. She required substantial/maximal assistance to roll left and right in bed and to sit up and lie down in bed. She was dependent on staff for transfer. A Care Plan initiated on 4/29/26, documented that Resident #18 had a self care deficit as evidenced by requiring assistance with ADLs (Activities of Daily Living). The care plan directed Resident 18 required a 2 person assist for bed mobility and toileting. Staff were to provide peri-care with every incontinent episode and as necessary. This care plan documented that Resident #18 was incontinent of bowels and was at risk for impaired skin, rashes, and irritation in the peri-area. It directed staff to provide bedpan/bedside commode as Resident #18 requests, and to provide peri-care after incontinent episodes. It documented that REsident #18 was incontinent of bladder and at risk for impaired skin, UTI's (urinary tract infections), and irritation in the peri-area. Staff were to clean peri-area with each incontinent episode. It documented that Resident #18 is at risk for psycho-social well being deficit and is at risk for changes in appetite, sleep patterns, ADL's, mood, socializations and increased sensitivity to environment. Staff were to encourage Resident #18 to express her feelings and concerns, to listen with empathy and report additional needs to nursing. A 5-Day Investigation summary for Self-report 5/9/26, documented that Resident #18 reported the evening of 5/9/26 that a CNA was in her room assisting her and the CNA started yelling at her. Upon initial interview Resident #18 did not state exact quotes or words used but stated the: staff member yelled at her. The staff member was immediately sent home. The investigation summary documented that after further interview, Resident #18 stated she could not provide exact quotes but stated she heard the f word, you're lying and I will get even with you. On 5/11/26 at 1:07 PM, Resident# 18 was lying in bed. She stated that she didn't remember the girl's name. This resident stated she told Staff X that she needed changed (cleaned up after urination). Staff X had probably stopped in Resident #18's room [ROOM NUMBER] or 5 times that day, but wouldn't change Resident #18. Staff X told Resident #18 that she should not have turned her call light off as Staff X had turned it on. Resident #18 reported that Staff X left her lying flat and Resident #18 could not reach her bed controls. Resident #18 stated she called her grandson and told him, and then Staff X came back into the room and was upset. Staff X left again without cleaning Resident #18 up. Resident #18 said that Staff Z, Licensed Practical Nurse (LPN) entered this resident's room. Resident #18 told Staff Z that she needed to be changed and that she had been lying in her urine and (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 0600 Level of Harm - Actual harm Residents Affected - Few	it was starting to hurt. Staff Z replied that she would get the CNA and she would help clean this resident up. Staff Z then got the CNA and they started to clean me up. Staff Z had to leave the room. This resident stated that's when the CNA started yelling at this resident. This resident reported that Staff X said ?you know you got me in trouble. You are not the only person who needs help here and(Staff X) couldn't get to all of them'. Resident #18 stated that the CNA started to leave the room and then yelled at resident #18. Staff X was cussing too. This resident stated she was not used to that kind of language. Resident #18 stated she had never talked like that and neither had her daughter. This resident stated that maybe her grandsons and her son in law may talk like that but they do not do it in front of me. This resident said that Staff X then started coming toward this resident and this resident thought Staff X was going to hit this resident. Resident #18 told Staff X to get out of this resident's room and don't come back. Resident #18 stated she was afraid. She repeated she thought Staff X was going to hit her. This resident stated that she probably didn't have the right to say that because the facility isn't her place, but this resident was scared. When asked about her hurting related to lying in urine, she said oh they put a medicine on me and that took care of it. She stated they have been using that medicine. This resident could not say exactly how long she had been lying in urine. On 5/11/26 at 2:31 PM, Staff Z stated she did go into the room with Staff X and then she (Staff Z) had to leave. Staff Z said this happened around 6:30 PM., Staff X was upset. Resident #18 was the first one Staff Z went to to pass medication after Staff Z started her shift for that night. Staff Z stated this resident reported that she needed to be changed and had needed to be changed for a while. Staff Z went and found Staff X and Staff X said that nobody had helped her all day and she needed help. Staff Z and Staff X went and changed Resident #18. This resident required a complete bed change. Staff Z assisted with changing this resident. Resident #18 asked if she could get her night cares done, like brushing her teeth and washing her face. Staff Z told this resident that Staff X would finish up with brushing this resident's teeth. This resident had told Staff Z that she had been waiting to be changed since 2 p,m, and Staff X had been in the room several times and would not change her. This resident said this in front of Staff X and Staff Z. Staff Z thinks Staff X said something like ?no one would help'. Staff Z said Staff X said something about that she had left this resident's call light on to get help. Staff Z didn't remember if this resident's call light was on. There wasn't any tension that Staff Z had noticed when Staff Z left the room. STaff Z stated they might have put some moisture barrier on this resident's peri area. Staff X was in the room for a little bit after Staff Z left. After this Staff X went up to the nurses' station and wondered why somebody had turned off the call light. Staff Z stated she told Staff X the call light being shut off was beside the point, that Staff X had to take care of residents needs and that Staff X can't just leave the call light on for several hours. It was apparent this resident had been laying in urine for awhile and this resident had a bowel movement as well. She didn't say how long she had been lying in the feces. Staff X proceeded to say that nobody had helped her all day. Staff BB, Certified Medication Aide (CMA), said that was not true. Staff Z said that Staff BB told Staff X that they had been helping Staff X and Staff X had been on her ipad for 3 hours sitting in the chair. Then Staff X got upset and went back to the breakroom. Staff X then came out of the breakroom and went into Resident #18's room. Staff Z stated she didn't know what went on in Resident #18's room as it was just Resident #18 and Staff X in the room. Staff Z said that Staff Y, Registered Nurse (RN) asked what was happening. Staff X said Resident #18 did not want Staff X taking care of her and did not want Staff X back in the room. Staff Y then went to talk with this resident and Staff X to find out what was going on. Staff Y came out of the room with Staff X and said that Staff X was going to go home. Staff Z stated that she had not seen this resident get upset with any staff before. Staff Z stated that Resident #18 was a very sweet lady. She wasn't even upset about not even being changed for a few hours. On 5/11/26 at 2:53 PM, Staff Y, Registered Nurse (RN), stated that she was covering the floor in the backside of the building. Staff Y said that Staff X was up front and they were talking. Staff X came up to them and said Resident #18 didn't want Staff X in her room anymore. Staff X could not give a specific reason. Staff (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Y said let's go talk with Resident #18. Staff X didn't really go into the room when they went to go talk with Resident #18, she just stood in the doorway. Staff Y asked this resident what was going on. Resident #18 replied that she didn't want Staff X her room. Resident #18 stated she felt uncomfortable with Staff X and that Staff X was accusing this resident of turning off her own call light. Staff Y said this resident reported that Staff X was raising her voice at this resident and Staff X's tone of voice was raised and she was really sassy with what she was saying. This resident reported it made her feel uncomfortable. Staff Y said that this resident's grandson was on the phone with this resident. The grandson was saying he was getting dressed and was coming up to the facility right now to talk to Staff X. Staff Y stated the grandson said that Staff X was not going to talk to his grandma like that or treat his grandma that way. Staff Y stated that Staff X remained in the doorway and when Staff Y looked back at Staff X, Staff X kind of said under her breath she's lying, that's not true. Staff Y stated it wasn't an unsafe environment where the residents could not be cared for. She stated Staff X came in around 1:00 PM. on that day. Staff Y had told her multiple times to go help the other aides. Staff X would grab the tablet and look at it like she was looking at the care plans saying she didn't know them. She was just walking around like she was lost and she wanted to go fill ice cups. Staff Y stated she didn't feel Staff X was very competent with organizing her day and knowing what the needs were at that time. That was the conversation Staff Y had with Staff X. STaff Y stated that Resident #18 was a very sweet lady. She is alert and oriented X3. Staff Y told Staff X she didn't see why this resident would lie and also told Staff X that this resident wouldn't be able to reach behind her to turn the switch for the call light off because it needs to be turned off at the wall. Staff Y told Staff X to go home. Staff Y said it was around 4 pm when they were getting residents up. Staff Y stated she asked Staff AA, CNA and Staff BB what Staff X had been doing because none of her people were up. They said they didn't know but she clocked in early. Staff X may have helped with transferring maybe a couple of hours. Staff Y said Staff X had went to Staff Y several times to ask what she should be doing. Even after they got everyone up she asked what she should do. She just didn't seem like she knew what to do. Staff Y had directed Staff X to go talk to her team and see what she could do to help. Staff Y said that Staff X told Staff Z that she was going to answer call lights and Staff Z said can you finish up with Resident #18 first. Resident #18 told Staff Y that Staff X had left her lying flat on her bed when Staff X had left the room to get this resident a blanket. On 5/12/26 at 11:28 AM, this resident's grandson stated he was on facetime with his grandma. He stated during the phone conversation he could hear the staff person throwing the blanket at his grandma. The blanket covered the phone as the facetime call went dark. Staff X said ?you don't know anything, you turned your own call light off'. This grandson said that there was no possible way Resident #18 could have turned the call light off. This resident said during a 1:30 PM call (this grandson calls her several times a day just to check in on her) she still didn't have water that she had asked for at 1:00 PM. This grandson called her back at 7 PM to see how it was going and this resident told him they hadn't gotten her the water and they hadn't come in to change her, they hadn't done anything for her. He said that during the facetime call he overheard Staff X say to his grandma to 'Shut the fuck up. You know nothing, you are going to get me in trouble. You turned off your own call light, no one else turned it off.' Staff X was yelling at my grandma and definitely sounded threatening. He stated he was getting dressed and was going to get to the facility to intervene and get my grandma some help. He stated he was in tears because of what Staff X was doing to my grandma. He said he wanted to get up there and stop it. On 5/12/26 at 12:55 PM, Staff BB stated that Staff X didn't ask Staff BB for assistance. After supper Staff BB saw Staff X go into Resident #18's room [ROOM NUMBER] or 3 times. Staff BB saw Staff X grab wipes after she came out and then she went back in. Staff BB was standing with Staff Y, and Staff X was yelling at Staff Y saying it wasn't my (Staff X's) fault, I (Staff X) haven't gotten any help since I got here. Staff BB stated she said (to Staff X) you don't need to be lying, that's not true. Staff BB said she helped with transferring Staff X's residents and assisting to dine in the dining room. Staff BB told Staff AA before supper that she needed to help Staff get 2 (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	residents up for supper. Staff AA did go help her. Staff BB said she told Staff X that the ipad was attached to her hand since she got to the facility and she had been sitting down in the chair. Staff BB stated there is enough staff if we work together, but you have to communicate. STaff BB hadn't worked with Staff X before. She really didn't know much about Staff X and hadn't seen her interact with any of the residents. Staff BB stated she had told Staff X that if she needed assistance she needed to go to Staff AA and ask her. Staff BB said that she told Staff X this early on in the shift when Staff X first got there. Staff BB stated Staff X said 'I know, I know'. Staff BB said that the next morning, Resident #18 asked Staff BB if she heard- ?that girl was in here and was cursing at me and accused me of shutting off my own call light. She came to my room [ROOM NUMBER] or 4 times and she didn't do anything for me'. ON 5/12/26 at 1:13 PM Staff AA, stated that anytime she would ask Staff X for help, Staff X would put it off so I would have to ask the nurse. Staff X got there at 1 and sat around and did nothing. Later that evening, Staff X wanted to say that nobody was helping her and Staff BB defended us because we were all helping her. One of the aides from the back had to come help me lay a resident down because she hadn't laid anyone down. I think it was close to 7:30/8:00 PM when Staff X left. The CNA came up front from the back and it was like 8:15 PM and we didn't get everyone laid down until after 10:00 PM. This was just the residents on Staff X's hall. Staff AA was done with the residents on her hall around 7 PM. Some of the residents we laid down had not been changed in awhile. Residents don't ever really stay up that long. Staff AA said she oriented Staff X a while back roughly around the first of April. Anytime Staff AA would tell her to do something or try to guide her she would just go and do her own thing. Staff AA stated she would ask Staff X to do something easy like assist residents to dine. It was almost like she was too afraid to do anything by herself. She would bring people back to their rooms instead. On 5/12/26 at 2:09 PM, Staff X stated she arrived at the facility that day about 1:00 PM. She wasn't there to work (until 2:00 PM) but her supervisor told her to go ahead and clock in. Staff X went to the hall she knew she was assigned to and asked if anyone needed help. She ended up assisting another CNA in a different hall. She asked Staff BB and another CNA if they needed help and they didn't so she started passing ice water and checking rooms. Staff X wasn't feeling well. Rounds were not going to be done. Resident #18 had pushed her call button and wanted to be cleaned up. They had told Staff X to look at the kardex before she did anything and if Staff X was unable to do something she should not turn the call light off. Resident #18 asked if she could be cleaned up. Staff X thought this was around 3:45 or 4 PM. Staff X reported this to Staff Y and Staff Y stated Resident #18 would have to wait a little while as they were getting people up for dinner. Staff X asked Staff Y who had turned the call light off. Staff X really didn't know who turned the call light off. Staff X said she tried to talk to the lady (Resident #18). Didn't go into her room until 3:45 PM. Staff X stated there was no truth to her sitting in the chair most of the shift. She was trying to show the other staff that Resident #18 was a check and change with an assist of 2. She denied cursing in front of the resident. Staff X stated they had her pretty upset. Staff X knew how bad it looked. Staff X stated that when Staff Y told her Resident #18 would have to wait, Staff X thought ?we know how bad' that was going to look. Staff X denied asking this resident if she shut off her own call light. Staff X said she told Staff Y that staff were supposed to leave the call light on if someone still needed help. Other residents needed help too. Staff BB was yelling and screaming. Staff X said she then asked Staff Z who turned the call light off?. Staff X said Resident #18 told her she didn't want Staff X in her room. Other residents needed help too. Finally Staff Z came in and Staff X asked her if she could help clean up Resident #18 as she hadn't been cleaned up since Staff X started her shift. Staff X thought Staff Z started her shift around 6:00 PM. Staff Z started freaking out because Resident #18 hadn't been checked and changed. Staff Z told me this lady has not been cleaned up so we are going to go in and clean her up. Then Resident #18 told me that she didn't want me in her room. Staff X stated that when they finally changed Resident #18 she was a complete bed change. Staff X verified that she had started work around 1 p.m. that day, didn't check on Resident #18 until 3:45 PM, and knew at that time she needed to be changed, but did not change (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	her until after 6:00 PM. She stated she needed a second person and nobody would help her. Staff X stated that she had never been investigated before but prior to this was sent home for another resident who had concerns. Staff X stated the facility had brought her back but then this happened. 