

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, provider interviews, resident interviews, staff interviews, family interviews and policy review the facility failed to ensure staff provided skin assessments, failed to notify the provider of deterioration timely and failed to implement interventions to prevent and treat the development and worsening of pressure ulcers for 7 of 8 residents reviewed (Resident #29, #2, #9, #30, #22, #23, and #21). The facility failure to assess a Stage II pressure ulcer from 12/16/25 through 1/3/26 resulted in Resident #29's wound to deteriorate to an unstageable ulcer due to necrosis (dead tissue) with infection that required debridement of the wound and then hospitalization. Significant debridement required with the wound base extending down into ligamentous structures running along the posterior sacrum and there was exposed bone. The facility reported a census of 28 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) that began as of January 2, 2026 on January 14, 2026 at 4:00 p.m. The facility staff removed the immediacy of the IJ on January 14, 2026, and decreased the scope to E through the following actions: In-service/education/training for pressure ulcer prevention and wound care - policy and practice update. a. All full time and part time clinical staff to complete the mandatory education/training before their next scheduled shift. All as needed (PRN) clinical staff to complete before their next scheduled shift. b. Audits to begin 1/15/26: completed weekly x 12 weeks. This was implemented due to an Immediate Jeopardy and focused on required practices to protect residents from avoidable skin breakdown and wound deterioration. Education Topics Covered: a. Review of updated Pressure Ulcer Prevention Policy. b. Weekly wound assessment completion and weekly skin assessment completion. c. Weekly Wound Care Rounds every Friday (mandatory participation & documentation) New skin concerns evaluated by Interdisciplinary Team (IDT) for Director of Nursing (DON) / Assistant Director of Nursing (ADON) notification, pressure relief interventions, proper Medical Doctor (MD) notification and order entry. d. Mandatory notification to DON and ADON of any skin or wound changes. e. Mandatory MD notification for any wound decline, worsening, or lack of improvement. Resident repositioning at least every 2 hours to be audited by charge nurse or leadership team member each shift every 2 hours. f. Repositioning residents at least every 2 hours - importance, frequency, and documentation. Daily shower/bath completion form to be implemented beginning 1/15/26 that included a section for new skin concerns, nurse notification and DON/ADON notification. Nurse to sign stating they documented a progress note regarding the new findings. g. Nurse aides must immediately notify the nurse on duty of any skin changes noted during bathing/showering. Findings include: The MDS (Minimum Data Set) assessment identifies the definition of pressure ulcers: Stage I is an intact skin with non-blanchable redness of a localized area usually over a bony prominence. Darkly pigmented skin may not have a visible blanching; in dark skin tones only it may appear with persistent blue or purple hues. Stage II is partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough (dead tissue, usually cream or yellow in color). May also present as an (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 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	intact or open/ruptured blister. Stage III Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle is not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining and tunneling. Stage IV is full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar (dry, black, hard necrotic tissue). may be present on some parts of the wound bed. Often includes undermining and tunneling or eschar. Unstageable Ulcer: inability to see the wound bed. Other staging considerations include: Deep Tissue Pressure Injury (DTPI): Persistent non-blanchable deep red, maroon or purple discoloration. Intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This area may be preceded by tissue that is painful, firm, mushy, boggy, warmer or cooler as compared to adjacent tissue. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (unstageable, stage 3, or stage 4). Do not use DTI to describe vascular, traumatic, neuropathic, or dermatologic conditions. 1. The MDS dated [DATE] documented Resident #29 had a BIMS of 15 indicating no cognitive impairment. The MDS documented Resident #29 had one or more unhealed pressure ulcers. The MDS documented a Stage 2 pressure ulcer present. The MDS documented Resident #29 had an admission date of 11/11/25. Review of Resident #29's (Electronic Health Record) EHR dated 11/26/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 16 that indicated Resident #29 was at risk for development of a pressure ulcer. Review of Resident #29 TAR documented a physician's order with a start date of 11/28/25 and end date of 12/16/25 to cleanse the sacral wound with wound cleanser, pat dry and apply Plurogel and foam patch daily until healed. A physician's order with a start date of 12/16/25 and discontinued date of 1/2/26 to cleanse the sacral wound with wound cleanser, pat dry and apply Santyl and foam patch every other day. Review of Resident #29's EHR dated 11/11/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 20 that indicated Resident #29 was not at risk for development of a pressure ulcer. Review of Resident #29's EHR, titled Skin Check documented the following: On 11/12/25 completed by Staff M, LPN documented no concerns. (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 11/29/25 open area on coccyx with no measurements or description. On 12/6/25 open area on coccyx with no measurements or description. On 12/6/25 slit above sacrum with current treatment in place with no measurements. Review of Resident #29's EHR titled, Wound Evaluation documented the following: On 11/28/25 at 7:37 AM entered by Staff MM, a minutes old in-house acquired Stage 2 pressure ulcer on the sacrum that had an area of 1.63 cm2, length of 3.24 cm, and width of 0.94 cm. On 12/6/25 at 9:29 PM entered by Staff MM, an in-house acquired Stage 2 pressure ulcer on the sacrum that had an area of 2.5 cm2, length of 4.17 cm, and width of 0.98 cm. Wound Evaluation documented additional care of cushion, incontinence management, and nutrition / dietary supplementation. Notes reported area stalled treatment changed and encouraged to allow staff to reposition. On 12/16/25 at 10:43 AM entered by Staff P, an in-house acquired stage 2 pressure ulcer on the sacrum that had no measurements. Wound Evaluation documented stage 2 pressure ulcer with no evidence of infection and additional care of cushion, nutrition / dietary supplementation and turning / reposition program. Review of Resident #29's EHR dated 12/16/25 titled, Skin and Wound Evaluation documented an in-house acquired stage 2 pressure ulcer with no measurements, superficial loss of tissue and no odor. Review of Resident #29's EHR, titled Skin Check documented the following: On 12/18/25 a pressure injury on coccyx and sacrum with no measurements or description. On 12/25/25 a pressure injury on sacrum with no measurements or description. On 1/1/25 a pressure injury on sacrum with no measurements or description. Review of Resident #29's EHR dated 12/23/25 titled Progress Notes documented wound condition reported to nurse practitioner order for wound care appointment. Review of Resident #29's EHR dated 12/25/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 9 that indicated Resident #29 was at a very high risk for development of a pressure ulcer. Review of Resident #29 TAR documented a physician's order with a start date of 12/29/25 for Cephalexin 500mg, give one tablet by mouth every 12 hours for buttocks ulcer infection for 5 days. Review of Resident #29's EHR dated 12/31/25 titled, Progress Notes documented Nurse Practitioner in facility to review chart and see resident. New orders for air mattress to bed. Review of Resident #29's EHR documented no skin assessments completed between 12/16/25 and 1/3/26. Interventions for wound management were not changed until 1/2/26 when seen at a wound (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	clinic. Review of Resident #29's EHR titled Infection Documentation dated 1/1/26 through 1/5/26 documented sacral ulcer infection with odor, no measurements, no description of wound and no medical doctor notification. On 1/3/26 at 9:54 AM entered by Staff J, an in-house acquired unstageable pressure ulcer on the sacrum that had an area of 14.6 cm², length of 6.63 cm, and width of 3.72 cm. Wound Evaluation documented unstageable pressure ulcer due to slough and / or eschar with a light amount of serous drainage and a strong odor. Wound Evaluation documented additional care of air flow pad, incontinence management, positioning wedge, repositioning devices, and turning / repositioning program. On 1/5/26 at 9:43 AM entered by Staff P, an in-house acquired stage 2 pressure ulcer on the sacrum that had an area of 15.78 cm², length of 6.57 cm, and width of 4.36 cm. Wound Evaluation documented stage 2 pressure ulcer with moderate amount of serous drainage and no odor. Wound Evaluation documented additional care of cushion, incontinence management, mattress with pump, nutrition / dietary supplementation and turning / reposition program. Review of Resident #29's EHR dated 1/5/26 titled, Skin and Wound Evaluation documented an unstageable pressure ulcer with slough and/or eschar that had an area of 15.8 cm², length of 6.6 cm, and width of 4.4 cm with no physician notification. Review of Resident #29's EHR titled, Care Plan documented a focus for potential for pressure injury development related to assist needed initiated on 11/11/25 with a in house stage 2 pressure ulcer on sacrum initiated 11/28/25. No new interventions in place for in-house acquired a stage 2 pressure ulcer that was found from 11/28/25. The care plan does not reflect any new interventions since returning from the hospital with a surgically debrided stage 4 pressure ulcer that requires a wound vacuum. Review of Resident #29's document dated 1/6/26 at 5:06 PM titled, Operative Report documented Resident #29 had a known sacral decubitus pressure ulcer for the last 2 months, who presented to the hospital with fevers and concern for sepsis from her sacral decubitus wound. She has undergone some minimal debridement of this in the wound care clinic already. Her wound had a foul smell and significant necrotic tissue, warranting urgent debridement in the operating room. Debridement of all of the nonviable completely necrotic tissue which had a foul odor. The base of the wound was down onto the ligamentous structures running along the posterior sacrum and there was exposed bone. A bone biopsy which was sent separately. Area was debrided, removal of the necrotic soft tissue down to the bone centrally, and then to the bilateral gluteal muscles. The total debrided area was 6 cm x 5.5 cm. Review of Resident #29's document dated 1/12/26 titled, Discharge Summary documented Resident #29 entered the Emergency Department (ED) at 4:40 PM with chief complaint of sacral wound ulcer. Resident #29 had a temperature of 101.3, a pulse of 116 and was found to be positive for influenza A. During review Resident #29 reported she underwent debridement though the wound care clinic on 1/2/26, at that time it was determined she may need a more aggressive surgical debridement and had been referred to the surgical clinic for debridement. Sacral dressing was removed to inspect the ulcer. Documented ulcer measured approximately 5cm x 5cm in surface area with significant soft tissue loss. There is a large necrotic area centrally, the ulcer itself was unstageable as the base was not able to be visualized. Foul smell from the wound consistent with tissue necrosis. Suspect the ulcer (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	expectation was that all changes in wounds worsening, lack of improvement or deterioration would also be reported to her or the ADON. The DON acknowledged Resident #29 skin assessments lacked an accurate assessment from 12/16/25 - 1/3/26 with measurements, a description of the wound or a photo. The DON acknowledged Resident #29's wound did not go from a stage 2 wound to that size of an unstageable pressure overnight and should have been documented with a physician notification before 1/3/26. On 1/15/26 at 1:30 PM Resident #29 stated she had to set an alarm on her phone to ensure the staff come to turn her every 2 hours or the staff will not reposition her. Resident #29 stated her doctor wants her repositioned every 2 hours. Resident #29 stated prior to going to the hospital the staff were not repositioning her every 2 hours and some overnight shifts the staff would only come in at 3:00 AM or 4:00 AM to reposition her in bed. Resident #29 stated she had multiple sclerosis and was not able to reposition herself in bed. Resident #29 stated she required the assistance of staff for repositioning. Resident #29 stated she had reported not being repositioned by the overnight staff several times to staff. Resident #29 stated when she entered the facility, she did not have any wounds on her bottom. On 1/21/26 at 1:51 PM Staff J, RN acknowledged he worked with Resident #29 prior to having the wound on her buttocks. Staff J stated he felt the deterioration of the wound on Residents #29 buttocks could have been prevented. Staff J stated Resident #29 was not being repositioned appropriately prior to the wounds appearing. Staff J stated some CNA's had reported the wound was not getting better and requested the nurse to look at it. Staff J explained the CNA was told to put some cream on it and did not assess the area. Staff J stated Resident #29 had an alarm to remind staff to reposition her since she had returned. Staff J stated he knew Resident #29 had issues brought up about overnight CNAs not being in her room. Staff J acknowledged if those aides are working, she told him she will set the alarm every 2 hours. On 1/22/26 at 11:29 AM Resident #29 stated last night Staff EE, Certified Nurse Assistant refused to change her brief and stated she was out of briefs. Resident #29 stated she had not had a BM. Resident #29 stated she was wet and nobody changed her at all last night. Resident #29 stated Staff EE only repositioned her at night but never changed her. Resident #29 stated she has had problems with Staff EE from the get go. Resident #29 stated Staff EE was not supposed to be caring for her because she had voiced concerns about how she cared for her in the past. Resident #29 stated she had told Staff R, CNA the concerns she had with Staff EE. Resident #29 said she thought Staff R told Staff P about the concerns with Staff EE. On 1/22/26 at 12:58 PM Staff EE, CNA stated she has very little interaction with Resident #29. Staff EE stated she was not supposed to have contact with Resident #29 but the facility kept putting her on that side. Staff EE stated she does work with Resident #29 and had worked with her last night. Staff EE stated she did have contact with Resident #29 last night. Staff EE acknowledged Resident #29 was on a 2 hour reposition schedule. Staff EE stated she repositioned her. Staff EE explained she did not toilet Resident #29 at night. Staff EE explained Resident #29 would turn on her call light at night asking for a brief change. Staff EE stated Resident #29 turned her call light on last night to be repositioned. Staff EE stated she took Staff Y when she was there but she left early but did not know what time. Staff EE stated she provided peri care to freshen her up down there but did not have to change her brief. Staff EE stated Resident #29 had not requested for her brief to be changed at any time overnight the night before. Staff EE stated Resident #29 had thought that she had a BM and wiped her up to show her that she had not had a BM. Staff EE stated she had Staff Y in the room with her at that time. Staff EE stated Resident #29 told her that she was a 3XL in brief size. Staff EE stated she did not change her brief because it was changed prior to her going in the room. Staff EE (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	stated Resident #29 never asked her to change the brief. Staff EE stated if she was doing peri care and the brief is dirty, she changed the brief but she told her that she had not had a BM then she said she would just wear the same brief. On 1/22/26 at 2:06 PM Staff R stated when she came in at 6:00 AM on 1/22/26 and Resident #29 stated she had asked to be changed because she had some urine incontinence on the overnight shift. Staff R stated Resident #29 explained Staff EE said there was no brief to change her with. Staff R stated Resident #29 told her that she told Staff EE that she was a 3XL brief. Staff R reported Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff R said Resident #29 told her Staff EE refused to change her. Staff R reported Resident #29's brief was saturated when she provided care that morning. Staff R stated she reported the concern to Staff J, RN. On 1/22/26 at 2:10 PM Staff J, RN stated Staff R had informed him Resident #29 reported she had not been changed on the overnight shift. Staff J reported Staff R stated Resident #29 stated she had asked to be changed because she had incontinence. Staff J stated Resident #29 stated Staff EE said there was no brief to change her with. Staff J stated Resident #29 told Staff EE that she was a 3xl brief. Staff J stated Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff J said Resident #29 told her Staff EE refused to change her brief. On 1/23/26 at 2:00 PM Staff Y, CNA stated she had assisted Staff EE with care on Resident #29. Staff Y stated she assisted Staff EE with repositioning Resident #29. Staff Y stated Resident #29 stated she had a bowel movement. Staff Y stated Staff EE checked Resident #29's brief, it was dry and there was no bowel movement. Staff Y stated Resident #29 does not always void at night. Staff Y stated Resident #29 was cognitive of when she needs to use the bathroom. Staff Y stated Resident #29 did not have incontinence. Staff Y stated she did not notify the nurse because Resident #29 had not urinated that shift. Staff Y stated Resident #29 told the staff that she did not need her briefs changed if it was not soiled. Staff Y stated she did not go back in Resident #29's room after that time. Staff Y stated typically during personal care she would change the brief but she let Resident #29 exercise her rights and her wishes. Staff Y stated Resident #29 was not soiled, the 2 of them just freshened her up. Staff Y stated Resident #29 was dishonest and a troublemaker. Staff Y stated she did not know if there were briefs because she was only the second person. Staff Y stated Resident #29 had never said anything about her brief size. Staff Y stated Staff EE did not have a conversation about not having any briefs available. Staff Y stated she minds her own business. On 1/26/26 at 2:43 PM Staff J, RN stated the CNA's have never notified him of a stage 1 or any discoloration. Staff J stated he does not know if CNA's know what pressure injuries are or when to notify the nurse. On 1/26/26 at 3:26 PM the DON stated she had heard CNA's report they had told the nurse and there was no documentation. The DON stated Resident #29 did not want Staff E in their room. The DON stated there were a lot of balls that were dropped when it comes to wound care in the facility. 2. The Minimum Data Set (MDS) assessment dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 indicating no cognitive impairment. The MDS documented Resident #2 was at risk for developing pressure ulcers/injuries and Moisture Associated Skin Damage (MASD) present. The MDS documented admission date for Resident #2 of 11/28/25. It also documented treatments for skin injury included pressure reducing device for chair, pressure (continued on next page)		

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	reducing device for bed, nutrition hydration intervention to manage skin problems. Review of Resident #2's Care Plan documented a focus initiated on 11/28/25 that Resident #2 had potential for pressure injury development. The Care Plan lacked any other skin issues and lacked the interventions identified on the MDS. It identified Resident #2 required the assistance of 1 staff for bed mobility and required the assistance of 1 staff for personal hygiene. Review of Resident #2's EHR dated 11/28/25 titled, Discharge Summary documented a Braden scale score of 17 with a reposition schedule at least every 2 hours. The Discharge Summary documented a wound undiagnosed gluteal cleft mid right. Review of Resident #2's Treatment Administration Record (TAR) documented a physician's order with a start date of 11/28/25 to cleanse buttocks with soap and water, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 11/28/25 to evaluate buttocks wound / peri wound for complications including symptoms of infection. A physician's order with a start date of 1/15/26 to cleanse sacral stage 2 pressure ulcer with wound cleanser, pat dry, apply a foam dressing and change every 3 days and as needed (PRN). A physician's order with a start date of 1/15/26 to evaluate stage 2 pressure wound/peri-wound for complications including symptoms of infection. Review of Resident #2's EHR documented the following: On 11/28/25 at 2:50 PM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis that was present on admission on the buttocks that had an area of 1.42 cm², length of 3.42 cm, and width of 0.61 cm. On 12/5/25 at 8:03 PM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis that was present on admission on the buttocks that had an area of 19.8 cm², length of 8.86 cm, and width of 5.66 cm. On 12/12/25 at 8:29 AM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that did not have any measurements with the assessment. On 12/23/25 at 10:14 AM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that had an area of 1.4 cm², length of 2.57 cm, and width of 1.29 cm. On 12/30/25 at 6:48 AM entered by Staff J, RN titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that had an area of <0.1 cm², length of 0.25 cm, and width of 0.21 cm. On 1/6/26 at 7:21 PM entered by Staff P titled, Wound Evaluation incontinence associated dermatitis on the buttocks that was present on admission that had an area of 15.65 cm², length of 7.01 cm, and width of 3.06 cm. Observation of the photo on EHR dated 1/6/26 at 7:21 PM entered by Staff P titled, Wound Evaluation revealed 2 areas of stage 2 present on sacrum / coccyx area at that time that were undocumented. Review of Resident #2's EHR dated 1/15/26 at 10:18 AM entered by Staff J titled, Wound Evaluation documented Stage 2 pressure ulcer on the sacrum that was in-house acquired that h		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, policy review, resident interviews, family interviews, and staff interviews the facility failed to provide an opportunity for a comprehensive care plan to be reviewed and revised by an interdisciplinary team composed of each resident and resident representative to allow developing the care plan and making decisions about his or her care. The facility also failed to complete revisions to care plans when there was a change in the residents care to 10 of 20 residents reviewed (Resident #23, #11, #7, #8, #21 #2, #3, #9, #29, and #30). The facility reported a census of 28 residents. Findings include: 1. According to the quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/24/2025, Resident #23 had a Brief Interview of Mental Status (BIMS) score of 3. A BIMS score of 3 suggested severe cognitive impairment. The MDS documented the following diagnoses for Resident #23: Alzheimer's disease, hip fracture, anxiety, depression, muscle weakness and diabetes mellitus. The MDS documented an admission date of 2/7/2025. Record review revealed a document titled Baseline Care Plan Summary with an effective date of 12/17/2024. The resident's Power of Attorney (POA) signed and dated on 1/9/2025. Record review revealed no care conference attendance sheets or documents. On 1/20/2026 at 11:28 AM Resident #23's emergency contact #1 stated since the new company has taken over, the family has not been a part of her care plan meetings. The previous owners were holding meetings quarterly with family present but that has not happened since January 2025. On 1/23/2025 at 10:39 AM via email communication the Administrator acknowledged facility was unable to locate Resident #23's care plan attendance sheets. 2. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognitive functioning. The MDS further revealed that Resident #11 was dependent on staff for chair/bed to chair transfers, transferring to the toilet, and tub/shower transfer. The MDS then revealed a diagnosis of unspecified fracture of the lower end of the right femur, muscle weakness, and difficulty in walking. Interview 1/20/26 at 10:43 AM with Resident #11 revealed that the staff utilize a whole body mechanical lift when transferring him with a sling. Resident #11 then revealed that sometimes there will only be one staff when transferring him with the lift, and sometimes there will be two staff. Review of Resident #11's Care Plan with a created date of 12/9/25 revealed Resident #11 requires staff assistance of one staff member for toilet transfer, and toileting with a gait belt. The Care Plan further revealed that Resident #11 was a stand pivot assist with one staff member and a gait belt. Interview 1/21/26 at 12:20 PM with Staff G Occupational Therapist Assistant revealed Resident #11 was a whole body mechanical lift transfer. Staff G then revealed on 12/17/25 she documented Resident #11 was a whole body mechanical transfer. Staff G further revealed when the physical therapy does the evaluation physical therapy will inform the nursing staff of how the resident transfers. Staff G then revealed Resident #11 was non-weight bearing on the right leg because of a right hip fracture that was on 12/3/25. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview 1/21/26 at 2:10 PM with the DON revealed that care plans should be updated accordingly. Interview 1/21/26 at 2:14 PM with Staff H LPN revealed that she did not get the update on the whole body mechanical lift from OT/PT and would expect them to update the care plan accordingly. 3. Resident #7's MDS dated [DATE] revealed a BIMS score of 11/15 indicating moderate cognitive deficit. The resident utilized a wheelchair (w/c) with partial/moderate assistance. The document disclosed diagnoses including chronic kidney disease, nonrheumatic aortic valve stenosis, unspecified osteoarthritis. The resident's Care Plan dated 1/7/25 contained 19 focus areas with goals/target dates and interventions. All 19 focus areas reflected goals that were revised on 1/7/25 with a target date of 4/8/25. 18/19 focus areas contained interventions for staff to follow that had not been changed since 4/23/24. The facility failed to revise Resident #7's Care Plan to reflect current needs, goals and target dates. The facility failed to reflect discontinuation of restorative nursing services as the facility does not offer this. Review of the Electronic Medical Record (EMR) on 1/21/26 identified no documentation in the Progress Notes or scanned documents indicating Care Conferences were held or updates were made to the Care Plan. On 1/22/26 at 1:40 PM Staff H, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist, stated the resident's Care Plan should have been revised when reviewed with the Director of Nursing (DON) and should be dated to reflect the updates. Staff H stated she did not schedule Care Plan Conferences. On 1/22/26 at 1:49 PM Staff N, Interim Director of Social Services, stated she had been in the position since 5/25. The staff stated Care Plans were reviewed quarterly. When asked about Care Conferences the staff stated she would have to locate the documents indicating the conferences were held with the resident representative. On 1/26/26 at 8:44 AM Staff N provided documents from Social Services indicating Care Plans were reviewed with the resident's representative on 6/16/25, 9/5/25 and 11/26/25. On 1/26/26 at 8:58 AM Staff N stated invitations for Care Conferences would go out to the resident/resident representative and interdisciplinary team (IDT) and a note should be placed in the Progress Notes. The staff acknowledged there were no entries in the Progress Notes for Care Conference invitations. The staff stated notices for conferences should go out 2-3 weeks in advance. At this time the Progress Notes revealed late entries dated 6/13/25 (time stamp 1/22/26 3:18 PM), 9/5/25 (time stamp 1/22/26 3:20 PM) and 11/26 (time stamp 1/22/26 3:21 PM) phone meetings were held for Care Plans. Staff N acknowledged she entered the Progress Notes following the interview on 1/22/26 at 1:49 PM. The staff stated the documents provided were completed by herself, but she could involve other IDT members. Staff N acknowledged Care Conference Notes should be in the Progress Notes and documentation should be put in the EMR at the time of the occurrence. The staff stated she had not been uploading documents into the EMR as part of the assessment/meeting process. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/26/26 at 11:51 AM resident representative stated she had not been invited to or taken part in a Care Plan Conference since the facility transition to new ownership the previous year. 4. Resident #8's MDS dated [DATE] revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document provided that the resident required partial/moderate assistance for upper and lower body dressing and required supervision/touching assistance for transfers and ambulation up to 50'. The document disclosed resident diagnoses of diabetes mellitus, cognitive communication deficit and obstructive sleep apnea. The resident's Care Plan reviewed on 1/20/26 at 3:50 PM revealed a focus of assistance with ADLs revised 4/8/24 with staff interventions of stand pivot transfer with assistance of 1 using a wheeled walker and ambulation with wheeled walker and assistance of 1 revised 4/8/24; walking with a device revised 9/23/25 and walking with assistance of 1 with a gait belt initiated 9/23/25. At the time of the review the facility failed to update the Care Plan to reflect a change in transfer status to the need for a dependent full body mechanical lift and the resident's diagnosis of Influenza A requiring personal protective equipment (PPE). The resident's Care Plan showed an intervention entered on 1/21/26 for the use of a Hoyer lift (dependent full body mechanical lift) with assistance of 2. The After Visit Summary dated 1/17/26 revealed the resident was transferred to the hospital following a fall and was discharged back to the facility with a diagnosis of the flu on the same date. On 1/20/26 at 11:35 AM observed signs posted outside of Resident #8's room for Enhanced Barrier Precautions (EBP) and Droplet Precautions. On 1/20/26 at 1:54 PM Resident #8 stated he had fallen recently, went to the hospital and got the flu. The resident stated he hasn't been able to stand up and transfer since getting sick. Observed a Hoyer lift in the resident's room during the interview. On 1/21/26 at 8:20 AM Staff C, CNA, stated when she worked on 1/16/26 the resident required standby assistance of 1 with a walker and was completing tasks for himself. The staff stated since getting Influenza A the resident had required significantly more assistance with care and transfers. On 1/22/26 at 12:27 PM Staff D, Certified Medication Aide (CMA), stated staff would look at the Electronic Medical Record/the Kardex for information on the resident's needs. On 1/22/26 at 1:40 PM Staff H, stated if she was aware of changes in a resident status she would put it on the Care Plan. The staff stated she was she was unaware of Resident #8 had a change in transfer ability. The staff stated any nurse could revise the Care Plan to change a resident's status. The staff acknowledged the resident did have a change in respiratory status with the diagnosis of Influenza A and the need for precautions. 5. Resident #21's MDS dated [DATE] Significant Change export ready revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document disclosed the resident did not have a catheter, was incontinent of bowel and bladder, and dependent for bed mobility and transfers. The document indicated the resident's diagnoses included heart failure, atrial fibrillation (A-fib) and impaired brain function. The MDS revealed the resident had (1) Stage 2 pressure ulcer, partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed, at the time of (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	admission. The EMR Clinical Physician Orders revealed the following orders: Urinary catheter: output every shift; start date 12/23/25 and discontinued 12/24/25. Urinary catheter: output every shift; start date 12/23/25 and discontinued 12/24/25. Urinary catheter: change urinary catheter 16f 10cc bulb; start date 12/23/25 and discontinued 12/24/25. Urinary catheter: catheter diagnosis: urinary retention; revision date 12/24/25 and discontinued 12/24/25. Urinary catheter: provide urinary catheter care every shift; start date 12/23/25 and discontinued 12/24/25. The EMR Progress Note entry on 12/24/25 disclosed staff observed the resident had removed her catheter with the balloon still inflated. The nurse obtained a physician order to discontinue the catheter use due to placing the resident at risk; the resident's daughter was present at the time and updated. The resident's Care Plan dated 12/30/25 revealed a focus area for indwelling catheter initiated on 12/23/25 and revised on 12/30/25. The interventions for staff included Enhanced Barrier Precautions (EBP) (initiated 12/24/25), monitor/record report signs/symptoms of urinary tract infection (UTI) (initiated 12/23/25), keep per area clean, position catheter bag and tubing below the level of the bladder, provide catheter care daily and as needed, record output every shift all dated 12/30/25. A focus area related to a pressure injury revised 12/30/25 included an intervention for use of EBP related to the wound and catheter. The facility failed to revise the Care Plan to reflect the discontinuation of the indwelling catheter per physician order on 12/24/25 and revise an intervention related to EBP needs on a pressure injury focus area. On 1/22/26 at 1:40 PM when asked about Resident #21's catheter, Staff H stated the resident did have a catheter. When asked about the Significant Change MDS dated [DATE] revealing the resident did not have a catheter and was incontinent of bowel and bladder, the staff responded the resident had a significant change related to hospice services being initiated. When provided with knowledge the catheter was discontinued on 12/24/25, Staff H acknowledged the Care Plan should have been updated to reflect that change in status. The staff stated any nurse could revise the Care Plan to reflect a change in a resident's status. On 1/26/26 at 8:58 AM Staff N stated Care Conferences were held quarterly and IDT members have their own components to complete. The staff stated the MDS Coordinator updates the Care Plan; however there may be sections in the Care Plan that were updated by whoever was assigned and the MDS Coordinator oversees the Care Plan to ensure all sections were completed. On 1/26/26 at 2:39 PM Staff J, Registered Nurse (RN), stated he did not update Care Plans. The staff stated when the residents were admitted as part of the admission process an initial Care Plan was (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	started. The staff stated the MDS Coordinator and Social Services complete the Care Plans. On 1/26/26 at 10:12 AM the DON and the Administrator discussed Care Plans and Care Plan Conferences. The Administrator stated that in normal circumstances he would expect the IDT to be in attendance at the Care Plan Conferences. Neither the Administrator nor the DON could answer to the frequency of Care Plan Conferences. The Administrator stated he was not aware the Care Plan Conferences were not being held with IDT members present. The Administrator acknowledged there was not a corporate liaison for the facility regarding skilled care social services. The DON stated she started to notice the previous week there might be a problem as she thought a Care Plan Conference should be held regarding a resident's change in needs. The DON expected Care Plans to be revised as needed, including the goals and target dates. The DON and Administrator concurred that the Care Plans and Kardex needed to be current regarding the resident's needs to allow for pulled staff and/or contract staff to meet the needs of the residents. 6. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. MDS documented Resident #2 was at risk for developing pressure ulcers/injuries and Moisture Associated Skin Damage (MASD) present. Review of Resident #2's MAR-TAR documented a physician's order with a start date of 1/11/26 and discontinued 1/12/26 to paint right heel deep tissue injury (DTI) daily with betadine and cover with dry dressing. A physician's order with a start date of 1/12/26 and discontinued 1/14/26 for the right heel to be cleansed, dry, painted with betadine and covered with mepilex foam once a day related to DTI. A physician's order with start date of 1/14/26 for wound on the right heel to be cleansed with wound cleanser, pat dry, apply Triple Antibiotic Ointment (TAO) and cover with foam dressing one time a day. A physician's order with a start date of 1/11/26 to evaluate right heel wound / peri-wound for complications including symptoms of infection. A physician's order with a start date of 11/28/25 to cleanse buttocks with soap and water, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 11/28/25 to evaluate buttocks wound / peri wound for complications including symptoms of infection. A physician's order with a start date of 1/15/26 to cleanse sacral stage 2 pressure ulcer with wound cleanser, pat dry, apply a foam dressing and change every 3 days and as needed (PRN). A physician's order with a start date of 1/15/26 to evaluate stage 2 pressure wound/peri-wound for complications including symptoms of infection. Resident #2's MDS dated [DATE] documented treatments for skin injury included pressure reducing device for chair, pressure reducing device for bed, nutrition hydration intervention to manage skin problems. Resident #2's EHR titled, Care Plan documented a focus initiated on 11/28/25 that Resident #2 had potential for pressure injury development. Resident #2's care plan did not have MASD documented or intervention in place. Resident #2's care plan did not have treatments for skin injury including pressure reducing device for chair or bed, nutrition hydration interventions to manage skin problems documented. Resident #2's care plan identified Resident #2 required the assistance of 1 staff for bed mobility and required the assistance of 1 staff for personal hygiene. On 1/12/26 at 11:20 am an observation of Resident #2 lying on a scoop mattress. Review of Resident #2's EHR dated 1/11/26 at 7:53 AM entered by Staff P, RN, ADON, Assistant Director of Health and Wellness, and Wound Nurse titled, Wound Evaluation documented a DTI to the right heel minutes old that was in-house acquired that had an area of 1.25 cm2, length of 2.42 cm, and (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	width of 1.1 cm. Review of Resident #2's EHR dated 1/6/26 at 7:41 PM titled, Skin Check documented no injury to right or left heel. Review of Resident #2's EHR dated 1/11/26 at 9:54 PM titled, Progress Notes documented reported on the am shift Resident #2 had an open area to the right heel. The exam showed suspected DTI. The area was cleansed, painted with betadine and protective dressing applied. Review of Resident #2's EHR dated 11/28/25 at 2:50 PM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis that was present on admission on the buttocks that had an area of 1.42 cm2, length of 3.42 cm, and width of 0.61 cm. Review of Resident #2's EHR titled, Care Plan documented a focus initiated on 11/28/25 that Resident #2 had potential for pressure injury development. Resident #2's care plan did not have MASD or DTI on the right heel documented or intervention in place. Resident #2's care plan did not have treatments for skin injury including pressure reducing device for chair or bed, nutrition hydration interventions to manage skin problems documented. Resident #2's care plan identified Resident #2 required the assistance of 1 staff for bed mobility and required the assistance of 1 staff for personal hygiene. On 1/13/26 at 1:59 PM Resident #2, stated with Staff A present in the room, that her left foot heel protecting boot was applied 1/12/26. Resident #2 stated she had not been assisted with repositioning the whole day. Resident #2 stated it was hard for her to turn to the right because she had a left sided stroke. Resident #2 stated the triangle wedges helped her to stay on her side when staff use them. Resident #2 stated it feels good because then she is off her back. On 1/13/26 at 1:59 PM an observation revealed no triangle wedges present in Resident #2's room. On 1/13/26 at 2:00 PM Staff R, CNA stated the facility was supposed to get Resident #2 an air mattress. On 1/21/26 at 1:51 PM Staff J, RN explained frequently on the long term side of the facility the positioning wedges were not utilized appropriately. Staff J acknowledged Resident #2 had a scoop mattress in her bed and that was not appropriate for pressure relief. Staff J stated the scoop mattress prevented Resident #2 from turning in bed. Staff J stated Resident #2 did not have any interventions in place that were being utilized when the MASD was present on her buttocks. Staff J stated the wedges in Resident #2's room were not being utilized. Staff J explained he assessed Resident #2's MASD the area had turned into a stage 2. Staff J stated that was when the pressure relief wedge was being utilized. On 1/26/26 at 11:35 AM Staff H, Licensed Practical Nurse / MDS Coordinator / Infection Preventionist stated she was familiar with Resident #2. Staff H stated she was not aware of any MASD on Resident #2's buttocks. Staff H stated the MASD should have been addressed on the care plan but everybody should be updating the care plan. Staff H stated she would not expect any other interventions in place besides creams for MASD on Resident #2 for pressure ulcer prevention. On 1/26/26 at 3:13 PM the DON explained the scoop mattress that Resident #2 had in her room was not appropriate for pressure relief. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	7. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. On 1/12/26 at 10:49 am Resident #3 stated she had not been invited to any care conferences. On 1/13/26 at 4:11 PM Resident #3's son stated he had not been contacted every 3 months to discuss his mothers care at the facility. Resident #3's son stated he had not been invited to a care conference for his mother since she had been at the facility. Review of Resident #3's EHR titled, Progress Notes documented no family invitation or Care Conference meetings held with resident or family. Review of Resident #3's EHR documented admission to the facility on 4/9/25. On 1/26/26 at 9:00 AM Staff N, Interim Social Services Director stated she would enter resident and resident family invites to care conferences in resident's EHR titled, Progress Notes. Staff N stated she could complete the Social Services Comprehensive Quarterly assessment by herself without any IDT but she invites the IDT. Staff N stated there was a base care plan meeting, then one at 30 days and then there was a care conference completed quarterly (every 3 months). Staff N explained things were dropped a little on her part. Staff N acknowledged a lot of the care conferences were not completed. Staff N stated she could not find any care conference meetings for Resident #3. Staff N stated the assessment should include who was present for the meeting. Staff N acknowledged the family and residents had not been a part of the quarterly assessments or the Social Services Comprehensive Quarterly assessment. Staff N stated the family, resident and team members should be identified in the comments sentence. Staff N stated she had discussed concerns with care conferences not being completed appropriately with the previous Administrator and then brought it to the current Administrator. Staff N stated she spoke to the Administrator about the concern when he started. Staff N stated the Administrator would work on getting more resources to help her get caught up to help things move smoothly and would reach out to corporate to ask if there was someone she could talk to about things she was unsure of. Staff N explained the corporation did not have anybody to help but to reach out to somebody that might have that knowledge because they do not have any other skilled facilities. Staff N stated she had reached out to a previous Social Services Director at the facility. Staff N explained during the care conference meeting the IDT should be invited and a part of development. Staff N stated the family and resident should be a part if they can. Staff N explained family and residents should be invited and the care conference meeting should be completed quarterly. On 1/26/26 at 10:08 AM the DON stated she expected nursing to be part of a care conference meeting. The DON explained the MDS Coordinator was a nurse and would represent both the nurse department and MDS. The DON stated care conferences should be completed when there was a significant change or if the resident had reached a plateau. The DON stated social services set the care conferences up. The DON stated residents and or family should be invited to the care conferences. 8. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #9 was at risk for developing pressure ulcers/injuries and one or more unhealed pressure injuries. On 1/20/26 at 11:31 AM Resident #9 stated the area on her buttocks started as a bed sore. Resident (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	#9 explained the area got better then got worse. Resident #9 stated she did not remember if she was wearing heel protectors or not when she was in bed before she had the area on her right heel. Resident #9 stated she did not have the area on her right heel when she entered the facility. Review of Resident #9's MAR-TAR documented a physician's order with a start date of 12/9/25 and discontinued date of 12/30/25 to cleanse right heel DTI with soap and water, pat dry, and apply skin prep twice a day. A physician's order with a start date of 12/30/25 and a discontinued date of 1/16/26 to cleanse right heel DTI with soap and water, pat dry, apply betadine, an ABD dressing and secure with roll gauze every 3 days until healed. A physician's order with a start date of 12/9/25 and discontinued date of 1/7/26 to cleanse left inferior buttocks stage 2 pressure ulcer with wound cleanser, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 12/9/25 and a discontinued date of 12/23/25 to cleanse left superior buttocks stage 2 pressure ulcer with wound cleanser, pat dry, apply Z guard every shift until healed. Review of Resident #9's EHR documented Resident #9 entered the facility on 12/4/25 with no documentation of pressure injury or DTI. Review of Resident #9's EHR dated 12/4/25 at 3:03 PM titled, admission / readmission Screener documented no injury to buttocks, right or left heel. Review of Resident #9's EHR dated 12/4/25 at 3:37 PM titled, Braden Scale for Predicting Pressure Sore Risk documented Resident #9 had a Braden score of 18 that indicated Resident #9 was at risk for development of a pressure sore. Review of Resident #9's EHR dated 12/8/25 at 2:37 PM entered by Staff P titled, Wound Evaluation documented an in-house acquired stage 2 pressure ulcer that was minutes old on the left superior gluteus that had an area of 6.35 cm2, length of 8.73 cm, and width of 1.98 cm. Review of Resident #9's EHR dated 12/9/25 at 10:01 AM entered by Staff P titled, Wound Evaluation documented an in-house acquired stage 2 pressure ulcer that was minutes old on the left inferior gluteus that had an area of 3.65 cm2, length of 2.54 cm, and width of 1.98 cm. Review of Resident #9's EHR dated 12/9/25 at 10:04 AM entered by Staff MM, Licensed Practical Nurse (LPN) titled, Wound Evaluation documented a minutes old in-house acquired DTI on the right heel that had no measurements but was present in the photo of the area. Review of Resident #9 EHR titled, Care Plan documented no focus, goals or interventions on prevention of a pressure sore. Pressure injury stage 2 left buttocks and DTI to right heel documented as initiated on 12/15/25 after pressure injuries had occurred. Review of Resident #9 EHR titled, Care Plan documented no focus, goals or interventions on prevention of a pressure sore. Pressure injury stage 2 left buttocks and DTI to right heel documented as initiated on 12/15/25 after pressure injuries had occurred. 9. The Minimum Data Set (MDS) dated [DATE] documented Resident #29 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #29 had one or more unhealed pressure ulcers. The MDS documented a Stage 2 pressure ulcer present. The MDS documented Resident #29 had an admission date of 11/11/25. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of Resident #29 MAR-TAR documented a physician's order with a start date of 11/28/25 and end date of 12/16/25 to cleanse the sacral wound with wound cleanser, pat dry and apply Plurogel and foam patch daily until healed. A physician's order with a start date of 12/29/25 for Cephalexin 500mg, give one tablet by mouth every 12 hours for buttocks ulcer infection for 5 days. A physician's order with a start date of 12/16/25 and discontinued date of 1/2/26 to cleanse the sacral wound with wound cleanser, pat dry and apply Santyl and foam patch every other day. Review of Resident #29's document dated 1/12/26 titled, Hospital Progress Notes documented Resident #29 was concerned about returning to the facility because she did not get repositioned. Document explained Resident #29 acknowledged she had never had an ulcer ever before entering the facility in November. Discharge plan for return to facility repositioning every 2 hours and placement of wound vacuum. Review of Resident #29's document dated 1/6/26 at 5:06 PM titled, Operative Report documented Resident #29 had a known sacral decubitus pressure ulcer for the last 2 months, who presented to the hospital with fevers and concern for sepsis from her sacral decubitus wound. She has undergone some minimal debridement of this in the wound care clinic already. Her wound had a foul smell and significant necrotic tissue, warranting urgent debridement in the operating room. Debridement of all of the nonviable completely necrotic tissue which had a foul odor. The base of the wound was down onto the ligamentous structures running along the posterior sacrum and there was exposed bone. A bone biopsy which was sent separately. Area was debrided, removal of the necrotic soft tissue down to the bone centrally, and then to the bilateral gluteal muscles. The total debrided area was 6 cm x 5.5 cm. Review of Resident #29's EHR titled, Care Plan documented a focus for potential for pressure injury development related to assist needed initiated on 11/11/25 with a in house stage 2 pressure ulcer on sacrum initiated 11/28/25. No new interventions in place for in-house acquired a stage 2 pressure ulcer that was found from 11/28/25. The care plan does not reflect any new interventions since returning from the hospital with a surgically debrided stage 4 pressure ulcer that requires a wound vacuum. 10. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. The MDS documented Resident #30 was at risk for development of pressure ulcers. The MDS documented no pressure ulcers. The MDS documented Resident #30 had an admission date of 12/2/25. Review of Resident #30 EHR titled, Care Plan documented no care plan update or intervention with unstageable skin found 12/23/25. On 1/26/26 at 11:35 AM Staff H, MDS Coordinator stated she was familiar with Resident #30. Staff H acknowledged there was no care plan update with unstageable skin found 12/23/25 and would have updated interventions as well. On 1/26/26 2:43 PM Staff J, RN stated he does not update care plans. Staff J stated Staff H, updated care plans. Staff J stated he does not think floor nurses updated the care plans or develop the interventions on the care plans. On 1/27/26 at 11:03 AM the DON stated there should be non-pharmaceutical interventions in place right away with any pressure ulcers like off loading and those interventions should be on the residents care plan. The DON explained Staff H builds the baseline care plan. The DON stated Staff H completed all the care plan updates. The DON stated a charge nurse sh		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the facility assessment, Center for Medicare and Medicaid Services (CMS) Payroll Based Journal (PBJ) Staffing Data Report for Quarter 4 2025 ([DATE] - [DATE]) review, facility staffing reports review, policy review and staff interviews, the facility failed to submit accurate staff reports for the PBJ Staffing Data Report. The facility reported a census of 28 residents. Findings include: The PBJ Staffing Data Report run date [DATE] for quarter 4 2025 triggered for failing to submit data for the quarter and one star staffing rating. Review of weekend staffing schedules for months of July, August, September, October, November, December and January revealed on [DATE] 10:00 PM - 6:00 AM 1 nurse and 1 Certified Nurse Assistant (CNA), [DATE] 6:00 AM - 2:00 PM 2 CNA, [DATE] 6:00 AM - 2:00 PM 2 CNA 2:00 PM - 10:00 PM 2 CNA, [DATE] 2:00 PM - 10:00 PM 1 nurse, [DATE] 6:00 AM - 2:00 PM 1 nurse, [DATE] 6:00 AM - 2:00 PM 1 nurse 2:00 PM - 10:00 PM 1 nurse 10:00 PM - 6:00 AM 1 nurse and 1 CNA, [DATE] 6:00 AM - 2:00 PM 1 nurse, [DATE] 6:00 AM - 2:00 PM 1 nurse and 2 CNA 2:00 PM - 10:00 PM 1 nurse and 3 CNA 10:00 PM - 6:00 AM 1 nurse and 1 CNA. Review of schedules Monday - Friday for months of July, August, September, October, November, December and January revealed on [DATE] 2:00 PM - 10:00 PM 1 nurse and 2 CNA, [DATE] 10:00 pm - 6:00 AM 1 nurse and 1 CNA, [DATE] 2:00 PM - 10:00 PM 1 nurse and 2 CNA, [DATE] 6:00 AM - 2:00 PM 1 nurse and 3 CNA, 2:00 PM - 10:00 PM 1 nurse and 3 CNA, 10:00 PM - 6:00 AM 1 nurse and 1 CNA, [DATE] 6:00 AM - 2:00 PM 1 nurse and 2 CNA 2:00 PM - 10:00 PM 1 nurse and 2 CNA, [DATE] 2:00 PM - 10:00 PM 1 nurse, [DATE] 10:00 pm - 6:00 AM 1 nurse and 1 CNA, [DATE] 2:00 PM - 10:00 PM 1 nurse and 3 CNA, [DATE] 6:00 AM - 2:00 PM 1 nurse and 3 CNA 2:00 PM - 10:00 PM 1 nurse 10:00 PM - 6:00 AM 1 CNA. On [DATE] at 10:50 PM Staff O, Certified Medication Assistant (CMA) / Certified Nurse Assistant (CNA) / Scheduler stated had worked as the scheduler for the facility since September of 2025. Staff O stated when developing a schedule she needs to make sure there is a CNA in every section GP1, GP2 and GP3. Staff O stated nurses on GP1 and GP2. Staff O stated on am shift and pm shifts. Staff O stated overnight shift there is only 1 nurse and 2 CNAs. Staff O acknowledged those assignments have not happened every day since she had taken over. Staff O stated there were days that the facility was a CNA short on the am shift. Staff O explained the facility had been short a nurse on am or pm because of call outs. Staff O stated there had not been a full shift where there had not been enough staff. Staff O explained she had very little training prior to entering into the position. Staff O stated she had asked the Administrator and Staff P, Registered nurse 9RN) / Assistant Director of Nursing (ADON) / Previous Interim Director of Nursing (DON) for any help on how she was doing. Staff O stated she was not aware of any RN coverage requirements for daily hours or 7 days a week. Staff O stated she was not aware of any CPR coverage in the building. Staff O stated she does not develop a schedule to have RN coverage. Staff O stated when she developed a schedule she was unaware any CPR coverage was required. Staff O stated the facility did not have a CPR certification list prior to survey team request. Staff O stated Staff P was the interim DON from September until current DON at the very end of December. Staff O stated Staff P worked Monday - Friday at least 8 hours. Staff O stated Staff P only comes into the facility on the weekends if needed for an IV flush. Staff O explained Staff P never worked 8 consecutive hours on the weekends. On [DATE] at 10:15 AM Staff J, RN stated Staff P usually worked Monday through Friday for 8 hours. Staff J explained Staff P does not work on weekends. Staff J stated he became a RN on [DATE]. Staff J stated the facility did not always have a RN. Staff J explained there would be no RN on Saturdays at times. Staff J stated there were times where there was no RN coverage on Saturday and Sunday. Staff J stated on [DATE] a nurse called in and he was the only nurse in the whole building. Staff J stated the DON did not answer the phone or respond. Staff J stated he called 3 different times and called the ADON once also no answer. Staff J explained Staff O was the on-call and had not been trained to pass (continued on next page)		

