STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165421	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Accura Healthcare of Newton East, LLC	1743 South Eighth Avenue East Newton, IA 50208

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on facility record review and staff interviews, the facility failed to ensure daily Registered Nurse (RN) coverage for 2 separate days within a 30-day schedule review. The facility reported a census of 52.Findings include: Review of nursing schedules from 1/16/26 to 2/14/26 revealed no RN scheduled for 2/8/26 & 2/14/26. On both days, two Licensed Practical Nurses (LPNs) provided the needed licensed nurse coverage. One LPN for the 12-hour day shift and another LPN for the 12-hours night shift. During an interview on 2/18/26 at 1:00 PM, the Administrator acknowledged and confirmed the lack of RN coverage for 2/8/26 and 2/14/26. This was an oversight as a result of recent staffing changes that reduced the number of floor RNs availability. The facility does not have a staffing policy which outlines the need for RN coverage at least 8 consecutive hours 7 days a week.

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, facility document review, and facility policy reivew, the facility failed to ensure temperatures were checked regularly for food to be served, refrigerator and freezer food storage, and dishwasher sanitation when temperature logs lacked documentation during 2 of 2 kitchen observations. The facility additionally failed to regularly test chemical solution to ensure sanitation of surfaces during 2 of 2 kitchen observations. The facility further failed to prevent cross contamination when raw beef thawed on a tray placed on top of a container with ready to eat ham and cheese sandwiches during 1 of 2 kitchen observations. The facility reported a census of 52 resident. Findings include: 1. During an initial kitchen observation on 2/15/26 at 10:30 AM and during a follow up observation on 2/16/26 at 11:50 AM, 4 of 4 refrigerators and 2 of 2 freezers stored various foods and beverages for resident meals. All refrigerators and freezers observed had a temperature log taped to the front or top, all logs had multiple entries left blank. A. Review of the facility provided documents titled, Refrigerator Temperature Log, dated February 2026, indicated that refrigerator temperatures were to be checked twice per day (AM and PM) and instructed staff to notify supervisor and maintenance if the refrigerator temperature was above 41 degrees Fahrenheit. Logs were reviewed between the dates of 2/01/26 and 2/16/26 for the following refrigerators: a1. Refrigerator Temperature Log, Location identified as: DA Cooler, dated February 2026, lacked documentation of temperature check on 4 out of 16 morning shifts and 4 out of 16 evening shifts. a2. Refrigerator Temperature Log, Location identified as: Cook, dated February 2026, lacked documentation of temperature check on 3 out of 16 morning shifts and 2 out of 16 evening shifts. a3. Refrigerator Temperature Log, Location: (blank-contained only milk), dated February 2026, lacked documentation of temperature check on 2 out of 16 morning shifts and 6 out of 16 evening shifts. a4. Refrigerator Temperature Log, Location: (blank- contained eggs and various foods), dated February 2026, lacked documentation of temperature check on 2 of 16 evening shifts. B. Review of the facility provided documents, titled Freezer Temperature Log, dated February 2026, indicated that freezer temperatures were to be checked twice per day (AM and PM) and instructed staff to notify supervisor and maintenance if the freezer temperature was above 0 degrees Fahrenheit. Logs were reviewed between the dates of 2/01/26 and 2/16/26 for the following freezers: b1. Freezer Temperature Log, Location identified as: Meat/ice cream, dated February 2026, lacked documentation of temperature check on 11 out of 16 morning shifts and 2 out of 16 evening shifts. b2. Freezer Temperature Log, Location: (blank), dated February 2026, lacked documentation of temperature check on 2 of 16 evening shifts. 