5/11/2026 12:12 PM Administrator acknowledged the concerns with this investigation. She stated that after their internal investigation this employee was no longer on their payroll. A Nursing Facility Abuse Prevention, Identification, Investigation and Reporting Policy updated on 7/8/24, included the following direction:To achieve compliance with state and federal requirements for preventing, identifying, investigation and reporting abuse in all CSSL facilities. Scope: All employees of [NAME] Street Senior Living managed facilities. Rational: All Residents have the right to be free from abuse, neglect, misappropriation of resident property, exploitation, corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This includes prohibiting nursing facility staff from taking acts that result in personal degradation* including the taking or using photographs or recordings in any manner that would demean or humiliate a resident, and prohibits using any type of equipment (c.g., cameras, smart phones, and other electronic devices) to take, keep. or distribute photographs and/or recordings on social media or through multimedia messages. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals. It shall be the policy of this facility to implement written procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident property.These procedures shall include the screening and training of employees, protection of Residents and the prevention, identification. investigation, and timely reporting of abuse, neglect mistreatment, and misappropriation of property, without fear of recrimination or intimidation. *Verbiage related to personal degradation is only written in lowa Code: therefore, only applicable to facilities located in lowa.Employee Screening: The facility shall screen all potential employees for a history of abuse, neglect, exploitation, misappropriation of property. or mistreatment of Residents. The facility will not employ or otherwise engage individuals who: (i) Have been found guilty of resident abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law: (ii) Have had a finding entered into the State nurse aide registry concerning resident abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property: or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. This will be accomplished through the following (including maintaining documentation of such results): Any of the following as a result of the willful misconduct or grossnegligence or reckless acts or omissions of a caretaker, taking into account the totality of the circumstances: a. A physical injury to, or injury which is at a variance with the history given of the injury, or unreasonable confinement, unreasonable punishment, or assault of a dependent adult which involves a breach of skill, care, and learning ordinarily exercised by a caretaker in similar circumstances. Assault of a dependent adult means the commission of any act which is generally intended to cause pain or injury to a dependent adult, or which is generally intended to result in physical contact which would be considered by a reasonable person to be in: insulting or offensive or any act which is intended to place another in fear of immediate physical contact which will be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act.b. Neglect of dependent adult? means deprivation of the minimum food, shelter, clothing, supervision, physical or mental health care. or other care necessary to maintain a dependent adult's life or physical or mental health. 6. Mental abuse is the use of verbal or nonverbal conduct which causes or has the potential to cause the resident to experience humiliation, intimidation, fear, shame, agitation, or degradation. 7. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds. to residents within hearing distance, regardless of age. ability to comprehend, or disability. Examples of mental and verbal abuse include, but are not (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	limited to: * Harassing a resident: * Mocking, insulting, ridiculing; * Yelling or hovering over a resident, with the intent to intimidate; * Threatening residents, including but limited to, depriving a resident of care or withholding a resident from contact with family and friends: and * Isolating a resident from social interaction or activities Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on the Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Reports, staff interviews, facility assessment review, and facility record review, the facility failed to provide sufficient staff to meet resident needs for 12 of 26 weekend days during the months of October, November, and December 2025. The facility reported a census of 58 residents. Findings include: The Centers for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for the facility for October 1 through December 31, 2025 revealed the facility had triggered the metric for Excessively Low Weekend Staffing which required follow-up during the survey process. The PBJ Nurse Staffing and Non-Nurse Staffing datasets provided information submitted by the facility on a quarterly basis. CMS had long identified staffing as one of the vital components of a nursing home's ability to provide quality care. In an interview on 5/5/26 at 1:59 p.m. Staff I, Certified Nursing Assistant (CNA) stated she had worked at the facility since July 2024. She stated the facility was really short staffed and as a result the residents showers had not been completed as assigned. In an interview on 5/6/26 at 8:26 a.m. with Staff M, CNA stated We used to have 4 CNA's but currently we have 3 [CNAs] and have been running around like chickens with our heads cut off. I don't even have time to chart as she had wiped sweat off her forehead and then she helped to pass breakfast trays to the residents. In an interview on 5/6/26 at 2:00 pm. Staff N, CNA stated she had worked at the facility for one year. She stated that down the hall that she had been assigned, she was by herself that day with six residents that required a Hoyer lift to transfer and at least eight residents that required two staff members to care for them. She stated I don't like the staffing and that the facility managers needed to look at how much care the residents needed. She stated that most of the staff try to get the residents showered as assigned, but the agreed that resident showers had not always been completed. She stated she felt that all the tasks assigned was not getting done, and stated at times the staff cannot get residents' incontinent pads checked and changed every two hours according to the residents' care plans. She stated I just feel we just don't have enough time [or staff] to give adequate care. In an interview on 5/6/26 at 2:54 p.m. with Staff O, CNA stated she had been a CNA for 20 years. She stated that staffing gets stressful at times and that at times she would stay to work the next shift because another CNA staff person had called in. She stated she was stressed as for the upcoming weekend the nursing schedule was short staffed. In an interview on 5/7/26 at 12:50 p.m. with the Administrator the PBJ Staffing Data Report for October 1 through December 31, 2025 was discussed which revealed the facility had triggered the metric for Excessively Low Weekend Staffing and the weekend Daily Staffing sheets were requested for those months. Review of the facility's 2026 Facility Assessment, revised November 2025 revealed it had been reviewed on April 2026 by the Administrator. The stated purpose of the Facility Assessment was a complete review of internal human and physical resources required by the facility to care for residents competently during day to day (including nights and weekends). operations. The assessment identified two distinct nursing units and that the CNAs were scheduled for three different eight-hour shifts: Day, Evening, and Night. On the Day Shift there were seven to eight CNAs needed, three on the smaller nursing unit and four to five on the larger nursing unit. On the Evening Shift, there were six to eight CNAs needed, two to three on the smaller unit and four to five on the larger nursing unit. On the night shift three to four CNAs were needed, the assessment did not differentiate the nursing units for the night shift. The assessment identified the licensed nurses were scheduled for two different 12-hours shifts: Day and Night. Each shift had two to four nurses working or a combination of nurses and Certified Medications Assistants (CMAs). The assessment did not differentiate the number of nurses/CMAs for each nursing unit. A review on the requested weekend Daily Staffing sheets for October 1 through December 31, 2025 revealed: a. On Sunday, 10/5/25: The Day Shift on the larger nursing unit was staffed with three CNAs. The Facility Assessment (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented four to five CNAs were needed. The Evening Shift on the larger nursing unit was staffed with four CNAs, but two of the CNA staff were crossed out with CI (Called In) noted by their names, which left two CNAs. The Facility Assessment documented four to five CNAs were needed. The Night Shift for the facility was staffed with one CNA on the smaller nursing unit and two CNAs on the larger nursing unit, but one of the CNA staff was circled with CI noted by her name, which left two CNAs for the night shift for the facility. The Facility Assessment documented three to four CNAs were needed. b. On Saturday, 10/11/25; Sunday, 10/26/25; the Evening Shift on the larger nursing unit was staffed with three CNAs. The Facility Assessment documented four to five CNAs were needed. c. On Sunday, 11/9/25 the Day Shift on the larger nursing unit was staffed with three CNAs. The Facility Assessment documented four to five CNAs were needed. c. On Sunday, 11/16/25:The Day Shift on the larger nursing unit was staffed with four CNAs, but one CNA was circled with NCNS (No Call No Show) noted by her name and another CNA was circled with CI noted by her name, which left two CNAs. The Facility Assessment documented four to five CNAs were needed. The Evening Shift on the larger nursing unit was staffed with four CNAs, but one CNA was circled with CI @ 2pm (Called In at 2:00 p.m.) noted by her name, which left three CNAs. The Facility Assessment documented four to five CNAs were needed. d. On Saturday, 11/22/25 the Day Shift on the larger nursing unit was staffed with five CNAs, but three CNAs were circled with CI noted by each of their names, which left two CNAs. The Facility Assessment documented four to five CNAs were needed. e. On Sunday, 11/23/25 the Day Shift on the larger nursing unit was staffed with four CNAs, but one CNA had been moved to the smaller nursing unit for a CNA that had CI noted by their name, which left three CNAs, The Facility Assessment documented four to five CNAs were needed. f. On Sunday, 11/30/25 the Day Shift on the smaller nursing unit was staffed with three CNAs, but on CNA had been crossed out with CI noted by their name, which left only two CNAs. The Facility Assessment documented three CNAs were needed. g. On Saturday, 12/6/5 for the Evening Shift:The smaller nursing unit was staffed with one CNA. The Facility Assessment documented two to three CNAs were needed. The larger nursing unit was staffed with three CNAs. The Facility Assessment documented four to five CNAs were needed. h. On Sunday, 12/14/25, the larger nursing unit had three CNAs scheduled. The Facility Assessment documented four to five CNAs were needed. i. On Saturday, 12/20/25 the smaller nursing unit had three CNAs scheduled with two CNAs crossed out with CI noted by their names, which left one CNA and an RN/CNA or two CNAs. The Facility Assessment documented three CNAs were needed. j. On Sunday, 12/21/25 the Day Shift on the smaller nursing unit was staffed with two CNAs. The Facility Assessment documented three CNAs were needed. In an interview on 5/11/26 at 12:06 p.m. with the Administrator the days noted above with excessively low staffing were reviewed. The Administrator revealed that the CI noted on the Daily Staffing sheets indicated that the CNA staff member had Called In for the shift that day and had not reported for work. She also revealed that the NCNS noted on the Daily Staffing sheets indicated that the staff person had been a No Call No Show for the shift that day, meaning that staff person had not called in and had not reported for work that day. The Administrator agreed with findings for the days and shifts noted above with excessively low weekend staffing.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to assess if a resident was appropriate to self-administer medications for one of one residents review for self-medication administration. Resident#54 was left unsupervised with medications. The facility reported a census of 58 residents. The Minimum Data Set (MDS) dated [DATE] for Resident #54 revealed the diagnoses of a heart dysrhythmia, high blood pressure, arthritis, depression and long-term gall bladder inflammation. The MDS identified that Resident #54 was taking antidepressant medication. A Brief Interview for Mental Status (BIMS) score of 13 suggested Resident #54 was cognitively intact. The Care Plan for Resident #54 revealed the risk for pain, a potential for altered mood and was elected for Hospice care due to his terminal condition. The Hospice care plan directed licensed nursing staff to provide medications as ordered. During an observation on 5/4/26 at 1:05 pm, Resident #54 was laying in bed with a bedside stand in front of him with a medication cup that contained a large pink pill, a large white pill and two smaller pills. It appeared that Resident #54 had a pill in his pinched fingers of the right hand. There was no licensed nursing staff in the room with Resident #54. Two Certified Nursing Assistants (CNA's) were assisting the room mate into the other bed in the room. Subsequent observations on 5/4/26 revealed: a. At 1:09 pm, Resident #54's left hand was holding the medication cup on his night stand with the same amount of medication in it.b. At 1:11 pm, Staff E, Licensed Practical Nurse (LPN) was in the hall outside Resident #54's room talking with another resident, then walked away.c. At 3:00 pm, Resident #54 continued to have the medication cup that contained the same medication on his night stand. During an interview on 5/4/26 at 3:00 pm, Resident #54 stated he could administer his own medication as he continued to hold the medication cup with the same medication in it. During an observation on 5/4/26 at 3:35 pm, after notifying Staff E, LPN that Resident #54 had medication on his night stand, Staff E took the medication cup, picked up the pill on Resident #54's blanket and stated, They are late, now I will have to see what they want me to do. Staff E left the room and Resident #54 shrugged his shoulders. During an interview on 5/4/26 at 3:35 pm, Staff E, LPN stated the medication in the medication cup was brought to Resident #54 earlier this morning. Staff E stated she then was asked to assist across the hall with a resident utilizing a mechanical lift. Staff E stated she had left the medication with Resident #54 and did not return to his room to see if he had taken them. The Medication Administration Record (MAR) dated May 2026 for Resident #54 revealed the following 6 am medications were administered and initialed by Staff E, LPN included:1. Allopurinol Oral Tablet 300 milligram (MG)(Allopurinol) Give 1 tablet by mouth in the morning for gout.2. Gabapentin Oral Capsule 300 MG(Gabapentin) Give 1 capsule by mouth in the morning for pain.3. Omeprazole Oral Tablet Delayed Release 20 MG (Omeprazole) Give 1 tablet by mouth in the morning for bile duct obstruction.4. Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth in the morning for depression.5.Sennosides Oral Tablet 8.6 MG (Sennosides) Give 1 tablet by mouth two times a day for constipation prevention.The Progress note dated 5/4/2026 at 3:45 pm revealed Resident #54 was requesting to only take the pills that are a necessity and was refusing to take the supplements. Staff E, LPN reached out to Nurse Practitioner to get a one-time order to administer Senna, Allopurinol, Omeprazole and Sertraline late. During an interview on 5/05/2026 at 1:59 pm, Staff I, Certified Nursing Assistant (CNA) reported observations of nurses leaving medications with resident's and walked away on multiple occasions. Staff I stated on 5/4/26 at 12 pm, Resident #54 was known for not taking his medication, noticed he still had his medication and notified Staff E, LPN.The VP of Clinical Operations provided a document titled Medication Administration Audit Report for Resident #54 dated 5/6/26 at 12:30 pm that revealed the Omeprazole, Allopurinol, Gabapentin, Sertraline and Sennosides were documented as administration date 5/4/26 at 9:03 am by Staff E, LPN. During an interview on 5/6/26 at 12:45 pm, The VP of Clinical Operations stated Resident #54 did not have an order to administer his own medication.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and resident council meeting, the facility nursing staff failed to notify the physician of a change of condition for 1 of 3 residents were reviewed (Resident #11). During a resident council meeting, Resident #11 reported having chest pain during the night to Staff J, Activities Director. Staff J filled out a grievance form and gave it to the Director of Nursing (DON) who failed to follow up and report the episode to the physician. The facility reported a census of 58 residents. Findings include:The Minimum Data Set (MDS) dated [DATE] for Resident #11 revealed the diagnoses of Parkinson's and was independent for activities of daily living. Resident #11 denied pain during the assessment. The Brief Interview for Mental Status (BIMS) score was 15 suggested an intact cognition.The Care Plan directed staff to monitor and document pain for probable cause of each pain episode and notify the physician if pain was a significant change from past experiences. During an interview on 5/4/26 at 1:26 pm, Resident #11 stated she had experienced chest pain during the night on 4/27/26, notified Staff G, Certified Nursing Assistant (CNA) and requested to see Staff H, Licensed Practical Nurse (LPN). Resident #11 stated the pain was a crushing pain that lasted about 15 minutes and she felt scared. Resident #11 stated the nurse did not respond, the pain subsided and she did not tell the nurse the next day. Resident #11 did inform staff in the Resident Council meeting on 4/28/26. A review of the Progress Notes for April/May 2026 revealed no documentation of Resident #11 had chest pain nor provider and family notification.During an interview on 5/04/2026 at 2:42 pm, Staff E, LPN stated she would believe Resident #11 if she would tell her anything, she was very believable. Staff E stated Resident #11 had not reported having chest pain. Staff E stated she would assess Resident #11 and give a report to the nurse practitioner tomorrow. During an interview on 5/7/26 at 8:38 am, Staff J, Activity Director stated on 4/28/26 was the first resident council she conducted. Staff J stated during the Resident Council meeting, Resident #11 stated she had chest pain overnight on 4/27/26 and the nurse did not come see her. Staff J stated she asked the Administrator what I do with the notes of concerns and was given grievance forms to fill out. Staff J stated she filled out a grievance form and gave it to the Director of Nursing (DON) the next morning on 4/29/26. During an interview on 5/07/2026 at 8:55 am, The Administrator stated when Staff J, Activity Director inquired what to do with the resident council concerns, she was given grievance forms to fill out and directed to give them to the responsible manager. The Administrator stated Staff J mentioned another resident's concern but couldn't remember if she was informed that Resident #11 having chest pain. The Administrator stated chest pain was a concern that would require immediate nurse assessment. During an interview on 5/06/2026 at 3:29 pm, The DON stated she was aware that Resident #11 complained of chest pain during a night shift and she told the CNA, who did tell the nurse but when they went back in to assess her she was asleep. The DON stated she was aware that Resident #11 filed a grievance that she complained of chest pain and the nurse did not come in to assess her. When inquired where it was documented that Resident #11 had chest pain, and the assessment and inquired if the provider was notified, the DON said no. The surveyor informed the DON that Resident #11 had the chest pain and informed Staff E, LPN on 4/4/26 who stated she would conduct an assessment and will notify the provider but there was no documentation of that assessment nor provider notification. The DON stated she would check on that but failed to provide a response to the survey team.During an interview on 5/7/26 at 8:26 am, Staff H, Licensed Practical Nurse (LPN) stated that he was the charge nurse on the over-night shift on 4/27/26. Staff H denied being informed of that Resident #11 had chest pain. Staff H stated if he was informed of that, he would have provided an assessment, notified the provider and provided pain management. Staff H verified he had worked on Resident #11's hall with Staff G, CNA and denied that the CNA had mentioned the chest pain episode.During an interview on 5/11/26 at 2:49 pm, The (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator stated she was going to need to meet with the DON as the time lines did not make sense on the grievance form and the investigation of the grievance.During a follow up interview on 5/11/26 at 3:19 pm, The Administrator stated she had a conversation with the DON, who stated she had dated everything with the date of the grievance report, 4/28/26, due to her inability to remember what day she was notified of Resident #11's episode. The Administrator stated the DON reported that she told Resident #11 that she planned to discuss the situation with the LPN and the CNA involved.A document dated 4/30/26 a note to Staff F, LPN that revealed a directive from the DON to have a discussion with Staff G, CNA related to care expectations and reporting concerns. The document listed the complaint from Resident #11 regarding the chest pain episode that was not verified with Staff H, LPN as of yet. The document stated the report of concerns, especially chest pain, needed to be reported to the nurse immediately. The directive included to monitor Staff G for the next 3 shifts and notify the DON in writing if there were further concerns.

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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. Based on record review and interviews, the facility failed to do the assessment for an initial Brief Interview of Mental Status (MDS), for Resident #34. The facility reported a census of 58 residents. Findings include:A Brief Interview of Mental Status (BIMS) dated 3/17/26 at 11:39 a.m., documented that Resident #34 was not assessed. On 5/7/26 at 12:41 p.m., the Administrator stated that the BIMS was not done with Resident #34's initial MDS. They had a PRN (as needed) traveling MDS person who worked on the MDS remotely. There was a miscommunication and it did not get conveyed to social services or anyone on the team in the facility that an MDS assessment needed to be done. A PRN BIMS was done today. A BIMS (PRN) dated 5/7/26 at 11:30 p.m., documented a score of 8 out of 15, which indicated moderately impaired cognition for Resident #34. A MDS 3.0 Completion policy dated 2025, directed the following:Policy:Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Definitions: OBRA Assessment refers to an assessment mandated by the Omnibus Budget Reconciliation Act of 1987, which specifies a Minimum Data Set (MDS) of core elements for use in assessing nursing home residents. PPS Assessment refers to an assessment used in the skilled nursing facility prospective payment system to classify residents into categories for payment purposes. ARD, or Assessment Reference Date, refers to the specific endpoint in the MDS assessment process (last day of MDS observation period). Comprehensive Assessment refers to the completion of the MDS, Care Area Assessment (CAA) process, and development and/or review of the comprehensive care plan.Policy Explanation and Compliance Guidelines:According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each resident's functional capacity, using the RAI specified by the State.Types of OBRA Assessments:Entry TrackingComplete and submit with every entry into the facility no later than entry date + 7 calendar days.The staff member who is completing the entry tracking enters his/her signature, title, and date completed.The Entry Tracking does not require an R.N. Coordinator's signature and may be completed and signed by any member of the interdisciplinary team.admission Assessment - completed within 14 days of admission counting the day of admission as day #1 when:The resident has no prior admission, orPrior admission was less than 14 days and no admission assessment was completed during the prior admission, orPrior admission ended with a Discharge Return not Anticipated; orPrior admission ended with a Discharge Return Anticipated and re-entry occurred >30 days after the discharge date .Annual Assessment - a comprehensive assessment completed using an ARD no >366 days from the most recent prior comprehensive assessment and no >92 days from the most recent quarterly assessment (counting ARD to ARD).Significant Change in Status Assessment (SCSA) - a comprehensive assessment completed within 14 days of the identification of a status change that meets the requirements outlined in Chapter 2 of the Version 3.0 RAI Manual.A significant change is a major decline or improvement in a resident's status that: (1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting, if a decline); (2) impacts more than one area of the resident's health status, and (3) requires interdisciplinary review and/or revision of the care plan.A SCSA is required when a resident enrolls in a hospice program or changes hospice providers and remains in the facility, or a resident in the facility receiving hospice services discontinues those services (known as revocation of hospice care) and remains in the facility.A SCSA cannot be completed prior to the completion of an OBRA admission assessment.Quarterly Assessment - completed using an ARD no >92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD).Discharge Assessment - completed using the discharge date as the ARD. Must be completed within 14 days of the discharge date /ARD.Significant Correction of a Prior Comprehensive Assessment - a comprehensive assessment completed when the resident's overall clinical status was not accurately represented (i.e., miscoded) on the erroneous comprehensive assessment and the error has not been corrected via (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	submission of a more recent assessment. Not to be confused with a Significant Change in Status Assessment. It must be completed no later than 14 days after the ARD and not later than 14 days after the determination was made that a significant error occurred.Significant Correction of a Prior Quarterly Assessment - completed when the resident's overall clinical status was not accurately represented (i.e., miscoded) on the erroneous quarterly assessment and the error has not been corrected via submission of a more recent assessment. Not to be confused with a Significant Change in Status Assessment. It must be completed no later than 14 days after the ARD and no later than 14 days after determining that the significant error occurred.Death Tracking Complete when a resident expires in the facility or when on LOA no later than discharge (death) date + 7 calendar days.The staff member completing the death tracking enters his/her signature, title, and date completed.The Death Tracking does not require an R.N. Coordinator's signature and may be completed and signed by any member of the interdisciplinary team.Types of PPS Assessments:5 Day/Initial Assessment The ARD must be set for days 1 through 8 of each Part A SNF covered stay.Must be completed within 14 days after the ARD (ARD + 14 days). If combined with the OBRA assessment, it must be completed by the end of day 14 of admission (admission date + 13 days). This assessment authorizes payment for the entire PPS stay (except in cases when an IPA is completed).Part A PPS Discharge Assessment - required under the Skilled Nursing Facility Quality Reporting Program.This assessment is completed on planned discharges when a resident's Medicare Part A stay ends, but the resident remains in the facility (unless it is an instance of an interrupted stay).If the End Date of the Most Recent Medicare Stay occurs on the day of or one day before the discharge date of a planned discharge, the OBRA Discharge Assessment and the Part A Discharge Assessment are both required and must be combined. When the OBRA and Part A PPS Discharge assessments are combined, the ARD must be equal to the discharge date .Must be completed within 14 days of after the End Date of Most Recent Medicare Stay.Interim Payment AssessmentThis is an optional assessment that authorizes payment for remainder of the PPS stay, beginning with the ARD.The assessment is completed as the SNF determines is necessary to account for changes in patient care needs. See Interim Payment Assessment (IPA) Policy.If performed, it must be completed within 14 days after the ARD (ARD + 14 days).Optional State Assessment - this is a standalone assessment required at the discretion of the state agency for payment purposes.Care Plan Team Responsibility for Assessment Completion:Interdisciplinary Responsibility for Completion of MDS Sections:The responsibility of all sections of the MDS will be clearly assigned. See MDS 3.0 Responsibility by Discipline supplemental document.Persons completing part of the assessment must attest to the accuracy of the section they completed by signature and indication of the relevant sections.The R.N. Coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI, once all other disciplines have completed their sections.Coding of Assessment:All disciplines shall follow the guidelines in Chapter 3 of the current RAI Manual for coding