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	medications. Staff J stated the facility was supposed to have 2 nurses or 1 nurse with 1 CMA and 3 CNAs on day shift. Staff J stated the pm shift was supposed to be the same as the am shift for staffing. Staff O stated the overnight shift was supposed to have one nurse and 2 CNAs. On [DATE] at 10:35 AM Staff Q, CNA stated staffing on the am shift was supposed to have 2 nurses and 3 CNAs on day shift. Staff Q stated there had been only 2 CNAs on the floor more than twice since she had been working at the facility. Staff Q explained there had been 1 nurse on the floor several times on days and evenings. On [DATE] at 11:23 AM Staff P acknowledged she had worked 8 hours a day for RN coverage. Staff P stated she works Monday through Friday usually at least 8 hours. Staff P stated she did not feel the schedule was an accurate representation of her shifts or hours worked because she is on every schedule. Staff P explained she felt her name just carried over every day. Staff P acknowledged her days off were not represented appropriately. Staff P stated in the nursing department there would be a minimum 2 nurses and 3 CNA's on am shift and pm shift. Staff P stated if the facility census was below 20 there are 2 CNAs and a bath aide. Staff P stated the pm shift required 2 nurses and 3 CNAs. Staff P stated the overnight shift required 1 nurse and 2 CNAs. Staff P stated she knew there had been a time or 2 where the nurse had not shown up for a while and the staff usually called and someone came into the facility. Staff P stated they have never made one nurse without a medication aide passing their medications that she could remember. Staff P stated she could not remember just one nurse on 2 - 10 shifts ever. Staff P stated she knew in the last 6 months there had been a couple days when the census was less than 20. Staff P acknowledged there were several weekends there was no RN coverage. On [DATE] at 10:45 AM the DON stated a minimum of 2 day nurses or nurse and a medication aide and 3 CNAs. The DON stated the pm shift should have the same staffing as am shift and the overnight shift was staffed with 1 nurse and 2 CNA's. The DON acknowledged the Facility assessment did not accurately reflect the amount of RN required on pm shift. On [DATE] at 8:53 AM the Administrator acknowledged the PBJ was not being submitted correctly by the corporation the facility utilized because the data that was being pulled reflected the wrong employees in the wrong area of the building. The Administrator stated staff in Assisted Living (AL) and memory care were being recorded on the Skilled Nursing Facility (SNF) side and some of the SNF staff were being recorded on the AL and memory care side. The Administrator stated that it was noticed in October. The Administrator stated during that quarter they definitely had nurse coverage and believed there was RN coverage. The Administrator stated they utilized agency for a bit as well. On [DATE] at 12:23 PM the Administrator stated the Facility Assessment for staffing was just an approximate number for staffing. The Administrator stated the Facility Assessment was not a minimum. The Administrator acknowledged the RN on the evening shift was not required but only a possible need. Review of document titled, Facility Assessment documented direct care staff hours per resident day (HPRD) or total hours per discipline on day shift 0.33 for RN, 0.33 for Licensed Practical Nurse (LPN), and 0.67 for CNA. Direct care staff hours per resident day (HPRD) or total hours per discipline on evening shift was 0.33 for RN, 0.33 for LPN, and 0.67 for CNA. Direct care staff hours per resident day (HPRD) or total hours per discipline on night shift was 0 for RN, 0.33 for LPN, and 0.67 for CNA. Review of undated policy titled, Reporting Direct Care Staffing Information (Payroll-Based Journal) documented Staffing and census information will be reported electronically to CMS through the Payroll-Based Journal system in compliance with 6106 of the Affordable Care Act. Beginning with the fiscal quarter of 2016 (beginning [DATE]), direct-care staffing and census information will be reported electronically to CMS through the Payroll-Based Journal (PBJ) system. Direct-care staffing information includes staff hired directly by the facility, those hired through an agency, and contract employees. Providers who are employed by the facility (including physicians) are included in direct-care staffing information; providers who bill Medicare directly are not included. For auditing purposes, reported staffing information is based on payroll records, or other verifiable information. Information may be uploaded to the PBJ system manually, or through a payroll time and attendance system, or a combination of both. The PBJ system is accessed (continued on next page)		

Department of Health & Human Services
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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	through the QIES. Manual entries are made only by designated personnel with training on the PBJ user interface.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on facility assessment, clinical record review, staff interviews, and facility plan review the facility failed to demonstrate good faith attempts to correct quality deficiencies based on issues that were identified with repeat deficiencies in 11 areas over the last year and development of performance improvement plans (PIPs) for monitoring and tracking for effectiveness. The facility reported a census of 28 residents. Findings include: Review of CMS Form 2567 with a date the survey was completed as 11/12/25 documented F-880 infection prevention and control. One repeated deficiencies identified during the current survey. Review of CMS Form 2567 with a date the survey was completed as 6/13/25 documented F-584 safe/clean/comfortable/homelike environment, F-657 care plan revision, F-684 Quality Care, F-686 treatment of pressure ulcer, F-725 sufficient nursing staff and F-842 resident records. Six repeated deficiencies identified during the current survey. Review of CMS Form 2567 with a date the survey was completed as 1/9/25 documented F-550 resident rights/exercise of rights, F-641 accuracy of assessments, F-684 Quality Care, F-812 food procurement, store/prepare/serve-sanitary and F-880 infection prevention and control. Five repeated deficiencies identified during the current survey. Review of a document titled, Provider History Report Standard Health Survey Deficiency Comparison documented F-684 quality of care and F-812 food procurement, store/prepare/serve-sanitary identified as a repeat deficiency on 3 of the last 4 standard health surveys also identified during the current standard survey. F-550 resident rights/exercise of rights, F-689 free of accidents and hazards and F-725 sufficient nursing staff identified as a repeat deficiency on 2 of the last 4 standard health surveys also identified during the current standard survey. F-584 safe/clean/comfortable/homelike environment, F-625 notice of bed hold policy and F-641 accuracy of assessments as concerns identified on one of the last 4 standard health surveys also identified during the current standard survey. Clinical record review completed on 1/29/26 at 12:20 PM revealed no QAPI policy in place with a description of how the facility would identify, report, track, investigate and analyze adverse events or problem-prone concerns, a description as to how the facility obtains and uses any feedback from resident representatives to identify high-risk or problem prone issues, and how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained established. On 1/29/26 at 12:23 PM the Administrator stated the QAPI committee reviewed the deficiencies and had not been very good at developing Performance Improvement Plans (PIPs) around the concerns. The Administrator stated he had reached out to the corporate office for help and they do not have a long term care skilled consultant for assistance. The Administrator stated the facility had been building their own policies as they go. The Administrator acknowledged the facility currently does not have a QAPI policy. The Administrator explained the facility does not have any PIPs developed currently. The Administrator acknowledged he had not developed any PIPs since being employed at the facility. The Administrator stated the QAPI committee did not feel any of the audits were not working but there probably could have been adjustments to be more helpful. The Administrator explained he felt training or performance was causing the repeated concerns. Review of document titled, Facility Assessment evaluation of infection prevention and control program risk assessment documented the facility must conduct a facility based and community based risk assessment. Gaps and issues should be identified and adapted to QAPI programs.		

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on facility assessment, clinical record review and staff interview the facility failed to properly establish and implement written policies and procedures for the Quality Assurance and Performance Improvement (QAPI) plan and properly monitor and measure its success and track performance to ensure that improvements are realized and sustained for the QAPI plan. The facility reported a census of 28 residents. Findings include: Clinical record review completed on 1/29/26 at 12:20 PM revealed no QAPI policy in place with a description of how the facility would identify, report, track, investigate and analyze adverse events or problem-prone concerns, a description as to how the facility obtains and uses any feedback from resident representatives to identify high-risk or problem prone issues, and how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained established. Clinical record review also revealed no Performance Improvement Plans (PIPs) developed to track or ensure improvements. On 1/29/26 at 12:23 PM the Administrator stated the facility reviewed the deficient practices from state surveys and had not been very good at developing Performance Improvement Plans (PIP) around the concerns. The Administrator stated he had reached out to the corporate office for help and they do not have a long term care skilled consultant for assistance. The Administrator acknowledged they have been building their own policies as they go. The Administrator stated the facility does not currently have a QAPI policy. The Administrator acknowledged the facility does not have any PIPs currently. The Administrator stated the facility had not developed any PIPs since he had been employed at the facility. Review of document titled, Facility Assessment evaluation of infection prevention and control program risk assessment documented the facility must conduct a facility based and community based risk assessment. Gaps and issues should be identified and adapted to QAPI programs. The Facility Assessment also documented under policies and procedures for provision of care some considerations were to describe how the facility would evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice. Include, for example, your process to determine if new or updated policies are needed, and how they are developed or updated. Examples of policies and procedures include pain management, IV therapy, fall prevention, skin and wound care, restorative nursing, specialized respiratory care for tracheostomy or ventilator, storage of medications and biologicals and transportation. Process for updating and rolling out new/updated policies documented policies and procedures are evaluated annually or more often as needed. The Administrator evaluates any potential revisions or changes to the policies and procedures.		