2. During an initial kitchen observation on 2/15/26 at 10:30 AM and during a follow up observation on 2/16/26 at 11:50 AM, one dishwasher was used to sanitize dishes. A dishwasher temperature log, posted on the wall, near the dish machine, lacked all but 1 entry between the dates of 2/01/26 and 2/16/26. C. Review of the facility provided document, titled Dishwasher Temperature Log, dated February 2026, indicated that a water temperature and chlorine sanitizer level were to be checked twice per day (AM and PM) to ensure proper sanitation levels were maintained. All entries between 2/01/26 and 2/16/26 were blank, except one entry recorded on 2/16/26 morning shift3. During an initial kitchen observation on 2/15/26 at 10:30 AM and during a follow up observation on 2/16/26 at 11:50 AM, 1 of 1 red bucket, chemical solution and water mix stations, used for sanitation of surfaces, was observed. A red bucket log, posted on the wall, next to station reviewed between the dates of 2/01/26 and 2/16/26, had multiple entries left blankD. Review of the facility provided document, titled Red Bucket Sanitizer Log, indicated that a chemical solution level was to be checked six times per day (6:00 AM, 9:00 AM, 12:00 PM, 2:00 PM, 5:00 PM, 7:00 PM), listed sanitizer concentration levels to be between 150 and 400 parts per million (ppm), and instructed staff to report any variations to the supervisor. Log reviewed between 2/01/26 and 2/16/26, lacked documentation of 6 times per day solution check for 11 of 16 days. 4. During an initial kitchen observation on 2/15/26 (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 10:30 AM and during a follow up observation on 2/16/26 at 11:50 AM, a binder contained temperature logs for food to be served from the steamtable to ensure food served was fully cooked at each meal. Food temperature logs were reviewed between the dates of 2/01/26 and 2/16/26 had many meal entries left blank. E. Review of the facility provided document, titled Steamtable Temperature Log, dated February 2026, indicated that a temperature was to be checked for each food item served, three times a day (breakfast, lunch, dinner). Log reviewed between 2/01/26 and 2/16/26, lacked documentation of food temperatures for 6 of 16 breakfast meals served, 8 of 16 lunch meals served, and for 4 of 16 dinner meals served.5. During an initial kitchen observation on 2/15/26 at 10:30 AM, a refrigerator stored a plastic container of ready to eat ham and cheese sandwiches, dated 2/14/26, on the bottom shelf and set on top of the sandwich container was a tray with package of thawing raw beef. During an interview on 2/15/26 at 10:30 AM, the Dietary Manager confirmed that temperature logs had not been completed during the initial kitchen observation. During an interview on 2/17/26 at 1:50 PM, the Dietary Manager reported being in role for approximately 2 months and stated education was provided to all dietary staff as of 2/17/26 on checking and completing all temperature logs per policy. The Dietary Manager reported that ham and cheese sandwiches were discarded due to raw product kept above ready to eat products and stated that education would also be provided to all dietary staff to remind about cross contamination when storing food. Review of the facility provided document, titled Education Form, revealed the following statement for staff to sign and date as acknowledged:As an employee in the dietary department, it is my responsibility to ensure temperature logs are checked and filled out per policy. And notify the Executive Director (ED) for any changes. The facility denied having policies or procedures for food storage, food temperatures, or sanitation upon request.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, staff interviews, and policy review, the facility failed to implement Enhanced Barrier Precautions (EBP) for 3 of 3 residents reviewed for EBP (Residents #7, #40 and #47), failed to properly handle, transport and process linens properly for 2 residents in Transmission Based Precautions (Residents #4 and #56), and failed to change out a resident's urinal in a timely manner (Resident #10). The facility reported a census of 52.Findings include:1. The Electronic Health Record (EHR) indicated that Resident #40 had an abscess on her left knee 11/16/25 that was drained on 11/18/25 and required a dressing change including packing. The dressing order changed on 2/16/26 but still included packing. The Care Plan initiated on 3/29/24 indicated that Resident #40 was placed in EBP on 11/27/24 for wounds. During an observation on 2/16/26 at 11:31 AM Staff A, RN performed wound care to Resident #40's left knee. She did not wear a gown during the dressing change. There was an EBP sign on Resident #40's door. 2. The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #47 had diagnoses neurogenic bladder. It also indicated that she had an indwelling catheter. The Care Plan initiated on 2/5/20 indicated that Resident #47 had an indwelling catheter. It also indicated that she was placed in EBP on 4/1/24. During an observation on 02/16/2026 at 7:36 AM Staff J, CNA took R#47 to the shower room on a shower chair. He then went to her room and was making her bed and putting an adult brief in her bed for when she returned from the shower. He was not wearing a