each assessment.Within 7 days after completing a resident's MDS assessment or tracking record, the facility must encode the MDS data (i.e., enter the information into the facility MDS software).Assessment Reference Date:The assessment reference date is established as reference point for all staff participating in the assessment process. Although staff members may work on completing a resident's MDS on different days, establishment of the assessment reference date ensures the commonality of the assessment period.Observation should continue through the assessment reference date at midnight.Interviews such as the BIMS, PHQ-2 to 9, Pain Interview, and Preferences for Customary and Routine Activities should be completed on or before the ARD.Care Area Assessment (CAA's):The CAA process outlined in Chapter 4 of the RAI manual is designed to assist the assessor in systematically interpreting the information recorded on the MDS to facilitate decision making regarding the resident's plan of care.There are 20 CAAs. The responsibility for completion of each CAA will be clearly assigned. See CAA and Care Plan Division of Responsibility - Expectation List supplemental document.Based on the CAA review, key findings regarding a resident's status are documented, including the nature of the condition, complications and (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	risk factors that affect the care planning decision, factors that must be considered in developing care plan interventions, and the need for referrals or evaluation by appropriate health professionals.Written documentation of the CAA findings and decision-making process may appear anywhere in the resident's record. Use the relevant columns on the CAA summary section of the MDS to document location and date of the information, and the decision to proceed or not to proceed to care planning.The CAA's are completed no later than 14 days after admission and each time a comprehensive MDS is completed.The R.N. overseeing the completion of the CAA's will sign the CAA Summary section at the Signature of R.N. Coordinator for CAA Process and Date Signed section. The date the process was completed will be entered beside the signature.The signature of the Person Completing Care Planning Decision can be any designated member of the care plan team or persons who facilitate the care planning decision-making process. The date entered here is the date the care plans for all triggered CAA's are complete.The care plan is completed no later than 7 days after the date in V0200C (CAA's completion date) as well as no later than 21 days from the date of admission in cases where the comprehensive assessment is an admission MDS.Correction of Errors on the Assessment:Errors identified prior to being submitted into iQIES or were submitted and rejected must be corrected. The facility has up to 7 days to encode and edit an MDS assessment after the MDS has been completed. (See the current RAI Manual Version 3.0 Chapter 5, 5.6 for details relating to significant errors vs. minor errors.)Errors identified in iQIES records must be corrected within 14 days after identifying the errors. Errors may include transcription errors, data entry errors, software product errors, item coding errors or other errors. Correction processes for MDS records that have been accepted into iQIES include Modification Requests, Inactivation Requests, and MDS 3.0 Individual Correction/Deletion or Move Requests.Modification Request:A Modification Request is used when an MDS record (assessment, entry tracking record, or death in facility tracking record) is in iQIES (already transmitted and accepted by CMS), but the information in the record contains clinical or demographic errors. It must be corrected within 14 days after identifying the errors. (See the current RAI Manual 3.0 Chapter 5, 5.7 for details relating to significant vs. minor errors.)The modification process is not permitted for certain items. The exceptions are listed in the current RAI Manual Version 3.0, Chapter 5.7.Inactivation Request:An inactivation request is used when a record has been accepted into iQIES but the corresponding event did not occur. An inactivation must be completed when specific items on the MDS are inaccurate. These items are listed in the current RAI Manual Version 3.0, Chapter 5.7.MDS 3.0 Correction, Deletion, and Move Requests:A few types of errors in a record in iQIES cannot be corrected with a Modification or Inactivation request. These errors are:The record has the wrong unit certification or licensure designation in Item A0410.The record has the wrong state code or facility ID in the control Items STATE_CD or FAC_ID.The record submitted was not for OBRA or Medicare Part A purposes.The record is a test record inadvertently submitted as production. If a record was submitted either with an error in Item A0410, not for OBRA or Medicare Part A purposes, or as a test record, the facility must complete the proper request within iQIES. The State Agency will review and either request, reject the request, or return the request and ask for additional information before approving or rejecting. (Refer to the iQIES Assessment Management: Assessment Submitter Manual for details.)In situations in which the state-assigned facility submission ID (FAC_ID) or state code (STATE_CD) is incorrect, an MDS 3.0 Manual Assessment Move Facility Request is required. The facility will complete the form and submit to the State Agency. (See the current RAL Manual 3.0 Chapter 5, 5.7 for details.)Reproduction of Data in the Resident's Record:The facility maintains 15 months of assessment data in the resident's active clinical record. The 15-month period is defined as 15 months following the completion date for all assessments and correction requests.Assessment data may be maintained electronically.If data is maintained electronically, and electronic signatures are not used, the facility must ensure hard copies of the MDS assessment signature pages are maintained for every MDS conducted in the resident's active clinical record for 15 months.Transmission Requirements:All assessments shall be transmitted (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the designated CMS system (iQIES) within 14 days of completion.Each assessment must be accepted into the system, as verified by validation reports.Validation Edits:For each file submitted, the submitter will receive confirmation that the file was received for processing and editing by iQIES (initial submission feedback).Fatal File Errors - file structure is unacceptable (e.g., not in a ZIP file), the file will be rejected. These errors must be corrected and resubmitted.Fatal Record Errors - file structure was validated; however, errors exist such as out of range response or inconsistent relationships between items. These records are rejected and must be corrected and resubmitted.Non-Fatal Errors (Warnings) - file structure was validated and accepted but with errors. Non-fatal errors should be evaluated to identify necessary corrective action.References:Centers for Medicare & Medicaid Services, Department of Health and Human Services. State Operations Manual (SOM): Appendix PP Guidance to Surveyors for Long Term Care Facilities. (2025 Revision) F636-F638 and F640.Centers for Medicare & Medicaid Services. Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.20.1. (October 2025) Chapters 2 & 5.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165399	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observations, interviews, and record review, the facility failed to provide grooming for 1 resident reviewed (Resident #34). The facility failed to trim resident's toenails which had grown long and were snagging on his socks. The facility reported a census of 58. Findings include:The 5-Day Minimum Data Set (MDS) Resident assessment dated [DATE] documented that Resident #34 (R34) required assistance from staff for the following; toileting hygiene, lower body dressing, shower/bathing, and putting on/taking off footwear. The MDS documented the R34's admission date as March 9, 2026. A care plan revised on 3/13/26, directed nursing staff that Resident #34 had a self-care deficit focus area evidenced by requiring assistance with ADLs (Activities of Daily Living).This resident was a 1 person assist. Staff were to encourage bathing 2x weekly, inspect skin during showers and alert charge nurse to any skin issues. Nursing staff were to check nail length and trim/clean on bath days and as necessary. On 5/5/26 at 9:56 AM, Resident #34 stated he would like his toenails clipped. He said that no one ever wants to trim them. Resident #34 stated his wife had her toenails trimmed recently. This resident said that when he asked why his toenails weren't trimmed, they told him he was not on the list. This resident said he didn't know how to get on the list. He repeated he just wants his toenails trimmed. On 5/6/26 at 11:15 AM, Staff K, Licensed Practical Nurse (LPN), when asked about whether or not Resident #34's toenails had been trimmed, Staff K stated that Resident #34 had not been at the facility very long. Staff K stated he initially admitted to the facility for skilled care with plans to return home. It was decided he was unable to go home. She stated this wasn't that long ago. She stated that his wife had her toenails trimmed by the podiatrist last week as she was on the list to be seen by the podiatrist. She didn't know if anyone had talked with him about being on the list. This LPN agreed to go look at his nails. She removed his socks and shoes. His large toes had approximately 1/4 inch growth from the tip of his toes. Resident #34 stated it had been difficult to put on his socks and shoes as they keep snagging on his toenails. He asked are you going to trim them. This staff person stated she would after breakfast. On 5/7/26 at 8:10 AM, Staff K stated that she did cut his toenails yesterday. She said she was able to trim all of them down. Staff K stated that Resident #24's son normally comes to pick up his laundry. She will talk with his son the next time he comes in and ask him if he wants to get on the podiatry list. She says she thinks (getting on the podiatry list) has something to do with what insurance a resident is on. Normally the Social Service Designee asks if this is a service the residents would like during the admission process. She stated that she believes it costs a little more for them to add this service on. This LPN stated the resident was happy to have his nails trimmed yesterday. On 5/7/26 at 8:44 AM, the Administrator stated that residents can get on the podiatrist list. The podiatrist comes to the facility at least every 3 months and sometimes more often. She stated that only clinical staff are able to trim nails and nurses are definitely able to trim them. They can ask if the resident would like to see the podiatrist and check if the podiatrist will be in the facility in the following week or so. If it would be awhile before the podiatrist would be in the facility, the nurses should go ahead and trim a residents nails. This administrator stated the facility is to trim residents nails no matter if they are skilled care or not. A Nail Care Policy dated 2025, directed staff:Policy:The purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health. Policy Explanation and Compliance Guidelines:Assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care, if possible.Report unusual or abnormal conditions of the nails to the physician and the responsible party (e.g., curling, color changes, separation from the nailbed, redness, bleeding, pain, odor, infection, etc.).Determine preferences regarding nail polish.Obtain history and preferences regarding podiatrist.Identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke.Routine cleaning and inspection of nails will (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be provided during ADL care on an ongoing basis.Routine nail care, to include trimming and filing, will be provided on a regular schedule (such as weekly on Wednesday 3-11 shift). Nail care will be provided between scheduled occasions as the need arises.The resident's plan of care will identify:The frequency of nail care to be provided.The type of nail care to be provided.The person(s) responsible for providing nail care (e.g., licensed nurse, nurse aide, podiatrist, activity professional).Principles of nail care:Nails should be kept smooth to avoid skin injury.Only licensed nurses shall trim or file fingernails of residents with diabetes. Toenails of residents with diabetes or circulation problems shall be filed only.If a resident has a toe infection, diabetes mellitus, neurologic disorders, renal failure, or PVD, toenail trimming should be performed by a physician or practitioner.Resident without complicating disease processes, may have their toenails clipped by staff who have received education and training to provide this service within professional standards of practice and as per facility policy.Each resident will have his/her own nail care equipment (e.g., clippers, emery boards, files, etc.). Equipment will not be shared between residents. Clean equipment after each use and before storing.Procedure:Perform hand hygiene and don gloves.Fill wash basin(s) with warm water. Soak hands/feet in wash basin for 10-20 minutes, unless resident has diabetes or circulation problems.Gently clean underneath nails with orange stick.If trimming is allowed, clip nails using nail clippers straight across and even with tops of the fingers/toes.Shape nails straight across using nail file, emery board, or the like.Dry hands/feet well with towel.Apply lotion to hands/feet. Remove gloves and perform hand hygiene.Document completion of task, any complications, or if resident refuses.