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on document review and staff interview the facility failed to have the minimum members of the quality assessment and assurance committee meet quarterly. The facility reported a census of 28 residents. Findings include: Review of document dated 4/17/25 titled, QAPI Attendance documented no Infection Preventionist (IP) present at the meeting. Review of document dated 7/17/25 titled, QAPI Attendance documented no Medical Director present at the meeting. Review of document dated 8/28/25 titled, QAPI Attendance documented no Medical Director or Infection Preventionist present at the meeting. Review of document dated 10/23/25 titled, QAPI Attendance documented no Director of Nursing (DON) or Assistant Director of Nursing (ADON) present at the meeting. Clinical record review completed on 1/29/26 at 12:20 PM revealed no QAPI policy in place with a description of how the facility would identify, report, track, investigate and analyze adverse events or problem-prone concerns, a description as to how the facility obtains and uses any feedback from resident representatives to identify high-risk or problem prone issues, and how the facility monitored the effectiveness of its performance improvement activities to ensure improvements are sustained established. On 1/29/26 at 12:23 PM the Administrator stated QAPI should meet a minimum of quarterly. The Administrator stated the Medical Director, Pharmacy Consultant, DON, MDS Coordinator, Social Services, Life enrichment, IP, Business Office and Kitchen is invited. The Administrator acknowledged there were 1 or 2 meetings that did not have all the required staff present. Stated he felt that the medical director missed a quarter. The Administrator acknowledged the DON or ADON was not available to make it to the meeting a quarter as well. The Administrator explained the facility did not currently have a QAPI policy.		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. Based on staff interviews, facility assessment review and facility policy review the facility failed to develop and implement a facility wide system to monitor protocols and the use of antibiotics prescribed to residents. The facility reported a census of 28 residents. Findings include: During an interview on 1/29/26 at 9:51 AM, Staff H, Infection Preventionist (IP) / MDS Coordinator stated she had been in the IP position since June 2025. Staff H explained the facility does not have currently have Antibiotic Stewardship Program. Staff H stated she is familiar with an Antibiotic Stewardship Program and the requirements. Staff H stated a review of antibiotic use for residents prescribed by the physicians was occurring. Staff H stated for the quarterly Quality Assurance and Performance Improvement (QAPI) meetings she does keep track of the residents that were prescribed antibiotics for the quarter, but nothing further. Staff H explained management talked about the results of lab cultures in the morning meetings daily but she does not track antibiotic use, or infection trends. During an interview on 1/29/26 at 10:27 AM, the Director of Nursing (DON) stated she would expect that the corporate office would provide the facility with updated policies for infection control and antibiotic stewardship. The DON explained the policies should be according to the federal regulation. The DON stated she was familiar with Antibiotic Stewardship, and the facility did not currently have tracking for infections, or trends. The DON acknowledged if the facility could not find trends if there was no tracking at the facility. The DON stated the facility should review antibiotics prescribed for residents for effectiveness and need with the physician. Review of the document titled, Facility Assessment, dated July 14, 2025, revealed participants included an Infection Preventionist, The Assessment list of Common Diagnoses/Conditions included Infectious Diseases, with the common diagnoses of Skin and Soft Tissue infections, Respiratory infections, Tuberculosis, Urinary Tract Infections, Infections with Multi-Drug Resistant Organisms, Septicemia, Viral Hepatitis, Clostridium difficile (commonly called c-diff which is bacterial infection often antibiotic-associated diarrhea and colon inflammation), Influenza, Scabies and Legionella's listed. The General Care section of the Assessment listed Infection Prevention and Control which listed specific care or practices, in part as Identification and containment of infections. The Evaluation of Infection Prevention and Control Program section indicated The facility has a qualified Infection Preventionist who leads the facility in providing training on prevention, identification, reporting, investigating, and controlling any infections or communicable diseases throughout the facility. Review of the undated facility policy titled, Infection Prevention and Control Program included a Policy Statement which declared An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The Policy Interpretation and Implementation section directed, in part: Elements in of the IPCP4. Antibiotic Stewardshipa. Culture reports, sensitivity data, and antibiotic usage reviews are included in surveillance activities.b. Medical criteria and standardized definitions of infections are used to help recognize and manage infections.c. Antibiotic usage is evaluated, and practitioners are provided feedback on reviews.		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on staff interviews, employee record review, and facility policy review, the facility failed to offer COVID 19 vaccinations and education regarding the benefits of vaccination to facility employees. The facility reported a census of 28 residents. Findings include: During an interview on 1/28/26 at 4:28 PM, Staff J, Registered Nurse (RN) stated he had not been offered a COVID 19 vaccine at the facility this last year. Staff J stated the facility did not inquire if he had received the recent Covid 19 vaccination. During an interview on 1/28/26 at 4:28 PM, Staff L, Certified Nursing Assistant (CNA) stated she had not been offered a COVID 19 vaccine at the facility this last year. Staff L stated the facility did not inquire if she had received the recent Covid 19 vaccination or her vaccination status. During an interview on 1/29/26 at 9:51 AM, Staff H, Infection Preventionist (IP) / MDS Coordinator stated she had been in the IP position since June 2025. Staff H stated the facility had never offered COVID 19 vaccines to the staff at the facility. Staff H stated there was an annual competency fair in which the facility provided mask fitting for COVID 19 but the staff are not educated outside of the competency fair about COVID 19. Staff H stated the fair occurred in February or April of 2025. Staff H stated the facility did not have a policy for employee's Covid 19 vaccine administration, documentation or education. Staff H acknowledged there were no documents to review for staff Covid vaccine administration, screening, education or current COVID-19 vaccination status. Review of facility employee files completed on 1/29/26 revealed no record of offering education or vaccinations to employees. During an interview on 1/29/26 at 10:27 AM, the Director of Nursing (DON) stated she did not know if staff screening, education, vaccine offered, and current COVID 19 vaccination status is required. The DON explained she would expect that the corporate office would provide the facility with an updated policy for employee vaccinations. Review of an undated facility policy titled Coronavirus Disease (COVID-19) - Infection Prevention and Control Measures revealed a Policy Statement which declared This facility follows infection prevention and control (IPC) practices recommended by the Centers for Disease Control and Prevention to prevent the transmission of COVID-19 within the facility. The Policy Interpretation and Implementation section directed, in part: a. The infection prevention and control measures that are implemented to address SARS-CoV-2 pandemic are incorporated into the facility infection prevention and control plan. These measures include: Encouraging staff, residents and visitors to remain up to date with all COVID -19 vaccine doses; Providing resources and counseling about the importance of receiving the COVID-19 vaccine		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on Resident Council Meeting, observations, clinical record review, resident interviews, staff interviews and policy review the facility failed to provide dignity and respect. Staff refused to wear gloves, a staff was reported to have gone through a resident's personal belongings, pushing a resident partially exposed in a wheelchair (w/c), residents reporting being spoken to rudely, residents stating care was denied or length of time to provide care, and fear of retaliation from staff to 6 of 12 residents reviewed (Resident #7, #17, #33, #16, #15 and #29). The facility reported a census of 28 residents. Findings include: 1. Resident #7's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive deficit. The document provided the resident utilized a manual w/c and required partial/moderate assistance. The document disclosed the resident had diagnoses of chronic kidney disease, nonrheumatic aortic valve stenosis, and unspecified arthritis. The resident's Care Plan dated 1/7/25 revealed a focus area related to Activities of Daily Living (ADLs) dated 4/23/24 with staff interventions of manual w/c mobility with assistance of 1, dressing tasks with maximal assistance of 1 and bathing requires assistance of 1 staff (revised 4/23/24). On 1/21/26 at 7:10 AM observed Staff I, Certified Nursing Assistant (CNA), push Resident #7 partially exposed down 2 hallways from the resident's bedroom until stopped at Staff H's (Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist) office. Staff H directed Staff I that she had past the shower room and needed to go back the other direction. Staff A, Registered Nurse (RN), was also present at Staff H's office. Staff A followed Resident #7 and Staff I down the hallways to the shower room. The total distance the resident traveled through the facility was 240' or $\frac{34}{100}$ the length of a football field. On 1/21/26 at 7:48 AM Staff H stated residents must be covered when being transported to the shower room. On 1/22/26 at 12:27 PM Staff Staff D, Certified Medication Aide (CMA), stated residents must be fully covered when being pushed in a w/c. On 1/26/26 at 2:39 PM Staff J, Registered Nurse (RN), expected that residents would be covered when being transported to the shower room whether in a w/c or shower chair. On 1/27/26 at 11:01 AM the Director of Nursing (DON) stated she expected residents to be fully covered when being transported to the shower room. The DON stated if a resident was wearing a hospital gown, the resident needed to be cocooned in 2 blankets, 1 for the front and 1 for the back to ensure complete coverage. On 1/28/26 at 11:14 PM when asked about a resident being partially exposed going to the shower room, the Administrator stated he expected residents to be covered with blankets. 2. Resident #17's MDS dated [DATE] revealed a BIMS score of 12/15 indicating moderate cognitive deficit (intact cognition 13-15). The self care area of eating revealed the resident was independent. The document disclosed the resident's diagnoses of atrial fibrillation (A-fib), heart failure, Non-Alzheimer's Dementia and Chronic Obstructive Pulmonary Disease (COPD). The MDS did not (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reveal any behaviors exhibited by Resident #17. The resident's Care Plan dated 1/20/26 revealed a focus area for assistance with ADL's dated 1/5/26 with an intervention of independence with eating. Focus areas related to antipsychotic medication and antidepressant medications revised 1/6/25 contained staff interventions of monitoring for anxiety/nervousness, irritability with over stimulation and crying/sadness. The Care Plan did not contain behaviors related to making false statements or refusing care. On 1/20/26 at 10:33 AM Resident #17 stated when she has voiced concerns about her care regarding her oxygen or needing assistance with her care, staff have responded with calm down, we are going to get you, you are a smart ass. The resident stated these responses by unidentified staff make her feel horrible and that she was voicing concerns, not trying to be hard to get along with. The resident further revealed that when asking her cold food to be reheated was told to be grateful she got food and that the food was not reheated. On 1/22/26 at 12:27 PM Staff D stated Resident #17 had not voiced concerns to her regarding any specific staff or concerns with her care. The staff stated residents should not be called names. On 1/26/26 at 2:39 PM Staff J stated residents should not be called names and assistance should be given when requested. On 1/27/26 at 11:01 AM the DON stated residents' needs should be addressed when requested and staff should not be calling residents names. On 1/28/26 at 11:14 AM the Administrator stated calling residents names was not acceptable. 3. Resident #33's Export Ready MDS dated [DATE] revealed a BIMS score of 14/15 indicating normal cognition. The document provided the resident required partial/moderate assistance for rolling, sitting to/from lying positions, transfers, toilet hygiene and dressing. The document provided the resident had continence of urine and frequent incontinence of bowel. The document disclosed resident diagnoses including heart failure, renal insufficiency, benign prostatic hyperplasia (BPH), diabetes mellitus, Parkinson's, and complete traumatic amputation of unspecified great toe. The Resident's Care Plan dated 1/24/26 revealed an assistance with ADL's focus area dated 1/17/26 with staff interventions of toileting assistance of 1 with a gait belt, transfer with walker and w/c mobility with assistance of 1. On 1/26/26 at 12:24 PM the resident's family reported that overnight staff had been extremely rude to the resident. The family stated examples included staff stating they couldn't help the resident and shutting his door despite the resident request for his door to remain open. The family further reported when assisting the resident with toileting the resident had urinated on clothing with the staff wiping the resident's pants and putting him back in bed without changing the garment. The family stated the tone and attitude of staff towards the resident was demeaning and undignified. On 1/27/26 at 10:25 AM during the Resident Council meeting the residents stated they were unaware of having rights, did not know if Resident Rights were posted in the facility, and did not know who to talk to about their rights. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/27/26 at 11:01 the DON stated the resident's needs should be addressed when requested. 4. According to the quarterly MDS assessment tool with a reference date of 1/2/2026 documented Resident #16 had a BIMS score of 11. A BIMS score of 11 suggested mild cognitive impairment. The MDS documented Resident #16 was independent with meals. The following diagnosis were listed for the resident: dementia. On 1/20/2026 at 11:52 AM revealed a sign outside of the dining room with the following meal times:a. Breakfast 7:30 AM-9:00 AMb. Lunch 12:00 PM-12:30 PMc. Supper 5:30 PM-6:00 PM On 1/21/2026 at 11:31 AM Resident #16 sat in the dining room at a table, by herself; no residents or staff present. Resident #16 hollered help, where is my food. At 12:29 PM a food cart was brought in to the dining room. On 1/22/2026 at 11:28 AM Resident #16 sat in the dining room at a table, alone in the room. Resident #16 yelled help, help me. On 1/27/2026 at 11:25 AM Resident #16 sat in the dining at the table, alone with a drink in front of her. On 1/28/2026 at 11:29 AM Resident #16 sat in the dining at the table, alone with a boost drink and clear cup in front of her. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) stated she was not sure why Resident #16 would be in the dining room alone that early before the meal is served. Would hope the resident would have asked to go to the dining room, at least she would assume that is the case. She acknowledged lunch is to start between 12:00 PM and 12:30 PM. The facility provided a document titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: 5. Establish and maintain a culture of compassion and caring for all residents and particularly those with behavioral, cognitive or emotional problems. 5. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of Resident #15's Medication Administration Records - Treatment Administration Records documented an order with start date of 1/19/26 for Enhanced Barrier Precaution related to wounds with gown and gloves required for high contact resident care activities. On 1/20/26 at 11:49 AM Resident #15 stated on 1/12/26 she sat in soiled urine and feces from 3:00 AM - 6:00 AM. Resident #15 explained she was told she could not get out of bed on her own. Resident #15 stated she had turned her call light on several times during that night. Resident #15 stated the staff do not take her to the bathroom on the overnight shift. Resident #15 stated she had talked to everyone about the concern, especially Staff P Registered Nurse (RN) / Assistant Director of Nursing (ADON). Resident #15 stated Staff EE, Certified Nurse Assistant (CNA) was working with Staff Y, CNA and Staff Y refused to wear gloves to clean her up after she used the toilet . Resident #15 stated (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that Staff Y was going through her bag of personal belongings. Resident #15 stated she told Staff J about the incident. On 1/21/26 at 7:43 AM Staff J, RN stated Resident #15 had voiced concerns to him. Staff J stated Resident #15 briefly mentioned staff going through her personal belongings. Staff J stated she knows there are certain people Resident #15 was hesitant to allow going into her room. Staff J stated those people are the girls on the overnight staff. Staff J stated Resident #15 had not mentioned that the overnight staff would not take her to the bathroom. Staff J stated he did not write a grievance for Resident #15 because they found the pants. Staff J stated he talked to Resident #15 about discussing with the overnight nurse about staff going through her stuff. Staff J stated staff going through Resident #15's stuff had been brought up to management. On 1/21/26 at 7:52 AM Staff R, CNA stated Resident #15 had voiced concerns to her about Staff Y, CNA rummaging through her stuff about a week ago on overnights. Staff R stated Resident #15 told her the reason she had laid in the bed with feces that morning was because Staff EE, CNA came into her room and was talking about recipes and Staff Y, CNA was going through her stuff. Staff R stated she told that to the Staff EE, CNA that was working overnights. Staff R stated she told Staff EE that she needed to stop bringing Staff Y, CNA in Resident #15's room because she was going through Resident #15 stuff. Staff R stated she told Staff J and Staff GG, LPN about the incident. Staff R stated Resident #15 told Staff Y that she needed to wear gloves when she was providing the cares and Staff Y told her she told her no and then Resident #15 refused the care. Staff R stated she did not inform any of the management of the incident. On 1/21/26 at 7:26 AM Staff P stated Resident #15 did not report any missing items but did say something was missing from her shoe. Staff P stated Resident #15 had never reported any staff going through her personal belongings. On 1/26/26 at 10:08 AM the DON stated she thought that the resident filled out the grievance with the Social Services Director. The DON stated the Social Services Director had spoken to Resident #15 and she did not want to fill out a grievance. The DON stated if a resident voiced concerns the staff should still fill out a grievance for that resident. On 1/27/26 at 11:03 AM the DON stated she expected grievances would be completed when residents reported any concerns and that was not being completed appropriately at the facility. She also stated she would have expected gown and gloves to be worn with Resident #15 when completing personal care because she is on EBP even if you are assisting with care. 6. The MDS dated [DATE] documented Resident #29 had a BIMS of 15 indicating no cognitive impairment. The MDS indicated Resident #29 required partial/moderate assistance for toileting hygiene. On 1/15/26 at 1:30 PM Resident #29 stated she had to set an alarm on her phone to ensure the staff come to turn her every 2 hours or the overnight staff will not reposition her. Resident #29 stated her doctor wants her repositioned every 2 hours. Resident #29 stated prior to going to the hospital the staff were not repositioning her every 2 hours some nights overnight staff would only come in at 3:00 AM or 4:00 AM to reposition her in bed. Resident #29 stated she had Multiple Sclerosis and was not able to reposition herself in bed. Resident #29 stated she required the assistance of staff for repositioning. Resident #29 stated she had reported not being repositioned by the overnight staff several times to staff. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/26 at 11:29 AM Resident #29 stated Staff EE, Certified Nurse Assistant (CNA) refused to change her brief last night. Resident #29 stated she was out of briefs and Staff EE refused to change her last night. Resident #29 stated she had not had a bowel movement but was incontinent of urine and nobody changed her at all last night. Resident #29 stated the Staff EE only repositioned her at night but never changed her. Resident #29 stated she has had problems with Staff EE from the get go. Resident #29 stated Staff EE was not supposed to be caring for her because she had voiced concerns about how she cared for her in the past. Resident #29 stated Staff EE treated her undignified. Resident #29 stated she did not feel like Staff EE had provided her with the appropriate dignity or respect when requesting to be cleaned up and change her brief. Resident #29 stated she had told Staff R, CNA the concerns she had with Staff EE. Resident #29 said she thought Staff EE told Staff P, Assistant Director of Nursing (ADON) about the concerns with Staff EE. On 1/26/26 at 1:00 PM Resident #29 stated Staff EE entered her room the night before and had spoken under her breath about that resident turning her into the state surveyors about not changing her on overnight shift. Resident #29 stated she was not afraid of the staff and felt there were plenty of rules that would keep her safe. Resident #29 stated she felt safe at the facility currently. Resident #29 stated Staff EE was not supposed to provide her care anyways so she was not afraid of care not being provided. Resident #29 stated she did feel like there was a lack of dignity with Staff EE coming into the room to confront her about what she had supposedly said to the state survey team. On 1/26/26 at 12:24 PM Resident #33's daughter stated there was a resident at the facility who did not want to speak up. Resident #33's daughter stated the resident next door Resident #29 was confronted by Staff EE as to what the resident had shared with the survey team. Resident #33's daughter stated she did not know how Staff EE found out about Resident #29 talking to the survey team but Staff EE approached the resident about it. Resident #33's daughter stated she had talked to the DON about all the concerns. On 1/12/26 at 12:49 PM Staff P, Assistant Director of Health and Wellness / Assistant Director of Nursing (ADON) / Registered Nurse (RN) stated there had not been any staff or residents that had reported staff were rough with resident care or short with residents. Staff P stated there had been staff that had been asked not to go in certain resident rooms. Staff P stated Resident #29 did not want Staff EE or Staff RR in her room because they were talking about their own lives and another resident down the hall while in her room. Staff PP stated Resident #29 thought it was disrespectful for them to talk about other residents in her room. On 1/12/26 at 1:09 PM the Director of Nursing (DON) stated there are several staff that really need to be let go. The DON stated because of the lack of DON presence prior to her starting in the position at the building there was not enough of a documentation trail to let the staff go. The DON stated 95% of the complaints are staff to staff complaints. The DON stated she was not aware of any staff that could not go into any resident's room. On 1/13/26 at 2:00 PM Staff R stated she talked to Staff A, Registered Nurse (RN) about Resident #29 not being repositioned appropriately last night. Staff R stated she spoke to Staff A about it that morning. Staff R stated Resident #29 reported she had not been repositioned or had her brief changed with incontinence the way she should have last night. On 1/13/26 at 2:50 PM Staff A acknowledged that Staff R had told her Resident #29 had not been repositioned on the overnight shift. Staff A stated Resident #29 had been noted to be soaked through the pad, the sheet to the bed when Staff R entered the room. Staff A stated the overnight nurse (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reported to her that he repositioned Resident #29 every 2 hours. Staff A stated there was a dark ring around Resident #29's bed pad that appeared to be indicative of not checking or changing but did know Resident #29 had been repositioned. Staff A stated she assisted Staff R with repositioning Resident #29 that morning. On 1/22/26 at 2:06 PM Staff R stated when she came in at 6:00 AM on 1/22/26 and Resident #29 stated she had asked to be changed because she had some urine incontinence on the overnight shift. Staff R stated Resident #29 explained Staff EE said there was no brief to change her with. Staff R stated Resident #29 told her that she told Staff EE that she was a 3XL brief. Staff R reported Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff R said Resident #29 told her Staff EE refused to change her. Staff R reported Resident #29's brief was saturated when she provided care that morning. Staff R stated she reported the concern to Staff J. On 1/22/26 at 2:10 PM Staff J, RN stated Staff R had informed him Resident #29 reported she had not been changed on the overnight shift. Staff J reported Staff R stated Resident #29 stated she had asked to be changed because she had incontinence. Staff J stated Resident #29 stated Staff EE said there was no brief to change her with. Staff J stated Resident #29 told Staff EE that she was a 3xl brief. Staff J stated Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff J said Resident #29 told her Staff EE refused to change her brief. On 1/22/26 at 12:58 PM Staff EE, CNA stated she did provide care for Resident #15. Staff EE stated Resident #15 had not voiced any concerns with her about other staff at the facility. Staff EE stated Resident #15 will say things that are not true. Staff EE stated she usually works with Staff Y and she would go into the resident room with her. Staff EE stated she had not worked with a staff that refused to wear gloves with Resident #15. Staff EE stated Resident #15 was making a fuss about a coworker who went into the room and was helping her out. Staff EE stated they usually work in pairs on the overnight shift. Staff EE stated the co-worker was Staff Y. Staff EE stated Resident #15 told Staff Y to wear gloves. Staff EE stated Staff Y was getting an ice pitcher not providing care. Staff EE stated the overnight staff do the rounds at night at 10:00 PM, 12:00 AM, 2:00 AM, 4:00 AM and 6:00 AM. Staff EE stated Staff Y asked Resident #15 why she wanted her to wear gloves. Staff EE stated Staff Y told Resident #15 I'm just holding your cup. Staff EE stated Resident #15 then said okay. Staff EE stated Staff Y did not apply gloves at that time. Staff EE stated after that everything was already done. Staff EE stated Resident #15 had not mentioned any concerns about staff going through her stuff. Staff EE stated she could not remember what staff had said staff were stealing her stuff. Staff EE stated maybe she or another overnight girl had stolen some stuff. Staff EE stated the conversation occurred a couple of days ago. Staff EE stated she had never stolen anything from Resident #15. Staff EE stated she had never gone through Resident #15's personal items. Staff EE stated Staff Y had not gone through her stuff or stolen anything. Staff EE stated Staff R does not want her to be on the skilled side of the building. Staff EE, CNA stated she has very little interaction with Resident #29. Staff EE stated if she was not supposed to have contact with Resident #29 but the facility kept putting her on that side. Staff EE stated she does work with Resident #29 and had worked with her last night. Staff EE stated she did have contact with Resident #29 last night. Staff EE acknowledged Resident #29 was on a 2 hour reposition schedule. Staff EE stated she repositioned her. Staff EE explained she did not toilet Resident #29 at night. Staff EE explained Resident #29 would turn on her call light at night asking for a brief change. Staff EE stated Resident #29 turned her call light on last night to be repositioned. Staff EE stated she took Staff Y when she was there but she left early but did not know what time. Staff EE stated she provided peri care to freshen her up (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	down there but did not have to change her brief. Staff EE stated Resident #29 had not requested for her brief to be changed at any time overnight the night before. Staff EE stated Resident #29 had thought that she had a BM and wiped her up to show her that she had not had a BM. Staff EE stated she had Staff Y in the room with her at that time. Staff EE stated Resident #29 told her that she was a 3XL in brief size. Staff EE stated she did not change her brief because it was changed prior to her going in the room. Staff EE stated Resident #29 never asked her to change the brief. Staff EE stated if she was doing peri care and the brief is dirty she changed the brief but she told her that she had not had a BM then she said she would just wear the same brief. On 1/23/26 at 2:00 PM Staff Y, CNA stated she typically worked overnights. Staff Y stated she only assisted on that skilled side. Staff Y stated she assisted by lifting a gown up when Staff EE completed peri care on Resident #15. Staff Y stated there are false accusations flying around the facility. Staff Y stated Staff EE was banned from the room and she went into the room to help Resident #29 because if there are 2 sets of eyes then the truth will come out. Staff Y stated she is in fear of reporting what she is supposed to report and they had not had a DON in a long time. Staff Y stated she did not need to wear gloves while holding a gown up while another staff completed peri care on Resident #15. Staff Y stated she had assisted Staff EE with care on Resident #29. Staff Y stated she assisted Staff EE with repositioning Resident #29. Staff Y stated Resident #29 stated she had a bowel movement. Staff Y stated Staff EE checked Resident #29's brief, it was dry and there was no bowel movement. Staff Y stated Resident #29 does not always void at night. Staff Y stated Resident #29 was cognitive of when she needs to use the bathroom. Staff Y stated Resident #29 did not have incontinence. Staff Y stated she did not notify the nurse because Resident #29 had not urinated that shift. Staff Y stated Resident #29 told the staff that she did not need her briefs changed if it was not soiled. Staff Y stated she did not go back in Resident #29's room after that time. Staff Y stated typically during personal care she would change the brief but she let Resident #29 exercise her rights and her wishes. Staff Y stated Resident #29 was not soiled, the 2 of them just freshened her up. Staff Y stated Resident #29 was dishonest and a troublemaker. Staff Y stated she did not know if there were briefs because she was only the second person. Staff Y stated Resident #29 had never said anything about her brief size. Staff Y stated Staff EE did not have a conversation about not having any briefs available. Staff Y stated she minds her own business. Staff Y acknowledged she had worked with Resident #15 but only went into Resident #15's room one time to help Staff EE. Staff Y stated the night before she had exchanged words with Staff R. Staff Y stated Staff R accused her of stealing for Resident #15. On 1/26/26 at 3:26 PM the DON stated Resident #33 family had overheard Staff EE in Resident #29's room and lectured the resident as to why she had talked about her to state. The DON stated she told Staff EE on Thursday or Friday that she was not supposed to be working on that side. The DON explained any staff who are not supposed to be caring for a resident should not be caring for that resident. The DON stated she had not spoken with Resident #29 about the concern that was reported to her. Stated she still needed to talk to Resident #29 but felt Resident #29 probably felt intimidated and scared. The DON stated Resident #15 and Resident #29 do not want Staff EE in their rooms. On 1/27/26 at 11:03 AM the DON stated she would expect all the residents be treated with dignity and respect. The DON stated she would not expect staff to approach Resident #29 about any concerns reported to management or the state survey team. Review of undated policy titled, Resident Rights documented Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include a dignified existence; be treated with respect, kindness, and (continued on next page)		

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dignity; be free from abuse, neglect, misappropriation of property, and exploitation; self-determination; be informed about their rights and responsibilities; privacy and confidentiality; voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal and have the facility respond to their grievances.		

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F 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on resident interviews, staff interviews, facility document review and policy review the facility failed to provide ongoing education to residents and/or their representatives on Resident Rights in a format that is understandable to them. The facility had a census of 28. Findings include: On 1/27/26 at 10:25 AM during the Resident Council meeting, the residents present indicated they were unaware of having rights, knowing what the Resident Rights were or if they were posted within the facility for their knowledge. Review of Resident Council Minutes for 11/25, 12/25 and 1/26 revealed a variety of facility leadership in attendance at the meetings with no education provided to the residents on Resident Rights. During the Resident Council meeting on 1/27/26 Staff K, Life Enrichment Director, stated she normally assisted with leading the Resident Council, but if she was not available an Activity Coordinator filled her position. Staff K acknowledged the staff had not been reviewing/educating residents on Resident Rights during Resident Council meetings. The Director of Nursing, DON, during the Resident Council meeting on 1/27/26 stated the residents were provided the Resident Rights as part of their admission packets, but concurred the Resident Rights needed to be reviewed with the residents on an ongoing basis. Neither Staff K nor the DON could confirm the Resident Rights were posted and readily available for the residents. The facility's Resident Rights Policy, undated, revealed the residents had the right to be supported by the facility in exercising their rights, be informed about their rights and the resident rights were to be posted throughout the facility.		