gown or gloves. There is an EBP sign on the outside of her room. 3. The Electronic Health Record (EHR) indicated that Resident #4 returned from the hospital on an antibiotic due to a urinary tract infection (UTI). The Care Plan initiated 6/13/24 lacked documentation that Resident #4 was in Transmission Based Precautions. During an observation on 02/16/2026 at 7:53 AM Resident #4's room had a contact precautions sign on the door and a Personal Protective Equipment (PPE) container outside the door. 4. The Electronic Health Record (EHR) indicated that Resident #56 was diagnosed with bacteremia and getting antibiotic transfusions at the transfusion center. The Care Plan initiated 10/18/24 indicated that Resident #56 was in EBP and lacked documentation that he was in Transmission Based Precautions. During an observation on 02/16/2026 at 7:53 AM Resident 56's room had a contact precautions sign on the door and a Personal Protective Equipment (PPE) container outside the door. During an observation on 2/17/26 at 11:54 AM no setting was noted on the washers for isolation (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	linen. During an observation on 02/17/2026 at 11:43 AM Staff D, Environmental Services Director put out a special container with yellow isolation bags for isolation linen by both TBP rooms. In an interview on 02/17/2026 at 10:54 AM Staff D, Environmental Services Director stated that she does not get isolation linen in a different colored bag and was not aware it needed to be washed separate or last. Stated she would confirm with her boss. In an interview on 02/17/2026 at 11:45 AM Staff E, CNA and Staff F, CNA both stated that they do not put isolation linen in its own colored bag. In an interview on 2/18/25 at 10:49 AM the ADON stated that staff are notified resident in EBP with signs, education and with new cases. She also stated that EBP would be required with wounds, catheters and feeding tubes. The DON stated that Personal Protective Equipment (PPE) required for EBP would be a gown, gloves and eye protection if something would splash. The surveyor reviewed the lack of PPE for catheter care, gastrostomy tube (tube inserted into stomach for nutrition) care, and wound care. Both the ADON and DON stated PPE should have worn in the 3 cases presented. In an interview on 2/18/26 at 1:55 PM the DON stated that residents who are in isolation should have their linens sent to laundry separately and should be in yellow biohazard bags. They will be doing that from now on. 5.The MDS completed on 11/25/25 revealed Resident #10 requires partial assistance for toileting hygiene. During an observation on 2/15/26 at 12:30 PM, a urinal was sat on Resident #10's bedside table. It was heavily soiled with a yellow residue as well as black grime around the opening. The date on the urinal was 1/16. Resident #10 confirmed they still use the urinal and confirmed the date on it. The only sink in the room was full of empty pop bottles and unusable. During an observation on 2/17/26 at 10:10 AM, the same urinal was noted on Resident #10's bedside table. The sink remained full of empty pop bottles. During an interview on 2/17/26, Staff L, CNA, explained Resident #10 prefers to use a urinal. Staff L believed the night shift staff change out urinals monthly. In an interview on 2/17/26 at 2:45 PM, the Assistant Director of Nursing (ADON) stated urinals should be changed out weekly or when needed due to infection control issues. When discussed the condition of the urinal, the ADON suspects staff may have attempted to change but the resident declined. However, the condition of the urinal in use is unacceptable. The Administrator confirmed, via an email on 2/18/26, there is not a policy related to changing out urinals. 6. Review of the MDS assessment, dated 12/18/25, revealed Resident #7 had problem with both short term and long term memory and had moderately impaired cognitive skills for daily decision making. The list of diagnoses included Cerebrovascular Accident (stroke), hemiparesis or hemiplegia (one sided weakness or decreased sensation); aphasia (inability to speak), and malnutrition. The MDS (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified that Resident #7 required feeding tube while a resident and received 51% or more of total calories per day and 501 milliliters (mL) or more of fluid intake per day. Review of the Care Plan, revised on 11/13/25, revealed a Focus area for artificial nutrition received with Percutaneous Endoscopic Gastrostomy (PEG tube or G-tube) related to stroke and dysphagia (difficulty swallowing). The Care Plan lacked identification of Focus area or intervention related to risk for infection or EBP utilized