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, resident and staff interviews, the facility failed to provide an assessment and timely intervention for the necessary care and services for 2 of 3 residents reviewed (Resident #11 and Resident #45). Resident #11 reported having chest pain over night that lasted 15 minutes. The licensed nursing staff failed to provide an assessment after receiving the information. Resident #45 had a wound requiring a wound vac (medical device that uses negative pressure to promote healing in wounds). The licensed staff failed to maintain and provide interventions to ensure proper functioning of the wound vac. The wound vac was missing several changes and was not properly secured and functioning during wound clinic visits. The facility reported a census of 58 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #11 revealed the diagnoses of Parkinson's and was independent for activities of daily living. Resident #11 denied pain during the assessment. The Brief Interview for Mental Status (BIMS) score was 15 suggested an intact cognition. The Care Plan directed staff to monitor and document pain for probable cause of each pain episode and notify the physician if pain was a significant change from past experiences. During an interview on [DATE] at 1:26 pm, Resident #11 stated she had experienced chest pain during the night on [DATE], notified Staff G, Certified Nursing Assistant (CNA) and requested to see Staff H, Licensed Practical Nurse (LPN). Resident #11 stated the pain was a crushing pain that lasted about 15 minutes and she felt scared. Resident #11 stated the nurse did not respond, the pain subsided and she did not tell the nurse the next day. Resident #11 did inform staff in the Resident Council meeting on [DATE]. During an interview on [DATE] at 1:39 pm, Staff R, CNA stated Resident #11 was clear in thought and was believable. A review of the Progress Notes for April/[DATE] revealed no documentation of Resident #11 had chest pain. During an interview on [DATE] at 2:42 pm, Staff E, LPN stated she would believe Resident #11 if she would tell her anything, she was very believable. Staff E stated Resident #11 had not reported having chest pain. Staff E stated she would assess Resident #11 and give a report to the nurse practitioner tomorrow. Progress Notes review through [DATE] failed to document an assessment for Resident #11 or notification to the provider and family. Resident council meeting minutes on [DATE] revealed the following;Nursing: Resident #11 stated she was having pains in her chest last night, she reported this to Staff G, Certified Nursing Assistant (CNA) and the nurse failed to come to her room to assess her pain. During an interview on [DATE] at 8:38 am, Staff J, Activity Director stated on [DATE] was the first resident council she conducted. Staff J stated during the Resident Council meeting, Resident #11 stated she had chest pain overnight on [DATE] and the nurse did not come see her. Staff J stated she asked the Administrator what I do with the notes of concerns and was given grievance forms to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fill out. Staff J stated she filled out a grievance form and gave it to the Director of Nursing (DON) the next morning on [DATE]. During an interview on [DATE] at 1:59 pm, Staff I, CNA stated Resident #11 did not report that she had chest pain and had a complete mind. Staff I stated the facility was short staffed and staff were not patient and ignored Resident #11. During an interview on [DATE] at 3:29 pm, The DON stated she was aware that Resident #11 complained of chest pain during a night shift and she told the CNA, who did tell the nurse but when they went back in to assess her she was asleep. The DON stated she was aware that Resident #11 filed a grievance that she complained of chest pain and the nurse did not come in to assess her. When inquired where it was documented that Resident #11 had chest pain, and the assessment and inquired if the provider was notified, the DON said no. The surveyor informed the DON that Resident #11 had the chest pain and informed Staff E, LPN on [DATE] who stated she would conduct an assessment and will notify the provider but there was no documentation of that assessment nor provider notification. The DON stated she would check on that but failed to provide a response to the survey team. During an interview on [DATE] at 8:26 am, Staff H, Licensed Practical Nurse (LPN) stated that he was the charge nurse on the over-night shift on [DATE]. Staff H denied being informed of Resident #11 having chest pain. Staff H stated if he was informed of that, he would have provided an assessment, notified the provider and provided pain management. Staff H verified he had worked on Resident #11's hall with Staff G, CNA and denied the CNA had mentioned the chest pain episode. During an interview on [DATE] at 8:55 am, The Administrator stated when Staff J, Activity Director inquired what to do with the resident council concerns, she was given grievance forms to fill out and directed to give them to the responsible manager. The Administrator stated Staff J mentioned another resident's concern but couldn't remember if she was informed that Resident #11 having chest pain. The Administrator stated chest pain was a concern that would require immediate nurse assessment. A document titled Grievance Form dated [DATE] revealed a summary of Resident #11's grievance. a. During the night on [DATE] Resident #11 experienced chest pain, reported the pain to the CNA and the nurse did not come to check on her. b. Investigation/Outcome revealed that education was provided to staff member related to communication with the nurse for complaints of pain. c. Signed by the DON, Grievance Officer and the Administrator. A document dated [DATE] a note to Staff F, LPN that revealed a directive from the DON to have a discussion with Staff G, CNA related to care expectations and reporting concerns. The document listed the complaint from Resident #11 regarding the chest pain episode that was not verified with Staff H, LPN as of yet. The document stated the report of concerns, especially chest pain, needed to be reported to the nurse immediately. The directive included to monitor Staff G for the next 3 shifts and notify the DON in writing if there were further concerns. During an interview on [DATE] at 3:29 pm, The DON stated she was aware that Resident #11 complained of chest pain during a night shift and she told the CNA, who did tell the nurse but when (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	they went back in to assess Resident #11, she was asleep. The DON stated she was aware that Resident #11 filed a grievance that she complained of chest pain and the nurse on duty did not complete an assessment. When inquired where it was documented that Resident #11 had chest pain, and the assessment and inquired if the provider was notified, the DON said no. During an interview on [DATE] at 8:26 am, Staff H, Licensed Practical Nurse (LPN) stated that he was the charge nurse on the over-night shift on [DATE]. Staff H denied being informed of Resident #11 having chest pain. Staff H stated if he was informed of that, he would have provided an assessment, notified the provider and provided pain management. Staff H verified he had worked on Resident #11's hall with Staff G, CNA and denied the CNA had mentioned the chest pain episode. 2. A Minimum Data Set (MDS) dated [DATE], documented diagnoses for Resident #45 included diabetes, infection of the foot, and open lesions. A BIMS revealed a score of 15 out of 15, which indicated intact cognition. This resident required applications of dressings to feet. A Census page documented that Resident #45 was admitted to the facility on 3//26/26. A Podiatry Clinic note dated [DATE], documentation included the following: Resident #45 is approximately 3.5 weeks post-op (post surgery). He has been placed at the facility for skilled care. Resident #45 reports that the dressing wasn't changed for the first 5 days he was there. Now changes are being performed every other day. The wound VAC was not applied correctly and the whole dressing was wet. The Assessment documented that this resident had a skin ulcer of left ankle with necrosis (death of cells) of bone. This was a postoperative examination at 3.5 weeks status post left ankle I&D (incision and drainage), hardware removal (removal of orthopedic (related to bone) implants that were initially placed to stabilize fractures, correct deformities, or support healing bones), external fixator (metal frame applied outside the body to stabilize broken bones in the ankle and lower leg) and wound VAC placement. Upon presentation the dressing was noted to be saturated and the wound VAC was not adhered to the wound and completely lifted and malfunctioning. No signs of pin sit infection. Antibiotics per infectious disease. This provider called the facility and discussed that Resident #45 was an hour late to his appointment, the wound VAC was not functioning, the dressing that was applied was completely saturated and there was no compression. A Podiatry Clinic note dated [DATE], documentation included the following: Resident #45 presented with a wound VAC battery dead and cannot reapply. Continue dressing changes Monday, Wednesday and Friday. Wound VAC to the medial wound (wound closer to the midline of the body) 125mmHg (unit of pressure) continuous, change canister once weekly. A Podiatry Clinic note dated [DATE], documentation included the following: Follow-up left lower extremity. Presents today for wound evaluation. Today is Wednesday, he reports the last VAC (wound vac) and dressing change was performed on Friday which goes against the podiatry clinic's provider's recommendations. Resident #45 stated the facility was now providing routine dressing changes. The provider did inspect his VAC prior to removing the dressing and it was set at 125 mmHg continuous, however the actual was 0 mmHg continuous. The provider did remove the dressing which was noted to be completely saturated in blood, the wound VAC was not adhered to the skin and not functioning. The surrounding tissue was macerated. Given the inability for the facility to maintain a VAC, the provider will stop VAC dressings at this time. Apply Betadine medially and (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	laterally into the superficial heel wound. Cover with gauze, gauze roll and Ace bandage. Strict non-weightbearing to the left lower extremity. Antibiotics per infectious disease. On [DATE] at 2:07 PM, a podiatry clinic nurse stated that multiple times they had talked with the facility related to the wound vac not functioning or not applied properly. They ended up having to discontinue it. She stated that on [DATE] the battery was dead on the wound vac. On [DATE] it was presented that the facility was not doing routine vac changes. The wound vac was set at 0 instead of 125 like it should have been set. The wound vac was not functioning. The primary concern was that we want the staff to be educated and to be able to properly use wound vacs. A Treatment Administration Record (TAR) for the month of April, had the following order: The Left Lower Extremity (LLE) was to be kept clean and dry and intact. Wound VAC was to be connected and running at 125mmHg every day and night shift. The start date was [DATE]. The discontinued date was [DATE]. The TAR was missing several entries of the wound vac changes. The [DATE] Treatment Administration Record directed the following: Wound vac to left medial ankle 125mmHg continuous. Change 3 times a week. every day shift every Monday, Wednesday and Friday. The start date for this order was [DATE]. The order was discontinued on [DATE]. The TAR was signed by a nurse on the following days [DATE], [DATE], [DATE], [DATE], and [DATE]. On [DATE] this was signed as refused and on [DATE] it was signed as held. The TAR was not signed for the wound vac changes on [DATE], [DATE] and [DATE]. The wound vac was discontinued on [DATE]. The [DATE] TAR directed the following: Left foot: Apply adaptic (non adherent dressing) followed by betadine soaked gauze to lateral incision, Xeroform (non-adherent wound dressing) around pin sites and wrap with soft roll and ace. every day shift. The start date was [DATE]. The treatment was discontinued on [DATE]. The TAR was not signed for this treatment getting done on [DATE] and on [DATE]. On [DATE] at 2:00 p.m., an observation of wound care for both right and left lower legs was done by Staff S, Registered Nurse (RN). during wound care Resident #45 stated that this nurse always did his wound care the right way but not all the nurses did. During the wound treatment observation this resident stated that the wound vac really helped a lot and his wounds have improved greatly. On [DATE] at 2:50 PM, Staff S, Registered Nurse stated that she did not know of a time that the wound vac wasn't changed or that the settings were off. She stated the wound vac settings were preset. She stated the only thing she remembers is that they had sent this resident to the podiatry clinic and his wound vac was working when this resident left the facility. However, the battery had died by the time he was at his appointment and the podiatrist was not happy about it. She stated if there were missing entries on changing the wound vac, it was probably because they had to change it in between times and that would have started the 3 day change cycle over. She said she hated to see the wound vac go as it was so helpful. She stated they had a pretty good system down and it was working well. She stated the reason they were given for the discontinuation of the wound VAC was that Resident #45 was ready for a different treatment. (continued on next page)

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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 observations, clinical record review, resident and staff interviews and policy review, the facility's licensed nursing staff failed to appropriately set and maintain oxygen devices for 1 of 2 residents reviewed for oxygen administration (Resident #20). The nursing staff reported adjusting the oxygen setting who were not licensed staff. The facility reported a census of 58 residents. The Minimum Data Set (MDS) dated [DATE] for Resident #20 revealed the diagnoses of asthma with dependence on oxygen delivery. The Care Plan for Resident #20 identified oxygen to be delivered at 2 Liters without further direction for nursing staff (Licensed Practical Nurse (LPN) and or Registered Nurse (RN)). The Physician Orders for Resident #20 revealed an order for 2 liters of oxygen and the direction for the nursing staff to change oxygen tubing every Wednesday. During an observation on 5/04/2026 at 2:33 pm, Resident #20 was in her bed with oxygen tubing dated 4/15/26 on tape that went into Resident #20's nose by a nasal cannula. The oxygen concentrator was delivering oxygen (O2) at 2.5 Liters through a dry humidifier bottle (bubblier) dated 4/25/26. During an interview on 5/4/26 at 2:33 pm, Resident #20 stated she felt dry in her nose and throat but had water to drink. Resident #20 stated she was not having respiratory distress and could feel the oxygen. During a second observation on 5/05/2026 at 8:00 am, Resident #20 was asleep in her bed. The oxygen concentrator continued to be delivering oxygen at 2.5 Liters with the humidification bottle dated 4/25/26 continued to be empty and the tubing dated 4/15/26 was not exchanged. During a third observation on 5/05/2026 at 12:25 pm, Resident #20's O2 tubing and humidification bottle had not been changed.During an observation on 5/5/26 at 1:25 pm, Staff E, Licensed Practical Nurse (LPN) walked toward Resident #20's room after the [NAME] President (VP) of Clinical Operations notified her that the O2 needed attention. Staff E entered Resident #20's room to discover the humidification bottle was exchanged and had fluid in it for the oxygen to flow through, not dated, and the tubing was not exchanged. Staff E checked the O2 meter to find it delivering 2.5 liters of oxygen and adjusted it to 2 liters. During an interview on 5/5/26 at 1:25 pm, Staff E, LPN stated she thought the oxygen tubing would be changed weekly, identified the night nurse to complete that task, and the humidification bottle would be changed when it became dry. During an interview on 5/05/2026 at 1:04 pm, The Administrator stated the O2 tubing should be changed weekly by the night nursing on night shift. During an interview on 5/05/2026 at 1:59 pm, Staff I, Certified Nursing Assistant (CNA) stated the CNA responsibility for oxygen was to make sure the tubing was on the resident and the humidification bottle that contained fluid. Staff I stated the CNA's would adjust the oxygen, turn it on and off, when the resident was transferred to a portable tank. Staff I stated that was the nurse responsibility, but when informed of the need to transfer to portable, the nurse would not respond. Staff I stated the CNA would be held responsible, but was aware that a CNA was not licensed to adjust oxygen. During an interview on 5/06/2026 at 2:00 pm, Staff N, CNA stated when a resident was off the concentrator and required a portable tank, she would turn the oxygen on and adjust the amount of oxygen to be delivered to the resident. Staff N stated it was expected that the CNA's perform this duty and had a key (the device to open the top of an oxygen tank to deliver the oxygen to the flow meter) attached to her name badge. During an interview on 5/06/2026 at 2:39 pm, Staff Q, CNA stated when she would transfer a resident from the oxygen concentrator to the portable tank, she would adjust the rate of oxygen flow but would not replace tubing or humidification bottles.During an interview on 5/06/2026 at 2:54 pm, Staff O, CNA stated she had the knowledge of how to change the water humidifier and would complete the task. The nurse will tell the CNA what the portable tank should regulated at and the CNA would set the delivery of oxygen when a resident was transferred. Policy titled Oxygen Administration dated 2025 revealed:1. Personnel authorized to initiate oxygen therapy include physicians, RNs, LPNs, and respiratory therapists. 2. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.3. Change humidifier bottle when empty, every 72 hours or per facility policy, or as recommended by the manufacturer. Use only sterile water for humidification.