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations, resident interviews, staff interviews, and facility document reviews the facility failed to provide residents and/or their representatives accessible reports related to surveys, certifications and complaint investigations for the facility during the 3 preceding years and any plan of correction with respect to the facility. The facility had a census of 28. Findings include: On 1/21/26 at 9:20 AM the Survey Binder did not have 3 years of surveys/complaints. On 1/22/26 at 8:00 AM the Survey Binder did not have 3 years of surveys/complaints. On 1/27/26 at 10:25 AM during the Resident Council meeting the residents present did not know about having recent State Inspection documents and plans of correction available for their review. The residents did not know where those documents would be kept for their knowledge. Staff K, Life Enrichment Director, present during the Resident Council meeting on 1/27/26 could not provide additional information regarding the availability of the State Inspections for residents and/or their representatives. On 1/27/26 during the Resident Council meeting the Director of Nursing (DON) could not provide additional information regarding the State Inspections for residents. Observation on 1/21/2026 at 11:47 AM revealed the survey results book on a table to the right of the Long-Term Care (LTC) entrance. The survey results book only contained one Centers of Medicare and Medicaid Services (CMS) form 2567 with a survey end date of 6/13/2025. Review of the Iowa Department of Inspections, Appeals, and Licensing website revealed the following surveys were completed at the facility: a) Survey end date of 1/26/2023 for an incident investigation with one deficiency cited,b) Survey end date of 1/10/2024 for their recertification and complaint/incident investigations with three deficiencies cited,c) Survey end date of 1/9/2025 for their recertification and complaint investigation with eight deficiencies cited,d) Survey end date of 6/13/2025 for an incident investigation with 11 deficiencies cited,e) Survey end date of 11/12/2025 for complaint investigation with three deficiencies cited. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) indicated she did not know who was in charge keeping the survey results book up to date. She was unsure if the Administrator would do this, she did not know. The facility was unable to produce a policy related to having survey results readily available.		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview, staff interviews, family interview, provider interview and policy review the facility failed to notify the resident's representative / family / Power of Attorney (POA) and physician for change in condition when a resident had a head injury and residents had a new or worsening wound for 4 of 4 residents (Residents #2, #15, #29, #30 and #23) reviewed. The facility reported a census of 28 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #2 was at risk for developing pressure ulcers/injuries and Moisture Associated Skin Damage (MASD) present. The MDS documented admission date for Resident #2 of 11/28/25 Review of Resident #2's (Electronic Health Record) EHR dated 11/28/25 titled, Discharge Summary documented a Braden scale score of 17 with a reposition schedule at least every 2 hours. The Discharge Summary documented a wound undiagnosed gluteal cleft mid right. Review of Resident #2's EHR documented on 11/28/25 a rash on buttocks upon entry. Review of Resident #2's Treatment Administration Record (TAR) documented a physician's order with a start date of 1/11/26 and discontinued 1/12/26 to paint right heel deep tissue injury (DTI) daily with betadine and cover with dry dressing. A physician's order with a start date of 1/12/26 and discontinued 1/14/26 for the right heel to be cleansed, dry, painted with betadine and covered with mepilex foam once a day related to DTI. A physician's order with start date of 1/14/26 for wound on the right heel to be cleansed with wound cleanser, pat dry, apply Triple Antibiotic Ointment (TAO) and cover with foam dressing one time a day. A physician's order with a start date of 1/11/26 to evaluate right heel wound / peri-wound for complications including symptoms of infection. A physician's order with a start date of 11/28/25 to cleanse buttocks with soap and water, pat dry, apply Z guard every shift until healed. A physician's order with a start date of 11/28/25 to evaluate buttocks wound / peri wound for complications including symptoms of infection. A physician's order with a start date of 1/15/26 to cleanse sacral stage 2 pressure ulcer with wound cleanser, pat dry, apply a foam dressing and change every 3 days and as needed (PRN). A physician's order with a start date of 1/15/26 to evaluate stage 2 pressure wound/peri-wound for complications including symptoms of infection. Review of Resident #2's EHR dated 1/6/26 at 7:41 PM titled, Skin Check documented no injury to right or left heel. Review of Resident #2's EHR dated 1/11/26 at 7:53 AM entered by Staff P, RN, ADON, Assistant Director of Health and Wellness, and Wound Nurse titled, Wound Evaluation documented a DTI to the right heel minutes old that was in-house acquired that had an area of 1.25 cm2, length of 2.42 cm, and width of 1.1 cm. Review of Resident #2's EHR dated 1/11/26 at 9:54 PM titled, Progress Notes documented reported on the am shift Resident #2 had an open area to the right heel. The exam showed suspected DTI. The area was cleansed, painted with betadine and protective dressing applied. Review of Resident #2's EHR titled Wound Evaluation documented the following: (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/28/25 at 2:50 PM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis that was present on admission on the buttocks that had an area of 1.42 cm2, length of 3.42 cm, and width of 0.61 cm. On 12/5/25 at 8:03 PM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis that was present on admission on the buttocks that had an area of 19.8 cm2, length of 8.86 cm, and width of 5.66 cm. On 12/12/25 at 8:29 AM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis on the buttocks that was present on admission that did not have any measurements with the assessment. On 12/23/25 at 10:14 AM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis on the buttocks that was present on admission that had an area of 1.4 cm2, length of 2.57 cm, and width of 1.29 cm. On 12/30/25 at 6:48 AM entered by Staff J, RN titled, Wound Evaluation documented incontinence associated dermatitis on the buttocks that was present on admission that had an area of <0.1 cm2, length of 0.25 cm, and width of 0.21 cm. On 1/6/26 at 7:21 PM entered by Staff P titled, Wound Evaluation documented incontinence associated dermatitis on the buttocks that was present on admission that had an area of 15.65 cm2, length of 7.01 cm, and width of 3.06 cm. Observation of the photo on EHR dated 1/6/26 at 7:21 PM entered by Staff P titled, Wound Evaluation revealed 2 areas of stage 2 present on sacrum / coccyx area at that time that were undocumented. Review of Resident #2's EHR dated 1/15/26 at 10:18 AM entered by Staff J titled, Wound Evaluation documented Stage 2 pressure ulcer on the sacrum that was in-house acquired that had an area of 1.67 cm2, length of 1.81 cm, and width of 1.19 cm. Review of Resident #2's MDS dated [DATE] documented treatments for skin injury included pressure reducing device for chair, pressure reducing device for bed, nutrition hydration intervention to manage skin problems. Review of Resident #2's EHR titled, Progress Notes documented on 1/15/26 Resident #2 was seen for right heel and buttocks at the facility by physician new orders for wound care. Resident #2's Progress Notes documented on 1/11/26 the physician was notified of the area on Resident #2's right heel. Resident #2's Progress Notes did not document physician notification of worsening wound on sacrum on 1/6/26. On 1/12/26 at 11:21 AM Resident #2 stated the area on her right heel started on 1/8/26. Resident #2 explained there was not a heel protecting boot available until 1/11/26. Resident #2 stated she spoke to Staff R, Certified Nurse Assistant (CNA) on 1/8/26 and Staff R told the nurse that was working. Resident #2 stated it was reported on the overnight shift. Resident #2 stated the area was now open and when she reported it was not open. Resident #2 stated there was a treatment started 1/11/26 to paint the area with betadine and apply a dressing. On 1/13/26 at 2:00 PM Staff R, CNA stated the area on Resident #2's heel was because she was not (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting up out of the bed. Staff R stated she reported the heel weeks ago to several nurses. Staff R explained Resident #2 did have an open area on her buttocks. Staff R stated she had notified the nurses about the open area. Staff R stated Resident #2 wants to lay in bed all day. On 1/13/26 at 2:37 PM Resident #2 stated her right heel was very red on 1/8/26 and worsened 1/10/26. Resident #2 explained that the nurse said she was going to paint the area and got her the heel protecting boot. On 1/26/26 at 3:13 PM the DON stated while reviewing Resident #2's Wound Evaluation documents that the sacral wound was a stage 1 on 12/23/25 and was a stage 2 on 1/6/26. The DON explained MASD assessment should have been closed and Stage 1 Pressure ulcer assessment should have been opened on 12/23/25. The DON stated the stage 2 was taken on 1/14/26 and added to the MASD photo. The DON stated Staff P, ADON educated the nurse to open the wound assessment as a stage 2. The DON acknowledged the facility received new orders for Resident #2's sacral wound on 1/15/26. The DON explained the physician should have been notified of the stage 1 pressure ulcer on the 1/23/26. The DON explained she felt the deterioration of the wound would have been preventable with change in treatment or appropriate identification of the wound change and deterioration. The DON explained all the facility had for a treatment on Resident #2's buttocks was a cream that was not working because the area became a stage 2. The DON explained Resident #2's heel wound would not have been evaluated till 1/18/26 but if the wound was open or there was a change in condition she would have expected physician notification. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:49 AM Resident #15 stated she told Staff P RN / Assistant Director of Nursing (ADON) about the sore on her foot and she did nothing about it. Resident #15 stated Staff J, RN was the nurse that finally did something about it. Review of Resident #15's TAR documented a physician's order with a start date of 1/15/26 to cleanse 2nd toe on left foot with wound cleanser, pat dry, apply Triple Antibiotic Ointment (TAO) and cover with band aid daily. Review of Resident #15's EHR dated 1/5/26 titled, Progress Note admission readmission Progress Note documented at 2:48 PM Resident #15 had an admission date of 1/5/26. The Progress Note documented reason for admission weakness post hospitalization for acute and chronic renal failure. The Progress Note documented no impaired skin integrity, no bruise, burn, deep tissue injury, diabetic ulcer, incontinence associated dermatitis, moisture associated skin damage, open areas, wound, rash, redness, skin tear or surgical incisions. Review of Resident #15's EHR dated 1/15/26 at 10:05 AM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.33 cm2, length of 0.98 cm, and width of 0.5 cm. The wound note described area red with slough and Physician notified. Review of Resident #15's EHR dated 1/16/26 at 4:57 PM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.33 cm2, length of 0.98 cm, and width of 0.5 cm. (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #15's EHR dated 1/23/26 at 5:27 PM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.11 cm², length of 0.62 cm, and width of 0.28 cm. Review of EHR documented no physician notification or treatment completed for Resident #15's wound since admission on [DATE] until 1/15/26 when Staff J RN addressed the area. On 1/26/26 at 3:26 PM the DON stated her concern was the initial admission skin assessment for Resident #15 was completed by Staff A, RN. The DON explained Staff A completed the assessment and left without documenting the assessment. The DON stated the evening nurse went in and completed the assessment again. The DON stated she did not think Staff A made an observation of her foot / toe. The DON explained Staff J documented the area as not facility acquired because Resident #15 stated she had the area before entering the facility. The DON stated Resident #15 was a good historian. The DON stated there were a lot of balls that were dropped when it comes to wound care in the facility. The DON stated the area should have been noticed on the admission skin assessment, the physician should have been notified then and a treatment started if the physician thought it warranted. The DON acknowledged Resident #15 was at the facility for a week and the wound was not assessed and not treated. The DON stated the CNA's should have noticed the wound when cleaning Resident #15's feet. 3. The MDS dated [DATE] documented Resident #29 had a BIMS of 15 indicating no cognitive impairment. The MDS documented Resident #29 had one or more unhealed pressure ulcers. The MDS documented a Stage 2 pressure ulcer present. The MDS documented Resident #29 had an admission date of 11/11/25. Review of Resident #29 TAR documented a physician's order with a start date of 11/28/25 and end date of 12/16/25 to cleanse the sacral wound with wound cleanser, pat dry and apply Plurogel and foam patch daily until healed. A physician's order with a start date of 12/29/25 for Cephalexin 500mg, give one tablet by mouth every 12 hours for buttocks ulcer infection for 5 days. A physician's order with a start date of 12/16/25 and discontinued date of 1/2/26 to cleanse the sacral wound with wound cleanser, pat dry and apply Santyl and foam patch every other day. Review of Resident #29's EHR dated 11/11/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 20 that indicated Resident #29 was not at risk for development of a pressure ulcer. Review of assessment completed by Staff M, LPN on 11/12/25 titled, CHI Skin Check documented no concerns. Review of Resident #29's EHR dated 11/26/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 16 that indicated Resident #29 was at risk for development of a pressure ulcer. Review of Resident #29's EHR dated 11/29/25 titled, Skin Check documented open area on coccyx with no measurements or description. Review of Resident #29's EHR dated 12/6/25 titled, Skin Check documented open area on coccyx with no measurements or description. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #29's EHR dated 12/16/25 titled, Skin and Wound Evaluation documented an in-house acquired stage 2 pressure ulcer with no measurements, superficial loss of tissue and no odor. Review of Resident #29's EHR dated 12/25/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 9 that indicated Resident #29 was at a very high risk for development of a pressure ulcer. Review of Resident #29's EHR dated 1/5/26 titled, Skin and Wound Evaluation documented an unstageable pressure ulcer with slough and/or eschar that had an area of 15.8 cm², length of 6.6 cm, and width of 4.4 cm with no physician notification. Review of Resident #29's EHR documented no skin assessments completed between 12/16/25 and 1/3/26. Interventions for wound management were not changed until 1/2/26 when seen at a wound clinic. On 1/21/26 at 1:51 PM Staff J, RN acknowledged he worked with Resident #29 prior to having the wound on her buttocks. Staff J stated he felt the deterioration of the wound on Residents #29 buttocks could have been prevented. Staff J stated Resident #29 was not being repositioned appropriately prior to the wounds appearance. Staff J stated some CNA's had reported the wound was not getting better and requested the nurse to look at it. Staff J explained the CNA was told to put some cream on it and did not assess the area. Staff J stated Resident #29 had an alarm to remind staff to reposition her since she had returned. Staff J stated he knew Resident #29 had issues brought up about overnight CNAs not being in her room. Staff J acknowledged if those CNA's are working she told him she will set the alarm every 2 hours. On 1/26/26 at 2:43 PM Staff J, RN stated the CNA's have never notified him of stage 1 or discoloration. Staff J stated he does not know if CNA's know what pressure injuries are or when to notify the nurse. On 1/26/26 at 3:26 PM the DON stated she had heard CNA's report they had told the nurse and there was no documentation. The DON stated Resident #29 did not want Staff E in their room. The DON stated there were a lot of balls that were dropped when it comes to wound care in the facility. On 1/14/26 at 2:45 PM Staff P acknowledged there was no assessment for Resident #29 and unclear of what actually was notified to the physician as far as the wound description. Staff P stated she was informed about the wound from Staff MM and does not know why an assessment with measurement, description and photo was not completed. Staff P acknowledged she had worked that day and she did not look at the wound either. Staff P stated Staff MM said the wound looked worse. Staff P said it was concerning there was no assessment completed, no documentation of what exactly the physician was notified of and no photo of the area taken when the area was found on Resident #29. Staff P acknowledged there had not been any change in Resident #29's orders from 12/16/25 till seen at the wound clinic on 1/2/26. Staff P stated the physician should have been notified of Resident #29's worsening condition to the wound, assessments should have been documented to ensure appropriate treatment and physician update. On 1/14/26 at 3:00 PM the DON stated her expectation was with all wounds an assessment would be completed weekly with measurements and description of the wound. The DON stated her expectation was to notify the physician if there was any deterioration or lack of improvement to ensure the (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appropriate treatment was being completed. The DON stated documentation of the physician notification would be documented in the resident's electronic health records. The DON stated her expectation was that all changes in wounds worsening, lack of improvement or deterioration would also be reported to her or the ADON. The DON acknowledged Resident #29 skin assessments lacked an accurate assessment from 12/16/25 - 1/3/26 with measurements, a description of the wound or a photo. The DON acknowledged Resident #29's wound did not go from a stage 2 wound to that size of an unstageable pressure overnight and should have been documented with a physician notification before 1/3/26. 4. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. The MDS documented Resident #30 was at risk for development of pressure ulcers. The MDS documented no pressure ulcers. The MDS documented Resident #30 had an admission date of 12/2/25. Review of Resident #30's EHR dated 12/22/25 titled, Skin Check documented no skin issues. Review of Resident #30's EHR dated 12/23/25 titled, Braden Scale for Predicting Pressure Sore Risk documented a Braden Score of 11 that indicated Resident #30 was at a high risk for development of a pressure ulcer. Review of Resident #30's EHR dated 12/23/25 at 1:22 PM entered by Staff P titled, Wound Evaluation documented a minutes old in-house acquired unstageable pressure ulcer on the sacrum that had an area of 1.88 cm2, length of 1.91 cm, and width of 1.31 cm. Review of fax dated 12/23/25 at 3:50 PM from nurse practitioner documented an order for high calorie protein supplement for wound twice a day to promote wound healing, an order to cleanse right buttocks with wound cleanser, pat dry apply Santyl ointment daily until healed for wound care, an order to cleanse left buttocks with wound cleanser, pat dry apply Santyl ointment daily until healed for wound care and consult wound care. Review of Resident #30's EHR dated 12/29/25 titled, Skin Check documented a pressure injury on sacrum and coccyx with no measurements or description. On 1/21/26 at 1:51 PM J, RN stated he had provided care to Resident #30 primarily Staff MM worked with Resident #30 but he worked on Resident #30 on Staff MM's days off. Staff J acknowledged the skin assessment for the UDA with admissions and discharges they are left over due at times. Staff J stated next thing you know there are 40 assessments needed to be completed. Staff J stated then you are in a hurry to complete them. Staff J stated during those times he might have just taken the report from the CNA that the wound had not changed. Staff J stated the wound was probably present on 12/22/25 when he completed the skin check. Staff J stated the wound on Resident #30 did not appear to be new on the 12/23/25 assessment. Staff J acknowledged the area should have been discovered prior to becoming an unstageable pressure ulcer. On 1/26/26 at 11:35 AM Staff H, MDS Coordinator stated she was familiar with Resident #30. Staff H acknowledged there was no care plan update with unstageable skin found 12/23/25 and would have updated interventions as well. Staff H stated the skin assessment completed for Resident #30 on 12/22/25 does not indicate there are any skin concerns. Staff H stated the wound found on 12/23/25 on Resident #30 was very unlikely to have developed overnight. Staff H stated there would have had to have been a breakdown in several areas of resident care for that to have developed on Resident (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	#30 overnight. On 1/14/26 at 7:39 AM Staff M, Licensed Practical Nurse (LPN) stated she had cared for Resident #30. Staff M stated she had reported an injury of unknown origin, a bruise to the forehead. Staff M stated 1/4/26 she went into Resident #30's room at 7:00 AM or 7:30 AM. Staff M stated Resident #30 had a scratch on the right side of her forehead. Staff M explained Resident #30 reported she had hit the table and also said she did not know what had happened. Staff M stated that afternoon when she was going to document that the injury and Resident #30's daughter came to the nursing desk. Staff M stated the area on Resident #30 had become a hematoma. Staff M acknowledged she started neuro checks and notified the doctor at that time. Staff M stated Resident #30's daughter notified a CNA and the CNA told her that Resident #30's daughter would like to talk to her. Staff M stated she entered Resident #30's room and the area was no longer a red mark. Staff M stated the area on the right side of her forehead was swollen. Staff M stated it looked like a goose egg and had started bruising. Staff M stated she called the on call provider at that time and he asked if the neuro had been started and if there was any altered mental status. Staff M reported Resident #30 was at her baseline. Staff M stated the daughter was at the facility late morning. Staff M stated she was going to call Resident #30's daughter and the physician but had not at that time. Staff M stated Resident #30 initially reported she hit her head on the table and then said she had fallen in her bathroom and daughter assisted her in getting to her bed. Staff M stated Resident #30's daughter said she did not assist Resident #30 to get up. Staff M reported it did not look like Resident #30 had hit her head there was no induration or swelling. Staff M stated Resident #30 was a poor historian. Staff M stated they did do an initial set of vitals when the red mark was found. Staff M explained she did an assessment at the same time when she was completing her daily assessment. Staff M stated the red area was documented in the daily assessment. Staff M stated she did not know if there was a procedure for injury of unknown origin. Staff M stated she was not aware of any procedure for injury of unknown origins with injury to the head or witness / unwitnessed head injury. Staff M stated Resident #30 was wearing pants and it was difficult for her to get up and would often get agitated if the staff tried to move her. Staff M stated she did not remove Resident #30's clothes. Staff M explained she pulled Resident #30's pant legs up but did not assess the hips or buttocks. Staff M stated Resident #30 was being transferred to the ER the next day and the daughter wanted her to be seen the next day based on the general decline of the resident. Staff M acknowledged she did not initiate neuro assessments when the injury was found on the head that morning. On 1/20/26 at 1:05 PM Resident #30's Daughter / Power of Attorney (POA) stated she walked into the facility around 12:30 PM or 1:00 PM on 1/4/26. Resident #30's Daughter / POA stated she found Resident #30 with a bruise on her knee and a wound on the right side of her head. Resident #30's Daughter / POA stated her mother said she fell in the bathroom that morning. Resident #30's Daughter / POA stated the staff said her mother told them she leaned forward toward the table and hit her head. Resident #30's Daughter / POA stated she was told the staff had used a full body mechanical lift on her and possibly bumped her head. Resident #30's Daughter / POA stated she was then told her mother was combative on Saturday night and might have bumped her head. Resident #30's Daughter / POA stated she asked where the knee bruise came from. Resident #30's Daughter / POA stated she came to the facility the next day and told the DON she wanted her mother sent to the hospital. Resident #30's Daughter / POA once at the hospital there was a huge bruise noticed on Resident #30 right hip and sent a picture to the DON. Resident #30's Daughter / POA was told they would have to look into the bruise. Resident #30's Daughter / POA stated Resident #30's right shoulder blade had a huge bruise on it as well when she was rolled over in the Emergency Department (ED) where both bruises were noted. Resident #30's Daughter / POA stated the goose egg was very large on the right side of Resident #30 head. Resident #30's Daughter / POA stated the bruising was not brought to her (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attention at all until seen in the ED. Resident #30's Daughter / POA stated the DON stated the bruising could have happened when transferred to hospital. On 1/14/26 at 1:51 PM MM, RN acknowledged she cared for Resident #29. Staff MM stated she notified Staff P of the change in condition of the wound. Staff MM stated she notified the nurse practitioner of the change of condition for Resident #29's wound on her buttocks. Staff MM stated she was off for a while and 12/23/25 was her first day back. Staff MM stated the wound had gotten larger and was open. Staff MM stated this was noticed and she notified Staff P wound nurse / interim DON. Staff MM stated the wound was still a stage 2 at that time but was larger. Staff MM stated there was no eschar present at that time. Staff MM stated the wound had worsened but was not showing signs of infection. Staff MM stated the treatment did not change at that time. Staff MM stated Staff P was supposed to take the picture that day. Staff MM stated she notified the nurse practitioner as well about the change in condition. Staff MM stated Resident #30 had a deterioration in the wound. On 1/12/26 at 1:09 PM the DON stated Resident #29 had an unstageable pressure ulcer on her sacrum. The DON explained Resident #29 had entered the facility on 11/11/25 and the wound must have been facility acquired. The DON acknowledged Resident #29's wound was not on the admission. The DON explained the first photograph of the wound was taken on 11/28/25. The DON stated the area on Resident #29 was on the gluteal fold or sacral area. The DON acknowledged the wound on Resident #29's sacral area had declined. The DON acknowledged the facility did not complete assessments with pictures, measurements, or description of the wound from 12/16/25 - 1/3/26. The DON acknowledged Resident #29's wound had deteriorated. The DON stated Resident #30 went to the hospital on 1/5/26. Resident #30 stated Resident #30 did have a wound. The DON explained Resident #30's wound was also on her buttocks. The DON stated the area was a facility acquired. On 1/20/26 at 4:32 PM the DON stated there was an injury of unknown origins that had happened to Resident #30. The DON explained the facility had completed an investigation and determined the injury was no longer of unknown origins. The DON stated that Resident #30 had a red area on the right side of her forehead at approximately 7:30 AM on 1/4/26. The DON explained Staff M notified her, an assessment was completed, and the physician was notified. The DON stated she asked Staff M if Resident #30 was on a blood thinner and Staff M told her no. The DON explained she would have only started neuro assessments if the resident was on a blood thinner and had an injury to the head of unknown origins or a change in cognition. The DON explained a neuro assessment was also completed. The DON stated Resident #30's daughter was notified. The DON stated Resident #30's daughter had come to the facility later in the afternoon and asked about the area on Resident #30 forehead as it was now a raised area. The DON stated Resident #30's daughter must have forgotten about the earlier notification. The DON stated the raised area was only there for about a day and had decreased and was almost gone the next day. The DON stated there was no other injuries to Resident #30 from the incident. The DON stated she completed an investigation and interviewed the staff. The DON explained the staff had stated Resident #30 did have a shower the day prior but had not fallen. The DON stated Resident #30 was aggressive and combative the night prior. The DON explained Resident #30 had kicked an employee in the groin and hit an employee. The DON stated Resident #30 stated she had hit her head on the bedside table on the morning of 1/4/26. The DON stated Resident #30's cognition was enough that she felt that is where the injury had come from. The DON explained the injury probably occurred from the aggression and combativeness of the evening before. The DON explained the staff had not notified the physician or family appropriately and some writes came from that incident. The DON stated she would have expected the staff would have notified the DON at 7:30 AM on the day the injury was found when the injury was found and the staff did not. The DON stated she expected the nurse would have notified the physician of the area on the head at 7:30 AM when it (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was found as well and that was not completed. The DON stated she would have expected the family of Resident #30 would have been notified of the injury as well at 7:30 when the injury was noticed. The DON stated neuro assessments should have been initiated when the area was found on Resident #30 forehead at 7:30 AM and the neuro assessments were not initiated. Review of Resident #30's EHR dated 1/4/26 titled, Neurological Assessment Flow Sheet documented neurological assessments were not started at 6:00 PM on 1/4/26. Review of Resident #30's EHR dated 1/4/26 at 7:49 PM titled, Skilled Note entered by Staff M documented Resident #30 had a hematoma to the right side of the forehead. On call provider made aware, DON made aware, Resident #30's daughter in and aware. Review of Resident #30's document dated 1/4/26 at 7:27 PM titled Fax documented physician notification that Resident #30 had a 3 cm x 2.5 cm hematoma to the right forehead of unknown origin. On 1/4/26 evening propranolol was held due to b/p 102/50 and pulse of 53. Called to inform the on call provider with no return call at this time. On 1/13/25 at 11:29 AM the Nurse Practitioner stated she was not notified that Resident #29 had returned and currently had strict orders for 2 hour repositioning. The Nurse Practitioner stated just seen Resident #29 and the CNA had told her Resident #29 was not adequately turned last night. The Nurse Practitioner stated she was shown the picture of the wound on 12/16/25. The Nurse Practitioner stated she did not hear anything again until the week of Christmas. The Nurse Practitioner stated she received a text from Staff MM reporting the		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observations, resident interviews, and staff interviews the facility failed to provide the residents with a comfortable / clean homelike environment by resident rooms found with various debris on the floor and failed to ensure resident's personal property was protected from loss or theft no personal inventory sheet was completed upon entry to the facility for 4 of 12 residents reviewed (Resident #15, #30, #38 and #11). The facility reported a census of 28 residents. Findings include:1. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:49 AM Resident #15 stated that Staff Y, Certified Nurse Assistant (CNA) was going through her bag of personal belongings with Staff EE, CNA present in the room. Resident #15 stated she told Staff J about the incident. On 1/20/26 at 11:52 AM Resident #15 stated she had 4 pairs of pants that were \$25 or \$30 apiece and only had 2 left. Resident #15 explained she was missing several shirts as well. Resident #15 stated she had told everyone that would listen. On 1/20/26 at 12:04 PM Resident #15 stated she had only had her bathroom cleaned twice since she had been at the facility. Resident #15 stated that she was the only person who had ever cleaned the bathroom. Resident #15 stated there was a bandage on the floor and the toilet had feces all over it. Resident #15 stated she had told several staff about the bathroom and the bathroom still had not been cleaned. Resident #15 stated he had not seen anyone come into her room, clean or sweep the floor. Resident #15 stated that debris on the floor was popcorn and had been on the floor since last week. On 1/20/26 at 12:08 PM an observation in Resident #15's room revealed a bandage on the floor, toilet had brown splatter all over the riser and white debris on the floor under the bedside table. On 1/21/26 at 8:32 AM an observation in Resident #15's room revealed a bandage on the floor, toilet had brown splatter all over the riser and white debris on the floor under the bedside table. Observation revealed the same concerns as 1/20/26. Review of Resident #15's (Electronic Health Record) EHR revealed no personal property list. Review of Resident #15's EHR dated 1/5/26 documented by Staff A, Registered Nurse (RN) at 2:48 PM documented an inventory list was completed and there were personal items present. On 1/21/26 at 7:43 AM Staff J, RN stated Resident #15 had voiced concerns to him. Staff J stated Resident #15 told him yesterday that she was missing a couple pairs of pants and some shirts. Staff J stated Resident #15 got all the pants back yesterday and is currently missing a shirt. Staff J stated Resident #15 briefly mentioned staff going through her personal belongings. Staff J acknowledged there are certain people Resident #15 is hesitant in allowing to go in her room. Staff J stated those people are the girls on the overnight. Staff J stated he discussed with Resident #15 about discussing with the overnight nurse about staff going through her personal belongings right away. Staff J stated staff going through Resident #15's stuff had been brought up to management. On 1/21/26 7:52 AM Staff R, CNA stated Resident #15 had voiced concerns to her about Staff Y, CNA (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	rummaging through her stuff about a week ago on overnights. Staff R stated she told that to the Staff EE, CNA that was working overnights. Staff R stated she told Staff EE that she needed to stop bringing Staff Y, CNA in Resident #15's room because she was going through Resident #15 stuff. Staff R stated she told Staff J and Staff GG, LPN about the incident. Staff R stated she did not inform any of the management of the incident. Staff R stated Resident #15 told her that she was missing a shirt and pants. Staff R stated laundry came and she had not heard anything else about the incident. On 1/21/26 at 10:45 AM Staff NN, Laundry stated if a missing item is reported she takes down what they are missing and she tells Staff OO, Laundry. Staff NN stated if she can not find the missing item she will pass the concern onto Staff OO because she is the staff that delivers the clothing to the residents. Staff NN stated she used to fill out resident grievance forms but since the new company had taken over she had not filled out any grievances for the residents that report missing items. Staff NN stated she does not know what the process was for the current facility owners. Staff NN stated she had not been in-serviced on what the procedure was. Staff NN stated she had not been notified of where a resident grievance form was because she does not know. Staff NN stated if she was supposed to have the forms the laundry department does not have them for sure. Staff NN stated sometimes missing items never make it to her department because the nurses and CNA's don't tell them. Staff NN stated when the laundry was delivered that was when the resident told them. On 1/22/26 at 7:50 AM Staff OO stated she had residents complain about missing items. Staff OO stated there was a problem that many clothes come without names to the laundry department. Staff OO stated it was difficult to know who the clothes belonged to. Staff OO stated when she gets time she will take the rack around to find out if the clothes are the residents that reported missing clothes. Staff OO stated the residents' family will make complaints and ask for missing items of clothing. Staff OO stated there is a section for lost and found. Staff OO stated the residents will report to the CNA's the items are missing but the CNA's do not pass it on to the laundry. Staff OO stated she frequently finds out the CNA's have been notified but never told them. Staff OO stated when a resident comes into the facility she does not know who is supposed to label the clothes. Staff OO stated when residents leave she will bring the missing clothes to the social services staff. Staff OO stated she was not aware of what a resident grievance form was. Staff OO stated she was not informed of any form to fill out for missing items or resident concerns. Staff OO stated Resident #15 had mentioned she was still missing a shirt. On 1/21/26 at 7:26 AM Staff P, Assistant Director of Nursing stated Resident #15 did not report any missing items but did say something was missing from her shoe. Staff P stated Resident #15 had never reported anyone going through her personal belongings. On 1/27/26 at 11:03 AM the DON stated she expected grievances would be completed when residents reported any concerns and that was not being completed appropriately at the facility. The DON acknowledged she did not know if a grievance had been filled out for Resident #15's missing shirt yet. The DON explained she did not know what the process was, if the missing items would be replaced and how many days that would take. On 1/21/26 at 4:45 PM the DON acknowledged there was no personal property list for Resident #15. The DON stated she expected a personal property list would be completed upon admission and updated with any items that were brought to the facility and not on the list already. 2. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/20/26 at 1:05 PM the daughter of Resident #30 stated she did not know if housekeeping did any cleaning in her mother's room. The daughter of Resident #30 stated the room would look the same for several days with the stuff left that should have been thrown away. Review of Resident #30's document dated 12/29/25 titled, Grievance Form documented Resident #30's daughter stated the floor was dirty, no trash can liners, no paper towels in the bathroom and house keeping needed to do better. The investigation was on 12/29/25 Staff N, Interim Director of Social Services had a conversation with daughter about the housekeeping issues. The daughter let Staff N know that the floor had been dirty, there were no trash can liners and no paper towels. The findings describing the concerns were reviewed with the housekeeping supervisor. Staff Z, Housekeeping Supervisor said he would get a hold of the housekeeper to go double check. Actions taken were to complete a daily check on the room to make sure everything is cleaned and stocked. Review of Resident #30's document dated 1/5/26 titled, Grievance Form documented Resident #30's daughter stated there was a lack of communication, housekeeping issues and nursing issues. Resident #30's daughter stated there was a lack of communication to the family. Resident #30's daughter requested all medical records and reported housekeeping issues. Findings indicated Staff N spoke with ADON and CEO, obtained all medical records, made a staff plan, talked to Staff Z about lack of hand towels. Staff Z let Staff N know he would check on it. Actions that were taken indicated daily checks on room to make sure it was clean, staff education, all medical records given to Resident #30's daughter. 3. The MDS dated [DATE] documented Resident #38 had a BIMS of 15 indicating no cognitive impairment. Review of Resident #38's EHR documented Resident #38 resided in room [ROOM NUMBER]. On 1/20/26 at 12:49 PM observation of copious amounts of white debris on the floor between the bed and recliner. On 1/21/26 at 8:31 AM observation of copious amounts of white debris on the floor between the bed and recliner similar debris as yesterday. On 1/21/26 at 7:52 AM Staff R, CNA stated she had spoken to the housekeeper about cleaning room number #7 and it never gets done. Staff R stated Resident #38's room was a mess and still looks the same today. Staff R stated that Resident #38's room has been looking like that since the previous weekend. Staff R stated housekeeping does not clean the rooms daily and does not know what the schedule is. Staff R stated these rooms on the skilled hall definitely had not been cleaned since before the weekend. On 1/21/26 at 12:00 PM Staff AA, CNA stated the facility needed better housekeeping. Staff AA stated the residents' rooms are gross and had never seen them swept or cleaned. On 1/21/26 at 10:29 AM Staff PP, Housekeeping stated she worked every other weekend opposite Staff QQ, Housekeeping. Staff PP stated housekeeping were expected to clean the residents' rooms every day. Staff PP stated high contact areas are cleaned every day. Staff PP stated bathrooms are swept every day and toilets are cleaned every day. Staff PP stated during the week the two of them work together. Staff PP stated she felt there was enough staff to complete all the tasks. Staff PP stated the housekeeping staff have enough time that at times the housekeeping staff are still looking (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for stuff to do once they have completed their tasks. Staff PP stated housekeeping staff work at 7:00 AM and clean the rooms only once a day. Staff PP stated at times when she comes in the morning she wonders what happened because the room is dirty again. On 1/21/26 at 10:29 AM Staff QQ stated she worked every other weekend opposite Staff PP. Staff QQ stated housekeeping staff did the deep cleans last weekend. Staff QQ stated she did a couple of the resident rooms this last weekend. Staff QQ stated the housekeeping staff are expected to clean the residents' rooms every day. Staff QQ stated high contact areas are cleaned every day. Staff QQ stated bathrooms are swept every day and toilets are cleaned every day. Staff QQ stated during the week the two of them work together. Staff QQ stated she felt there was enough staff to complete all the tasks. Staff QQ stated they have enough time to complete all the tasks and at times they are still looking for stuff to do once they have completed their tasks. Staff QQ acknowledged the residents' rooms are not cleaned daily. On 1/21/26 at 10:20 AM the Assistant Director of Nursing (ADON) stated staff had brought concerns about not replacing garbage can liners and such to her attention but had not heard any concerns about the rooms being dirty. On 1/21/26 at 10:15 AM the Director of Nursing (DON) stated she expected resident rooms would be cleaned daily. The DON stated housekeeping staff were not available on the weekends but expected light housekeeping would be completed by CNA's when time allowed. On 1/29/26 at 8:11 AM the Administrator sent an email that documented no policy for environmental cleanliness. 4. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Interview 1/20/26 at 10:37 AM with Resident #11 revealed his reading glasses went missing, and nobody can find them. Resident #11 further revealed they had been missing a week now. Resident #11 then revealed that he reported this to the nurse. Follow up interview 1/21/26 at 4:23 PM with Resident #11 revealed that he did have glasses, and that he reported this to the DON. Review of the inventory list revealed there was no inventory list of personal items to review. Interview 1/21/26 at 4:45 PM with the DON revealed that the facility staff had not found the inventory list, and that she did not recall Resident #11 telling her that his glasses were gone. The DON then revealed that glasses would definitely be on the inventory list. Interview 1/21/26 at 4:45 PM with the Administrator revealed glasses would be part of the personal items list.		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident council meeting, resident interview, staff interviews, document review and policy review the facility failed to document grievances when residents voiced concerns, educated staff on where grievance forms could be found and when to fill grievance forms out, make prompt efforts to resolve grievances the resident may have and have grievance forms available for staff, residents and resident family members to complete for 2 of 2 residents reviewed (Resident #15 and #29). The facility reported a census of 28 residents. Findings include: On 1/27/26 at 10:25 AM at the Resident Council meeting, the residents present stated they were unaware of what grievances were, where to locate a grievance form, how to file a grievance and if the facility responded to grievances. 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:49 AM Resident #15 stated on 1/12/26 she sat in soiled urine and feces from 3:00 AM - 6:00 AM. Resident #15 explained she was told she could not get out of bed on her own. Resident #15 stated she had turned her call light on several times during that night. Resident #15 stated the staff do not take her to the bathroom on the overnight shift. Resident #15 stated she had talked to everyone about the concern, especially Staff P Registered Nurse (RN) / Assistant Director of Nursing (ADON). Resident #15 stated she told Staff P about the sore on her foot and she did nothing about it. Resident #15 stated Staff J, RN was the nurse that finally did something about it. Resident #15 stated Staff EE, Certified Nurse Assistant (CNA) was working with Staff Y, CNA and Staff Y refused to wear gloves to clean her up after she used the toilet. Resident #15 stated that Staff Y was going through her bag of personal belongings. Resident #15 stated she told Staff J about the incident. On 1/20/26 at 11:52 AM Resident #15 stated she had 4 pairs of pants that were \$25 or \$30 apiece and only had 2 left. Resident #15 stated she was also missing several shirts. Resident #15 stated she had told everyone that would listen about the missing items. Review of resident grievances provided by the facility documented no grievances from Resident #15. On 1/21/26 at 7:26 AM Staff P stated Resident #15 did not report any missing items but did say something was missing from her shoe. Staff P stated Resident #15 had never reported any staff going through her personal belongings. On 1/21/26 at 7:43 AM Staff J, RN stated Resident #15 had voiced concerns to him. Staff J stated Resident #15 told him yesterday that she was missing a couple pairs of pants and some shirts. Staff J stated Resident #15 got all the pants back yesterday and was currently missing a shirt. Staff J stated Resident #15 briefly mentioned staff going through her personal belongings. Staff J stated she knows there are certain people Resident #15 was hesitant to allow going into her room. Staff J stated those people are the girls on the overnight staff. Staff J stated Resident #15 had not mentioned that the overnight staff would not take her to the bathroom. Staff J stated he did not write a grievance for Resident #15 because they found the pants. Staff J stated he talked to Resident #15 about discussing with the overnight nurse about staff going through her stuff. Staff J stated staff going through Resident #15's stuff had been brought up to management. On 1/21/26 at 7:52 AM Staff R, CNA stated Resident #15 had voiced concerns to her about Staff Y, (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	around Resident #29's bed pad that appeared to be indicative of not checking or changing but did know Resident #29 had been repositioned. Staff A stated she assisted Staff R with repositioning Resident #29 that morning. On 1/22/26 at 2:06 PM Staff R stated when she came in at 6:00 AM on 1/22/26 and Resident #29 stated she had asked to be changed because she had some urine incontinence on the overnight shift. Staff R stated Resident #29 explained Staff EE said there was no brief to change her with. Staff R stated Resident #29 told her that she told Staff EE that she was a 3XL brief. Staff R reported Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff R said Resident #29 told her Staff EE refused to change her. Staff R reported Resident #29's brief was saturated when she provided care that morning. Staff R stated she reported the concern to Staff J, RN. On 1/22/26 at 2:10 PM Staff J stated Staff R had informed him Resident #29 reported she had not been changed on the overnight shift. Staff R stated Resident #29 stated she had asked to be changed because she had incontinence. Staff J stated Resident #29 stated Staff EE said there was no brief to change her with. Staff J stated Resident #29 told Staff EE that she was a 3xl brief. Staff J stated Resident #29 said Staff EE told her that she would not get her another brief, reapplied the brief in the front, walked out of the room and did not return the rest of the night. Staff J said Resident #29 told her Staff EE refused to change her brief. On 1/21/26 at 10:48 AM an observation of a sign on a table near the entrance of the facility that documented the facility grievance policy with the previous DON's phone number and email address also documenting grievance forms can be found at each nursing desk and at the front entrance. No grievances forms available at that table. On 1/21/26 at 10:53 AM Staff A, RN stated she does not know where to find any grievance forms if a resident had any concerns. On 1/21/26 at 10:57 AM Staff R, CNA stated she does not know where resident grievance forms would be located. Staff R stated she could find out though. On 1/21/26 at 10:57 AM Staff J, RN stated if a resident had a grievance he would direct the resident to the social services office. Staff J stated he would fill the grievance form out for the resident after getting the form social services. Staff J stated he thought there were grievance forms in a drawer at the nursing station. Staff J searched for grievance forms. Staff J explained there were no grievance forms available at the nursing desk. On 1/21/26 at 10:59 AM Staff H, Licensed Practical Nurse (LPN) / MDS Coordinator / Infection Preventionist (IP) stated if a resident had a grievance she would direct the resident to the social services office. Staff H stated she would fill the grievance form out for the resident after getting the form social services. On 1/21/26 at 11:40 AM the Director of Nursing (DON) stated she would ask the social worker where the grievance forms were and thought they were in her office but did not know where else the residents or residents family could find the forms. On 1/21/26 at 11:45AM the Assistant Director of Nursing (ADON) stated she would ask the social worker where the grievance forms were and thought they were in her office but did not know where (continued on next page)		

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	else the residents or residents family could find the forms. On 1/21/26 at 11:48 AM an observation of a sign on a table near the entrance of the facility that documented the facility grievance policy with the previous DON's phone number and email address also documenting grievance forms can be found at each nursing desk and at the front entrance. No grievances forms available at that table. On 1/21/26 at 11:50 AM the Administrator stated he was not sure where the grievance forms were available for the residents or the resident family members. The Administrator stated he would assume they would be located on the other side of the building where the residents were but was unaware of where the grievance forms were located. The Administrator acknowledged the sign documented grievance forms available at the front entrance and at each nursing desk. The Administrator acknowledged grievance forms were not available. Review of undated policy titled, Grievances / Complaints, Recording and Investigation documented all grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). The Administrator has assigned the responsibility of investigating grievances and complaints to the Grievance Officer. Upon receiving a grievance and complaint report, the Grievance Officer will begin an investigation into the allegations. The department director(s) of any named employee(s) will be notified of the nature of the complaint and that an investigation is underway. The investigation and report will include, as applicable: The date and time of the alleged incident. The circumstances surrounding the alleged incident. The location of the alleged incident. The names of any witnesses and their accounts of the alleged incident. The resident's account of the alleged incident. The employee's account of the alleged incident. Accounts of any other individuals involved (i.e., employee's supervisor, etc.); and Recommendations for corrective action. The Grievance Officer will record and maintain all grievances and complaints on the Resident Grievance Complaint Log. The following information will be recorded and maintained in the log: the date the grievance/complaint was received. The name and room number of the resident filing the grievance/complaint (if available); the name and relationship of the person filing the grievance/complaint on behalf of the resident (if available); the date the alleged incident took place. The name of the person(s) investigating the incident. The date the resident, or interested party, was informed of the findings; and the disposition of the grievance (i.e., resolved, dispute, etc.). The Resident Grievance/Complaint Investigation Report Form will be filed with the Administrator within five (5) working days of the incident. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten business days of the filing of the grievance or complaint. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. A copy of the Resident Grievance/Complaint Investigation Report Form must be attached to the Resident Grievance/Complaint Form and filed in the business office. Copies of all reports must be signed and will be made available to the resident or person acting on behalf of the resident. Review of undated policy titled, Resident Rights documented Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to retain and use personal possessions to the maximum extent space and safety permits; privacy and confidentiality; voice grievances to the facility, or other agency that hears grievances, without discrimination or reprisal and without fear of discrimination or reprisal and have the facility respond to their grievances.		

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F 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on personnel file review, staff interviews and policy review the facility failed to perform further background checks clearing an employee for hire that was on probation for exploitation. The facility reported a census of 28 residents. Findings include:Review of Staff A's Registered Nurse (RN) employee file revealed the following:Hired date of 9/8/2025;Single Contact License and Background Check completed on 9/4/2025 at 2:36 PM;Background Check showed further research under the criminal history section;QuickConfirm License Verification Report dated 9/4/2025 at 2:53 PM showed her RN license was on probation-RN privilege adverse action by Nebraska;QuickConfirm License Verification Report documented on 10/30/2024 action was taken against Staff's Nebraska nursing license; against privilege to practice-yesQuickConfirm License Verification Report documented Staff A was on probation from 4/18/2025-4/18/2027 in Iowa for error in prescribing, dispensing or administering medication or sedation, against privilege to practice-noStaff A's employee file did not contain further research documentation to confirm whether or not she could work at the facility.On 1/30/2026 at 8:05 AM the Administrator stated after speaking with corporate office, they learned the background check company can only go back 30 days after a background check has been completed. In order to resubmit for it to be completed again they would need Staff A to complete the paperwork and she is no longer employed at the facility. The facility provided a document titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives:4. Conduct employee background checks and not knowingly employ or otherwise engage any individual who has:a. been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law;b. had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; orc. 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.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on personnel file review, policy review, document review, and staff interviews the facility failed to implement the abuse and neglect policy by not completing background checks prior to staff employment. The facility also failed to implement their abuse policies when staff reported concerns about a staff member and complete further research when Staff A's background check suggested one be completed. The facility reported a census of 28 residents. Findings include: Review of Staff A's Registered Nurse (RN) employee file revealed the following: a) hired date of [DATE]; b) Single Contact License and Background Check completed on [DATE] at 2:36 PM; c) Background Check showed further research under the criminal history section; d) QuickConfirm License Verification Report dated [DATE] at 2:53 PM showed her RN license was on probation-RN privilege adverse action by Nebraska; e) QuickConfirm License Verification Report documented on [DATE] action was taken against Staff's Nebraska nursing license; against privilege to practice-yes f) QuickConfirm License Verification Report documented Staff A was on probation from [DATE]-[DATE] in Iowa for error in prescribing, dispensing or administering medication or sedation, against privilege to practice-no. Staff A's employee file did not contain further research documentation to confirm whether or not she could work at the facility. On [DATE] at 8:05 AM the Administrator stated after speaking with corporate office, they learned the background check company can only go back 30 days after a background check has been completed. In order to resubmit for it the be completed again they would need Staff A to complete the paperwork and she is no longer employed at the facility. On [DATE] at 12:27 PM Staff D Certified Medication Aide (CMA) stated there was an issue about a month ago when Resident #3 had her call light on and asked for something for pain. Staff D saw she got something 30 minutes prior and let her know she already had something for pain. Resident #3 denied receiving any pain medications with her morning medications. Staff D stated when Resident #3 has pain, she will ask her what she wants. Resident #3 will request Tylenol. Staff D stated Staff A is the only staff member that signs out Resident #3's oxycodone as given. Staff D stated Resident #3 would be reliable, could rate her pain on the pain scale and would be able to tell staff which pain medication she wants. She believed Resident #3 would be a good historian. Staff D stated about two weeks prior to the surveyors coming in to the building, she had passed medications on both Long-Term Care and Skilled residents. Staff A approached her wanting the keys for the medication room on the skilled side. Staff A did labs and just assumed that's why she was asking for the medication room key. Staff D needed to start her medication pass so she went to the medication room, knocked on the door to get her keys back. She saw Staff A had the skilled side tool box that had narcotics in it. Staff A stated Resident #20 wanted something for pain. She had pulled oxycodone from the box. She reported this to the ADON the day it happened, [DATE]. She also wrote a (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	statement about this issue and put it in the Administrator's office and now the Director of Nursing (DON) has the statement. These kinds of concerns had been reported so many times. There were suspicions of Staff A being the only nursing signing out Resident #1's PRN oxycodone, back dating the time when she would sign out narcotics on days she came in late. She would sign out the narcotics when she was not even in the building at that time. On [DATE] at 12:47 PM Staff J RN stated on the first day he trained Staff A she was to start at 6:00 AM but she did not show up until about 6:45 AM. He asked what she was comfortable with and she stated she worked on the Skilled side a few times but she knew how to use their Electronic Health Record (EHR). They decided she could pass medication on Long-Term Care Hall and he would help the other staff and her when they needed help. He stated there was a 15-minute window when he was not around her while she passed medications. Staff A started with Resident #3 but he was not sure if it was the day they changed her wound vac or not. Staff A signed out in the narcotic book that she had administered Resident #3's oxycodone but she never got in the drawer in the medication cart to get the medication out. From that point he did not leave her alone. He watched her whole medication pass and any time there was a schedule medication given other than a narcotic, Staff A would get in the narcotic drawer but when it was a PRN oxycodone, she did not get in the narcotic drawer. When asked if she said anything to her, he stated he did not, it was not his place. He felt this was to be handled by management. He stated he let the on-call person know his concerns via text. On [DATE] at 7:40 AM he sent a text to the Staff O Scheduler/CNA/CMA who was on call. He sent, I don't know about this nurse. Staff O replied, I know. Staff J then sent, like I'm watching her like a hawk and there's some questionable things happening. I won't let her out of my sight so she can't lie, but someone needs to come double check that I am not crazy so she can't say I set her up. Staff O said, I understand completely. Staff J then sent, it's nothing on you, I just feel like I can't leave her to do anything alone. He stated no one from management talked to him about his concerns. Later that day, he noticed Staff A had back charted when she gave residents their oxycodone. She did not get in to work until about 6:45 AM that day and she was signing out medications as being given at 6:15 AM. On [DATE] at 8:55 AM the Scheduler stated when she received that text on [DATE] she stated staff are always saying stuff about new staff when they first start. She felt it was a personnel issue, did not think too much of it. On [DATE] at 11:02 AM the ADON acknowledged she did not look in to the concerns about Staff A further when Staff D came to her. On [DATE] at 12:10 PM the DON stated in regards to the concerns brought to the ADON's attention from Staff D, she was informed they investigated the time the medication was signed out but nothing further. When the resident stated she did not receive the medication that Staff A pulled, but was later found on the medication cart next to her cup; this should have been looked in to further as well. She indicated she was just informed that Staff J had notified the Scheduler via text message his concerns with Staff A during her training shifts. She acknowledged this should have been looked into further. The DON indicated she was not aware of the note Staff DD had sent to the HR department. When the DON completed the self report in regards to Staff A signing out Resident #3's oxycodone as given but the resident denied receiving the medication, she only interviewed Resident #3. The other residents where they found concerns on their count sheets were not interviewed based on their low BIMs scores, were deceased , or discharged . She felt someone from the State Agency would be here to complete an investigation. She denied interviewing staff members as well. While completing a narcotic check they noted Resident #32 was missing 3 milliliters (mL) of hydromorphone after Staff A had signed it out as being given. She denied an investigation was completed. (continued on next page)		