by staff for resident's indwelling device. During an observation on 2/15/26 at 11:30 AM, Resident #7's room lacked signage posted inside or outside of room to inform staff of EBP required for Resident #7's indwelling device. Observed a pole next to bed with 1/2 full bottle of nutritional solution and 1/2 full bag of water hung with tubing lined into an electronic dispensing pump. During an observation on 2/15/26 at 12:33 PM, Staff J, Certified Nursing Assistant (CNA), transported Resident #7 via wheelchair into Resident #7's room, Staff J did not apply any additional PPE upon entrance into room. At 12:37 PM, Staff J exited Resident #7's room and retrieved linens from the clean linen closet and re-entered Resident #7's room, again without additional PPE applied. At 12:39 PM, Staff J, exited Resident #7's room, without wearing or removing any additional PPE, and held Resident #7's soiled personal clothing in one hand and a closed trash bag in the other hand, walked through hallway to a soiled linen closet. During an observation on 2/17/26 at 9:05 AM, signage for EBP posted outside of Resident #7's room with PPE supplies available in a cart set near room. During an observation on 2/17/26 at 2:11 PM, Staff A, Registered Nurse (RN) performed flush of Resident #7's feeding tube, no EBP additional PPE worn during procedure. Review of the facility policy, titled Enhanced Barrier Precautions, updated 11/13/24, revealed the policy Statement as follows: It is the policy of this facility to implement Enhanced Barrier Precautions for the prevention of transmission of multi-drug resistant organisms (MDRO). The policy defined Enhanced Barrier Precautions (EBP) as referring to an infection control intervention designed to reduce transmission of multi-drug resistant organisms that employs targeted gown and gloves use during high contact resident care activities. The Section titled, Policy Explanation and Compliance Guidelines, instructed the following: b. Initiation of EBP: 2. An order for EBP will be obtained for residents with any of the following: i) Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous statis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO. ii) Infection or colonization with a CDC (Centers for Disease Control)- targeted MDRO when contact precautions do not otherwise apply. c. Implementation of EBP: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. Make gowns and gloves readily accessible to staff. Note: face protection may also be needed if performing activity with risk of splash or spray (i.e., wound irrigation, tracheostomy care). 2. PPE for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room. 3. Ensure alcohol-based hand rub is readily available for staff. 4. Position a trash can inside the resident room and/or near the exit for discarding PPE after removal, prior to exit of the room or before providing care for another resident in the same room. 5. The Infection Preventionist will incorporate periodic monitoring and assessment of adherence to determine the need for additional training and education. 6. Provide education to residents and visitors. 7. Do no restrict room placement or out-of-room activities due to EBP. d. High-contact resident care activities include: 1. Dressing 2. Bathing 3. Transferring 4. Providing hygiene 5. Changing linens 6. Changing briefs or assisting with toileting 7. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes 8. Wound care: any skin opening requiring a dressing (excluding shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. h. EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on employee file review, staff interview, and policy review, the facility failed to ensure the completion of dependent adult abuse training for 1 of 5 employees reviewed (Staff K, Certified Nurse's Aide [CNA]). The facility reported a census of 52. Findings include: Employee file review of Staff K, Certified Nurses Aide (CNA) revealed a hire date of 8/6/25. The file lacked documentation that Staff K completed dependent adult abuse training within six months of the hire date. During an interview on 2/18/26 at 1:00 PM, the Facility Administrator acknowledged and confirmed the lack of dependent adult abuse training for Staff K. The policy Nursing Facility Abuse Prevention, Identification, Investigation, and Reporting policy, updated 10/22/22, noted the following: a. Within six months of hire, each employee shall be required to complete an initial 2-hour training course provided by the Iowa Department of Human Services relating to the identification and reporting of dependent adult abuse training; b. All nurses' aide shall receive initial and annual resident adult abuse prevention training.