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	165399	A. Building B. Wing	05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Regency Care Center	815 High Road Norwalk, IA 50211

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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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and policy review, the facility failed to obtain physician's orders for peritoneal dialysis, to provide initial and ongoing assessment and oversight of peritoneal dialysis (PD), and to provide consistent care and documentation per professional standards of practice for 1 of 2 residents reviewed that received peritoneal dialysis in the facility (Resident #69). Resident #69 received peritoneal dialysis in the facility which was connected and disconnected by her sons. The nurses did not provide these interventions. The facility was unable to produce provider's orders for the dialysis, documentation of assessments for this dialysis, documentation of the connecting and disconnecting of the peritoneal dialysis, and clarification for who was to turn on and shut off the dialysis. The staff at the facility allowed this to go on without seeking clarification. This resident required hospitalization related to avulsion of her external peritoneal dialysis tubing (a medical emergency when the external catheter or transfer set is forcibly torn, pulled or ripped from the body) resulting in a loss of a large amount of fluid and intervention to repair the avulsion. The facility had failed to assess the port sites or show they cared for or overall managed the PD in their facility. The facility reported a census of 58 residents. Findings include: A Minimum Data Set, dated [DATE], documented diagnoses for Resident #69 included End Stage Renal Disease (ESRD), dependence on renal dialysis, diabetes, malnutrition and non-Alzheimer's dementia. A Brief Interview for Mental Status revealed a score of 4 out of 15, which indicated severely impaired cognitive functioning. This resident received dialysis.Resident #69's care plan documented that she had a self care deficit as evidenced by requiring assistance with Activities of Daily Living (ADLs), impaired balance during transitions requiring assistance and/or walking, incontinence. She was a 1 person assist for transfers and toileting. This care plan was initiated on 12/31/25. A Census page documented that this resident was admitted on [DATE] and billing was discontinued on 1/13/26. The Medication Administration Record/Treatment Administration Record (MAR/TAR) for the month of December and the month of January lacked orders for hooking Resident #69 up or taking her off peritoneal dialysis (PD). There is no record of administration of dialysis that the facility was able to provide. Doctor's Orders since this resident was admitted through the day she was discharged did not include the solution that was to be used for dialysis. The only mention of peritoneal dialysis in this resident's doctor's orders was to apply gentamicin (antibiotic) cream to the PD exit site. The facility provided a hospital dialysis nurse note dated 12/25/25 at 7:00 p.m., from the hospital that she was at prior to coming to the facility. It documented that a CCPD (continuous cyclic peritoneal dialysis (home based dialysis)) initiation PD machine setup aseptically(minimizing contamination of microorganisms) per orders. Orders as follows : 1.5 % dialysate (fluid to remove waste products) 2.5 L(liter) fills x 4 exchanges= 10 L Number of hours: 9 Dressing aseptically changed. Site has drainage/redness with a spot at 11 o'clock open that's red and has drainage as well. Providers aware. Reported to dialysis RNA Care Plan initiated on 12/31/25, directed staff that Resident #69 required dialysis therapy and remained at risk for declines in alteration in renal status with the progression of this disease process. PD in the facility. It directed staff that a Dialysis flow sheet was to be completed daily to observe for shunt access site complications-report abnormalities to the physician. The facility could not produce this flow sheet. A Nurse's Progress note dated 12/31/2025 at 7:45 p.m., documented that Resident #69 arrived at the facility at 1:45 p.m. Resident arrived viaAmbulance service accompanied by EMS. Both sons were present when the resident arrived. Resident situated in room [ROOM NUMBER]. Educated about call light, assessments completed, vitals taken. Son stated that her blood pressure runs low all the time. Evidenced by the lower blood pressure obtained during vitals. Son brought a machine for PD from home, supplies brought in by the dialysis home company. The family was very helpful for obtaining information. No complaints of pain or discomfort noted at this time.Will continue to help this resident get settled and comfortable in the facility. Authored by Staff T, Registered Nurse (RN) Assistant (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (ADON). A Daily Skilled Charting Note dated 1/2/26 at 2:53 a.m., documentation included that this resident was sleeping soundly in bed, son hooked up PD tonight before he left. Call light is in place, no acute nursing needs at this time, will continue with the current plan of care.A Daily Skilled Charting Note dated 1/3/26 at 12:35 a.m., documentation included that this resident was sleeping soundly in bed, son hooked up PD tonight before he left.A Daily Skilled Charting Note dated 1/4/26 AT 12:00 a.m., documentation included that this resident is hooked up to PD, currently watching videos on her phone. No c/o pain or discomfort. Spoke with son tonight and he prefers that he is the one to hook up and disconnect the PD machine. Will continue with the current plan of care.A General Progress Note dated 1/10/26 at 10:32 p.m., documented that resident's sons in facility and advised this RN that resident will be taking a break from dialysis tonight so did not need to begin cycle for this HS (hour of sleep) shift.Gastrointestinal: PD catheter present Metabolic: Reviewed and Normal/Negative. General: Awake, Alert, No Acute Distress, Calm, Cooperative, Gastrointestinal: Abdomen Soft, Non-Tender, Normoactive Appears Comfortable BS Eye: Pupils Normal Genitourinary: No TendernessA Resident Care Conference note dated 1/12/26 at 10:36 a.m., documented the resident's son- has been having issues. He has concerns with night nursing staff but loves the day staff. He mentioned that he was informed there was an RN able to unhook and do PD for this resident but now is having to come in himself or another family member and do it themselves. They are frustrated and disappointed. He mentioned that a machine was unplugged due to extensive beeping and lack of training for nursing staff for PD. He mentioned that there is a PD helpline phone number on the PD machine that should be utilized. He mentioned that he would be willing to see if the facility could change Resident #69's PD to be during day shift but have therapy come before 10 AM on PD days to still have therapies for her of course.A Nurse Practitioner's note dated 1/12/26 at 3:40 p.m, documentation included: Resident being seen today for c/o of pain in right big toe. No wound or open areas noted on exam. Has a hx of gout on a every other day dosing of allopurinol(medicine for gout). Will increase to daily.A General Progress Note dated 1/13/26 at 6:02 p.m., documented that the resident's family took the resident to the bathroom and PD began draining large amounts of pinkish drainage. Family here and requesting emergency room (ER). New order to send to ER for eval and treatment. Family followed.A Kidney Physician's Progress Note dated 1/15/26, documented the reason for visit was PD catheter dislodging. Patient (Resident #69) has been evaluated by vascular surgery, they felt to have avulsed her external extension tubing along with the titanium. Her PD catheter was fixed externally yesterday. Will plan to resume CCPD tonight. Son would like to know if patient needs to return back to the facility versus going home. This doctor had coordinated this with primary team, will request physical therapy to evaluate patient and make recommendations for discharge planning. Total time spent 38 minutes with more than 50% of the time to counsel patient and her son at bedside regarding above medical management including resuming CCPD tonight and coordinate care with internal medicine team.A Hospital Progress Note dated 1/15/26 at 8:37 p.m., documented that Resident #69 was admitted on [DATE]. The Assessment and Plan was PD catheter dysfunction status post external catheter revision. Patient was evaluated by vascular and recommended bedside external catheter revision which was completed on 1/14/26. Continue empiric (initiation of antibiotic for suspected microorganisms before the lab can identify which organisms) IV vancomycin and IV ceftazidime (antibiotics).On 5/5/26 at 4:46 p.m., Resident #69's son stated that staff were not properly trained for peritoneal dialysis. He stated the first day his mom got to the facility, the nurse on staff asked the family if she could have a refresher because she hadn't done the peritoneal dialysis in a while. Resident #69 was admitted on [DATE] at approximately 2:00 to 2:30 p.m. The CNAs were not trained to handle peritoneal dialysis. They were trying to maneuver her with the cord. Trying to understand the machine with the noises. Trying to disconnect her from the machine so that she could use the bathroom. Everything about it was evident they were not trained at all. The day shift care was okay. The night shift was absolutely terrible. The dialysis was supposed to go 9 hours. Resident #69's son stated that because the staff were untrained, this son and his (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	brother hooked up and unhooked the peritoneal dialysis. This son the final thing that got his mom was she ended up having to go to the hospital. She had sat down in the restroom and said that she saw something running down her leg, then the tube was in her hand. This son said that his mom had carpal tunnel, so she didn't have the strength in her fingers to disconnect the tubing because it came apart at the clamp. This was around the same time the cord was wrapped around the bed. One time my brother got there and the machine was unplugged with the alarm going off. (The staff should have) called the 1-800 number. On 5/6/26 at 1:23 p.m., Staff V, Licensed Practical Nurse (LPN), Assistant Director of Nursing (ADON) stated the family took Resident #69 into the bathroom. They took her in there without staff assistance. They then came to report that the resident was leaking fluid all over the floor. Resident #69 was sent to the hospital. She did not return to the facility. Staff V didn't know what happened but if she had to guess, she'd say the family took this resident home because the family wanted her to go home in the first place, and did not want to bring her to the facility. The PD was not draining/leaking before this incident. On 5/7/26 at 11:20 a.m., the Home Therapies Manager (dialysis care partner) stated that she manages the home therapies. She stated they train this facility's staff to provide care. They have a contract with them. She stated the facility staff was trained. They gave a refresher course in December. In the contract we only have to train once, but for safety reasons and turnover she likes to go there and train annually. She had no issues with the facility staff. They did reach out that night to our nurse and this Home Therapies Manager fully believed they did what they needed to do. Everything was provided like it should have been. Only RNs and LPNs receive the training. The drain line goes into the toilet. Possibly the tubing could have been wrapped around the bed . She said that both of those sons, and Resident #69 had been trained to do the dialysis at home. She said that since they were in the nursing home the sons should not be doing anything with the dialysis. They had been educated on the fact that they were not to be doing anything with the dialysis while in the nursing home. On 5/07/2026 at 11:33 a.m., Staff T, Registered Nurse (RN), ADON- Staff were properly trained on PD. Resident #69 was down Hall 3 and the sons were primarily doing her PD. They were doing this at home. Most of the time we wouldn't even know they were hooking the PD up. They would just do it. They were very intimidating. One son argued with Staff T, saying it was his mom and they could do what they wanted. Staff T stated she was the one that took Resident #69 to the bathroom the night the stuff started gushing out. Staff T took her to the bathroom. It was a little after 7p.m. The daughter in law was in the room. Resident #69 was not hooked up to dialysis. Staff T never saw this resident's tubing kinked or wrapped around her bed. Nothing like that. Staff T always made sure it was straight. CNAs were all good with Resident #69 and knew what to do. Staff T had no concerns with them providing care, transferring her or toileting her. That evening Staff T and Resident #69 were in the bathroom. Staff T stated she was sorta picking up around the bathroom while Resident #69 was on the toilet. All of a sudden Staff T heard a [NAME] like the faucet was turned on. Staff T stated that Resident #69 was not a very big person and didn't know where all the fluid was coming from. Staff T clamped the tubing off. Staff T sent her out per the Nurse Practitioner's orders and the dialysis company the facility uses. Resident #69 told Staff T that the tube just started leaking. This resident said she hadn't pulled on the tubing or anything. There had been no problems with the tubing leaking or anything like that before this incident. On 5/7/26 at 1:32 PM, Staff V, Licensed Practical Nurse (LPN), ADON when asked why she documented and said that family was in the bathroom with resident when her tube came out, Staff V stated she just documented what staff had told her. She wanted to make sure something was in the chart. This nurse stated she never once heard that Staff T was in the room with Resident #39. She only heard that family was in the room, so she documented what she heard. She stated she couldn't say for sure that she documented that family was in the bathroom with the resident as it was a while ago and she isn't at the facility today to review the documentation. The entry was read to her. She stated that she documented what she was told. On 5/20/26 at 4:52 p.m., Staff H, LPN (6p.m. to 6 a.m. shift) stated there was one resident who the sons hooked up to dialysis. He stated he had not been (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	trained on how to do the peritoneal dialysis prior to this resident coming to the facility. He said that he did get training on peritoneal dialysis after she had left the facility. He stated he has been at the facility about a year. He stated there have been other residents who required peritoneal dialysis, but other nurses would have to put them on and take those residents off dialysis because he couldn't do it. He stated there hasn't been a resident in the facility that has required peritoneal dialysis since he has been trained. He doesn't remember Resident #69's son asking him to hook his mother up to dialysis. He repeated he wouldn't have been able to because he hadn't been trained. On 5/20/26 at 6:55 p.m., Staff W, LPN (6p.m. to 6 a.m. shift) stated that Resident #69's family pretty