Department of Health & Human Services
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of document dated [DATE] titled, Single Contact License and Background Check documented Staff Y, Certified Nurse Assistant (CNA) had her background check completed on [DATE]. Review of undated document titled, List of New Hires Since Last Annual Survey documented Staff Y had a start date of [DATE]. Review of document dated [DATE] titled, Single Contact License and Background Check documented Staff A, Registered Nurse (RN) had her background check completed on [DATE]. Review of undated document titled, List of New Hires Since Last Annual Survey documented Staff A had a start date of [DATE]. Review of Staff R, CNA Personnel file revealed no Mandatory Reporter / Dependent Adult Abuse training or Single Contact License and Background Check completed. Review of undated document titled, List of New Hires Since Last Annual Survey documented Staff R had a start date of [DATE]. An email sent by the Administrator at 1:48 PM on [DATE] documented he was unable to locate the Mandatory Reporter / Dependent Adult Abuse training or Single Contact License and Background Check for Staff R. Review of staff personnel files for Staff F, Dietary Aide, Staff S, Cook, Staff U, Cook, Staff V, Dietary Staff, Staff W, Dietary Staff and Staff X, [NAME] did not have any Single Contact License and Background Check completed. Review of undated document titled, List of New Hires Since Last Annual Survey documented a hire date for Staff F of [DATE], Staff S of [DATE], Staff U of [DATE], Staff V of [DATE], Staff W of [DATE] and Staff X of [DATE]. On [DATE] at 11:03 AM the DON stated she would like the background checks on all the staff that would be in contact with residents on file at the facility including the kitchen staff. On [DATE] at 8:53 AM the Administrator stated the kitchen staff are employed by a contract company. The Administrator stated the employees in the kitchen were supposed to have their background check completed by the company that employed them but the company sent an email that explained the staff were all hired from the previous facility's owner. The Administrator acknowledged the facility did not have background checks completed on a significant amount of the kitchen staff at the facility. The Administrator stated the contract company was rerunning the background checks currently. Review of undated policy titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program documented Residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to conduct employee background checks and not knowingly employ or otherwise engage any individual who has; been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	court of law; had a finding entered into the state nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or 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.		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility investigative file review, resident and staff interviews, and facility policy review the facility failed to complete a thorough investigation when it was reported Staff A signed out Resident #3's oxycodone but failed to administer the medication. The facility also failed to investigate concerns brought to them from staff members related to Staff A in September and December. The facility reported a census of 28 residents. Findings include: 1. According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of [DATE] documented Resident #3 had a Brief Interview of Mental Status (BIMS) score of 11. A BIMS score of 11 suggested mild cognitive impairment. Resident #3 did not receive a scheduled pain medication regimen; she did receive as needed (PRN) pain medications or was offered and declined. During the pain assessment Resident #3 did have pain at any time in the last 5 days occasionally. Resident #3 indicated the pain rarely the pain made it hard for her to sleep nor did it limit her day-to-day activities. The MDS documented Resident #3 rated her pain at a 4 out of 10 (zero being no pain and ten as the worst pain you can imagine). The MDS documented Resident #3 had received an opioid. The MDS documented the following diagnoses for Resident #3: stage 4 pressure ulcer of sacral region, renal failure, stroke, stage 4 pressure ulcer of right and left buttock. The Care Plan Focus Area with a revision date of [DATE] documented Resident #3 was on an analgesic medication therapy related to pain. The Care Plan directed staff to administer medications as ordered and monitor of adverse effects and monitor the effectiveness of medication. A second Care Plan Focus Area with a revision date of [DATE] documented Resident #3 had complaints of pain. The Care Plan directed staff to administer medications as ordered and monitor for adverse effects. Staff were directed to ask residents what non-medication pain relief methods have helped in the past and attempt to utilize these strategies and to notify the physician if pain management interventions are unsuccessful. Review of Resident #3's [DATE] Medication Administration Review (MAR) revealed the following orders:-Oxycodone (narcotic pain medication) oral tablet 10 milligrams (mg). Give one tablet by mouth every 6 hours needed (PRN) for pain. The medication was signed out being given by Staff A Registered Nurse (RN) on: a) [DATE] at 11:09 AM for a pain rating of 5; b) [DATE] at 9:40 AM for a pain rating of 5; c) [DATE] at 10:20 AM for pain rating of 7; d) [DATE] at 11:45 AM for a pain rating of 7. Review of Staff A's timecard for the [DATE] revealed on [DATE] Staff A closed out for lunch from 9:53 AM until 10:23 AM. Review of Resident #3's [DATE] MAR from 1/2 revealed the following orders:-Oxycodone (opioid to treat severe pain) oral tablet 10mg. Give one tablet by mouth every 6 hours PRN for pain. The medication was signed out has being given by Staff A on: a) [DATE] at 9:00 AM for a pain rating of 5, b) [DATE] at 10:00 AM for a pain rating of 6, c) [DATE] at 12:36 PM for a pain rating of 7, d) [DATE] at 7:27 PM for a pain rating of 6, e) [DATE] at 8:45 AM for a pain rating of 7, f) [DATE] at 9:48 AM and 9:07 PM for a pain 7 both times, g) [DATE] at 8:10 AM for a pain rating of 6 and at 8:01 PM for a pain rating of 7, h) [DATE] at 10:15 AM and 8:15 PM for a pain rating of 7, i) [DATE] at 8:50 PM for a pain rating of 7, j) [DATE] at 9:35 AM for a pain rating of 7, k) [DATE] at 8:40 AM and 8:39 PM with a pain rating of 7, l) [DATE] at 8:15 AM for a pain rating of 7, m) [DATE] at 9:50 AM and 8:50 PM with a pain rating of 7, and n) [DATE] at 8:49 AM for a pain rating of 7. Review of Staff A's timecard for [DATE] revealed the following:[DATE] she clocked out for lunch from 9:50 AM until 10:20 AM; [DATE] she clocked out for lunch from 9:48 AM until 10:18 AM; [DATE] she clocked out for lunch from 10:00 AM until 10:30 AM; [DATE] she clocked out for lunch from 9:50 AM until 10:20 AM. Record review revealed the following Progress Note: on [DATE] at 9:00 AM PRN oxycodone was given by Staff A for anticipatory pain related to a wound care clinic appointment. On [DATE] at 9:26 AM Resident #3 stated she has not requested a PRN pain medication for a long time. She stated staff will ask if she wants a PRN pain medication but she will tell them no. She added she felt staff would not give a PRN pain medication unless she asks for it. Resident #3 stated she is used to how her body feels and denied (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	requesting PRN pain medication very often. Resident #3 stated her pain was under a 5 at the time of the interview. When asked if she requested a PRN medication this morning, she denied doing so and stated she would know if the nurse gave her any extra medications. On [DATE] at 9:59 AM Staff A stated she has had interactions with Resident #3 today and had voiced concerns of pain to her this morning. Resident #3 had rated her pain at a 7 and that was when Staff A stated she asked if she wanted any pain medication this morning. Staff A stated whenever a resident has a pain level of 6 to 10, she offers a pain medication. Staff A stated she does not talk to Resident #3 a lot but she seemed okay and cognitively aware. 2. According to the admission MDS assessment tool with a reference date of [DATE], documented Resident #11 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. Resident #11 received a scheduled pain medication regimen and received a PRN pain medication or was offered and declined. The MDS documented Resident #11 had occasional pain any time in the last 5 days. Resident #11 reported he rarely had pain that made it hard for him to sleep at night and occasionally had pain that limited his participation in therapy sessions and his day-to-day activities. The MDS listed the following diagnoses for Resident #11: right femur fracture and malignant neoplasm of prostate. The Care Plan Focus Area with an initiated date of [DATE] documented Resident #11 complained of pain. The Care Plan directed staff to administer medications as ordered and monitor for adverse effects and notify the physician if pain management interventions are unsuccessful. Review of Resident #11's [DATE] MAR revealed the following order: hydrocodone-acetaminophen (treatment of pain) oral tablet 5-325mg, give one tablet by mouth every 8 hours PRN for severe pain. The order had a start date of [DATE] at 10:59 AM. The order was signed out as being given by Staff A on: a) [DATE] at 8:14 AM for a pain rating of 6, at 7:20 PM for a pain rating of 6; b) [DATE] at 8:40 PM for a pain rating of 7; c) [DATE] at 11:07 AM for a pain rating of 7 and at 7:35 PM for a pain rating of 8; d) [DATE] at 8:00 PM for a pain rating of 7; e) [DATE] at 8:00 AM for a pain rating of 7; f) [DATE] at 9:19 AM for a pain rating of 6 and at 8:22 PM for a pain rating of 7; g) [DATE] at 8:38 AM for a pain rating of 7. On [DATE] at 9:29 AM Resident #11 was lying in bed, watching TV. He stated he has pain and it's all over, it's there all the time. When he has pain, he will ask for Tylenol first but every once in a while, he will ask for something strong. When asked what that stronger medication was, he stated tramadol. Since they got the order for hydrocodone a few weeks ago, he has asked for it once but they never brought it for him. When asked if Staff A, the nurse with a boot on her foot, has ever asked if needed the hydrocodone or brought one in for him, he denied seeing her with that medication for him. He again stated he has only asked for it once but he never got it. He indicated he knows what medications he takes and would know if they put it with other medications. 3. According to the admission MDS assessment tool with a reference date of [DATE] documented Resident #32 had a BIMS score of 12. A BIMS score of 12 suggested mild cognitive impairment. The MDS documented she did not have a scheduled pain medication regimen; she did receive a PRN medication or was offered and declined it. Resident #32 reported occasional pain over the last 5 days. Resident #32 reported she rarely had pain that made it hard for her to sleep at night, limited her participation in therapy sessions, and did not limit her day-to-day activities. The MDS documented she rated her pain a 6 on a scale from 0-10. The MDS documented the following diagnoses for Resident #32: acute respiratory failure with hypoxia, atrial fibrillation, heart failure, and renal failure. The Care Plan does not address pain management. Review of Resident #32's [DATE] MAR reviewed the following order: hydromorphone (treatment of severe pain), give 0.25 milliliters (mL) by mouth every 1 hour as needed (PRN) for pain/shortness of breath; with a start date of [DATE]. Review of the order revealed Staff A signed out the medication as given on [DATE] at 8:32 AM for a pain rating of 6. Review of Resident #32's chart revealed a document titled Controlled Drug Report/Record/Disposition Form. The form was for Resident #32's hydromorphone 0.25mL order. It documented when the medication was delivered on [DATE] there was 15mL in the bottle. On [DATE] at 8:30 AM Staff A signed out she gave 0.25 mL with 14.75 mL remaining in the bottle. On [DATE] at 1:00 PM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) documented there (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was 11.75mL remaining in the bottle; 3mL missing. Review of the facility's investigative file revealed it lacked staff and resident interviews. On [DATE] at 12:27 PM Staff D Certified Medication Aide (CMA) stated there was an issue about a month ago when Resident #3 had her call light on and asked for something for pain. Staff D saw she got something 30 minutes prior and let her know she already had something for pain. Resident #3 denied receiving any pain medications with her morning medications. Staff D stated when Resident #3 has pain, she will ask her what she wants. Resident #3 will request Tylenol. Staff D stated Staff A is the only staff member that signs out Resident #3's oxycodone as given. Staff D stated Resident #3 would be reliable, could rate her pain on the pain scale and would be able to tell staff which pain medication she wants. She believed Resident #3 would be a good historian. Staff D stated about two weeks prior to the surveyors coming in to the building, she had passed medications on both Long-Term Care and Skilled residents. Staff A approached her wanting the keys for the medication room on the skilled side. Staff A did labs and just assumed that's why she was asking for the medication room key. Staff D needed to start her medication pass so she went to the medication room, knocked on the door to get her keys back. She saw Staff A had the skilled side tool box that had narcotics in it. Staff A stated Resident #20 wanted something for pain. She had pulled oxycodone from the box. These kinds of concerns had been reported so many times. There were suspicions of Staff A being the only nursing signing out Resident #1's PRN oxycodone, back dating the time when she would sign out narcotics on days she came in late. She would sign out the narcotics when she was not even in the building at that time. On [DATE] at 2:00 PM Staff Y Certified Nursing Assistant (CNA) stated in December she heard Resident #3 had asked for a pain pill and Staff A stated she was not eligible for one. The resident told her she had not had a pain pill all day. Staff Y stated she heard Resident #20 had requested a pain medication and it was signed out by Staff A as given. But the resident denied receiving the pain medication. Staff A then found the pain pill in a medication cup by her drinking cup. The ADON was made aware of this and told Staff A to give Resident #20 her pain medication. On [DATE] at 10:45 AM Staff H Licensed Practical Nurse (LPN) stated she has never given Resident #3 a PRN for pain. When she does her pain assessments, Resident #3 would say no. If she did have pain, she would rate it 5 of 6. She denied ever giving Resident #3 a oxycodone for pain. She added, she would never go with that medication first because she would be unsure how she would react to it. She would start with her Tylenol PRN. When she started to complain of left shoulder pain, they got orders for a PRN cream/gel but would always start with Tylenol when she needed/requested something for pain. On [DATE] at 12:47 PM Staff J RN stated on the first day he trained Staff A, she was passing medications on the Long-Term Care side of the building. When she went to pass Resident #3 her morning medications and Staff A signed out her oxycodone. He was not sure if it was the same day they did her wound vac change but she never took oxycodone. Resident #3 always said Tylenol was enough. That morning Staff A signed out the medication in the narcotic book but never got in the drawer on the medication cart to retrieve the medication. From that point on he did not leave her alone while passing medications. The same thing happened with Resident #1; Staff A signed out the oxycodone medication but did not see her give the medication to the resident nor did he see her get in the drawer to get the medication out. He noticed any other medication that required to be signed out in the narcotic book, she obtained the medication and administered it to the resident, except the oxycodone. Staff J stated Resident #1 was [AGE] years old and with the amount of oxycodone Staff A had signed out as being given to her, one would think that resident would be sedated but when you would assess her, she was awake and fine. On [DATE] at 10:05 AM Staff DD LPN laughed when asked if Resident #3 experienced a lot of pain. She stated no, every once in a while, but not all the time. She would usually give her Tylenol or her PRN gel if she did have pain and when she would follow up for effectiveness it would help. When she did have pain, she would report pain to her left shoulder or her neck and back some times; rating it between 3 and 6. Staff DD stated Resident #3 had not asked for anything stronger and she would always offer Tylenol first. She indicated when she would come in for her 2:00 PM-10:00 PM shift after (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff A worked, Resident #3 would ask for a Tylenol, Staff DD stated Resident #11 has scheduled Tylenol. This morning, he rated his pain at a 3 and asked him to let her know if he would need anything for pain. She denied ever giving him his hydrocodone. She has noted his pain is more when he is in bed, which is rare because he sits in his recliner a lot. There was one time when the narcotic count was off. She had Staff A call Staff P Assistant Director of Nursing (ADON) to figure it out before Staff A left the building. Staff A had them document the correct count on the narcotic count sheet. Staff DD indicated Staff A would always complain about picking up extra hours and hurting. Staff DD stated there was a letter sent to the Human Resource Staff in December. On [DATE] at 10:21 AM Staff DD shared the document she provided to the Human Resource Staff in December. It documented staff had noticed that narcotics are being given to residents multiple times a day to residents who never ask for pain medications. There have been multiple count corrections and there have never been issues with narcotics prior to their new employee. On [DATE] at 8:55 AM the Scheduler stated when she received that text on [DATE] she stated staff are always saying stuff about new staff when they first start. She felt it was a personnel issue, did not think too much of it. On [DATE] at 11:02 AM the ADON stated they noticed around November-ish that Staff A was giving Resident #1 and Resident #3 their PRN pain medications a lot. She did talk with Staff A about this; with her history, heard of her not giving those medications after signing them out. Staff A told her she is the only one that cared about the residents, when she assessed them and asked for pain medication should it give it to them. The ADON stated she believed her and she regrets it after looking at the issues deeper. While completing spot checks she would talk to Resident #3. The resident stated she would not receive a PRN all the time but acknowledged she asked a couple of times for something for pain. The ADON did not specifically ask what she requested. She just asked if she was in pain and if she received something for it; she answered yes to both questions. The ADON also spoke with Resident #1 and would ask if she was hurting. Resident #1 would say yes or no but would not recall if she received anything or not. She was looking at the narcotic book once a week and did notice Staff A gave a lot pain medication. She noticed this around November. The ADON acknowledged she did not look in to things further. She believed Staff A was giving the medications she signed out and should have looked further in to things. When asked about the concerns brought to her from Staff D she felt the concern was falsifying the time but was able to get that figured out after looking at the handwriting closer. The ADON stated she did see the medication in the medication cup that Staff A found on the medication cart next to her water bottle. She did acknowledge they are not to have medications left on the medication cart, but she watched Staff A administer the medication that was requested by the resident. It was a red flag to her that Staff A walked right passed the resident's room with the medication to set it on the medication cart. She questioned why she did not administer the medication as walked passed the resident's room, Staff A said she had to go to the bathroom. She did not look further in to this either, she took it as it was. She believed they could have handled the accusations better. On [DATE] at 12:10 PM the DON stated she started at the facility on [DATE]. The DON stated she was just alerted of Staff D's concern about pulling a pill out of the narcotic box in the medication room on the skilled hall. The DON said her understanding was they have a medication aide passing medications, so why was Staff A doing that. When she went in there Staff D did not think anything of it because Staff A would draw blood and that's where the supplies were located. When Staff D knocked on the door to get the medication cart keys back, she saw Staff A pulling a medication out of the box. The ADON pulled the keys and went to talk to the resident the medication was for. The resident stated she did not receive the pill, so she went to Staff A about this. Staff A stated it was in the medication cart, she had set the pill in a medication cup and put it in the cart drawer. When they opened the drawer on the medication cart there was no cup with a pill in it. Staff A then found the medication cup with the pill in it on top of the medication cart next to her water bottle. She immediately took the pill to the resident. After this happened, they did not let allow Staff A to hold the narcotic keys. She was told she would need to ask the other nurse or CMA if she needed (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to give a narcotic. Staff A came in to her office bawling, told her it was embarrassing that she did not have her narcotic keys. The DON stated in regards to the concerns brought to the ADON's attention from Staff D, she was informed they investigated the time the medication was signed out but nothing further. When the resident stated she did not receive the medication that Staff A pulled, but was later found on the medication cart next to her cup; this should have been looked in to further as well. At that time the DON stated she did not know about Staff A's previous issue with taking narcotics at her two previous jobs. The Administrator told her to keep an eye on Staff A, so they allowed her to have the keys back. The DON was not aware of the note that Staff DD typed up. The DON was asked to discuss the missing hydromorphone. Staff A had signed in the medication as received it at the facility. Hospice had ordered the medication for the Resident #32. Staff A had signed out the medication as being given on [DATE]; 0.25mL given. That was the only person that signed out the medication. The liquid medication came as 15mL in a bottle. There should have been 14.75mL after Staff A documented she administered 0.25mL. Staff A documented 14.75mL remained but when they did a check on all narcotics on [DATE], they noticed there was 11.75mL left; noting 3mL was missing from the bottle. The DON stated since Staff A has been out of the building Resident #3 has only been getting Tylenol for pain and has been fine. She indicated she was just informed that Staff J had notified the Scheduler via text message his concerns with Staff A during her training shifts. She acknowledged this should have been looked into further. The DON indicated she was not aware of the note Staff DD had sent to the HR department. When the DON completed the self-report in regards to Staff A signing out Resident #3's oxycodone as given but the resident denied receiving the medication, she only interviewed Resident #3. The other residents where they found concerns on their count sheets were not interviewed based on their low BIMs scores, were deceased , or discharged . She felt someone from the State Agency would be here to complete an investigation. She denied interviewing staff members as well. While completing a narcotic check they noted Resident #32 was missing 3 milliliters (mL) of hydromorphone after Staff A had signed it out as being given. She denied an investigation was completed. On [DATE] at 1:12 AM during the exit conference with the facility, the Administrator stated he was unaware of the text that was sent from Staff J to the Scheduler in September. He also stated he was unaware of the letter Staff DD sent to the Human Resource Staff. On [DATE] at 1:57 PM Staff A stated on the day she was asked to leave the facility Resident #3 told Staff D CMA that she needed something for pain on [DATE]. When she was told Resident #3 denied asking for and receiving a pain pill on [DATE] she stated the resident was confused because she asked her for a pain pill. When asked if Resident #11 ever asked for a pain medication when she worked, she stated he definitely did get pains pills when he asked for them. Staff A was asked to talk about Resident #3's pain and relief regimen. She stated the resident's pain was always moderate to severe in her shoulders or back, basically her full body; just hurt everywhere. They would try a gel to her shoulders but the resident would still complaint of pain. When asked why Tylenol was not tried first, Staff A stated if the resident's pain was rated at a 7 or above, she would give her oxycodone. Anything below that she would give Tylenol. Staff A added it got to the point where she was routinely giving Resident #3 her oxycodone. When asked what that meant, Staff A stated she would pretty much give it to her without asking. She would give pain medications prophylactically. When asked about Resident #11's pain and relief regimen she stated he had right hip and knee pain that he would rate between a 6 and 7. She indicated he received routine Tylenol was not working so she would give him his hydrocodone and it was somewhat effective. Staff A was shown the MARS for Resident #3 and #11, with her consistently signing out the medication. She acknowledged she could see that it would be concerning. Then stated the other nurses at the facility are hesitant to give the narcotics. But with her trauma background, they always gave pain medications. She again stated she gave the pain medications prophylactically, even if the residents did not ask for it. She then stated she did not do this all the time. Staff A was informed the other nurses at the facility reported Resident #3 and #11 not having enough pain for them to give them a narcotic routinely. Staff A stated everyone was (continued on next page)		

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	getting those medications prior to her starting. Staff A was also informed Resident #3 and #11 have not been receiving them since she was terminated. She stated when she worked at the trauma unit at the hospital, they always gave people pain medications. Staff A stated Resident #3 and #11 asked for their pain medications, when she was told these residents both denied asking for their pain medications as frequently as they were signed out as being given. Staff A was also informed that Resident #3 was interviewed on [DATE] roughly 40 minutes after she signed out her oxycodone as being given. Resident #3 denied asking for her oxycodone, as well as stating she never received a pain medication that morning. Staff A stated she asked for a pain pill, she gave it then the resident asked 10 minutes later for something for pain. She was confused that day and is at time. Staff A denied ever signing out a resident's narcotic medication and taking it for herself. She indicated she would never take pain medications from a patient in need. The facility provided a document titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program. The policy statement included: residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The resident abuse, neglect and exploitation prevention program consists of a facility-wide commitment and resource allocation to support the following objectives: Protect residents from abuse, neglect, exploitation or misappropriation of property by anyone including, but not necessarily limited to: facility staff;		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff and family interviews, and facility policy review. The facility failed to provide oral cares for 5 of 5 residents (Resident #22, #2, #3, #29, and #30) reviewed and also failed to provide toileting and repositioning for Resident #29. The facility reported a census of 28 residents. Findings include: 1. According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 10/31/2025 documented Resident #22 had a Brief Mental Status (BIMS) score of 4. A BIMS score of 4 suggested severe cognitive impairment. The MDS documented the resident required substantial/maximal assistance with oral hygiene. Resident #22 had the following diagnoses listed: multiple sclerosis, neurogenic bladder, dementia and depression. The Care Plan Focus Area with a revision date of 11/18/2020 documented Resident #22 had activities of daily living (ADL) self-care performance deficit due to her multiple sclerosis diagnoses and required the assistance of one staff for daily grooming (personal hygiene and oral care). On 1/20/2026 at 10:30 AM observed a sign on top of her heating/cooling unit. A hand written note was present that stated please brush Resident #22's teeth every day. On 1/20/2026 at 11:15 AM Resident #22's emergency contact #1 stated sometimes her teeth are not brushed much. She has noticed this a lot when she visits. When asked if Resident #22 would refuse her teeth be brushed, she indicated the resident would allow staff to complete oral cares on her. On 1/22/2026 at 8:25 AM Resident #22 was asked if staff brushed her teeth this morning, she stated not today. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) was informed of the sign in Resident #22's room informing staff to brush her teeth every day. She stated that has not been brought to her attention and she has not been in her room. She indicated oral cares should be completed at least twice a day. When asked who is to complete this task, she indicated ideally the Certified Nurses Assistants (CNA) but nurses or anyone on the clinical team could complete oral cares. She added if the resident is receiving occupational therapy (OT) oral care can be completed with them as well. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS indicated Resident #2 required supervision or touching assistance from staff for oral hygiene. Review of Resident #2's EHR documented no documentation of oral care provided. On 1/12/26 at 11:21 AM Resident #2 stated she does have a toothbrush in her bathroom. Resident #2 stated it does depend on the staff if oral care was provided. Resident #2 stated her husband came to the facility in the evenings and would help her with brushing her teeth. Resident #2 stated in the morning if she was going to therapy she would be in the wheelchair and would go to the bathroom. Resident #2 stated Occupational Therapy used to help her but she no longer saw OT. Resident #2 stated occasionally a Certified Nurse Assistant (CNA) would assist her with oral care. Review of Resident #2's Electronic Health Record (EHR) titled, Care Plan with initiation date of 12/5/25 documented Resident #2 required an assist of 1 staff for oral care. (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS indicated Resident #3 required partial / moderate assistance with oral hygiene. On 1/13/26 at 4:11 PM Resident #3's son stated his mother would require staff to complete oral care for her because she can not get out of bed by herself. Review of Resident #3's EHR titled, Care Plan with initiation date of 4/12/25 documented Resident #3 required an assist of 1 staff for oral care. Review of Resident #3's EHR documented no documentation of oral care provided. On 1/12/26 at 10:49 AM an observation revealed no toothbrush in Resident #3's room. On 12/26/26 at 1:00 PM an observation of Staff P, Assistant Director of Health and Wellness / Assistant Director of Nursing (ADON) entered Resident #3's room, looked for a sponge dental swab or a toothbrush. On 12/26/26 at 1:05 PM Staff P acknowledged there was no equipment in Resident #3's room to provide oral care. On 1/12/26 at 12:17 PM Staff C, CNA stated the staff provide oral care to the residents. Staff C stated she completed oral care with Resident #3 that morning. Staff C stated she gets Resident #3 a new toothbrush everyday because she does not know what happened to the toothbrush the day prior. Staff C stated she offers Resident #3 a basin and toothbrush and Resident #3 did her own brushing. Staff C stated she Resident #3 only required set-up only according to the care plan. 4. The Minimum Data Set (MDS) dated [DATE] documented Resident #29 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. MDS documented Resident #29 required supervision or touching assistance for oral hygiene. Review of Resident #29's EHR titled, Care Plan documented an intervention / task for oral care dated 11/19/25 that Resident #29 required an assistance of one for oral care. Review of Resident #29's EHR documented no documentation of oral care provided. On 1/15/26 at 1:30 PM Resident #29 stated she had to set an alarm on her phone to ensure the staff come to turn her every 2 hours or the staff will not reposition her. Resident #29 stated her doctor wants her repositioned every 2 hours. Resident #29 stated prior to going to the hospital the staff were not repositioning her every 2 hours some overnight shifts the staff would only come in at 3:00 AM or 4:00 AM to reposition her in bed. Resident #29 stated she had multiple sclerosis and was not able to reposition herself in bed. Resident #29 stated she required the assistance of staff for repositioning. Resident #29 stated the staff rarely provided oral care to her. Resident #29 stated she would like oral care but felt like she should be able to do it on her own but she could not even sit up in bed on her own. Resident #29 stated she would appreciate staff assisting with oral care. On 1/22/26 at 11:29 AM Resident #29 stated she was told last night by Staff EE, Certified Nurse Assistant (CNA) refused to change her brief. Resident #29 stated she was out of briefs and Staff EE refused to change her last night. Resident #29 stated she had not had a bowel movement but was (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	incontinent of urine and nobody changed her at all last night. Resident #29 stated the Staff EE only repositioned her at night but never changed her. Resident #29 stated she has had problems with Staff EE from the get go. Resident #29 stated Staff EE was not supposed to be caring for her because she had voiced concerns about how she cared for her in the past. Resident #29 stated Staff EE treated her undignified. Resident #29 stated she did not feel like Staff EE had provided her with the appropriate dignity or respect when requesting to be cleaned up and change her brief. Resident #29 stated she had told Staff R, CNA the concerns she had with Staff EE. Resident #29 said she thought Staff EE told Staff P, Assistant Director of Nursing (ADON) about the concerns with Staff EE. 5. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. The MDS documented Resident #30 required substantial / maximal assistance for oral hygiene. Review of Resident #30's EHR titled, Care Plan documented an intervention / task for oral care dated 12/3/25 that Resident #30 required an assistance of one for oral care. Review of Resident #30's EHR documented no documentation of oral care provided. On 1/20/26 at 1:05 PM Resident #30's daughter stated frequently she would come to the facility at random times and would have food on her mother's face and mouth. Resident #30's daughter stated it looked as though her mother's teeth had not been brushed. On 1/12/26 at 12:49 PM Staff P stated Resident #29 did not want Staff EE or RR in her room because they were talking about their own lives and another resident down the hall. Staff P stated Resident #29 thought it was disrespectful for them to talk about other residents in her room. Staff P stated it was an expectation that all residents receive oral care even if the resident does not have teeth. Staff P stated if the resident had dentures they should be cleaned or soaked overnight. On 1/12/26 on 1:09 PM the DON stated oral care should be completed or offered and documented if refused. The DON explained assistance the resident required should be on their care plan as well. On 1/21/26 at 8:11 AM Staff R, CNA stated if the resident is cognitive she would ask if the resident wanted their teeth brushed before or after the meal. Staff R stated if the resident was not cognitively aware she would complete the oral cares before breakfast. Staff R stated she frequently found residents with food on residents faces and hands not cleaned from dinner. Staff R stated she had brought it up to the management at the facility. On 1/27/26 at 11:03 AM the DON stated oral care should be completed twice a day ideally by CNA or the nurses if the CNA's are too busy. Review of undated policy titled, Oral Care documented the purposes of the procedure was to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent oral infection. Review the resident's care plan to assess any special needs of the resident. Assemble the equipment and supplies as needed. The following information should be recorded in the resident's medical record: The date and time the mouth care was provided. The name and title of the individual(s) who provided the mouth care. All assessment data obtained concerning the resident's mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record. Complaints of pain or discomfort of mouth. The certified nursing assistant should report to the licensed nurse to record in the medical record. If the resident refused the treatment, the reason(s) why and the intervention taken. The signature and title of the person recording the data.		

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F 0678 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on facility document review, Facility Assessment review and staff interviews the facility failed to provide sufficient nursing staff with appropriate competencies and skill sets by not having a staff on duty at the facility trained in cardiopulmonary resuscitation (CPR) at all times. The facility reported a census of 28 residents. Findings include: On [DATE] at 11:03 AM the DON stated there was nothing available for CPR certification on any staff at the facility. The DON explained there was no list for CPR certified staff and no way Staff O planned 24 hour CPR coverage at the facility. The DON stated Staff O thought as long as a nurse was present that nurse was CPR certified. The DON stated she expected the facility would have a list of CPR certified staff to ensure appropriate coverage. On [DATE] at 11:11 AM Staff P stated the facility did not have any CPR list when she was the interim DON from [DATE] - [DATE]. Staff P stated there was no list for CPR certified staff when she was the interim DON and CPR coverage was not being assessed 24 hours a day at the facility. Review of facility staff schedules for [DATE] - [DATE] revealed no CPR coverage for 283 shifts. On [DATE] at 10:50 PM Staff O, Certified Medication Assistant (CMA) / Certified Nurse Assistant (CNA) / Scheduler stated had worked as the scheduler for the facility since September of 2025. Staff O explained she had very little training prior to entering into the position. Staff O stated she was not aware of any required CPR coverage in the building. Staff O stated she does not develop a schedule to have RN coverage. Staff O stated when she developed a schedule she was unaware any CPR coverage was required. Staff O stated the facility did not have a CPR certification list prior to survey team request. On [DATE] at 10:15 AM Staff J, RN stated the facility had not asked for his CPR certification until [DATE]. Review of document titled, Facility Assessment documented staff training/education and competencies considerations to describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. List (or refer to or provide a link to) all staff training and competencies needed by type of staff. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and how often they are reviewed after that. Staff competency review competency-based evaluations of staff knowledge and skills required to maintain or improve residents' physical, functional, mental, and psychosocial well-being. Evaluate competency levels among employees, contract staff, and volunteers to meet professional standards of practice. Training programs that evaluate the facility's training program to ensure alignment with needs identified in resident assessments and regulatory standards. Assess training adequacy for new and existing staff, managers, nursing, and direct care staff, contractors, and volunteers.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, clinical record review, interviews and policy review the facility failed to protect residents from possible accidents and injuries for 4 of 12 residents (Residents #7, #41, #2 and #3) reviewed. The facility failed to protect residents when dependently pushed in manual wheelchairs (w/c's) without the use of footrests and using only 1 staff member with the use of dependent non-weight bearing mechanical lifts. Additionally the facility failed to protect the residents from possible scalding injuries with water temperatures above the recommended temperature range for burn prevention. The facility reported a census of 28 residents. Findings include:1. Resident #7's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive deficit. The resident utilized a manual w/c with partial/moderate assistance. The document disclosed diagnoses including chronic kidney disease, nonrheumatic aortic valve stenosis, unspecified osteoarthritis. The resident's Care Plan dated 1/7/26 disclosed a focus area of requiring assistance with activities of daily living (ADLs) revised 4/23/24. Interventions for staff included manual w/c for mobility with assistance of 1, transfers with a sit to stand lift with staff assistance of 2 and dressing and bathing with maximal assistance of 1. On 1/21/26 at 7:10 AM observed Staff I, Certified Nursing Assistant (CNA), push Resident #7 without w/c foot pedals down 2 hallways from the resident's bedroom until stopped at Staff H's, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist office. Staff H directed Staff I that she had passed the shower room and needed to go back the other direction. Staff A, Registered Nurse (RN), was also present at Staff H's office. Staff A followed Resident #7 and Staff I down the hallways to the shower room. The total distance the resident traveled through the facility was 240' or &frac34; of a football field. The facility failed to stop the transport of Resident #7 in a w/c without footrests. On 1/21/26 at 7:48 AM Staff H stated she hadn't noticed Resident #7 did not have footrests on her w/c. The staff stated residents must have footrests on the w/c prior to being pushed. 2. Resident #41's MDS dated [DATE] revealed a BIMS score of 3/15 indicating severe cognitive impairment. The document disclosed the resident was dependent on staff for the use of a manual w/c. The document provided the resident had diagnoses including acute kidney failure, high blood pressure, and diabetes mellitus. The resident's Care Plan dated 1/20/26 provided a focus area for ADL assistance revised on 1/10/26 with staff interventions for use of manual w/c with assistance of 1 and transfers with assistance of 1 using a gait belt dated 1/12/26. On 1/20/26 at 1:04 PM observed Staff E, CNA, push Resident #41 from the dining room to the living room meeting 1 unidentified staff member in the hallway. Observed the resident's feet to be dragging on the floor during the dependent mobility. The distance traveled was approximately 75'. The facility failed to ensure the resident's feet were on footrests while being transported in a w/c. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/21/26 at 2:22 PM Staff J, Registered Nurse (RN), stated a resident must have footplates prior to being pushed in a w/c. On 1/22/26 at 12:27 PM Staff D, Certified Medication Aide (CMA), stated residents' feet must be on the foot pedals prior to pushing them in their w/c's. On 1/27/26 at 9:28 AM Staff G, Certified Occupational Therapy Assistant (COTA), stated residents should have their feet on footrests prior to being pushed. On 1/27/26 at 11:01 AM the Director of Nursing (DON) stated she expected that residents have their feet on footrests, dignity bags if necessary, clean appearance, dressed and/or covered prior to being pushed in a w/c. The DON stated she would expect any staff, especially a Charge Nurse or someone on the Leadership Team, to step in to stop w/c dependent mobility if the resident's feet were not on footrests. On 1/28/26 at 11:14 AM during an interview with the Administrator and DON, the Administrator acknowledged footrests should be in place prior to pushing a resident in a w/c. The DON stated during the Nurse Meeting on the previous day she started training on a w/c policy. On 1/29/26 at 11:13 AM the Administrator provided the facility did not have a policy related to w/c safety and use. On 1/29/26 at 11:50 AM when asked for clarification about the w/c policy that was referenced by the DON that was being trained, the Administrator stated he had not reviewed that policy and wanted to read through it first. 3. The Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. The MDS documented Resident #2 was dependent on staff for the chair to bed transfer and required the staff to do all of the effort. Resident #2 does none of the effort to complete the activity or the assistance of 2 or more staff is required for the resident to complete the activity. Review of Resident #2's EHR documented Resident #2 required a full body mechanical lift with the assistance of 2 staff. On 1/12/26 at 11:21 AM Resident #2 stated she was required to use a full body mechanical lift for transfers. Resident #2 stated it depended on the staff as to how the full body mechanical lift was utilized. Resident #2 stated some staff use 1 staff but most staff use 2 when they transfer her. Resident #2 stated she has been a nurse for 30 years and knows there should be 2 staff when a resident was transferred in a full body mechanical lift. Resident #2 stated she would tell the staff to get a second staff for the full body mechanical lift and the staff asked her if she didn't trust the staff. Resident #2 stated she told the staff it was not that she did not trust them but what if the sling breaks? Resident #2 explained she was worried she would end up on the floor. Resident #2 stated it did worry her when she was being transferred. 4. The MDS dated [DATE] documented Resident #3 had a Brief BIMS of 11 indicating moderate cognitive impairment. The MDS documented Resident #3 was dependent on staff for the chair to bed transfer and required the staff to do all of the effort. Resident #3 does none of the effort to complete the activity or the assistance of 2 or more staff is required for the resident to complete the activity. (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/12/26 at 10:49 am Resident #3 stated she does not like to use the full body mechanical lift. Resident #3 stated she grabs the staff around the neck and the staff place her in the wheelchair. Resident #3 stated she did not remember when the staff last used a full body mechanical lift to transfer her. Resident #3 stated the staff will wheel the full body mechanical lift into her room but they decide not to use it. On 1/8/26 at 5:22 PM Staff BB stated when he was trained the staff told him that the lift was based on the manufacturer's recommendations and they were able to utilize the full body mechanical lift with only one person. Staff BB stated he reported the incident to Staff MM, Licensed Practical Nurse (LPN) and did not think anything became of it. On 1/12/26 at 12:37 PM Staff A, Registered Nurse (RN) stated occasionally she will be asked to help with full body mechanical lift transfers but not very often. Staff A stated she had seen staff transfer residents that required a full body mechanical lift with only one staff. Staff A stated she always reeducated the staff to request help and she would be able to help. Staff A stated all the staff do it all the time. Staff A stated she frequently saw Staff RR, Certified Nurse Assistant (CNA) and Staff JJ, CNA transfer residents that required a full body mechanical lift with only one staff. On 1/12/26 at 1:09 PM the DON stated every mechanical lift at the facility required 2 staff to utilize for resident transfers. On 1/14/26 at 1:51 PM Staff MM, RN stated there were a couple staff that she had to remind they needed 2 people to transfer residents with a full body mechanical lift. Staff MM stated there were reports from other staff that so and so was in the room transferring by themselves with a full body mechanical lift. Staff MM stated Staff BB came to her about a complaint that staff were not helping him with full body mechanical lift transfers. On 1/21/26 at 7:52 AM Staff R, CNA stated staff are not supposed to transfer residents with full body mechanical lifts alone but when a nurse will not help she has to transfer with only one staff. On 1/28/26 at 2:04 AM a review of a document titled, Water Temperature logs documented on 1/27/25 water temperature in resident room on a-hall 122, b-hall 121, rehab hall 122 and laundry 145. On 2/26/25 water temperature in resident rooms on a-hall 121, b-hall 121, rehab hall 122 and no water temperatures taken in laundry. On 3/25/26 water temperature in resident rooms on a-hall 122, b-hall 122, rehab hall 122 and no water temperatures taken in laundry. On 4/22/25 water temperature in resident rooms on a-hall 121, b-hall 122, rehab hall 122 and no water temperatures taken in laundry. On 5/20/25 water temperature in resident rooms on a-hall 122, b-hall 122, rehab hall 119 and no water temperatures taken in laundry. 6/18/25 water temperature in resident rooms on a-hall 121, b-hall 120, rehab hall 120 and no water temperatures taken in laundry. On 7/18/25 water temperature in resident rooms on a-hall 122.4, b-hall 121.9, rehab hall 122.3 and laundry 140.1. On 8/22/25 water temperature in resident rooms on a-hall 122, b-hall 121.4, rehab hall 122.3 and laundry 139.7. 9/26/25 water temperature in resident rooms on a-hall 121.9, b-hall 122.1, rehab hall 122 and laundry 143. On 10/21/25 water temperature in resident rooms on a-hall 122.3, b-hall 121.4, rehab hall 120.7 and laundry 120.2. On 11/14/25 water temperature in resident rooms on a-hall 122.4, b-hall 122.6, rehab hall 123.2 and laundry 144.5. No water temperatures obtained since 11/4/25. On 1/28/26 at 2:04 PM Staff Z, Director of Plant Operations explained it was probably his job to review the temperatures every month but he did not. Staff Z acknowledged he did not know what water temperature was too hot for resident rooms or for resident showers. Staff Z explained he was (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	unaware of appropriate water temperature for the facility high or low. On 1/29/26 at 10:27 AM the DON said 124 degrees for resident room water temperatures was a little too hot. The DON explained she was not sure what the temperature should be to prevent burns or the timeframe as to when a burn would occur. On 1/28/26 at 2:56 PM the Administrator stated he was not a temperature expert and could not speak to the appropriate temperature of water for the shower or resident rooms off the top of his head. The Administrator stated it would be good if Staff Z was trained in the appropriate water temperatures for resident use but was not sure if Staff Z had ever been trained in the appropriate water temperatures for resident use. No policies presented for appropriate water temperatures for resident rooms and shower rooms, full body mechanical lift use or transportation of residents in wheelchairs.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observations, staff interview and facility policy review the facility failed to provide drinks to residents, during lunch service. The facility reported a census of 28 residents. Findings include: During dining room observations on 1/21/2026 at 12:05 PM observed six residents sitting at the tables with 4 residents at the assisted tables with two staff and a family member present. There were no drinks on the tables. At 12:17 PM a therapist brought Resident #40 to the dining room table, asked if she wanted a glass of water and the resident accepted it. At 12:21 PM Staff F Dietary Aide (DA) brought a drink cart down the hall from the kitchen to the dining room and began to hand out drinks to residents at the assisted tables. At 12:25 PM Staff F left the dining room with menu tickets. At 12:29 PM Staff F entered the dining room with the food cart, at 12:31 PM delivered 3 trays to residents that did not require assistance with feeding. The residents continued to not have drinks on their table. At 12:37 PM Resident #34 propelled herself from the table to the drink cart and got a can of pop out of the ice bucket and returned to her table. Resident #17 went to the drink cart to get a can of pop for herself and Resident #9. At 12:43 PM Resident #39 asked Staff F for a pop to drink. Resident #38 received his food but was not offered anything to drink. Resident #40 was not offered anything other than water to drink. At 1:00 PM Resident #38 continued to no have drinks at his table with his lunch. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) stated it was brought to her attention last week that Certified Nursing Assistants (CNA) are responsible for distributing drinks during meal service. She would like to see that dietary staff do this as this pulls nursing staff off the floor. When asked who is responsible for passing drinks to the residents in the dining room, she indicated the dietary staff are supposed to but did not know for certain. Inquired if residents were able to get their own drinks when no staff are present and distributing them to other residents and the DON stated she did not think so because of a sanitary point of view but they should be able to request what they want to drink with their meals. She added drinks should be offered and told what is available. The DON state the point of having CNAs in the dining room is to supervise and assist the residents while they eat. The CNAs can't supervise and assist while passing drinks. She indicated she will need to discuss this with the Administrator and Dietary Manager. The facility provided a document titled Resident Hydration and Prevention of Dehydration. This facility will strive to provide adequate hydration and to prevent and treat dehydration. 6. Nurses' Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care.		