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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 electronic heath record (EHR) review, observation, resident interview, staff interview, and policy review, the facility failed to consistently complete smoking assessments for 1 of 1 residents reviewed for smoking (Resident #22). The facility reported a census of 52. Findings include: The Annual Minimum Data Set (MDS) Assessment completed on 11/13/25 noted the use of tobacco for Resident #22. The MDS documented that the resident had a readmission date of 8/22/25 from a short-term hospital stay. The MDS documented a Brief Interview for Mental Status score of 15 out 15, which revealed intact cognitive skillsDuring an observation on 2/16/26 at 1:15 PM, Resident #22 was observed vaping in the designated smoking area. Upon review of completed Smoking Assessments, no assessments were completed during all of 2025. The two most recent assessments were dated 10/23/24 and 2/11/26. In an interview on 2/16/26 at 3:15 PM Staff L, Certified Nurse's Aide, reported Resident #22 was vaping since they started working at the facility in September 2025. Staff L reported Resident #22 may smoke a cigarette once in a while when their vape pen is not fully charged. In an interview on 2/16/26 at 3:50 PM, Resident #22 explained they had stopped smoking in January 2025 but then started vaping sometime between July 2025 and September 2025. Resident #22 confirmed the occasional use of cigarettes. In an interview on 2/17/26 at 2:45 PM, the Assistant Director of Nursing (ADON) noted smoking assessments are completed quarterly by nursing staff or the MDS Coordinator. The ADON confirmed Resident #22 had stopped smoking for a time and then started vaping. The ADON was not sure when this occurred. Upon review of the EHR, the ADON acknowledged and confirmed the lack of smoking assessments for late 2025. These assessments should have resumed once it was identified that the resident was vaping. The policy Resident Smoking, updated 4/14/25, noted the following: a. Residents will be asked about tobacco use during the admission process and during each quarterly or comprehensive MDS assessment process b. Residents who smoke will be furthered assess, using the Resident Safe Smoking Assessment, to determine whether or not supervision is required for smoking or is resident is safe to smoke at all c. Safe smoking assessment will be completed on residents using e-cigarettes

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on electronic health record (EHR) review, observations, resident interview, staff interviews, and policy review, the facility failed to update the Care Plans for 2 of 17 Care Plans reviewed (R#22 for vaping, and R#36 for driving). The facility reported a census of 52. Findings include: The Minimum Data Set (MDS) Assessment completed on 11/13/25 noted the use of tobacco for Resident #22.During an observation on 2/16/26 at 1:15 PM, Resident #22 observed vaping in the designated smoking area. The Care Plan, with an end target date of 5/13/26, lacked a Focus Area and Interventions related to active smoking. Upon further review, smoking was addressed on previous Care Plan updates but removed on 7/28/25.In an interview on 2/16/26 at 3:50 PM, Resident #22 explained they had stopped smoking in January 2025 but then started vaping sometime between July 2025 and September 2025. Resident #22 confirmed the occasional use of cigarettes. In an interview on 2/17/26 at 2:45 PM, the Assistant Director of Nursing (ADON) noted floor nursing staff, activities staff, and the dietitian all have access to resident Care Plans. The ADON voiced Care Plans should be updated as needed and not wait until the resident's Comprehensive Assessments or MDS are due. The ADON acknowledged and confirmed Resident #22's Care Plan should have been updated when they started to vape. The policy Comprehensive Care Plans, updated 12/3/25, outlined the following: a. The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care; b. The comprehensive Care Plan will describe Resident specific interventions that reflect the resident's needs and preferences and align with the resident's cultural identity; c. The comprehensive Care Plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. The Care Plan will be updated in a timely manner to ensure that services are furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. 2. The Electronic Health Record (EHR) indicated that Resident #36 (R#36) had diagnoses of malignant neoplasm of the liver, reduced mobility and unspecified abnormalities of gait and mobility. It indicated he was receiving chemotherapy treatments through 2/6/26. The current MDS completed on 2/5/26 indicated R#36 had a Basic Interview for Mental Status (BIMS) score of 10. R#36 had a BIMS of 15 upon admission on [DATE], on five other MDS assessments he also scored a 15, and on 8/14/25 he scored 13. The clinical record lacked documentation to address the drop in the BIMS score from a 15 to a 10, and it lacked documentation of evaluation of his ability to drive a vehicle safely. The Progress Notes indicated that the current Director of Nursing (DON) documented on 11/19/25 that she asked R#36 if he would like to drive himself in the vehicle he keeps at the facility to his medical appointment, or if she should arrange transportation. He requested that she arrange transportation.The Care Plan initiated 9/9/24 lacked documentation that Resident #36 was driving