much did everything with this resident's dialysis. This LPN didn't think it was set up for the family to do the dialysis. They actually just did it. She stated she would come in at 6 p.m., get report and then monitor the dining room until it was cleared out. By that time when she looked into this resident's room the family would already be in the process of setting her dialysis up. She would be taken off of it after Staff W left, it was usually 7 in the morning or so when they would disconnect the PD. Staff W would leave at 6/6:30 a.m. The family was trained with her PD because they had been doing it at home before she ever came to us. I think they said maybe a year they had been doing it at home. There were no issues with staff during the night, no issues with them toileting her and no issues with tubing getting wrapped around the bed that she knew of. Staff W said she sure doesn't remember that happening. She stated they all questioned if the family should be doing the PD. It was kind of an odd situation. Staff W said she had been trained in PD before that. We kept a close eye on her during the night. We never had any problems with the PD at night and never heard of anyone having problems with the PD during the night at all. The only time Staff W heard about a problem with the dialysis was when Resident #69 was sent to the hospital. The family kept in touch with the dialysis company and kept all of those records in a notebook. The dialysis solution was kept in this resident's room, but they normally carried it into the facility at night. One of the brothers kept the solution in his truck. One night they were setting her PD up and they came and asked if we had the longer tubing set because all they had was the shorter one. The family kept the solution. The family didn't want anyone doing anything for her as far as setting up the dialysis. Staff W believed one of the sons would come in just before breakfast to undo Resident #69 from the dialysis. The family had a lot of people in her room at night during the evenings. There would be from 4 people to 7 or 8 people in her room, just helping set things up. 05/07/2026 12:41 PM VP of Clinical Operations and the Administrator stated that they did not know why there was a discrepancy with documentation of this resident being sent out. Staff V, ADON documented the family had toileted their mom, and the other ADON, Staff T, stated she was with her in the bathroom when the event happened. They were going to look into this. acknowledged that there are no doctor's orders for peritoneal dialysis solution, no documentation of it being given or who started and stopped the PD. They will also look into this. Acknowledged that the sons were doing the PD instead of staff, and there was nothing care planned about the sons being the ones to manage the PD. They acknowledged that the Home Therapies Manager had reported that the sons should not have been handling the dialysis and that this manager had told the sons that. This VP and Administrator acknowledged that the facility should have been putting this resident on the peritoneal dialysis nightly and taking her off the peritoneal dialysis in the morning. On 5/11/2026 at 12:12 p.m., The Administrator stated that they were unable to find any further documentation for Resident #69's peritoneal dialysis. This Administrator stated she had talked with the DON and a binder keeps coming up, but no one can find the binder. This Administrator stated the Medical Director said he remembers the resident being here and said he only saw Resident #69 for the required visits. A State of Iowa Certificate of Death filed on 2/19/26, documented that Resident #69's date and time of death was on 2/8/26 at 11:14 a.m. at a Medical Center. The immediate cause of death was septic shock due to or as a consequence of respiratory failure and end stage renal disease. A Peritoneal Dialysis policy dated 2025, directed the following: This facility will provide the necessary care and treatment, consistent with professional standards of practice, physician orders, the comprehensive (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person-centered care plan, and the resident's goals and preferences, to meet the special medical, nursing, mental, and psychosocial needs of residents receiving peritoneal dialysis.Purpose:The facility will assure that each resident receives care and services for the provision of peritoneal dialysis consistent with professional standards of practice. This will include:The ongoing assessment of the resident's condition and monitoring for complications before and after dialysis treatments received at the facility.Safe administration of peritoneal dialysis in the nursing home provided by qualified trained staff/caregivers, in accordance with State and Federal laws and regulations.Ongoing assessment and oversight of the resident before, during and after dialysis treatments, including monitoring of the resident's condition during treatments, monitoring for complications, implementation of appropriate interventions, and using appropriate infection control practices: andOngoing communication and collaboration with the dialysis facility regarding dialysis care and services.Definitions:Continuous Ambulatory Peritoneal Dialysis (CAPD) - A treatment in which dialysis solution is introduced through a catheter into the abdomen via gravity and the bag is disconnected. After a specific period of time, the catheter is reconnected and drains the solution containing wastes back into the bag. CAPD does not require a machine; the process uses gravity to fill and empty the abdomen. CAPD may be provided during three or four exchanges during the day and one overnight.Continuous Cycler-Assisted Peritoneal Dialysis (CCPD) - Uses a machine to fill and empty the abdomen three to five times during the night. In the morning, the last fill remains in the abdomen with a dwell time that is individualized according to the resident's needs. In some cases, an additional exchange is done in the mid-afternoon to increase the amount of waste removed and to prevent excess fluid absorption.End Stage Renal Disease - The stage of renal impairment that appears irreversible and permanent, and requires a regular course of dialysis or kidney transplantation to maintain life.Dialysis - A process by which dissolved substances are removed from a patient's body by diffusion from one fluid compartment to another across a semipermeable membrane. The two types that are currently in common use are hemodialysis (HD) and peritoneal dialysis (PD).Dialysis Facility - Means an entity that provides outpatient maintenance dialysis services or home dialysis training and support services, or both.Home Dialysis - Home dialysis means dialysis performed at home by an ESRD patient or caregiver who has completed an appropriate course of training.Compliance Guidelines:The facility will inform each resident before or at the time of admission, and periodically thereafter during the resident's stay, of dialysis services available.Residents may receive chronic dialysis treatments through two options, if the facility allows it. This includes:In-Center Dialysis: This can involve either:Transporting the resident to and from an off-site or on-site certified ESRD facility for dialysis treatments; orTransporting the resident to a certified ESRD facility that is located within or adjacent to the facility.Home Dialysis: The resident receives dialysis treatments in the nursing home and can be administered by the resident, a family member or friend, dialysis facility staff or nursing home personnel. Any individual(s) that administers dialysis treatments must be trained, competent, and knowledgeable in all aspects of dialysis care before initiating treatments. The facility will ensure that staff who perform peritoneal dialysis in the nursing home are trained and qualified, receiving training and competency from a qualified dialysis trainer from a certified dialysis facility.The facility will coordinate and collaborate with the dialysis facility to assure that:The resident's needs related to dialysis treatments are met;Only trained and qualified staff/caregivers administer the dialysis treatments:The provision of the dialysis treatments and care of the resident meets current standards of practice for the safe administration of the dialysis treatments;Documentation requirements are met to assure that treatments are provided as ordered by the nephrologist, attending practitioner and dialysis team; andThere is ongoing communication and collaboration for the development and implementation of the dialysis care plan by nursing home and dialysis staff.The facility will monitor for and identify changes in the resident's behavior that may impact the safe administration of dialysis before and after treatment and will inform the attending practitioner and dialysis facility of the changes.The facility will identify who is allowed to provide (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	peritoneal dialysis treatments to residents, in accordance with State licensing rules. The facility will maintain documentation of completion of competency/training for staff or other individuals providing the dialysis treatments.The facility will establish, in collaboration with the nursing home medical director and the dialysis facility, dialysis specific policies/procedures based upon current standards of practice to include but are not limited to: The identification of all staff or contracted individuals who are allowed to provide peritoneal dialysis and the training required;The documentation of training and competency requirements for individuals providing dialysis treatments;If the facility allows a resident/family member or other individual to provide peritoneal dialysis treatments, documentation that training and competency was provided by the certified dialysis facility;Procedures for the initiation, administration and discontinuation of peritoneal dialysis treatments, types of monitoring required before, during and after the treatments, including documentation requirements;Procedures for methods of communication between the nursing home and the dialysis facility, including how it will occur, with whom, and where the communications and responses will be documented;The development and implementation of interventions, based upon current standards of practice, including, but not limited to documentation and monitoring of complications, weights, access sites, nutrition and hydration, lab tests, vital signs including blood pressure and medications; Management of dialysis emergencies including procedures for medical complications, and for equipment and supplies necessary;Provision of medications on dialysis treatment days;Procedures for monitoring and documenting nutrition/hydration needs;Assessing, observing, and documenting care of access site; Safe and sanitary care and storage of dialysis equipment and supplies;Responsibility for reporting adverse events, including who to report to, investigating the event and correcting identified problems;Response and management of technical problems related to peritoneal dialysis treatments such as power outages or:For peritoneal dialysis, how to recognize impaired flow and drainage or failure of the peritoneal dialysis cycler;For peritoneal dialysis, how and when to stop dialysis and/or seek help when there are significant issues.Dialysis specific infection control policies including but not limited to: Transmission based precautions including blood borne precautions, placement/location (cohorting), staff/visitor personal protective equipment (PPE) requirements, indications for the use of gloves, masks and hand hygiene;Potential health care associated infections (HAI) including Hepatitis B and tuberculosis;Restrictions for visitors/roommates, if any, during provision of peritoneal dialysis;Handling, using, and disposing of equipment/supplies, medications or other products in accordance with manufacturer's instructions, and in accordance with all applicable Federal, State, and local laws and regulations.Access to clean sink for hand washing, in addition, disposal needs to be addressed for dialysis by-products from the dialysis treatment;Housekeeping/laundry policies for cleaning/sanitizing the location(s) where treatments are provided, including linen handling and waste disposal;Peritoneal catheter care and dressing changes; andCleaning and disinfecting dialysis equipment, including procedures for spills and splashes of blood or effluent on furnishings, equipment, floors and supplies.The facility is responsible for the ongoing coordination of dialysis care in collaboration with the certified dialysis facility. The facility will establish specific written guidance for the provision of treatments, and handling complications and emergencies during the provision of peritoneal dialysis.The facility will have contact information available to staff assuring that dialysis qualified licensed professional staff are available by phone 24 hours a day 7 days a week, including who to communicate with regarding peritoneal dialysis related issues.Peritoneal dialysis may be performed by either the resident (if physically and cognitively capable) or an individual, such as a family member (if allowed by the facility), nursing home staff or a contracted caregiver who has completed training/competency by a qualified trainer from a Medicare certified dialysis facility.The facility will maintain documentation of the required ongoing dialysis training in order to assure qualified staff/caregivers are capable of providing peritoneal dialysis treatments. Training based upon current standards of practice must include, but not be limited to the following;Specific (step-by-step) instructions on how to use the resident's prescribed dialysis equipment (e.g. peritoneal dialysis (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cycler) and instructions in home dialysis procedures for peritoneal dialysis to facilitate adequate dialysis as prescribed by the practitioner;Training in proper storage and administration of Erythropoiesis-Stimulating Agents (ESAs), if applicable; How to identify/recognize medical emergencies, implement immediate responses/actions and methods for contacting emergency medical systems;How to recognize, manage, and report dialysis complications, including catheter, tunnel or exit site infection; peritonitis, catheter dislodgement; hypotension; hypokalemia; failure of sufficient dialysate to drain from the peritoneal space; protein malnutrition;Indications for the use of gloves, masks, and other personal protective equipment, methods for hand hygiene, peritoneal catheter care and dressing changes, cleaning and disinfecting dialysis equipment, cleaning and disinfection procedures for spills and splashes of effluent;How to properly dispose of needles, effluents, disposable items, and tubing and to minimize risks of infection or injury to self and others and to prevent environmental contamination (e.g. using impervious puncture resistant containers for disposal of sharps, placing empty dialysate bags and tubing in intact plastic bags before discarding.); andRecognizing, managing and reporting power outages, failure of the peritoneal dialysis cycler.Peritoneal dialysis may be provided by the following modalities:Continuous ambulatory peritoneal dialysis (CAPD) Continuous cycler-assisted peritoneal dialysis (CCPD)The physician's order for the individualized prescriptions must include at least the number of exchanges or cycles to be done during each dialysis session, the volume of fluid with each exchange, duration of fluid in the peritoneal cavity, the concentration of glucose or other osmotic agent to be used for fluid removal, and the use of automated, manual or combined techniques.Before, during and after receiving the peritoneal dialysis, the facility staff must, based on the physician's orders and professional standards of practice, do the following:Obtain vital signs, weights, assess the resident's stability, level of consciousness, and comfort or distress;Monitor for post-dialysis complications and symptoms such as, but not limited to dizziness, nausea, fatigue, or hypotension;Report identified or suspected complications immediately to the attending physician and dialysis staff to enable timely interventions;Documentation of ongoing evaluation of the peritoneal catheter, including assessment of catheter related infections and tunnel for condition, monitoring for patency, leaks, infection, and bleeding at the site;Monitor for complications such as peritonitis.The facility will communicate with the attending physician, dialysis facility and/or nephrologist of any canceled or postponed dialysis treatments and document any responses to the changes in treatment in the medical record. If dialysis is canceled or postponed, the facility and dialysis staff will provide or obtain ongoing monitoring and medical management for changes such as fluid gain, respiratory issues, review of relevant lab results, and any other complications that occur until dialysis can be rescheduled based on resident assessment, stability and need. In the event circumstances do not allow dialysis to be provided by the designated trained and qualified individual, the facility must immediately notify the dialysis facility in order to make arrangements to assure that no dialysis treatments are missed.Dialysis may be stopped, postponed, or delayed due to dialysis equipment failure. If this happens during dialysis, the staff and practitioner must assess the resident immediately to as[TRUNCATED]