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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 facility document review, Facility Assessment review and staff interviews the facility failed to provide enough nursing staff to assure residents safety with transfers, provided appropriate care and resident care completed in a timely manner. The facility reported a census of 28. Findings include: Review of weekend staffing schedules for months of July, August, September, October, November, December and January revealed the following: On 7/6/25 10:00 PM - 6:00 AM 1 nurse and 1 CNA On 7/13/25 6:00 AM - 2:00 PM 2 CNA On 8/3/25 6:00 AM - 2:00 PM 2 CNA, 2:00 PM - 10:00 PM 2 CNA On 9/20/25 2:00 PM - 10:00 PM 1 nurse On 9/21/25 6:00 AM - 2:00 PM 1 nurse On 11/18/25 6:00 AM - 2:00 PM 1 nurse, 2:00 PM - 10:00 PM 1 nurse, 10:00 PM - 6:00 AM 1 nurse and 1 CNA On 1/4/26 6:00 AM - 2:00 PM 1 nurse On 1/17/26 6:00 AM - 2:00 PM 1 nurse and 2 CNA, 2:00 PM - 10:00 PM 1 nurse and 3 CNA, 10:00 PM - 6:00 AM 1 nurse and 1 CNA. Review of weekday schedules Monday - Friday for months of July, August, September, October, November, December and January revealed the following: On 7/7/25 2:00 PM - 10:00 PM 1 nurse and 2 CNA On 8/4/25 10:00 pm - 6:00 AM 1 nurse and 1 CNA On 9/2/25 2:00 PM - 10:00 PM 1 nurse and 2 CNA On 1/12/26 6:00 AM - 2:00 PM 1 nurse and 3 CNA, 2:00 PM - 10:00 PM 1 nurse and 3 CNA, 10:00 PM - 6:00 AM 1 nurse and 1 CNA On 1/13/26 6:00 AM - 2:00 PM 1 nurse and 2 CNA, 2:00 PM - 10:00 PM 1 nurse and 2 CNA On 1/14/26 2:00 PM - 10:00 PM 1 nurse On 1/16/26 10:00 pm - 6:00 AM 1 nurse and 1 CNA On 1/19/26 2:00 PM - 10:00 PM 1 nurse and 3 CNA On 1/20/26 6:00 AM - 2:00 PM 1 nurse and 3 CNA, 2:00 PM - 10:00 PM 1 nurse, 10:00 PM - 6:00 AM 1 CNA. Review of facility staff schedules for 7/1/25 - 1/19/26 revealed an RN was not present in the building for 8 consecutive hours on 8/23/25, 9/5/25, 9/12/25, 10/11/25, 10/25/25, 11/8/25, 11/18/25 11/22/25, 11/23/25, 12/7/25, 12/20/25, 12/21/25, 12/28/25, 1/9/26 and 1/17/26. On 1/12/26 at 11:21 AM Resident #2 stated she was required to use a full body mechanical lift for transfers. Resident #2 stated it depended on the staff as to how the full body mechanical lift was utilized. Resident #2 stated some staff use 1 staff but most staff use 2 when they transfer her. Resident #2 stated she has been a nurse for 30 years and knows there should be 2 staff when a resident was transferred in a full body mechanical lift. Resident #2 stated she would tell the staff to get a second staff for the full body mechanical lift and the staff asked her if she didn't trust the staff. Resident #2 stated she told the staff it was not that she did not trust them but what if the sling breaks? Resident #2 explained she was worried she would end up on the floor. Resident #2 stated it did worry her when she was being transferred. On 1/12/26 at 12:00 PM Staff AA, CNA stated the facility needed more staff. Staff AA stated there were a lot of residents that require assistance with mechanical lifts. Staff AA explained the facility needed more staff to meet the needs of the residents because it takes 2 staff to transfer residents with a mechanical lift appropriately. Staff AA explained when staff need help to transfer a resident with a mechanical lift the resident might have to wait for 30 or 40 minutes for the transfer until a second staff member becomes available. On 1/28/26 at 10:50 PM Staff O, Certified Medication Assistant (CMA) / Certified Nurse Assistant (CNA) / Scheduler stated she had worked as the scheduler for the facility since September of 2025. Staff O stated when developing a schedule she needs to make sure there is a CNA in every section GP1, GP2 and GP3. Staff O stated nurses on GP1 and GP2. Staff O stated on am shift and pm shifts. Staff O stated on the overnight shift there was only 1 nurse and 2 CNAs. Staff O acknowledged those assignments have not happened every day since she had taken over. Staff O stated there were days that the facility was a CNA short on the am shift. Staff O explained the facility had been short a nurse on am or pm because of call outs. Staff O stated there had not been a full shift where there had not been enough staff. Staff O explained she had very little training prior to entering into the position. Staff O stated she had asked the Administrator and Staff P, Registered nurse / Assistant Director of Nursing (ADON) / Previous Interim Director of Nursing (DON) for any help on how she was doing. Staff O stated she was not aware of any RN coverage requirements for daily hours or 7 days a week. Staff O stated she does not (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	develop a schedule to have RN coverage. Staff O stated Staff P was the interim DON from September until current DON at the very end of December. Staff O stated Staff P worked Monday - Friday at least 8 hours. Staff O stated Staff P only comes into the facility on the weekends if needed for an IV flush. Staff O explained Staff P never worked 8 consecutive hours on the weekends. On 1/28/25 at 10:15 AM Staff J, RN stated Staff P usually worked Monday through Friday for 8 hours. Staff J explained Staff P does not work on weekends. Staff J stated he became a RN on 1/1/26. Staff J stated the facility did not always have a RN. Staff J explained there would be no RN on Saturdays at times. Staff J stated there were times where there was no RN coverage on Saturday and Sunday. Staff J stated on 1/17/26 a nurse called in and he was the only nurse in the whole building. Staff J stated the DON did not answer the phone or respond. Staff J stated he called 3 different times and called the ADON once also no answer. Staff J explained Staff O was the on-call and had not been trained to pass medications. Staff J stated the facility was supposed to have 2 nurses or 1 nurse with 1 CMA and 3 CNAs on day shift. Staff J stated the pm shift was supposed to be the same as the am shift for staffing. Staff O stated the overnight shift was supposed to have one nurse and 2 CNAs. On 1/28/26 at 10:35 AM Staff Q, CNA stated staffing on the am shift was supposed to have 2 nurses and 3 CNAs on day shift. Staff Q stated there had been only 2 CNAs on the floor more than twice since she had been working at the facility. Staff Q explained there had been 1 nurse on the floor several times on days and evenings. On 1/28/26 at 11:23 AM Staff P acknowledged she had worked 8 hours a day for RN coverage. Staff P stated she works Monday through Friday usually at least 8 hours. Staff P stated she did not feel the schedule was an accurate representation of her shifts or hours worked because she is on every schedule. Staff P explained she felt her name just carried over every day. Staff P acknowledged her days off were not represented appropriately. Staff P stated in the nursing department there would be a minimum 2 nurses and 3 CNA's on am shift and pm shift. Staff P stated if the facility census was below 20 there are 2 CNAs and a bath aide. Staff P stated the pm shift required 2 nurses and 3 CNAs. Staff P stated the overnight shift required 1 nurse and 2 CNAs. Staff P stated she knew there had been a time or two where the nurse had not shown up for a while and the staff usually called and someone came into the facility. Staff P stated they have never made one nurse without a medication aide passing their medications that she could remember. Staff P stated she could not remember just one nurse on 2 - 10 shifts ever. Staff P stated she knew in the last 6 months there had been a couple days when the census was less than 20. Staff P acknowledged there were several weekends there was no RN coverage. On 1/29/26 at 10:45 AM the DON stated there should be a minimum of 2 day nurses or a nurse and a medication aide and 3 CNAs. The DON stated the pm shift should have the same staffing as am shift and the overnight shift was staffed with 1 nurse and 2 CNA's. The DON acknowledged the Facility assessment did not accurately reflect the amount of RN required on pm shift. On 1/29/26 at 12:23 PM the Administrator stated the Facility Assessment for staffing was just an approximate number for staffing. The Administrator stated the Facility Assessment was not a minimum. The Administrator acknowledged the RN on the evening shift was not required but only a possible need. Review of the undated document titled, Facility Assessment documented direct care staff hours per resident day (HPRD) or total hours per discipline on day shift 0.33 for RN, 0.33 for Licensed Practical Nurse (LPN), and 0.67 for CNA. Direct care staff hours per resident day (HPRD) or total hours per discipline on evening shift was 0.33 for RN, 0.33 for LPN, and 0.67 for CNA. Direct care staff hours per resident day (HPRD) or total hours per discipline on night shift was 0 for RN, 0.33 for LPN, and 0.67 for CNA.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on facility document review, Facility Assessment review and staff interviews the facility failed to provide sufficient nursing staff with appropriate competencies and skill sets by not providing staff orientation for newly hired staff or agency staff. The facility reported a census of 28 residents. Findings include: On 1/12/26 at 12:00 PM AA, CNA stated she had worked at the facility for about 4 months. Staff AA stated when she started there was not an orientation check list. Staff AA stated the facility just threw her out to the floor. Staff AA stated she did not receive any training when she started. Staff AA stated she had worked as a CNA prior to working at the facility. On 1/8/26 at 5:22 PM Staff BB, CNA stated he had not received any formal training at the facility. Staff BB stated he was given to a young lady for 3 days to follow and another CNA to work with for a couple nights. Stated there was not a checklist or orientation packet when he was hired. Staff BB stated it would have been nice to have a checklist or orientation packet to ensure he knew how the facility wanted him to complete everything. Staff BB stated all facilities are different with requirements on mechanical lifts, snack delivery and other resident care oriented areas. On 1/14/26 at 8:40 AM Staff H, Licensed Practical Nurse (LPN) / MDS Coordinator / Infection Preventionist (IP) stated the new staff are orientated by other staff. Staff H acknowledged she was not sure if there was a checklist or an orientation packet at the facility for new hires and agency staff. On 1/12/26 at 12:49 PM Staff P, Assistant Director of Health and Wellness (Assistant Director of Nursing ADON) stated the facility did not have an orientation packet or checklist for newly hired staff or agency staff. Staff P said the new staff usually just were assigned to work with a CNA that had worked at the facility for a while as training. On 1/13/26 at 5:40 PM the Director of Nursing (DON) acknowledged the facility did not have an orientation packet or checklist for new hired staff or agency staff that she was aware of. Review of document titled, Facility Assessment documented staff training/education and competencies considerations to describe the staff training/education and competencies that are necessary to provide the level and types of support and care needed for your resident population. Include staff certification requirements as applicable. List (or refer to or provide a link to) all staff training and competencies needed by type of staff. Consider if it would be helpful to indicate which competencies are reviewed at the time the staff member is hired, and how often they are reviewed after that. Staff competency review competency-based evaluations of staff knowledge and skills required to maintain or improve residents' physical, functional, mental, and psychosocial well-being. Evaluate competency levels among employees, contract staff, and volunteers to meet professional standards of practice. Training programs that evaluate the facility's training program to ensure alignment with needs identified in resident assessments and regulatory standards. Assess training adequacy for new and existing staff, managers, nursing, and direct care staff, contractors, and volunteers.		

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 document review, facility assessment review and staff interviews the facility failed to ensure a Registered Nurse (RN) was at the facility for 8 consecutive hours. The facility reported a census of 28. Findings include: Review of facility staff schedules for 7/1/25 - 1/19/26 revealed an RN was not present in the building for 8 consecutive hours on 8/23/25, 9/5/25, 9/12/25, 10/11/25, 10/25/25, 11/8/25, 11/18/25 11/22/25, 11/23/25, 12/7/25, 12/20/25, 12/21/25, 12/28/25, 1/9/26 and 1/17/26. On 1/28/26 at 10:50 PM Staff O, Certified Medication Assistant (CMA) / Certified Nurse Assistant (CNA) / Scheduler stated had worked as the scheduler for the facility since September of 2025. Staff O stated when developing a schedule she needs to make sure there is a CNA in every section GP1, GP2 and GP3. Staff O stated nurses on GP1 and GP2. Staff O stated on am shift and pm shifts. Staff O stated on the overnight shift there is only 1 nurse and 2 CNAs. Staff O acknowledged those assignments have not happened every day since she had taken over. Staff O stated there were days that the facility was a CNA short on the am shift. Staff O explained the facility had been short a nurse on am or pm because of call outs. Staff O stated there had not been a full shift where there had not been enough staff. Staff O explained she had very little training prior to entering into the position. Staff O stated she had asked the Administrator and Staff P, Registered nurse / Assistant Director of Nursing (ADON) / Previous Interim Director of Nursing (DON) for any help on how she was doing. Staff O stated she was not aware of any RN coverage requirements for daily hours or 7 days a week. Staff O stated she does not develop a schedule to have RN coverage. Staff O stated Staff P was the interim DON from September until current DON at the very end of December. Staff O stated Staff P worked Monday - Friday at least 8 hours. Staff O stated Staff P only comes into the facility on the weekends if needed for an IV flush. Staff O explained Staff P never worked 8 consecutive hours on the weekends. On 1/28/25 at 10:15 AM Staff J, RN stated Staff P usually worked Monday through Friday for 8 hours. Staff J explained Staff P does not work on weekends. Staff J stated he became a RN on 1/1/26. Staff J stated the facility did not always have a RN. Staff J explained there would be no RN on Saturdays at times. Staff J stated there were times where there was no RN coverage on Saturday and Sunday. Staff J stated on 1/17/26 a nurse called in and he was the only nurse in the whole building. Staff J stated the DON did not answer the phone or respond. Staff J stated he called 3 different times and called the ADON once also no answer. Staff J explained Staff O was the on-call and had not been trained to pass medications. Staff J stated the facility was supposed to have 2 nurses or 1 nurse with 1 CMA and 3 CNAs on day shift. Staff J stated the pm shift was supposed to be the same as the am shift for staffing. Staff O stated the overnight shift was supposed to have one nurse and 2 CNAs. On 1/28/26 at 11:23 AM Staff P acknowledged she had worked 8 hours a day for RN coverage. Staff P stated she works Monday through Friday usually at least 8 hours. Staff P stated she did not feel the schedule was an accurate representation of her shifts or hours worked because she is on every schedule. Staff P explained she felt her name just carried over every day. Staff P acknowledged her days off were not represented appropriately. Staff P stated in the nursing department there would be a minimum 2 nurses and 3 CNA's on am shift and pm shift. Staff P stated if the facility census was below 20 there are 2 CNA's and a bath aide. Staff P stated the pm shift required 2 nurses and 3 CNA's. Staff P stated the overnight shift required 1 nurse and 2 CNA's. Staff P stated she knew there had been a time or 2 where the nurse had not shown up for a while and the staff usually called and someone came into the facility. Staff P stated they have never made one nurse without a medication aide passing their medications that she could remember. Staff P stated she could not remember just one nurse on 2 - 10 shifts ever. Staff P stated she knew in the last 6 months there had been a couple days when the census was less than 20. Staff P acknowledged there were several weekends there was no RN coverage. On 1/29/26 at 10:45 AM the DON acknowledged the Facility Assessment did not accurately reflect the amount of RN coverage required on pm shift. (continued on next page)		