or had a vehicle at the facility. In addition, it did not identify that Resident #36 needed to sign-out or could leave the campus without supervision.During an observation on 2/15/26 at 11:15 AM Resident #36 was noted to go outside of the building. He then entered a vehicle outside, left his walker on the sidewalk and drove away. During an observation on 2/15/26 at approximately 11:30 AM R#36 parked his vehicle next to his walker. He had a sack with him then that he placed on his walker and re-entered the facility.During an observation on 2/17/26 at 1:50 PM the facility resident sign out book lacked documentation that Resident #36 had left the faciity on 2/15/26 despite him leaving on that date.In an interview on 2/16/26 at 9:45 AM R#36 stated he can drive and the only thing is he has to wear his glasses. He added that he does have to sign in and out as well.In an interview on 2/17/26 at 10:11 AM Staff B, Life Enrichment Coordinator stated that R#36 has his car outside. She stated she was told he had insurance and a driver's license but was not sure if anyone checked his ability to drive.In an interview on 02/17/2026 at 10:40 AM with the Corporate Nurse, DON and the (continued on next page)

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	165421	A. Building B. Wing	02/18/2026

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administrator, the Corporate Nurse stated that she has been asking around to staff and R#36 may go out and sit in the car but he does not drive it. The surveyor informed them of the observation of him leaving the facility in his car on 2/15/26. All stated that they were unaware he was driving.In an interview on 2/17/26 at 12:40 PM Staff C, Designated Medical Practitioner (DMP) stated she was unaware that R#36 was driving and she had never heard of such a thing. None of the resident's drive and would definitely not be supportive of it. She added that she would be writing an order for no driving before she left the facility.In an interview on 2/18/26 at 12:07 PM the Administrator stated that R#36 should not have been driving and that a lot of people have driver's licenses that are not safe to drive.A policy for residents driving was requested and the Administrator stated they did not have a policy for residents driving.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on clinical record review, observation, and staff interviews, the facility failed to perform wound care as the physician ordered for 1 of 1 resident (Resident #40) reviewed for wound care.Findings include: The Electronic Health Record (EHR) indicated that Resident #40 had an abscess on her left knee 11/16/25 that was drained on 11/18/25 and required a dressing change including packing. The dressing order changed on 2/16/26 but still included packing. The Physician's Orders included lidocaine external gel 2% that was discontinued on 1/16/26. The new dressing change order lacked an order for lidocaine to be placed on the wound prior to the dressing change.The Care Plan initiated on 3/29/24 indicated that Resident #40 was placed in Enhanced Barrier Precautions (EBP) on 11/27/24 for wounds. It lacked documentation on the location of the wound. It directed staff to administer medications as ordered.During an observation on 2/16/26 at 11:31 AM Staff A, RN performed wound care to Resident #40's left knee. After removal of the old dressing and cleaning of the wound, Staff A applied lidocaine (medication to numb the area) gel directly over the wound site and waited one minute to let it take effect.In an interview on 2/18/26 at 9:20 AM Staff A stated that the wound nurse gave dressing change orders for Resident #40 to the ADON. When the surveyor questioned her about the order she looked it up and stated that it did not include an order for lidocaine. She looked up lidocaine and stated that lidocaine had been discontinued 1/16/26. She assumed it was part of the order as they used it when packing previously.In an interview on 2/18/26 at 9:25 AM the ADON stated that she did rounds with the wound nurse and obtained the new wound order from her. The new order did not include lidocaine gel. It was used in the past as the resident was experiencing pain during the dressing change but did not experience pain during the new dressing change. Therefore, it was not included in the new dressing change order. Stated it should not have been used and if the nurse that used it felt she needed it, she should have called the physician and obtained an order.On 2/18/26, a policy on Physician's orders was requested and the Corporate Nurse stated they did not have a policy on it. They should simply follow the Physician's orders.