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, resident representative interviews, and policy review the facility failed to provide medically-related Social Services in assisting and obtaining Medicaid applications and Power of Attorney documents for 1 of 1 Residents (Resident #57) reviewed. The facility reported a census of 58 residents. Findings include:Review of Minimum Data Set (MDS) dated [DATE] revealed Resident #57's admission to the facility on 2/6/26 and a Brief Interview for Mental Status (BIMS) assessment completed on 2/23/26 resulting in a score of 6 indicating severe cognitive impairment. Resident #57's diagnoses included urinary tract infection, diabetes, COPD, respiratory failure, anxiety, depression, and requiring substantial/maximal assistance with the use of a wheelchair. Review of Resident #57's Care Plan initiated 2/13/26 documented impaired cognitive function and thought processes. The Care Plan documented that the resident used a walker in the bedroom with assist of one staff member, and used a wheelchair for distance mobility with assist of one staff member.Review of Resident #57's admission Record- Facesheet revealed private pay as primary payer. Review of Resident #57's Electronic Health Records (EHR) revealed admission Agreement and documentations signed by Resident #57 on 2/4/26 and signed witness Staff D, Social Services/Admissions. admission Agreement documents indicated Resident #57's expected primary payor source Medicare/Medicaid. Further documentation titled Advance Directives Policy and Record failed to indicate Resident #57 having a Power of Attorney. Review of a Progress Note- Resident Care Conference dated 4/15/26 at 10:24 AM noted Resident #57's Family Representative attended the care conference and the facility Business Office Manager to call on 4/17/26 to check Medicaid status. In an interview on 5/5/26 at 2:38 PM, Resident #57's Contracted Representative stated contracted hire started in the fall of 2025 to assist Resident #57 with Medicaid applications. This application had been completed December 2025, pending further bank statement documentation to finalized approved coverage. During this time Resident #57 was hospitalized with a UTI and the pending bank statements had not been submitted as a result voiding any Medicaid coverage. Contracted Representative explained after Resident #57's admission to the facility communication attempts had been made to the facility to discuss the Medicaid applications with no response. Resident #57 communicated with the Contracted Representative that facility staff had been asking her for the needed documents to complete this application and requested the Contracted Representative assist the facility. The Contracted Representative again tried to communicate with the facility to provide and discuss needed documents to complete the Medicaid application, with refusal from the facility to communicate with her. The Contracted Representative further explained, per the facility, due to Resident #57's cognitive status, Resident #57 was not able to make these decisions for herself so the facility had contacted a lawyer to implement an emergency conservator to control Resident #57's financials. At this time the Contracted Representative informed the facility Resident #57 does have a Medical Power of Attorney and this person should be contacted to be appointed Resident #57's financial representative. Review of provided Email communication between Resident #57's Contracted Representative and Facility's Business Office staff revealed the following communications:a. 4/16/26 at 12:19 PM Contracted Representative notified Staff A, Corporate Director of Business Office Services, providing consent and documents for Resident #57 and notifying Contracted Representatives will be at the facility later this day to assist with the Medicaid Application. b. 4/17/26 at 9:02 AM Contracted Representative provided bank statements for Resident #57 for December 2025 to March 2026 and noted charges on Resident #57's bank statements that would need clarification and follow-up to meet requirements of the Medicaid process. c. 4/21/26 at 12:48 PM, Resident #57's POA communicating to the facility his communication with the Contracted Representative and his request for the Contracted Representatives assistance with Resident #57's care. d. 4/30/26 at 7:00 PM Resident #57's POA (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conservatorship for Resident #57 due to low BIMS score and poor cognition. In an interview on 5/7/26 at 2:46 PM, Facility Administrator and VP of Clinical Operations acknowledged the miscommunications between facility staff, Contracted Representatives, POA and Resident #57 and agreed the Medicaid Application process should have been initiated on Resident #57's admission as well as obtaining POA documentation for Resident #57's records on admission to the facility. Facility Administrator informed the Medicaid application for Resident #57 had been completed and submitted in the past couple of days and was pending. Review of Facility provided Resident Rights policy, revealed the following:1. The resident has the right to exercise his or her rights as a resident of the provider and as a citizen of the United States. 2. In the case of a resident adjudged incompetent the rights of the resident devolve to and are exercised by the resident representative appointed under state law to act on the resident's behalf. 3. In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative. 4. The resident or resident representative has the right to access personal and medical records pertaining to him or herself and shall have access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual. 5. Residents have the right to manage their own money and financial affairs or to choose someone to manage their money and financial affairs for them, including prior notice of any charges the Provider may impose against a resident's personal funds.6. The Provider will provide the Resident with needed social services including counseling, help solving problems with other residents, help in contacting legal and financial professionals and discharge planning.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews, and policy review, the facility staff failed to ensure Enhanced Barrier Precautions (EBP) were in place for residents with multidrug-resistant organisms (MDROs) (Resident #24), failure of staff to wear appropriate personal protective equipment (PPE) when providing care to residents on EBP (Resident #8), and failure to follow proper infection control practices to prevent the transmission of infection with blood sugar monitoring. The facility reported a census of 58 residents.Findings include:1. Review of MDS dated [DATE] revealed Resident #24 BIMS of 11 indicating moderate cognitive impairment with diagnoses of Multidrug-Resistant Organism ((MDRO) bacteria that have become resistant to three or more classes of antibiotics) and Urinary Tract Infection, and incontinent of bowel and bladder with need for substantial/maximal assistance with ambulation and use of walker or wheelchair. Review of Resident #24's Care Plan initiated 1/23/26 documented incontinent of bladder and risk for UTIs with interventions to provide peri-care with each incontinence episode, monitor/document for signs and symptoms of UTI, and obtain labs as ordered and notify physicians of results. Observation of resident #24's room on 5/4/26 at 12:28 PM failed to indicate EBP. Review of Resident #24's lab results revealed the following: a. 1/10/26 Urine Culture: >100,000 Proteus mirabilis/penneri. Multi-Drug Resistant Gram-Negative Rod. (Indicating growth of MDRO bacteria in urine) (Isolation required)b. 1/16/26 Urine Culture: 50,000-100,000 Proteus mirabilis-ISOLATION IS REQUIRED. (Indicating growth of MDRO bacteria in urine) (Isolation required)c. 4/9/26 Urine Culture: >100,000 Klebsiella pneumoniae, 10,000-49,000 Proteus mirabilis. (Indicating growth of MDRO bacteria in urine) (Isolation required) During an interview on 5/7/26 at 2:46 PM, VP of Clinical Operations, reviewed Resident #24's urine cultures and acknowledged due to MDRO results resident #24 should have been and should be under EBP with incontinent cares. Review of facility provided Enhanced Barrier Precautions dated 3/25/24 revealed the following: 1. Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.2. EBPs are indicated (when contact precautions do not otherwise apply) for residents infected or colonized with CDC-targeted MDROs. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #8 revealed the diagnoses of cerebral palsy, benign prostatic hyperplasia (BPH is an enlargement of the prostate gland that squeezes the urethra effecting the urinary system) and required maximal assistance from staff for personal hygiene and was dependent for toilet. The MDS identified indwelling catheter. The Care Plan for Res #8 directed staff to utilize Enhanced Barrier Precautions (EBP) related to the presence of a catheter. During an observation on 5/6/26 at 11:35 am, Staff P, Certified Nursing Assistant (CNA) provided catheter care for Resident #8. Resident #8 had a urinary leg bag attached to his left leg. Staff P placed a barrier on the floor with a container to contain the drained the urine (a graduate). Staff P put gloves on but failed to practice the EBP by putting the gown on as directed on the EBP sign on Resident #8's door. The PPE storage outside the door contained gowns, gloves and masks if needed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for splatter. Staff P paced the graduate onto her knee to stabilize it instead of releasing the straps from around Resident #8's leg and bring the bag to the graduate when she emptied it. Infection Control Policy revealed: Standard Precautions:a. All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services.b. Hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures.c. All staff shall use personal protective equipment (PPE) according to established facility policy governing the use of PPE.d. Licensed staff shall adhere to safe injection and medication administration practices, as described in relevant facility policies.e. Environmental cleaning and disinfection shall be performed according to facility policy. All staff have responsibilities related to the cleanliness of the facility and are to report problems outside of their scope to the appropriate department. Isolation Protocol (Transmission-Based Precautions):A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by current CDC guidelines.Residents will be placed on the least restrictive transmission-based precaution for the shortest duration possible under the circumstances. 3. On 5/6/26 at 11:13 AM, Staff U, Certified Medication Aide (CMA), stated she was going to check a resident's blood sugar. She went into Resident #41's room and obtained a blood sample. After obtaining the blood sample, Staff U picked up the supplies and walked out of the room. When asked if she should have done anything differently, Staff U replied that she should have removed her gloves after obtaining the blood sample and sanitized her hands (prior to touching other objects). On 5/6/26 at 12:15 PM, the [NAME] President of Clinical Operations stated that Staff U had let her know what happened. This [NAME] President of Clinical Operations stated that she had no questions and understood the infection control concerns. Policy: The purpose of this procedure is to provide guidelines for the disinfection of capillary-blood glucose sampling devices to prevent transmission of blood borne diseases to residents and employees. Definitions: Cleaning is the removal of visible soil from objects and surfaces normally accomplished manually or mechanically using water with detergents or enzymatic products. Disinfection is a process that eliminates many or all pathogenic microorganisms, except bacterial spores, on inanimate objects. Policy Explanation and Compliance Guidelines The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. If the manufacturers are unable to provide information specifying how the glucometer should be cleaned and disinfected, then the meter will not be used for multiple residents. The glucometers will be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C and Hepatitis B virus. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions regardless of whether they are intended for single resident or multiple resident use. Procedure: Obtain needed equipment and supplies: Gloves, glucometer, alcohol pads, gauze pads, single-use lancet, blood glucose testing strips, disinfecting wipes. Wash hands. Explain the procedure to the resident. Provide privacy. Put on gloves. Obtain capillary blood glucose sampling according to facility policy. Remove and discard gloves, perform hand hygiene prior to exiting room. Reapply gloves if there is visible contamination of the device or if the resident is HIV or Hepatitis B or C positive. Retrieve (2) disinfectant wipes from container. Using first wipe, clean first to remove heavy soil, blood and/or other contaminants left on the surface of the glucometer. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufacturer's instructions. Allow the glucometer to air dry. Discard disinfectant wipes in waste receptacle. Perform hand hygiene.