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

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NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The DON acknowledged a RN should be present in the building 8 consecutive hours a day every day. On 1/29/26 at 12:23 PM the Administrator stated the facility assessment for staffing was just an approximate number for staffing. The Administrator stated the facility assessment of staffing was not a minimum. The Administrator acknowledged the RN on the evening shift was not required but only a possible need. Review of document titled, Facility Assessment documented direct care staff hours per resident day (HPRD) or total hours per discipline on day shift 0.33 for RN. Direct care staff hours per resident day (HPRD) or total hours per discipline on evening shift was 0.33 for RN. Direct care staff hours per resident day (HPRD) or total hours per discipline on night shift was 0 for RN.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on facility assessment review, facility document review and staff interviews the facility failed to complete an employee performance review at least once every 12 months. The facility reported a census of 28 residents. Findings include: On 1/21/26 at 7:52 AM Staff R, Certified Nurse Assistant (CNA) stated she had never had a performance evaluation since working at the facility. Staff R explained she had worked at the facility since 12/23. On 1/28/26 at 4:19 PM Staff N, CNA / Interim Social Services Director stated she had gotten evaluations when the previous owners ran the facility. Staff N stated she had not had an evaluation in over a year. On 1/28/26 at 4:28 PM Staff J, Registered Nurse (RN) had worked at the facility for 6 years. Staff J stated he had not had any performance evaluations in the last year. Staff J stated had not had a performance evaluation since 2021. Review of Personnel File for Staff J documented no performance evaluations. Review of document titled, Facility Assessment documented employees are provided with an annual performance appraisal and potential merit pay increase at that time. The Facility Assessment also documented under policies and procedures for provision of care some considerations were to describe how the facility would evaluate what policies and procedures may be required in the provision of care, and how you ensure those meet current professional standards of practice. Include, for example, your process to determine if new or updated policies are needed, and how they are developed or updated. Examples of policies and procedures include pain management, IV therapy, fall prevention, skin and wound care, restorative nursing, specialized respiratory care for tracheostomy or ventilator, storage of medications and biologicals and transportation. Process for updating and rolling out new/updated policies documented policies and procedures are evaluated annually or more often as needed. The Administrator evaluates any potential revisions or changes to the policies and procedures.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and facility policy review the facility failed to employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition services. Areas identified for failure for employment of nutritional management staff with competencies included food preparation, meal delivery not including licensed nurses, nurse aides or paid feeding assistants involved with assisting residents with eating, meal service delivery in a timely manner to maintain food safety and temperature and within 45 minutes or less of resident request and facility's scheduled time for meals. Findings include: During continuous dining room observation on 1/20/2026 at 11:50 AM Resident#9 and #17 stated all the meals are always late. They indicated breakfast was not served until 9:00 AM today. Both residents stated breakfast is the worst because residents can not get their meals until everyone is at the assisted table with staff present. They stated it's not the kitchen's fault but some residents will get tired of waiting and will leave the dining room. Food is not hot when it gets here and the cold foods are not always cold. Resident #17 stated they don't even know how to make toast correctly; it's like they take the bread over the toaster or just serve dry bread. When they have cinnamon toast it's always soggy. The gravy is always cold. Resident #15 asked where is the food? At 12:25 PM Staff F Dietary Aide entered the dining room and asked if they can start serving lunch. At 12:28 PM a tray of 15 desserts in bowls, 2 pureed desserts not covered entered the dining room from the kitchen. At 12:32 PM Staff F left the dining room and went to the kitchen with the tray cart and 12 desserts were not covered. At 12:34 PM Staff F returned to the dining room from the kitchen with 12 uncovered desserts on the tray cart. When staff asked him what it was he told them it was an orange marshmallow dessert. At 12:36 PM Staff F again, left the dining room with the tray cart to the kitchen with 10 desserts still uncovered. At 12:37 PM Staff F returned with the tray cart with the desserts uncovered. At 12:37 PM Staff F left the dining room again with the desserts left uncovered to the kitchen; to get silverware. He returned at 12:39 PM with the desserts still uncovered. Staff F then passed 3 desserts to the main table, 1 dessert to a resident at the assisted table. Staff F left the dining room at 12:39 PM with 7 uncovered desserts remaining on the cart; to the kitchen. Staff F and Dietary Manager did not have a name tag on. It is 64 feet from assisted table to the kitchen and 52 feet from the second table of residents to the kitchen. During continuous dining room observations on 1/21/2026 at 8:03 AM no one present at the assisted table and 3 residents at the other table. Resident #9 stated she has been in the dining room since 7:30 AM. Staff F entered the dining room with no service trays at 8:05 AM to pass out silverware to the residents. At 8:14 AM Resident #16 stated bring breakfast, come on. Resident #16 continued to say bring the people down as she looked at the table where the residents that required assistance sat. She then stated help, bring some people down so we can have some breakfast, bring some food. At this time no nursing or dietary staff were present in the dining room. Resident #16 continued to say where are those people that sit over there (pointing to the table where the assisted residents sit). Staff J Registered Nurse (RN) entered the dining room and Resident #16 asked him where the people are and he told her they would be there soon. Resident #9 said well hopefully then started to laugh. Resident #16 asked are you going to bring me food? I want my breakfast. I just want my breakfast. Will you please bring some people down here? Resident #16 asked Staff J why they don't have food and he said he did not know. Resident #16 asked where are the people that sit over there (pointing to the assisted table), aren't we going to get any breakfast. At 8:31 AM two resident were placed at the assisted table. Resident #16 stated I want some breakfast, another resident to her to shut up. At 8:34 (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12:18 PM Staff F, Dietary Aide, stated 3 mechanical soft diets were required. Staff V chopped the noodles in the steam table pan, added regular Chicken Alfredo, regular vegetables, covered, placed on the warming shelf and then moved to the transport cart placing an insulated cover over each, along with additional plates of regular servings of Chicken Alfredo/noodles and vegetables. 12:27 PM Staff F wrapped silverware for the dining room as silverware was not available during the noon meal. Continuous observation beginning at 12:29 PM Staff V transported the delivery cart to the dining room. Staff F followed with wrapped silverware. Staff F required assistance with differentiating the mechanical soft plates from the regular plates as the plates did not have meal tickets with them for resident identification. An unidentified resident requested a meal substitution. Residents provided meals, but did not have silverware to eat their meals. Staff requested Resident #6's adaptive cup as the resident did not have it at the time her plate was delivered. Staff V and Staff F returned to the kitchen with Staff preparing plates and Staff F wrapping silverware. Uncovered refrigerated desserts were loaded onto the transport cart with Staff F confirming with Staff V that individuals with pureed diets were to have applesauce instead of pureed [NAME] Fruit Crumble. The desserts were pre-plated without differentiation of serving size per menu requirement. 12:43 PM Staff V stated was going to begin preparing room service trays, but was not able to match meal tickets for who had been served meals, who was missing and who required room trays. 12:45 PM Staff U, Cook, stated she would locate missing meal tickets and check with the floor nurses as to who required a room tray. 12:46 PM a renal plate request was made for a room tray. Staff V provided (2) 4 ounce (oz.) servings of noodles, (2) 6 oz. servings of Chicken [NAME] and (1) 4 oz. serving of vegetables for the renal plate. The staff did not refer to the menu for renal diet. At 12:47 PM Staff F took the adaptive cup to the dining room that had been requested at 12:29 PM. A resident requested a second ham sandwich. At 1:03 PM Staff F placed the last room tray into the insulated cart for delivery to the nursing floor. Staff V stated meal service was completed and no more resident meals were to be served. The resident who requested a second ham sandwich was not provided one. No residents with a regular diet were provided a dinner roll. Residents with mechanical soft diets neither received a soft dinner roll nor modified Chicken [NAME] and [NAME] Fruit Crumble. At 1:07 PM Staff U stated she was able to recall all of the missing temperatures from the previous weeks for the cook's refrigerator. The staff stated she was not responsible for the other refrigerators/freezer despite her initial being on them with temperatures that were not there previously. At 1:10 PM Staff R, Certified Nurse Assistant, stated the room tray delivery cart was missing 2 room trays. Staff J, Registered Nurse (RN), stated they had provided the list of who needed room trays and what their diets were to Staff U. (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:18 PM Resident #32 did not have a room tray in the delivery cart. At 1:23 PM the last room tray was to be delivered. At 1:27 PM temperatures Staff V completed temperatures of the last room tray with the Chicken [NAME] at 132 degrees, vegetables at 135 degrees and the refrigerated [NAME] Fruit Crumble at 56 degrees. When Staff V was asked if it was acceptable for the tray temperatures, the staff responded it had been over 30 minutes since he prepared the tray. The staff stated the plate with the entree and vegetables was fine but the dessert was too hot. Staff V made no attempt to correct the room service tray until asked for a third time what the CNA should do for providing the resident a room tray. Staff V provided Staff R with the plate that had returned to the kitchen and gave the staff a new dessert. On 1/22/26 at 1:57 Staff HH, Registered Dietitian, acknowledged she had found numerous concerns with the kitchen the previous month when she had completed her inspection and those results had been shared with the Administrator who told her he would be sharing with the contract kitchen company. The staff stated the cook(s) were to follow the menus as presented and if they were not able to complete the approved menu she needed to be contacted for approval on substitutions. The RD stated residents with therapeutic diets must have their foods altered to the appropriate consistency and residents with specific diet orders must have those diets followed. The staff stated temperatures were required prior to meal services. The RD stated the food temperatures for the final meal tray were outside of the required range - hot foods must be above 135 degrees and cold foods below 41 degrees. The RD stated that all food or drink items crossing a threshold must be covered. When asked about the last room trays being delivered at 1:30 PM, the RD responded that it was an hour outside of the meal service time. On 1/27/26 at 11:01 AM the Director of Nursing (DON) acknowledged there was a problem with the coordination of the kitchen and nursing staff with meal service. The staff stated the CNAs could not be expected to pass beverages when they were supposed to be assisting residents with their meals. The DON stated she had heard complaints regarding the length of time for meal service and the delivery of room trays. On 1/27/26 at 1:39 PM Staff II, Chief Executive Officer (CEO) for the kitchen services contract company, stated the kitchen staff have a 30 day on-boarding training with the company including in-person and on-line training. The staff stated the kitchen staff were all experienced employees of the previous owners and they had transferred with the change of ownership. Staff II stated they were hoping to hire a new Kitchen Director to provide improved oversight of the kitchen staff. Staff II stated there typically was a corporate level staff onsite for the kitchen once a month. The staff stated he and the staff interviewing for the Kitchen Director position had both observed and recognized concerns with the kitchen staff and the meal delivery service. Staff II stated he thought nursing should be more involved in meal/plate deliveries. The staff did concur it was not good practice that meal tickets were not completed and used during meal service, diets were not modified to correct consistency or therapeutic diets were not followed, temperatures outside of the requirements and the staff didn't immediately attempt to correct and that meal service was taking over an hour longer than expected. On 1/28/26 at 10:35 AM Staff LL, CNA, stated a resident had not been provided a breakfast tray. The staff stated she had called the kitchen at 8:30 AM, 10:00 AM and again at 10:30 AM. During a discussion on 1/28/26 at 11:14 AM with Administrator and the DON regarding the concerns (continued on next page)		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the kitchen staffing and meal service, the Administrator stated it was difficult with some aspects of the kitchen due to using a contract company. The Administrator further stated some of the problems related to communication amongst the departments. Per the facility provided document for meal times breakfast was to be served 7:30 AM to 9:00 AM, lunch 12:00 PM to 12:30 PM, and supper 5:30 PM to 6:00 PM. The undated kitchen policy for Food Storage and Protection provided food shall be stored, prepared, served, transported, and distributed with protection at all times from potential contamination. The undated kitchen policy for Menu Compliance identified all meals served to residents following the approved menu for both regular and therapeutic diets. The policy disclosed all staff involved with food preparation or service shall receive training on menu compliance and therapeutic diet requirements. The undated kitchen policy for Food Service Delivery to Nurse Assisted Dining room disclosed all meals use approved, clean, and insulated carts or containers designed to maintain proper food temperatures and protect food from contamination; hot foods shall be maintained at a temperature of 135 degrees Fahrenheit or higher, and cold foods shall be maintained at a temperature of 41 degrees Fahrenheit or lower during transport, plating, holding, and service. The policy further disclosed upon delivery the nursing staff shall verify proper food temperatures, accuracy of resident's meal cards and diet orders and food quality/presentation and integrity. The undated kitchen policy for Diet Order Changes and Communication disclosed to ensure all diet orders were communicated accurately, implemented promptly and documented shall originate from a physician or RD or speech language pathologist (SLP) and be communicated immediately to the Food Service Director and Nursing Leadership. The undated kitchen policy for Mechanical Soft/Processed Diets provided that ground or finely chopped meats be served with gravy or sauce and foods should be modified with food processors, choppers or grinders. The undated kitchen Food Safety Training Requirements for Frontline Employees provided that there would be ongoing training for all employees annually with options of hygiene, thermometers, preparing/cooking, cleaning/sanitizing, and receiving/storing.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility document review, staff interviews, and facility policy review the facility failed to provide a well balanced diet that meets nutritional and special dietary needs of residents by not following the approved menu for a meal. The facility reported a census of 28 residents. Findings include: Observation on 1/21/26 at 10:34 AM Staff V Cook/Dietary Manager, prepared 3 puree meals. The staff completed the puree process for egg noodles, Chicken [NAME] and vegetables following the menu. Following completion of the modification of the Chicken [NAME] and noodles, the staff added additional [NAME] sauce to the top to prevent drying out of the modification. The 2 plates required for the nursing facility were covered with plastic and placed on the warming shelf. Continuous observation of the meal service on 1/21/26 beginning at 12:02 PM noted the following: Staff V re-warmed the pureed plates from 147 degrees to 167 degrees in the microwave and set on the delivery cart. Staff V prepared 3 mechanical soft plates with 4 ounce (oz) chopped serving of noodles, a 6 oz serving of regular Chicken [NAME] on top of the noodles and a 4 oz. serving of vegetables. The staff covered the plates and placed them on the warming shelf before transferring them to the delivery cart. Staff V did not consistently utilize meal tickets/resident completed menus for serving plates with resident choices. Staff V confirmed to Staff F, Dietary Aide, that the residents with pureed diets were to be served applesauce instead of the refrigerated [NAME] Fruit Crumble. In the dining room, residents stated they wanted alternatives to the entree, including requesting seconds. At 1:03 PM Staff V stated the meal service was completed and all residents had been served. The facility's menu spreadsheet for the noon meal on 1/21/26 for regular diets provided the residents were to be served 6 ounces (oz.) Chicken [NAME] over 4 oz. egg noodles, 4 oz. mixed vegetables, #8 scoop of [NAME] Fruit Crumble and 1 dinner roll. No dinner rolls were served to the residents. All desserts were pre-plated without differentiation for the various diets served. The facility's menu spreadsheet for the noon meal on 1/21/26 for mechanical soft diets for the meal provided the residents were to be served 6 oz. ground Chicken [NAME] over 4 oz. chopped egg noodles, #8 scoop of soft chef's vegetable of choice (no corn), soft chopped #8 scoop of [NAME] Fruit Crumble, and soft dinner roll with 1 margarine. No dinner rolls with margarine were served to the residents. All desserts were pre-plated without differentiation for the various diets served. The facility's menu spreadsheet for the noon meal on 1/21/26 for liberal renal diets for the meal provided the resident were to be served 6 oz. Chicken [NAME] over 4 oz. egg noodles, 4 oz. mixed vegetables, #12 scoop of [NAME] Fruit Crumble and dinner roll. No dinner roll was served to the resident. All desserts were pre-plated without differentiation for the various diets served. The facility's menu spreadsheet for the noon meal on 1/21/26 for consistent carbohydrate (CCHO) diets (diabetic) provided the residents were to be served 6 oz. Chicken [NAME] over 4 oz. egg noodles, 4 oz. mixed vegetables, #12 scoop of [NAME] Fruit Crumble and dinner roll. No dinner rolls were served to the residents. All desserts were pre-plated without differentiation for the various diets served. The facility's menu spreadsheet for the noon meal on 1/21/26 for pureed diets for the meal provided the residents were to be served 6 oz. pureed Chicken [NAME] over 4 oz. pureed egg noodles, #10 scoop of pureed vegetable of chef's choice (no corn), #10 scoop of pureed [NAME] Fruit Crumble. The residents were provided with applesauce that was pre-plated, unknown amount. The facility failed to follow the menu for all residents on regular, mechanical, CCHO and liberal renal diets who received Chicken [NAME] by not providing them with a dinner roll. The facility failed to serve and differentiate portion sizes for residents with therapeutic diets. On 1/22/26 at 1:57 Staff HH, Registered Dietitian, stated the cook(s) needed to follow the menus as presented and if they were not able to complete the approved menu she needed to be contacted for approval for substitutions. On 1/27/26 at 1:39 PM Staff II, Chief Executive Officer (CEO) for the kitchen services contract company, expected the (continued on next page)		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen staff to prepare the food as directed on the menus. Staff II stated if the cook was unable to make something on the menu it was expected that the RD be contacted for assistance on an appropriate substitution. On 1/28/26 at 11:14 AM the Administrator stated he hoped with the new Dietary Manager the kitchen service would improve with meal service. The undated kitchen policy for Menu Compliance identified all meals served to residents following the approved menu for both regular and therapeutic diets. The policy disclosed all staff involved with food preparation or service shall receive training on menu compliance and therapeutic diet requirements.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews and policy review the facility failed to provide food at an appetizing temperature to 6 of 20 residents reviewed (Resident #17, #42, #36, #44, #3 and #15). The facility reported a census of 28 residents. Findings include: 1. Resident #17's MDS dated [DATE] revealed a BIMS score of 12/15 indicating moderate cognitive impairment. The document disclosed the resident was independent with eating. On 1/20/26 at 10:45 AM the resident stated the food was not hot when it was supposed to be hot. The resident stated she did tell undisclosed staff that the food was not hot and was told to be grateful she got food. The resident stated she ate in the dining room. 2. Resident #42's MDS dated [DATE] revealed a BIMS score 12/15 indicating moderate cognitive deficit. The document disclosed the resident was independent with eating. On 1/20/26 at 12:49 PM Resident #42 stated she ate in her room and had room trays. The resident stated her food had been cold when her trays were delivered. Observed on 1/21/26 at 1:27 PM the final room tray to be delivered by Staff R, Certified Nurse Assistant (CNA). Requested the tray be returned to the kitchen for temperature checks. Staff V, Cook/Dietary Manager, completed temperature checks with the Chicken [NAME] at 132 degrees, vegetables at 135 degrees and refrigerated [NAME] Fruit Crumble at 56 degrees. On 1/22/26 Staff HH, Registered Dietitian (RD), stated foods must be served above 135 degrees for hot foods and below 41 degrees for cold foods. 3. Review of Resident #36's MDS dated [DATE] revealed a BIMS score of 13 indicating intact cognitive functioning. Interview on 1/20/26 at 12:05 PM with Resident #36 revealed that the food is often cold when it should be warm. Resident #36 revealed that he usually eats in his room, and when the room tray comes the food is usually cold on the tray. 4. Review of Resident #44's MDS dated [DATE] revealed a BIMS score of 14 indicating intact cognitive functioning. Interview on 1/20/26 at 12:42 PM with Resident #44 revealed that he still had his breakfast tray sitting on his bed side table at this time, and had not yet received his lunch. Resident #44 then revealed that the food is cold when it comes on the room trays. Observation 1/20/26 at 1:20 PM a room tray was delivered to Resident #44's room for lunch. Observation 1/20/26 at 1:24 PM the last room tray was obtained and the food was checked for temperature with the macaroni salad temping at 134 degrees, and the mandarin orange fluff temping at 62 degrees. On 1/29/2026 at 10:21 AM Staff DD Licensed Practical Nurse (LPN) shared a document she provided to the Human Resource staff in December. It documented a resident was left sitting straight up in bed (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the side table locked in placed over her body while she was hunched over her lunch tray on 11/30/2025 at 3:00 PM. It also documented meals trays were left in front of sleeping residents in their rooms, hours after meals have been over. 5. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. On 1/13/26 at 4:11 PM Resident #3's son stated his mother said sometimes the food was delivered lukewarm and wished it was dropped off to her room warmer. On 1/22/26 at 9:26 AM an observation of Resident #3's breakfast tray delivered to the room. On 1/22/26 at 9:26 AM Resident #3 acknowledged her food was just dropped off. Resident #3 stated the food was not very warm at that time. Resident #3 explained she would like the food served warmer. 6. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:57 AM Resident #15 stated she eats her meals in her room and the food is brought lukewarm. Resident #15 explained she wished that the food was served warmer. Resident #15 stated sometimes the staff will heat the food up but she does not always ask. On 1/21/26 at 8:08 AM Staff R, CNA stated Resident #15 had complaints about the temperature of the warm food being cold or the cold being hot. Staff R stated that it was mostly on the evening shift. Review of undated policy titled, Food Service Delivery to Nurse Assisted Dining Room documented to ensure that food delivered from the main kitchen to the Nurse Assisted Dining Room is transported, plated, held, and served in a safe and sanitary manner when nursing staff are responsible for meal service, in compliance with state health department, food safety and long-term care regulatory standards. Hot foods shall be maintained at a temperature of 135 degrees Fahrenheit or higher, and cold foods shall be maintained at a temperature of 41 degrees Fahrenheit or lower during transport, plating, holding, and service. Review of undated policy titled, Meal Program documented residents must be able to come to the dining room. Temporary tray service may be provided to the dwelling unit following illness or injury. A fee will be charged to any resident who requests a meal in their room; unless ill, returning from the hospital or otherwise incapacitated - to be determined by the Resident Care or Executive Director.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and policy review the facility failed to prepare, serve and distribute food in accordance with food service safety for 3 of 8 residents (Resident #3, #9, #15) reviewed, as well as general practices for mealtime service. The facility reported a census of 28 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. On 1/22/26 at 9:26 AM an observation of Resident #3's breakfast tray delivered to the room. On 1/22/26 at 9:26 AM Resident #3 acknowledged her food was just dropped off. Resident #3 stated 9:30 AM does feel a little late for breakfast but the breakfast meal has come much later. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #9 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:29 AM Resident #9 stated you never know when the meal will be served. Resident #9 stated she knows it will be another at least 30 minutes from now at a minimum. Resident #9 stated the facility's biggest shortcoming was the timing for food service. 3. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:57 AM Resident #15 stated she eats her meals in her room and the food is brought lukewarm. Resident #15 explained she wished that the food was served warmer. Resident #15 stated sometimes the staff will heat the food up but she does not always ask. On 1/21/26 at 8:08 AM Staff R, Certified Nurse Assistant (CNA) stated Resident #15 had complaints about the temperature of the hot food being cold or the cold food being hot. Staff R stated the food was cold because the kitchen staff brought the food so late. Staff R stated it was 1:00 PM last week when lunch was started and 9:00 AM when breakfast was started. Staff R stated Staff V, [NAME] is the staff that has the trays delivered so late. Staff R stated the biggest problem with the food was the time of the food delivery especially with the room trays. On 1/27/26 11:03 AM the DON acknowledged the CNA's had voiced concerns about meals coming out late in the halls for room tray delivery. The DON stated the room trays are passed last during the meals. During dining room observation on 1/20/2026 at 12:28 PM a tray of 15 desserts in bowls, 2 pureed desserts not covered entered the dining room from the kitchen. At 12:32 PM Staff F left the dining room and went to the kitchen with the tray cart and 12 desserts not covered. At 12:34 PM Staff F returned to the dining room from the kitchen with 12 uncovered desserts on the tray cart. When staff asked him what it was, he told them it was an orange marshmallow dessert. At 12:36 PM Staff F again, left the dining work with the tray cart to kitchen with 10 desserts still uncovered. At 12:37 PM Staff F returned with the tray cart with the desserts uncovered. At 12:37 PM Staff F left the dining room again with the desserts left uncovered to the kitchen; to get silverware. He returned at 12:39 PM with the desserts still uncovered. Staff F then he passed 3 desserts to the main table 1 dessert to a (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident at the assisted table. Staff F left the dining room at 12:39 PM with 7 uncovered desserts remaining on the cart; to the kitchen. It is 64 feet from assisted table to the kitchen and 52 feet from the second table of residents to the kitchen. At 12:43 PM Staff E Certified Nursing Assistant (CNA) removed a slice of bread from a bread bag with her bare hands. Staff E placed it on Resident #13's plate, applied butter with a knife, cut the bread up and fed it to the resident. On 1/21/2026 at 11:43 AM observations of items in the resident's Whirlpool refrigerator on the Long-Term Care (LTC) hall included the following items: a clear pitcher with a sticker dated 1/10/2026, no label indicating what the light orange liquid is; in the freezer a Styrofoam Sonic cup dated 1/4 with unidentifiable markings above the date; freezer racks have rust like markings (dark orange in color) where the shelving unit comes together; one bag of opened ice in the freezer with no date, the bag left open to air; an unlabeled white grocery bag of items on the door shelf of the refrigerator; an unlabeled white grocery bag of white Styrofoam to-go boxes on the shelf of the refrigerator; a bottle of tain seasoning with an expiration date of July 2023 on the door shelf of the refrigerator; an unlabeled floral bag that appears to be a lunch bag on the bottom shelf of the refrigerator door; an unlabeled, opened pink paper container with a white frozen substance with black specks on top; found on a shelf in the freezer; on the refrigerator door the follow sign was present: Resident Food Only. All items must be dated and labeled. Any staff items, undated items, and unlabeled items will be discarded! On 1/21/2026 at 11:52 AM observations of items in the resident's refrigerator on the Skilled Hall included the following items: a Healthy Choice frozen dinner on the door shelf of the freezer, with no label; an unlabeled plastic mug with frozen white substance instead in the freezer; light brown stains on a door shelf in the refrigerator; on the top shelf of the refrigerator two items wrapped in white napkins dated 1/20/2026 with initials on both of them; a clear pitcher with blue tape on the lid, dated 11/27 with initials on it. The liquid at the bottom of the pitcher was off white, the lid to seal to the pitcher is light brown in color; slices of pizza wrapped in napkins on a shelf in the refrigerator; an unlabeled Styrofoam container with brown/black food in it; (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	an unlabeled to go cup from Panera with soap like food in it; on the refrigerator door was a sign that read: Prepared food or opened food items should be discarded when: the food item does not have specific manufacturer expiration date and as been refrigerated for 7 days, the food items is leftover for more than 72 hours, and the food item is older than the expiration date. on the refrigerator door the follow sign was present: Resident Food Only. All items must be dated and labeled. Any staff items, undated items, and unlabeled items will be discarded! During dining room observations on 1/21/2026 at 12:21 PM a cart of drinks was brought to the hall then brought in to the dining room. Staff F brought three residents their drinks, holding the rims of the cups for each cup. Staff C Certified Nursing Assistant (CNA) also brought three residents their drinks holding the rims of the cups for each cup. At 12:40 PM Staff F brought in a food cart with 19 dessert dishes uncovered. At 12:43 PM 11 uncovered desserts on the cart were taken back to the kitchen. At 12:48 PM the food cart returned to the dining room with one uncovered dessert bowl and the final tray was delivered in the dining room. On 1/29/2026 at 10:21 AM Staff DD Licensed Practical Nurse (LPN) shared ta document she provided to the Human Resource staff in December. It documented a resident was left sitting straight up in bed with the side table locked in placed over her body while she was hunched over her lunch tray on 11/30/2025 at 3:00 PM. It also documented meals trays were left in front of sleeping residents in their rooms, hours after meals have been over. During the initial kitchen visit on 1/20/26 at 8:30 AM the following observations were made: The single door freezer did not have an internal thermometer. The temperature logs for the single door freezer and salad bar were incomplete. The salad cart contained uncovered food items and food spillage. Staff F, Dietary Aide, stated the salad cart was last used the previous day. The walk-in refrigerator and freezer had incomplete temperature logs posted. The walk-in refrigerator contained expired cottage cheese, undated fresh produce, no internal thermometer, unidentifiable package, dirty shelves and floor. While inspecting the walk-in refrigerator Staff V, Cook/Dietary Manager entered and removed several items stating they shouldn't be here. The triple sink was full of water in 2 sinks with water continuously running spilling onto the counter of the triple sink and into the 3rd sink; dishes present in all sinks. Open containers of liquids under the sink. Dirty dishes with leftover food present from previous day's meals. Dish racks standing on end on the floor. Items removed from the walk-in refrigerator by Staff V were placed on top of the garbage can and (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	beside the garbage can. An incomplete cleaning log. Standing water on the counter with coffee/tea makers. The cook line refrigerator temperature log posted was incomplete. The cook line refrigerator contained jars of grape jelly without open dates and a jar of Sauerkraut revealing open 3/3, undated eggs and several food items that were unidentified and undated. Counters, shelves and floor dirty with food particles, stains present. Staff V acknowledged the lack of internal thermometers, undated items, overall dirty presentation of the kitchen, the presentation of the salad cart and the incomplete temperature logs for all refrigerators and freezers. The staff stated all items would be fixed. Staff V stated he would talk to the staff about the incomplete logs. During a continuous observation on 1/21/26 beginning at 10:34 AM the following was noted: All refrigerator/freezer/salad bar logs were completed with Staff V stating see all done now. Staff FF, Dietary Aide, presented with a full beard and no beard net. Staff FF prepared meatloaf with a single gloved hand. The staff did not consistently complete hand hygiene between glove changes and prior to touching the raw hamburger with the gloved hand would touch various surfaces and kitchen items with the gloved hand. During a continuous observation on 1/21/26 beginning at 12:02 AM the following was noted: Staff V did not take temperatures of all food items on the steam table prior to initiation of the meal surface. Staff V did not take temperatures of the vegetables, hamburgers, plain [NAME] sauce or ham. Staff V and Staff F left the kitchen to serve meals to the residents in the dining room. Observed Staff V and Staff F touch the sides of the plates while serving the residents. Upon entry into the kitchen Staff V and Staff F did not initially wash their hands. Staff F proceeded to wrap silverware without hand hygiene. Staff V washed his hands, donned gloves, obtained a kitchen utensil, used a utensil to get a hamburger from the steam table, and placed it on a plate and chopped the burger. The staff proceeded to touch the bun wrapper, obtained a bun, placed it on the plate, and placed the hamburger on the bun. Staff V touched the hamburger and bun with the gloved hands to prepare it in the manner the resident preferred. Staff V continued to meal service without changing gloves. Staff F removed the refrigerated uncovered tray of [NAME] Fruit Crumble from the walk-in pantry, placed it on the delivery cart and transported to the dining room. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 1:03 PM Staff F loaded the last room tray into the room tray insulated cart for delivery. At 1:23 PM Staff R, Certified Nurse Assistant (CNA) removed the last tray from the insulated cart. At 1:27 PM Staff R provided Staff V with the last room tray for obtaining temperatures of the food items on the tray: Chicken [NAME] at 132 degrees, vegetables at 135 degrees and the refrigerated [NAME] Fruit Crumble at 56 degrees. When Staff V was asked if it was acceptable for the tray temperatures, the staff responded it had been over 30 minutes since he prepared the tray. The staff stated the plate with the entree and vegetables was fine but the dessert was too hot. Staff V made no attempt to correct the room service tray until asked for a third time what Staff R should do for providing the resident a room tray. Staff V provided Staff R with the plate that had been returned to the kitchen and gave the staff a new dessert. Observed Staff FF on 1/28/26 at 8:45 AM in the kitchen without a beard net. The Cleaning Log labeled dishwashing dated for the week of 1/19/26 revealed no tasks were completed for 1/19/26 and items for 1/20/26 were identified as all completed by 9:00 AM. The Salad Bar Temperature Log revealed missing data for 8 entries (1/11 PM, 1/12 PM, 1/13 PM, 1/14 AM and PM, 1/17 PM, 1/18 PM, 1/19 PM) The Freezer Temperature Log revealed missing data for 7 entries (1/12 PM, 1/13PM, 1/14 PM, 1/17 PM, 1/18 PM, 1/19 PM). The Walk-in Freezer Temperature Log revealed missing data for 10 entries (1/6 PM, 1/7 PM, 1/11 PM, 1/12 PM, 1/13 PM, 1/14 PM, 1/17 PM, 1/18 PM, 1/19 AM and PM). The Walk-in Refrigerator Temperature log revealed missing data for 9 entries (1/1 AM, 1/11 PM, 1/12 PM, 1/13 PM, 1/14 PM, 1/17 PM, 1/18 PM, 1/19 AM and PM). The [NAME] Line Temperature Log revealed missing data for 9 entries (1/1 AM, 1/9 AM, 1/11 PM, 1/12 PM, 1/13 AM and PM, 1/17 PM, 1/18 PM, 1/19 PM). The Skilled Nursing Kitchen Observation Document dated 12/4/25 disclosed the facility received 1 of 19 points possible. The document cited numerous areas prioritizing attention including cleaning floors/vents/shelves/appliances, dry/cold food storage with labeling foods with use by date, discarding expired foods, numerous food items undated, maintaining refrigerator(s) at 41 degrees or below, use temperature forms to document and document corrective actions when needed, discard produce not of good quality, and placing pull dates on foods that were being thawed in the refrigerator. The facility provided document for meal times indicated breakfast was to be served 7:30 AM to 9:00 AM, lunch 12:00 PM to 12:30 PM, and supper 5:30 PM to 6:00 PM. On 1/22/26 at 1:57 PM Staff HH, Registered Dietitian (RD), acknowledged she had found numerous concerns with the kitchen the previous month when she had completed her inspection and those results had been shared with the Administrator who told her he would be sharing with the contract kitchen company. Staff HH stated temperature logs should be done at a minimum of 2x/day to ensure correct temperature and thermometers must be inside the refrigerator/freezers. The staff stated the (continued on next page)		

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Form Approved OMB
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cleaning logs should be completed and signed as indicated on the log. Staff HH stated all foods must be temped prior to meal service and logged. The staff stated individuals with any facial hair should have beard/face nets. Staff HH stated all food items must have a received date and opened date on them. The staff stated items must be disposed of based on the open dates and items such as Sauerkraut and pickles should be discarded 30 days after opening. The staff stated that all food or drink items crossing any threshold must be covered. Staff HH stated the food temperatures for the final meal tray were outside of the required range - hot foods must be above 135 degrees and cold foods below 41 degrees. When asked about the last room trays being delivered at 1:30 PM, the RD responded that it was an hour outside of the meal service time. On 1/27/26 at 11:01 AM the Director of Nursing (DON) acknowledged there was a problem with the coordination of the kitchen and nursing staff with meal service. The staff stated the CNAs could not be expected to pass beverages when they were supposed to be assisting residents with their meals. The DON stated she had heard complaints regarding the length of time for meal service and the delivery of room trays. On 1/27/26 at 1:39 PM Staff II, Chief Executive Officer (CEO) for the kitchen services contract company, stated the kitchen staff have a 30 day on-boarding training with the company including in-person and on-line training related to all areas of the kitchen including hygiene, food safety and preparation. The staff stated the kitchen staff were all experienced employees of the previous owners and they had transferred with the change of ownership. Staff II stated there typically was a corporate level staff onsite for the kitchen once a month. The staff stated it was the expectation that all logs, temperature and cleaning, were completed as required. The staff stated the kitchen staff were not using the correct logs for documentation as they contained the heading for the previous company. Staff II stated all food items must be labeled and dated due to safety concerns and items must be discarded to prevent illness. The staff stated all food items must be covered before leaving the kitchen with plastic wrap and an insulated cover (if needed). Staff II stated foods must be served at the appropriate temperatures, and temperatures must be taken/logged prior to the meal service. The staff expected dishes to be done and garbage disposed of by the end of the shifts. When asked about the observations related to the length of time for the meal services, the staff stated nursing should be assisting with meal delivery to minimize errors with diets and to be present at the time meal service should begin to decrease the waiting to start meal time. During a discussion on 1/28/26 at 11:14 AM with Administrator and the DON regarding the concerns with the kitchen staffing and meal service, the Administrator stated it was difficult with some aspects of the kitchen due to using a contract company. The Administrator acknowledged Staff FF had not been wearing a beard net, but that was corrected this morning. The Administrator stated he was hopeful with a newly hired Dietary Manager the kitchen concerns would decrease. The undated kitchen policy for Cleaning Frequency provided food contact surfaces, utensils, kitchenware should be maintained in a clean, sanitary manner and free of encrusted grease deposits and other accumulated soil. The undated kitchen policy for Food Storage and Protection provided food shall be stored, prepared, served, transported, and distributed with protection at all times from potential contamination. The undated kitchen policy for Food Service Delivery to Nurse Assisted Dining room disclosed all meals use approved, clean, and insulated carts or containers designed to maintain proper food temperatures and protect food from contamination. The policy further disclosed upon delivery the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nursing staff shall verify proper food temperatures, accuracy of resident's meal cards and diet orders and food quality/presentation and integrity. The undated kitchen policy for Hairnet and Hat Policy revealed all hair must be kept under a hat or hairnet and beards must be covered with a hairnet or beard net. The undated kitchen policy for Gloves revealed all kitchen staff must wash their hands prior to application of gloves and gloves should be changed between tasks including when handling different food items. The document further stated gloves must be substituted for proper hand hygiene and staff should avoid contact between gloved hands and non-food-contact surfaces. The undated kitchen provided document for Annual Food Safety Training for Individuals included handwashing, use of gloves, thermometers, holding hot and cold foods, receiving and storing food, cleaning/sanitation, and preparing/cooking food. The undated kitchen provided In-service training for handwashing identified that hand washing should occur prior to beginning work, before putting on gloves, before handling different types of food and after handling trash or contaminated items. The facility's undated Food Handling Policy stated food would be stored, handled and served to minimize risk for foodborne illness. The policy included all employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. The policy disclosed functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state-specific requirements.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observations and staff interviews the facility failed to properly dispose of room trays with left-over food and beverages in a timely manner. The facility further failed to dispose of garbage and waste properly. The facility reported a census of 28 residents. Findings include: On 1/21/2026 at 7:00 AM outside room GP10 observed a cart with room trays, plates, and cups on it. Breakfast had not been served prior to this. The Minimum Data Set (MDS) Coordinator/Infection Preventionist observed the surveyor in front the cart and removed it from the hall at 7:05 AM. At 9:06 AM in a cubie across from the Clinical Office observed three meal trays that contained what looked like an uncovered bowl of vegetable soup, cup of brown liquid, uncovered ice cream cups, two plates with sloppy joe sandwiches on them (from 1/20/2026 lunch meal), carrots, green beans, opened fruit cup and silverware. At 9:45 AM the food trays remained in the cubie across from the clinical office. At 10:30 AM the trays had been moved to a cart and placed in front of the nurse's station (main) by the Long-Term Care (LTC) entrance. At 10:53 AM cart with trays remained by the nurse's station by the LTC entrance. At 11:30 AM the cart with the trays was gone. On 1/22/2026 at 7:50 AM a cart of trays was observed outside of the kitchen with plates of chicken alfredo (lunch from 1/21/2026), a plate with a hot dog, core of an apple, various food items (unable to determine what food items), cups, silverware, condiments, food wrappers, clothing protectors. At 9:16 AM the cart remained in the hall. At 9:53 AM the cart had been removed from the hall. On 1/22/2026 at 2:18 PM the Dietician stated dirty trays should be picked up timely, it was not acceptable to have the trays in the halls from the previous day. She added trays should be picked up maybe in an hour or two after the meal but not the next day. She was not sure if dietary staff or nursing staff were to pick them up and take them to the kitchen. She acknowledged they do not have enough dietary staff. On 1/29/2026 at 8:00 AM a cart of trays, a red cooler and ice scoop was observed in the hall behind the nurse's station after entering the through LTC entrance. The cart had multiple room trays and uncovered food on all three shelves of the cart. A meal ticket was observed on the cart for Resident #3's lunch on 1/28/2026. The cart also had blue latex gloves, medication cups, cups with fluid in them, silverware. At 9:00 AM the cart remained in the hall. At 9:30 AM the cart was removed from the hall. On 1/29/2026 at 10:21 AM Staff DD Licensed Practical Nurse (LPN) shared a document she provided to the Human Resource staff in December. It documented a resident was left sitting straight up in bed with the side table locked in placed over her body while she was hunched over her lunch tray on 11/30/2025 at 3:00 PM. It also documented meals trays were left in front of sleeping residents in their rooms, hours after meals have been over. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) believed the Certified Nursing Assistants (CNAs) were responsible for removing resident's room trays when they are done with their meals. The DON stated she would like the staff to do a sweep after 45 minutes to see if trays are ready to be picked up. She added, some residents like to pick at their food longer than that, but that should be care planned. The DON was asked after the room trays are removed from a resident's room, where do they go. She acknowledged they should go to the kitchen, put on a cart inside the kitchen. When asked if they can be left out in the halls, she stated no that's gross and a tripping hazard. She stated it was not acceptable to have food trays in the halls with the previous day's food on them. They should be picked up after 45 minutes served or within an hour. (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observed during the initial kitchen visit on 1/20/26 at 8:30 AM the following: The walk-in refrigerator contained expired cottage cheese, undated fresh produce, no internal thermometer, unidentifiable package, dirty shelves and floor. While inspecting the walk-in refrigerator Staff V, Cook/Dietary Manager entered and removed several food items stating they shouldn't be here. The counter next to the dish machine held dirty dishes from the previous day's meal(s) with discarded food items on them. Items removed from the walk-in refrigerator by Staff V had been placed on top of the overflowing garbage can and beside the garbage can. The garbage can did not have a lid. The garbage/garbage can was located beside the door where staff transported food out of the kitchen. On 1/27/26 at 11:01 AM the Director of Nursing (DON) stated trays should be picked up from rooms and returned to the kitchen, and carts should be moved into the kitchen if the staff have gone home. On 1/27/26 at 1:39 PM Staff II, Chief Executive Officer (CEO) for the kitchen services contract company, stated the kitchen staff were all experienced employees of the previous owners and they had transferred with the change of ownership. Staff II stated there typically was a corporate level staff onsite for the kitchen once a month. The staff expected that garbage be disposed of in a timely manner. Staff II stated staff should not be needing to take large amounts of items out of the walk-in refrigerator to the garbage can and leaving them there. The staff stated regarding the large stacks of dishes with food waste on them stacked on counters and on carts in and outside the kitchen, if they were returned after the kitchen closed they would not be managed until the next day. Staff II stated the kitchen staff got off work at 8:30 PM. On 1/28/26 at 11:14 AM Administrator stated management of the kitchen was difficult due to using a contract company. The staff stated with a new Dietary Manager the hope would be for things to improve in the kitchen. The undated kitchen policy for Food Storage and Protection provided food shall be stored, prepared, served, transported, and distributed with protection at all times from potential contamination. The undated facility did not have a policy specific to garbage disposal and/or management of room trays after mealtime service.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, policy review and facility document review the facility failed to provide complete and accurate records when inventory lists were not completed, failed to accurately document administration of medication, documented treatments completed before doing them, failed to lock or close a laptop leaving confidential health information accessible, and documented refrigerator temperatures falsely for 7 of 12 resident reviewed (Resident #3, #15, #11, #44, #21, #3 and #11). The facility reported a census of 28 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] documented Resident #3 had a Brief Interview for Mental Status (BIMS) of 11 indicating moderate cognitive impairment. The MDS revealed Resident #3 had diagnoses of pressure ulcer of sacral region stage 4, pressure ulcer of right buttocks stage 4 and pressure ulcer of left buttocks stage 4. Review of Resident #3's Medication Administration Record (MAR) documented a physician's order with a start date of 11/19/25 for oxycodone 10mg one tablet to be given every 6 hours as needed for pain. Resident #3's MAR indicated the medication was administered on 1/22/26 at 8:49 AM by Staff A. Further review of Resident #3's MAR documented Staff A had administered oxycodone 18 times from 1/1/26 - 1/22/26. Resident #3's MAR documented Staff A was the only staff that was administering oxycodone to Resident #3 for the month of January 2026. On 1/22/26 at 9:26 AM Resident #3 stated she had not requested an as needed (PRN) pain medication for a long time. Resident #3 stated the staff ask if she wants PRN pain medication but she says no. Resident #3 stated she did not feel the staff give the medication unless she asked. Resident #3 stated she was so used to how her body feels that she does not request PRN medication very often. Resident #3 stated pain level is under 5 at that moment. Resident #3 explained the pain level was probably around a 2 or 3. Resident #3 stated she had not requested any PRN pain medication today. Resident #3 stated she would know if the nurse gave her any extra medications. On 1/22/26 at 9:53 AM an observation of narcotics count for Resident #3 with the Director of Nursing (DON) present. The observation revealed 29 tablets present in the medication bubble pack. Observation of 29 documented on Resident #3's count sheet. Observation revealed Staff A, Registered Nurse (RN) documented last administration on 1/22/26 at 8:50 AM. On 1/22/26 at 9:59 AM Staff A stated she had interactions with Resident #3 that morning. Staff A stated Resident #3 had voiced concern of pain to her this morning. Staff A stated Resident #3's pain level was at a 7 that morning. Staff A stated she asked Resident #3 if she wanted any PRN pain medication that morning. Staff A stated whenever a resident has a pain level of 6 - 10 she offers a PRN pain medication. Staff A stated she asks her every single day about PRN pain medication. Staff A stated she had to do a pain assessment on the MAR-TAR every single day. Staff A stated she was required to do a follow-up assessment after any pain medication administration. Staff A stated she had to wait about 30 minutes but she usually waits till 45 minutes before completing the follow-up assessment. Staff A stated she did a follow up for effectiveness for pain in back or left shoulder for Resident #3. Staff A stated Resident #3 remembered her giving the pain medication this morning when she did the follow-up assessment. Staff A stated she followed up for effectiveness at about 9:27 AM with Resident #3. Staff A stated she did not talk to Resident #3 a whole lot but Resident #3 seemed okay and cognitively aware at the time. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/22/26 at 9:57 AM the DON stated she had concerns with Staff A related to false documentation and misappropriation of medications. On 1/22/26 at 10:29 AM the DON acknowledged she had just spoken to Resident #3 and she Resident #3 stated she had not requested any PRN pain medication but would like some now. The DON stated she had taken Staff A's keys a couple of weeks ago when Staff D, Certified Medication Assistant (CMA) said Staff A had signed the medication out at 1:00 PM. The DON stated Staff A reported she was embarrassed and needed the narcotic medication key to complete her job appropriately. The DON explained Resident #3 was getting oxycodone randomly with other nurses and when Staff A started it was twice a day every single day. The DON acknowledged the increase in oxycodone administration for Resident #3 by Staff A was alarming. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #15 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. On 1/20/26 at 11:52 AM Resident #15 stated she had 4 pairs of pants that were 25 or 30 dollars apiece and only had 2 left. Resident #15 stated she was also missing several shirts. Resident #15 stated she had told everyone that would listen. Review of Resident #15's (Electronic Health Record) EHR revealed no personal property list. Review of Resident #15's EHR dated 1/5/26 by Staff A, RN at 2:48 PM documented inventory list was completed and there were personal items present. On 1/20/26 at 11:49 AM Resident #15 stated Staff Y was going through her bag of personal belongings. Resident #15 stated she told Staff J about the incident. On 1/21/26 at 4:45 PM the DON acknowledged there was no personal property list for Resident #15. The DON stated she expected a personal property list would be completed upon admission and updated with any items that were brought to the facility and not on the list already. On 1/27/26 at 11:03 AM the DON stated she would expect accurate documentation of medication administration. The DON stated she expected grievances would be completed when residents reported any concerns and that was not being completed appropriately at the facility. The DON acknowledged she did not know if a grievance had been filled out for Resident #15's missing shirt yet. The DON explained she did not know what the process was, if the missing items would be replaced and how many days that would take. 3. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 15 indicating intact cognition. Interview 1/20/26 at 10:37 AM with Resident #11 revealed his reading glasses went missing, and nobody can find them. Resident #11 further revealed they had been missing a week now. Resident #11 then revealed that he reported this to the nurse. Follow up interview 1/21/26 at 4:23 PM with Resident #11 revealed that he did have glasses, and that he reported this to the DON. Review of the clinical record revealed there was no inventory list of personal items to review. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview 1/21/26 at 4:45 PM with the DON revealed that the facility staff had not found the inventory list, and that she did not recall Resident #11 telling her that his glasses were gone. The DON then revealed that glasses would definitely be on the inventory list. Interview 1/21/26 at 4:45 PM with the Administrator revealed glasses would be part of the personal items list. 4. Review of Resident #44's Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was admitted to the facility from another nursing home on 1/15/26. The MDS then revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS further revealed Resident #44 utilized a feeding tube while at the facility. Review of Resident #44's EHR page titled, Clinical Physician's Orders revealed an order to flush Resident #44's tube with 25 milliliters of water twice a day starting 1/15/26. Review of Resident #44's Medication Administration Record (MAR) 1/21/26 at 10:15 AM dated 1/1/2026 through 1/31/2026 revealed Staff A Registered Nurse (RN) had initialed the MAR as having given the enteral flush. Interview 1/21/26 at 10:40 AM with Staff A RN confirmed that she had signed off the water flush prior to giving the water flush. Staff then revealed that she must have signed off the water flush while she was giving the morning medications. Interview 1/21/26 at 11:06 AM with the DON revealed that staff should not be signing off treatments, or medications prior to being completed. Follow up interview 1/21/26 at 3:00 PM with the DON revealed that the facility does not have a policy related to signing medications after completing treatments as this is a standard of nursing care. The DON revealed that staff should sign off treatments and medications after they are administered. 6. Resident #21's MDS dated [DATE] Significant Change export ready revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document indicated the resident's diagnoses included heart failure, atrial fibrillation (A-fib) and impaired brain function. The MDS revealed the resident had (1) Stage 2 pressure ulcer, partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed, at the time of admission. The resident's Care Plan dated 12/30/25 revealed a focus area of Pressure injury - Stage 2 sacrum (lower vertebrae near the tailbone) related to immobility revised 12/30/25. Interventions for staff included treatments as ordered and document appearance at least weekly dated 12/23/25, assess/record wound healing 12/30/25, Enhanced Barrier Precautions (EBP) 12/30/25. Observed on 1/21/26 at 1:42 PM Staff A, Registered Nurse (RN), take treatment cart with a laptop computer to Resident #21's room. The staff positioned the cart outside of the resident's room, looked at the resident's electronic medical record (EMR), partially closed the computer without locking the screen, left the area to obtain supplies, returned to the cart, obtained the rest of the supplies and entered the resident's room for the treatment. Upon completion of the treatment Staff A returned to the computer, opened the screen, and entered documentation. The facility failed to ensure Health Insurance Portability and Accountability Act (HIPAA) security for (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #21. Staff A left an unlocked partially open laptop computer in a semi-open position which allowed staff/visitors/residents access to the resident's medical record. On 1/28/26 at 11:14 AM the Administrator and DON stated the staff needed to be aware of HIPAA violations related to conversations in the hallways and computers. The DON stated it was 1 button to lock the screen on a computer. The Administrator stated staff should not be falsifying documentation, if something was not done, it was not done they should not be going back and completing it. 7. Observed during kitchen visit on 1/20/26 at 8:30 AM the following: Incomplete temperature logs for the single door freezer and salad bar. The salad cart contained uncovered food items, food spillage on the cart and under it. No mop bucket/wet floor signs present. Incomplete walk-in refrigerator and freezer temperature logs. Incomplete cleaning log - no documentation on 1/19/26 and 1/20/26 all tasks marked as completed. Incomplete cook line refrigerator temperature log. No wet floor signs, mop buckets present at 9:10 AM. During the observation Staff F, Dietary Aide, stated the salad cart was last used the previous day. Staff V, Cook/Dietary Manager, acknowledged the incomplete temperature logs and stated they would be fixed. The Cleaning Log labeled dishwashing dated for the week of 1/19/26 revealed no tasks were completed for 1/19/26 and all items for 1/20/26 completed by 9:00 AM. Items identified as completed included clean out Salad Bar Fridge, Sweep and Mop behind and under the Salad Bar. The Salad Bar Temperature Log revealed missing data for 8 entries (1/11 PM, 1/12 PM, 1/13 PM, 1/14 AM and PM, 1/17 PM, 1/18 PM, 1/19 PM) The Freezer Temperature Log revealed missing data for 7 entries (1/12 PM, 1/13PM, 1/14 PM, 1/17 PM, 1/18 PM, 1/19 PM). The Walk-in Freezer Temperature Log revealed missing data for 10 entries (1/6 PM, 1/7 PM, 1/11 PM, 1/12 PM, 1/13 PM, 1/14 PM, 1/17 PM, 1/18 PM, 1/19 AM and PM). The Walk-in Refrigerator Temperature log revealed missing data for 9 entries (1/1 AM, 1/11 PM, 1/12 PM, 1/13 PM, 1/14 PM, 1/17 PM, 1/18 PM, 1/19 AM and PM). The [NAME] Line Temperature Log revealed missing data for 9 entries (1/1 AM, 1/9 AM, 1/11 PM, 1/12 PM, 1/13 AM and PM, 1/17 PM, 1/18 PM, 1/19 PM). Observed on 1/21/26 at 10:34 AM all refrigerator/freezer/salad bar logs completely filled out. During observation Staff V stated see all done now. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Salad Bar Temperature Log revealed data completed for the missing 8 entries with initial. The Freezer Temperature Log revealed data completed for the missing 7 entries with an initial. The Walk-in Freezer Temperature Log revealed data completed the missing 10 entries with an initial. The Walk-in Refrigerator Temperature log revealed data completed for the missing 9 entries with an initial. The [NAME] Line Temperature Log revealed data completed for the missing 9 entries with an initial. All temperature logs completed with the new data contained the same initial. On 1/21/26 at 1:03 PM Staff V when asked about the completed temperature logs all being completed, the staff stated he contacted Staff U, Cook, and she was able to provide the missing temperatures. On 1/21/26 at 1:07 PM Staff U stated she was the evening cook and had a great memory for numbers and could recall the missing temperatures When asked about the specifics of the single door freezer, salad cart, and walk-in freezer and refrigerator, the staff stated she wasn't responsible for those, only the cook line refrigerator and those were the temperatures she remembered. The facility failed to accurately record the temperatures for the refrigerators and freezers throughout the month of January as documentation for the missing data indicated the same staff knew all of the missing temperatures for the appliances. The facility failed to accurately record the cleaning tasks completed as recorded. On 1/22/26 at 1:57 PM Staff HH, Registered Dietitian (RD), expected temperatures for the freezers and refrigerators be checked twice daily to ensure fully functioning. The staff stated she did not see how someone could remember the specific temperatures of appliances several days later. Staff HH stated she expected the cleaning logs to be filled out as the tasks were completed. On 1/26/26 at 10:12 AM the Administrator stated documentation should accurately reflect what was completed and when it was completed. 8. Review of Resident #3's September 2025 Medication Administration Review (MAR) revealed the following order: -Oxycodone (narcotic pain medication) oral tablet 10 milligrams (mg). Give one tablet by mouth every 6 hours needed (PRN) for pain. The medication was signed out being given by Staff A RN on: 9/26/2025 at 6:15 AM for a pain rating of 5. Review of Staff A's timecard for September 2025 revealed on 9/26/2025 she clocked in to work at 7:00 AM. Review of Resident #3's December 2025 MAR revealed the following order: -Oxycodone oral tablet 10mg. Give one tablet by mouth every 6 hours PRN for pain. The medication (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was signed out as given by Staff A on: 12/2025 at 10:20 AM for pain rating of 7; Review of Staff A's timecard for the December 2025 revealed on 12/22/2025 Staff A clocked out for lunch from 9:53 AM until 10:23 AM. Review of Resident #3's January 2026 MAR from 1/2 revealed the following orders: -Oxycodone oral tablet 10mg. Give one tablet by mouth every 6 hours PRN for pain. The medication was signed out has being given by Staff A on: 1/5/2026 at 10:00 AM for a pain rating of 6; 1/11/2026 at 9:48 AM for a pain rating of 7; 1/16/2026 at 10:15 AM for a pain rating of 7; 1/21/2026 at 9:50 AM for a pain rating of 7. Review of Staff A's timecard for January 2026 revealed the following: 1/5/2026 she clocked out for lunch from 9:50 AM until 10:20 AM; 1/11/2025 she clocked out for lunch from 9:48 AM until 10:18 AM; 1/16/2025 she clocked out for lunch from 10:00 AM until 10:30 AM; 1/21/2025 she clocked out for lunch from 9:50 AM until 10:20 AM. Record review revealed the following Progress Note: on 1/2/2026 at 9:00 AM PRN oxycodone was given by Staff A for anticipatory pain related to a wound care clinic appointment. On 1/30/2026 at 11:02 AM the Social Worker stated Resident #3 did not have an appointment on 1/2/2026 for the wound clinic but had one scheduled on 1/5/2026. 9. According to the admission MDS assessment tool with a reference date of 12/5/2025, documented Resident #11 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. Resident #11 received a scheduled pain medication regimen and received a PRN pain medication or was offered and declined. The MDS documented Resident #11 had occasional pain any time in the last 5 days. Resident #11 reported he rarely had pain that made it hard for him to sleep at night and occasionally had pain that limited his participation in therapy sessions and his day-to-day activities. The MDS listed the following diagnoses for Resident #11: right femur fracture and malignant neoplasm of prostate. The Care Plan Focus Area with an initiated date of 12/5/2025 documented Resident #11 complained of plan The Care Plan directed staff to administer medications as ordered and monitor for adverse effects and notify the physician if pain management interventions are unsuccessful. (continued on next page)		