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interviews, and electronic health record (EHR), and policy review, the facility failed to identify, evaluate and analyze hazard(s) and risk(s) to prevent potential avoidable accidents for 1 of 1 reviewed, (Resident#36). In addition, the facility failed to assess if the Resident was safe to drive a vehicle on his own. The facility reported a census of 52. Findings include:The Electronic Health Record (EHR) indicated that Resident #36 had diagnoses including malignant neoplasm of the liver, reduced mobility and unspecified abnormalities of gait and mobility. It indicated he was receiving chemotherapy treatments through 2/6/26. He currently had a Basic Interview for Mental Status (BIMS) score of 10 from the Quarterly Minimum Data Set (MDS) dated [DATE], which indicated difficulty with cognitive skills. (The BIMS score was down from 15 at the time of his previous MDS assessment.) The EHR lacked documentation of evaluation of his ability to drive a vehicle safely.The Progress Notes indicated that the current Director of Nursing (DON) documented on 11/19/25 that she asked Resident #36 if he would like to drive himself in the vehicle he keeps at the facility to his medical appointment, or if she should arrange transportation. He requested that she arrange transportation.Health Status Note dated 1/24/26 at 7:50AM documented a call placed to oncology for clarification on cancer drug, discontinue pill forms because the resident will be starting infusions due to increased size of tumor. Infusion port to be placed on 1/28/26. Progress Note dated 2/6/26 at 1:347PM documented the resident had chemo pump removed today.The Care Plan initiated 9/9/24 lacked documentation that Resident #36 was driving or had a vehicle at the facility.The Care Plan for the resident documented a goal with revision date of 10/10/25 as follows; the resident will adequately use coping mechanisms through review date. The Care Plan included the following interventions for staff; assess for change in condition/function, assess for contributing factors for behavior, assess for coping mechanisms for when the resident is upset, and perform labs as ordered.A focus area in the Care Plan for Resident #36 initiated on 11/12/25 indicated Resident #36 had potential for impaired cognitive function/dementia or impaired thought processes related to (r/t) Disease Process Cancer.During an observation on 2/15/26 at 11:15 AM Resident #36 was noted to go outside of the building. He then entered a vehicle outside, left his walker on the sidewalk and drove away. During an observation on 2/15/26 at approximately 11:30 AM Resident #36 parked his vehicle next to his walker. He had a sack with him then that he placed on his walker and re-entered the facility.During an observation on 2/17/26 at 1:50 PM the facility resident sign out book lacked documentation that Resident #36 had left the faciity on 2/15/26 despite him leaving on that date.In an interview on 2/16/26 at 9:45 AM Resident #36 stated he can drive and the only thing is he has to wear his glasses. He added that he does have to sign in and out as well.In an interview on 2/17/26 at 10:11 AM Staff B, Life Enrichment Coordinator stated that Resident #36 had his car outside. She stated she was told he had insurance and a driver's license but was not sure if anyone checked his ability to drive.In an interview on 02/17/2026 at 10:40 AM with the Corporate Nurse, DON and the Administrator, the Corporate Nurse stated that she has been asking around to staff and Resident #36 may go out and sit in the car but he does not drive it. The surveyor informed them of the observation of him leaving the facility in his car on 2/15/26. All stated that they were unaware he was driving.In an interview on 2/17/26 at 12:40 PM Staff C, Designated Medical Practitioner (DMP) stated she was unaware that Resident #36 was driving and she had never heard of such a thing. None of her resident's drive and would definitely not be supportive of it. She added that she would be writing an order for no driving before she left the facility.In an interview on 2/18/26 at 12:07 PM the Administrator stated that Resident #36 should not have been driving and that a lot of people have driver's licenses that are not safe to drive.The American Cancer Society lists a possible side effect of taking chemotherapy as having trouble remembering things, focusing, finishing tasks or (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	learning something new. These are symptoms of cognitive impairment, also known as chemo brain or brain fog.A policy for residents driving was requested and the Administrator stated they did not have a policy for that. No documents were provided concerning Resident #36's ability to safely drive or that the vehicle was in safe working order. The only thing provided was a current driver's license for Resident #36.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, and staff interview, the facility failed to initiate adequate interventions to prevent significant weight loss for 1 of 1 resident (Resident #12) reviewed for nutrition.Findings include:The Minimum Data Set (MDS) assessment dated [DATE] for Resident #12 identified a Brief Interview for Mental Status (BIMS) score of 5 indicating severe cognitive impairment. It also indicated that the resident ate independently.The Care Plan initiated on 10/21/23 indicated that Resident #12 ate in the dining room independently with set up. It identified that Resident #12 was at risk for altered nutrition due to a history of mild protein-calorie malnutrition, irritable bowel syndrome and rheumatoid arthritis. The directives for staff included the following:Invite the resident to activities that promote additional intake. Provide and serve diet as ordered. Provide and serve supplements and fortified foods as ordered.RD to evaluate and make diet change recommendations as needed. The resident needs cueing, tray set-up and socialization at meals. Assist with filling out the menu.It also identified that Resident #12 had an unplanned or unexpected weight loss related to poor food intake. The directives for staff included the following:Give the resident supplements as ordered. Alert nurse or dietitian if not consuming on a routine basis. If weight decline persists, contact physician and dietician immediately. Labs as ordered. Report results to the physician and ensure the dietician is aware.Monitor and evaluate any weight loss. Determine percentage lost and follow facility protocol for weight loss.Monitor and record food intake at each meal. Offer substitutes as requested or indicated. Weigh at the same time of day and record: as directed.The Electronic Health Record (EHR) indicated that between February 1st-17th, 2026 at lunch that 26 meals lacked documentation for the amount of meal eaten by Resident #12. It also indicated that between January 1st-31st, 2026 that 24 meals lacked documentation for the amount of meal eaten as well.The dietary notes revealed the following: On 12/15/25 at 8:56AM it was documented that Resident #12's weight was 147.8 pounds (lbs). It indicated significant weight loss at 30, 90 and 180 days. Percentages were 5, 15 and 20% respectively. Weights were 155.8 lbs on 11/3/25, 174.9 lbs on 9/2/25 and 186 lbs on 6/4/25. She is often seen getting up and leaving without eating or eating very little. She would benefit from sitting with other tablemates and staff for tray set-up, cueing and socialization. Likes to snack throughout the day- can offer higher nutrition snacks such as 1/2 sandwich and milk, banana and peanut butter, yogurt.On 1/5/26 it is documented that Resident #12's weight was 142.6 lbs. It indicated weight loss at 30 days and significant weight loss at 90 and 180 days. Percentages were 3.5, 13 and 20% respectively. Weights were 147.8 lbs on 12/1/25, 164.8 lbs on 10/5/25 and 178.2 lbs on 7/1/25. She would benefit from sitting at the assisted table with staff cueing. She is able to tell staff what she wants to eat for meals and would need set-up to be independent in dining with cueing.During continuous observation on 2/16/26 at 8:46AM Resident #12 was sitting at her dining room table not eating. Staff had cut up pancakes and opened her syrup but no other assistance or encouragement was provided for 20 minutes. No substitute was offered.During continuous observation on 2/16/26 at 9:14 AM Resident #12 still had not eaten any food. She did drink all her fluids. No staff assistance or encouragement was provided for an additional 13 minutes. No substitute was offered.During an observation on 2/16/26 at 9:27 AM Staff J, CNA showed up and assisted Resident #12 out of the dining room. During an observation on 2/16/26 at 12:15 PM Resident #12 received her tray at her normal table. She moved her bread around and then picked up her spoon and took one bite and no more. She drank all of her liquids. No prompting or cueing noted from the staff. At 12:31 PM she got up and ambulated away from the table with her walker. No substitute was offered.During an observation on 2/17/26 at 8:44 AM Resident #12 was eating toast at the breakfast table alone. No cueing or encouragement noted from the staff. She got up and walked away from the table with her walker.During an observation on 2/18/26 at 8:40 AM Resident #12 was sitting at the assist table next to Staff J and had just a little egg left on her plate. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She was talking and interacting with staff. She had a toy cat she was fake attacking Staff J with.In an interview on 2/17/26 at 7:42 AM Staff A, RN stated that Resident #12 needs reminders to eat. She has had significant weight loss recently with rapid mental decline as well. They were considering moving her to the assisted table but had not yet as they moved her room in December and didn't want to move her table too soon and interfere with her routine.In an interview on 2/17/26 at 11:05 AM Staff H, Dietician confirmed her documentation on 12/15/25 and 1/05/26 in the EHR. She was last at the facility at the end of January 2026. She made sure that the facility was aware of her recommendations as they didn't always have meetings. Could not remember the staff she notified but is aware that they might not be there either due to high turn over. She does supply reports to the facility. She feels the Resident #12 needed to be at the assisted table and had recommended it repeatedly for months as she needs cues and often just stands up and walks off. She was told there was no room at the assisted table.In an interview on 2/17/26 at 12:20 PM Staff G, ARNP stated she was aware of Resident #12's weight loss. She feels that her cognitive decline has attributed to it. She believed that on 1/15/26 when she documented continued weight decline with Dietary following that Resident #12 was sitting at the assisted table. She was not aware that she was not and felt she should be. In an interview on 2/18/26 at 8:35 AM the Corporate Nurse stated she had the dietician's notes from 12/15/25 and 1/5/26 but they lacked information where she usually puts new items. Her recommendations were still noted to be in the documentation as listed in the EHR notes. The information was just not listed in the column that indicated new items. She stated that the facility does not have a policy on weight loss.In an interview on 2/18/26 at 8:40 AM Staff I, CNA stated that Resident #12 ate pretty well this morning.In an interview on 2/18/26 at 8:40 AM Staff J, CNA stated that Resident #12 ate her toast and all but a little bit of her 3 eggs along with 3 glasses of water.In an interview on 2/18/26 at 9:40 AM Staff A, RN stated that Resident #12 was moved to the assist table last night and she ate well then as well.