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Form Approved OMB
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NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #11's January 2026 MAR revealed the following order: hydrocodone-acetaminophen (treatment of pain) oral tablet 5-325mg, give one tablet by mouth every 8 hours PRN for severe pain. The order had a start date of 1/12/2026 at 10:59 AM. The order was signed out as being given by Staff A on: 1/16/2026 at 8:14 AM for a pain rating of 6, at 7:20 PM for a pain rating of 6; 1/17/2026 at 8:40 PM for a pain rating of 7; 1/18/2026 at 11:07 AM for a pain rating of 7 and at 7:35 PM for a pain rating of 8; 1/19/2026 at 8:00 PM for a pain rating of 7; 1/20/2026 at 8:00 A for a pain rating of 7; 1/21/2026 at 9:19 AM for a pain rating of 6 and at 8:22 PM for a pain rating 7; 1/22/2026 at 8:38 AM for a pain rating of 7. On 1/29/2026 at 9:29 AM Resident #11 was lying in bed, watching TV. He stated he has pain and it's all over, it's there all the time. When he has pain, he will ask for Tylenol first but every once in a while, he will ask for something strong. When asked what that stronger medication was, he stated tramadol. Since they got the order for hydrocodone a few weeks ago, he has asked for it once but they never brought in it for him. When asked if Staff A, the nurse with a boot on her foot, has ever asked if needed the hydrocodone or brought one in for him, he denied seeing her with that medication for him. He again stated he has only asked for it once but he never got it. He indicated he knows what medications he takes and would know if they put it with other medications. On 1/22/2026 at 12:27 PM Staff D Certified Medication Aide (CMA) stated there was an issue about a month ago when Resident #3 had her call light on and asked for something for pain. Staff D saw she got something 30 minutes prior and let her know she already had something for pain. Resident #3 denied receiving any pain medications with her morning medications. Staff D stated when Resident #3 has pain, she will ask her what she wants. Resident #3 will request Tylenol. Staff D stated Staff A is the only staff member that signs out Resident #3's oxycodone as given. Staff D stated Resident #3 would be reliable, could rate her pain on the pain scale and would be able to tell staff which pain medication she wants. She believed Resident #3 would be a good historian. On 1/23/2026 at 2:00 PM Staff Y Certified Nursing Assistant (CNA) stated in December she heard Resident #3 had asked for a pain pill and Staff A stated she was not eligible for one. The resident told her she had not had a pain pill all day. Staff Y stated she heard Resident #20 had requested a pain medication and it was signed out by Staff A as given. But the resident denied receiving the pain medication. On 1/28/2026 at 12:47 PM Staff J RN stated on the first day he trained Staff A in September, she was passing medications on the Long-Term Care side of the building. When she went to pass Resident #3 her morning medications and Staff A signed out her oxycodone. He was not sure if it was the same day they did her wound vac change but she never took oxycodone. Resident #3 always said Tylenol was enough. That morning Staff A signed out the medication in the narcotic book at a time when she was not in the building. She was 45 minutes to an hour late but Staff A signed out the (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication at a time when she was no here. She also never got in the drawer on the medication cart to retrieve the medication. On 1/29/2026 at 10:05 AM Staff DD LPN laughed when asked if Resident #3 experienced a lot of pain. She stated no, every once in a while, but not all the time. She would usually give her Tylenol or her PRN gel if she did have pain and when she would follow up for effectiveness it would help. When she did have pain, she would report pain to her left shoulder or her neck and back some times; rating it between 3 and 6. Staff DD stated Resident #3 had not asked for anything stronger and she would always offer Tylenol first. She indicated when she would come in for her 2:00 PM-10:00 PM after Staff A worked, Resident #3 would ask for a Tylenol Staff DD stated Resident #11 has scheduled Tylenol. This morning, he rated his pain at a 3 and asked him to let her know if he would need anything for pain. She denied ever giving him his hydrocodone. She has noted his pain is more when he is bed, which is rare because he sits in his recliner a lot. There was one time when the narcotic count was off. On 1/29/2026 at 10:21 AM Staff DD shared ta document she provided to the Human Resource staff in December. It documented a resident in room [ROOM NUMBER] was left sitting up in her recliner from 4:00 AM on 11/30/25 until 3:00 PM on11/30/25 without being checked on, changed, or wound care done. The resident stated that she was not changed and was not moved out of her recliner all day. It is care planned for this resident to only be up 2 hours a day per wound doctor's order. The foam dressing on her wounds were not changed, the date on the dressing stated 11/28/2025 and it was planned to be changed today 11/30/2025. It was documented that wound care and transfers were done and taken care by Staff A and Staff C CNA. On 1/30/2026 at 12:10 PM the DON stated she had some disciplinary actions for Staff A but she is no longer an employee here; she would not be able to sign them. She stated staff had filled out confidential concerns forms that she received on the 14th in regards to Staff A's performance. She had one form from Staff DD for falsifying documentation. Staff A had worked on the Long-Term Care hall and signed off treatments as being done but they were not completed. Staff A had left the facility before Staff DD had noticed the treatments were not completed. No policy provided by the facility for resident personal inventory lists or accurate documentation of administration of medications. The facility's Food Handling Policy stated food would be stored, handled and served to minimize risk for foodborne illness. The policy included all employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. The policy disclosed functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day and documented according to state-specific requirements. Review of undated policy titled, Grievances / Complaints, Recording and Investigation documented all grievances and complaints filed with the facility will be investigated and corrective actions will be taken to resolve the grievance(s). Upon receiving a grievance and complaint report, the Grievance Officer will begin an investigation into the allegations. The Resident Grievance/Complaint Investigation Report Form will be filed with the Administrator within five (5) working days of the incident. The resident, or person acting on behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within ten business days of the filing of the grievance or complaint. The Grievance Officer will coordinate actions with the appropriate state and federal agencies, depending on the nature of the allegations. All alleged violations of (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	neglect, abuse and/or misappropriation of property will be reported and investigated under guidelines for reporting abuse, neglect and misappropriation of property, as per state law. Review of undated policy titled, Resident Rights documented Employees shall treat all residents with kindness, respect, and dignity. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to retain and use personal possessions to the maximum extent space and safety permits.		

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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 observations, facility policy review, and staff interviews the facility failed to ensure staff utilized consistent infection controls techniques as evidenced by a failure to complete hand hygiene during resident cares, remove personal protective equipment prior to exiting a residents room, sanitize shared resident equipment after use, and ensure catheter tubing, and oxygen tube secured in a position to not fall on the floor for 6 of 12 residents (Resident's #2, #22, #23, #11, #3 and #17) in the sample, and failed to review the infection control policy at least annually. The facility reported a census of 28 residents. Findings include: 1. Review of the Minimum Data Set (MDS) dated [DATE] documented Resident #2 had a Brief Interview for Mental Status (BIMS) of 15 out of 15 which indicated intact cognition. Review of Resident #2 Physician orders revealed the following orders: a. Cleanse, dry, paint with betadine and cover with Mepilex Foam dressing to right heel. One time a day for DTI (deep tissue injury). Start date 1/12/26. b. Ketoconazole External Cream 2%. Apply to Groin topically in the morning for redness. Start date 11/28/25. c. Miconazole External Powder 2%. Apply to under bilateral breasts topically two times a day for redness. Start date: 11/28/25. d. Nystatin External Cream 100000 UNITS/GR (gram). Apply to under bilateral breasts topically two times a day for redness. Start date: 11/28/25. During an observation on 1/13/26 at 1:54 PM, Staff A, Registered Nurse (RN) donned a gown, completed hand hygiene, donned gloves prior to starting wound care for Resident #2. Staff A cleansed the area under Resident #2 breasts with peri wipe. Staff A then applied nystatin cream and miconazole powder under the residents' breasts. Staff A pulled the residents gown over her and removed her gloves. Without completing hand hygiene, Staff A donned new gloves cleansed Resident #2 abdominal fold with peri wipe and applied Ketoconazole cream. Staff A then removed her gloves, and without completing hand hygiene applied new gloves. Staff A then pulled down the resident's gown over her abdomen, pulled up the top bed sheet up over the resident's abdomen, and pulled the sheet up over the residents' feet. Staff A removed the dressing from the resident's right heel. The heel wound appeared open, with a dark brown area around the wound. The surrounding area around the wound appeared red with a pea sized area of slough in the middle, without completing hand hygiene, Staff A cleaned the area with betadine, applied a new dressing to the right heel, and reapplied the residents boot. Staff A then removed her gloves and gown, and completed hand hygiene. 2. Review of the MDS, dated [DATE] documented Resident #22 had a BIMS of 4 out of 15, which indicated a severe cognitive impairment. The MDS indicated Resident #22 utilized an indwelling catheter. Review of Resident #22's Physician Orders revealed an order with a start date of 11/6/25 for 60 mL (milliliter) flush of serial water every evening shift. During an observation on 1/13/26 at 1:54 PM, Staff JJ, Certified Nurse Assistant (CNA) walked out of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #22's room into the hall with a gown and gloves on. Staff JJ walked down the hall and around the corner to the long-term care side of the facility. Staff A, RN also present in the hall. During an interview on 1/13/26 at 1:54 PM, Staff A, RN stated there was no reason for Staff JJ, CNA leave a resident's room and walk down the hall and turn the corner with a gown and gloves on. During an interview on 1/13/26 at 1:55 PM, Staff JJ, CNA stated she was wearing a gown and gloves because Resident #22 had a catheter. Staff JJ stated she had forgotten to doff the gown and gloves before leaving Resident #22's room. Staff JJ acknowledged she was walking down the hallway with gown and gloves on after emptying Resident #22's catheter. 3. Review of the MDS, dated [DATE] documented Resident #23 had a BIMS of 3 out of 15 which indicated a severe cognitive impairment. The MDS indicated Resident #23 had an unstageable pressure injury (an obscured full thickness skin and tissue loss). Review of Resident #23's Physician's Order revealed an order to wash a right heel wound, pat dry; apply xeroform, ABD (abdominal pad, a highly absorbent type of dressing), and rolled gauze, ace wrap. Change every 2 days for the right heel pressure ulcer. During an observation on 1/14/26 at 7:24 AM, Staff M, Licensed Practical Nurse (LPN) and Staff O, CNA/ Certified Medication Assistant (CMA) entered Resident #23 room to complete a wound treatment. Both staff donned gowns. Staff M, LPN completed hand hygiene and donned gloves. Staff O, without completing hand hygiene, donned gloves. Staff M moved the residents blanket back from over her feet while Staff O held up the residents' right leg. Staff M removed the heel protector, removed the old dressing, and cleansed the wound area on right heel. The wound appeared to be the size of a dime. Also noted on the inner right heel a red wound bed. Without completing a glove change or hand hygiene, Staff M, LPN applied xeroform, and gauze wrapped over the dressing with tape applied. Staff M then applied an ace wrap around the gauze dressing prior to putting a sock on the foot. Staff O, CNA then allowed the residents leg to set in the heel protector, while Staff M gathered trash, and cleansed the scissors. Staff O placed a fall mat in place on the floor, and placed the bed in the low position. Both staff took off gowns and removed gloves. Staff M completed hand hygiene. Staff O exited the resident's room, walked down the hall to put the garbage in the receptacle. Staff O then completed hand hygiene. During an interview on 1/14/26 at 7:39 AM, Staff M, LPN stated had she no concerns with the wound treatment. Staff M stated Resident #23 had an open wound so that is why EBP is in place with the use of Personal Protective Equipment (PPE consisting of a gown and gloves) worn. During an interview on 1/14/26 at 8:40 AM, Staff H, MDS Coordinator / Infection Preventionist (IP) stated the nurse should have changed gloves between the old and the new dressing. Staff H stated hands should have been sanitized prior to applying gloves, before entering and when leaving the room. Staff H stated once everything was placed in the trash staff should have completed hand sanitization before walking down the hall. Staff H explained hand hygiene should be completed between glove changes for wound treatments after cleansing before applying the new dressing. 4. Review of Resident #11's MDS dated [DATE] revealed a BIMS score of 15 out of 15 which indicated intact cognition. During an interview on 1/20/2026 at 10:45 AM, Resident #11 stated that he has had a urinary catheter (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	since 2009 when he had cancer. Resident #11's catheter drainage bag was noted to be lying on the floor by his recliner at this time. During an observation on 1/21/2026 at 10:35 AM, Resident #11's catheter bag was lying on the floor next to the recliner. During an observation on 1/21/2026 at 2:09 PM, Resident #11's catheter drainage bag noted to be tucked into the pocket on the recliner at this time. During an observation on 1/21/2026 2:18 PM, Staff B, CNA and Staff C, CNA completed hand hygiene and donned gloves and a gown for EBP. Staff B and Staff C then helped remove Resident #11's pants and brief. Without a change of gloves or hand hygiene, Staff B and Staff C then completed peri care. Resident #11 observed to have a bowel movement at this time. After cleaning up the resident, Staff C changed gloves without completing hand hygiene and completed care of the resident's urinary catheter. After emptying the collection bag, Staff B placed Resident #11's catheter bag back into pocket of recliner. Staff C then moved the mechanical lift from Resident #11's room and parked it in the hallway. Staff C did not wipe down the lift. During an interview on 1/21/2026 at 2:39 PM, Staff B, CNA and Staff C, CNA stated they could have changed their gloves more, and completed hand hygiene more during the cares for Resident #11. Staff B further revealed that she should not have placed the urine drainage bag into the recliner pocket. During an interview on 1/21/2026 at 2:44 PM, the Assistant Director of Nursing (ADON) stated she would expect the catheter bag to not be placed into the pocket of the recliner. During an interview on 1/21/2026 at 2:49 PM, the DON stated she would expect the appropriate hand hygiene and glove changes to be completed during catheter cares, and transfers. The DON further revealed that she would expect the mechanical lifts to be sanitized after use in EBP rooms. 5. Review of the MDS for Resident #3, dated 11/7/25 revealed the resident dependent for bed to chair transfers. The list of diagnoses included a stage 4 pressure ulcer to sacrum. Review of the Care Plan revealed a direction for staff to use a mechanical lift with the assist of two staff and the use of EBP due to a catheter and open wounds. During an observation on 1/21/2025 at 10:44 AM, Staff B CNA, and Staff D, CNA assisted Resident #3 from her bed to her recliner with a mechanical lift. Enhanced Barrier Precaution signage posted on the resident's door. Staff B and D wore a gown and gloves during the transfer. Once the transfer was completed, without being sanitized, the mechanical lift was placed in the hall, against the wall, to the right of the resident's door. During an interview on 1/27/2026 at 11:02 AM, the DON stated after staff have assisted the resident with a transfer that required a mechanical lift, staff are expected to wipe down the lift before putting it out in the hallway. 6. Review of Resident #17 MDS, dated [DATE] revealed a BIMS score of 12 out of 15, which indicated a moderate cognitive impairment. The list of diagnoses included chronic obstructive pulmonary disease (COPD), and indicated the resident utilized oxygen while a resident. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #17 Physician Orders revealed an order for oxygen at 2L (liter)/minute via an unspecified route with start date of 1/5/26. During an observation on 1/20/26 at 10:37 AM, Resident #17 seated in her recliner with the oxygen concentrator turned on, the nasal cannula not in her nose, and the oxygen tubing lying on the floor not connected to the concentrator. The resident stated she was having a hard time catching her breath and the use of her oxygen had been a mess since she was admitted to the facility. The resident stated she had been using oxygen for 5 years, prior to admission, and required 2L. Observed the concentrator to be set at 4L/minute. During an observation on 1/20/26 at 10:42 AM Staff J, RN responded to the Resident #17 call light. The staff untwisted the resident's nasal cannula, checked the tubing for air, and provided it to the resident. The resident checked for oxygen prior to placing it on her face. The resident stated there was no air in the tubing. Staff J observed the tubing end on the floor and re-attached it to the concentrator. During an interview on 1/27/26 at 11:01 AM, the DON stated oxygen tubing ends should not lie on the floor. The DON stated if the end(s) of the tubing come into contact with the floor, the tubing should be thrown away and new tubing should be obtained. 7. Review of an undated policy titled, Infection Prevention and Control Program documented no review date. On 1/29/26 at 9:51 AM Staff H, IP/MDS Coordinator stated she had been in the IP position since June 2025. Staff H stated the IPCP had not been reviewed annually with the medical director / Administration / management team. Staff H stated they talk about the infection results of cultures in the morning meetings but she does not track infections, infection rates, or antibiotic use. Staff H stated she does not track antibiotic trends. On 1/29/26 at 10:27 AM the DON stated she would expect that the corporate office would provide the facility with updated policies for infection control. The DON stated the policies should be according to the federal regulation. The DON stated the facility did not currently have tracking for infections with trends if there were any. The DON acknowledged the facility can not find trends if there is no tracking at the facility. The DON stated review of the antibiotics that residents were on at the facility for effectiveness and need with the physician should be occurring. Review of an undated policy titled, Infection Prevention and Control Program revealed a Policy Interpretation and Implementation section which included in part: The IPCP is developed to address the facility-specific infection control needs and requirements identified in the facility assessment and the infection control risk assessment. The program is reviewed annually and updated as necessary. Review of an undated facility policy titled; Enhanced Barrier Precautions revealed Policy Statement which declared Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents. The Policy Interpretation and Implementation section directed, in part: 1. Enhanced barrier precautions (EBPs) refer to infection prevention and control interventions designed to reduce the transmission of multi-drug-resistant organisms (MDROs) during high contact resident care activities. (continued on next page)		

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Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165466	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on clinical record review, and staff interviews the facility failed to provide a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN), Form CMS-10055 for 3/3 residents reviewed (Resident #50, #51, #52). The facility reported a census of 28. Findings include: 1. Resident #50 signed a Notice of Medicare Non-Coverage (NOMNC), Form CMS 10123-NOMNC approved 12/31/11, on 10/17/25 indicating coverage of his skilled nursing services would end on 10/21/25. The facility failed to provide the SNF ABN, CMS Form-10055, for the resident to complete. The facility failed to utilize a current Center for Medicare Services (CMS) NOMNC Form CMS-10124-DENC expiration 11/30/27.2. Resident #51 signed a NOMNC, Form CMS 10123-NOMNC approved 12/31/11, on 10/17/25 indicating coverage of his skilled nursing services would end on 10/19/25. The facility failed to provide the SNF ABN, CMS Form-10055, for the resident to complete. The facility failed to utilize a current Center for Medicare Services (CMS) NOMNC Form CMS-10124-DENC expiration 11/30/27.3. Resident #52 signed a NOMNC, Form CMS 10123-NOMNC approved 12/31/11, on 9/30/25 indicating coverage of his skilled nursing services would end on 10/2/25. The facility failed to provide the SNF ABN, CMS Form-10055, for the resident to complete. The facility failed to utilize a current Center for Medicare Services (CMS) NOMNC Form CMS-10124-DENC expiration 11/30/27. On 1/28/26 at 1:15 PM Staff N, Interim Director of Social Services, stated she had been trained by the previous Director of Social Services the SNF ABN was only completed if a resident chose to remain in the facility or was on Medicare Part B services. The staff acknowledged she knew what the SNF ABN CMS Form-10055 was and did have access to it. The staff stated she did not know the CMS NOMNC form had been updated and was using a form she found from the previous director and changed the heading to reflect the current facility name. Staff N stated she did not have access to a support person/corporate level consultant for additional training. On 1/28/26 at 2:35 PM at 2:35 PM the Administrator stated he was not aware the SNF ABN form was not being utilized with the NOMNC. The Administrator was not aware the facility was not using the current NOMNC Form CMS-10124-DENC expiration 11/30/27, but would be correcting that.		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff and resident interviews, and facility policy review the facility failed to ensure 3 of 5 residents (Resident #3, 11, and 32) reviewed were free from exploitation. The facility reported a census of 28 residents. Findings include:1.According to the Quarterly Minimum Data Set (MDS) assessment tool with a reference date of 11/7/2025 documented Resident #3 had a Brief Interview of Mental Status (BIMS) score of 11. A BIMS score of 11 suggested mild cognitive impairment. Resident #3 did not receive a scheduled pain medication regimen; she did receive as needed (PRN) pain medications or was offered and declined. During the pain assessment Resident #3 did have pain at any time in the last 5 days occasionally. Resident #3 indicated the pain rarely the pain made it hard for her to sleep nor did it limit her day-to-day activities. The MDS documented Resident #3 rated her pain at a 4 out of 10 (zero being no pain and ten as the worst pain you can imagine). The MDS documented Resident #3 had received an opioid. The MDS documented the following diagnoses for Resident #3: stage 4 pressure ulcer of sacral region, renal failure, stroke, stage 4 pressure ulcer of right and left buttock.The Care Plan Focus Area with a revision date of 7/2/2025 documented Resident #3 was on an analgesic medication therapy related to pain. The Care Plan directed staff to administer medications as ordered and monitor of adverse effects and monitor the effectiveness of medication. A second Care Plan Focus Area with a revision date of 7/2/2025 documented Resident #3 had complaints of pain. The Care Plan directed staff to administer medications as ordered and monitor for adverse effects. Staff were directed to ask residents what non-medication pain relief methods have helped in the past and attempt to utilize these strategies and to notify the physician if pain management interventions are unsuccessful.Review of Resident #3's December 2025 Medication Administration Review (MAR) revealed the following orders:-Oxycodone (narcotic pain medication) oral tablet 10 milligrams (mg). Give one tablet by mouth every 6 hours needed (PRN) for pain. The medication was signed out being given by Staff A Registered Nurse (RN) on: a) 12/3/2025 at 11:09 AM for a pain rating of 5;b) 12/5/2025 at 9:40 AM for a pain rating of 5;c) 12/22/2025 at 10:20 AM for pain rating of 7;d) 12/27/2025 at 11:45 AM for a pain rating of 7.Review of Staff A's timecard for the December 2025 revealed on 12/22/2025 Staff A closed out for lunch from 9:53 AM until 10:23 AM.Review of Resident #3's January 2026 MAR from 1/2 revealed the following orders:-Oxycodone (opioid to treat severe pain) oral tablet 10mg. Give one tablet by mouth every 6 hours PRN for pain. The medication was signed out has being given by Staff A on: a) 1/2/2026 at 9:00 AM for a pain rating of 5, b) 1/5/2026 at 10:00 AM for a pain rating of 6, c) 1/6/2026 at 12:36 PM for a pain rating of 7, d) 1/7/2026 at 7:27 PM for a pain rating of 6, e) 1/10/2026 at 8:45 AM for a pain rating of 7, f) 1/11/2026 at 9:48 AM and 9:07 PM for a pain 7 both times, g) 1/12/2026 at 8:10 AM for a pain rating of 6 and at 8:01 PM for a pain rating of 7, h) 1/16/2026 at 10:15 AM and 8:15 PM for a pain rating of 7, i) 1/17/2026 at 8:50 PM for a pain rating of 7, j) 1/18/2026 at 9:35 AM for a pain rating of 7, k) 1/19/2026 at 8:40 AM and 8:39 PM with a pain rating of 7, l) 1/20/2026 at 8:15 AM for a pain rating of 7, m) 1/21/2026 at 9:50 AM and 8:50 PM with a pain rating of 7, and n) 1/22/2026 at 8:49 AM for a pain rating of 7. Review of Staff A's timecard for January 2026 revealed the following:1/5/2026 she clocked out for lunch from 9:50 AM until 10:20 AM;1/11/2025 she clocked out for lunch from 9:48 AM until 10:18 AM;1/16/2025 she clocked out for lunch from 10:00 AM until 10:30 AM;1/21/2025 she clocked out for lunch from 9:50 AM until 10:20 AM.Record review revealed the following Progress Note: on 1/2/2026 at 9:00 AM PRN oxycodone was given by Staff A for anticipatory pain related to a wound care clinic appointment. On 1/22/2026 at 9:26 AM Resident #3 stated she has not requested a PRN pain medication for a long time. She stated staff will ask if she wants a PRN pain medication but she will tell them no. She added she felt staff would not give a PRN pain medication unless she asks for it. Resident #3 stated she is used to how her body feels and denied requesting PRN pain medication very often. Resident #3 stated her pain was under a 5 at the (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	time of the interview. When asked if she requested a PRN medication this morning, she denied doing so and stated she would know if the nurse gave her any extra medications. On 1/22/2026 at 9:59 AM Staff A stated she has had interactions with Resident #3 today and had voiced concerns of pain to her this morning. Resident #3 had rated her pain at a 7 and that was when Staff A stated she asked if she wanted any pain medication this morning. Staff A stated whenever a resident has a pain level of 6 to 10, she offers a pain medication. Staff A stated she does not talk to Resident #3 a lot but she seemed okay and cognitively aware. 2. According to the admission MDS assessment tool with a reference date of 12/5/2025, documented Resident #11 had a BIMS score of 15. A BIMS score of 15 suggested no cognitive impairment. Resident #11 received a scheduled pain medication regimen and received a PRN pain medication or was offered and declined. The MDS documented Resident #11 had occasional pain any time in the last 5 days. Resident #11 reported he rarely had pain that made it hard for him to sleep at night and occasionally had pain that limited his participation in therapy sessions and his day-to-day activities. The MDS listed the following diagnoses for Resident #11: right femur fracture and malignant neoplasm of prostate. The Care Plan Focus Area with an initiated date of 12/5/2025 documented Resident #11 complained of pain. The Care Plan directed staff to administer medications as ordered and monitor for adverse effects and notify the physician if pain management interventions are unsuccessful. Review of Resident #11's January 2026 MAR revealed the following order: hydrocodone-acetaminophen (treatment of pain) oral tablet 5-325mg, give one tablet by mouth every 8 hours PRN for severe pain. The order had a start date of 1/12/2026 at 10:59 AM. The order was signed out as being given by Staff A on: a) 1/16/2026 at 8:14 AM for a pain rating of 6, at 7:20 PM for a pain rating of 6; b) 1/17/2026 at 8:40 PM for a pain rating of 7; c) 1/18/2026 at 11:07 AM for a pain rating of 7 and at 7:35 PM for a pain rating of 8; d) 1/19/2026 at 8:00 PM for a pain rating of 7; e) 1/20/2026 at 8:00 AM for a pain rating of 7; f) 1/21/2026 at 9:19 AM for a pain rating of 6 and at 8:22 PM for a pain rating of 7; g) 1/22/2026 at 8:38 AM for a pain rating of 7. On 1/29/2026 at 9:29 AM Resident #11 was lying in bed, watching TV. He stated he has pain and it's all over, it's there all the time. When he has pain, he will ask for Tylenol first but every once in a while, he will ask for something stronger. When asked what that stronger medication was, he stated tramadol. Since they got the order for hydrocodone a few weeks ago, he has asked for it once but they never brought it for him. When asked if Staff A, the nurse with a boot on her foot, has ever asked if needed the hydrocodone or brought one in for him, he denied seeing her with that medication for him. He again stated he has only asked for it once but he never got it. He indicated he knows what medications he takes and would know if they put it with other medications. 3. According to the admission MDS assessment tool with a reference date of 1/20/2026 documented Resident #32 had a BIMS score of 12. A BIMS score of 12 suggested mild cognitive impairment. The MDS documented she did not have a scheduled pain medication regimen; she did receive a PRN medication or was offered and declined it. Resident #32 reported pain occasional pain over the last 5 days. Resident #32 reported she rarely had pain that made it hard for her to sleep at night, limited her participation in therapy sessions, and did not limit her day-to-day activities. The MDS documented she rated her pain a 6 on a scale from 0-10. The MDS documented the following diagnoses for Resident #32: acute respiratory failure with hypoxia, atrial fibrillation, heart failure, and renal failure. The Care Plan does not address pain management. Review of Resident #32's January 2026 MAR reviewed the following order: hydromorphone (treatment of severe pain), give 0.25 milliliters (mL) by mouth every 1 hour as needed (PRN) for pain/shortness of breath; with a start date of 1/15/2026. Review of the order revealed Staff A signed out the medication as given on 1/16/2026 at 8:32 AM for a pain rating of 6. Review of Resident #32's chart revealed a document titled Controlled Drug Report/Record/Disposition Form. The form was for Resident #32's hydromorphone 0.25mL order. It documented when the medication was delivered on 1/15/2026 there was 15mL in the bottle. On 1/15/2026 at 8:30 AM Staff A signed out she gave 0.25 mL with 14.75 mL remaining in the bottle. On 1/22/2025 at 1:00 PM the Director of Nursing (DON) and Assistant Director of Nursing (ADON) documented there was 11.75mL remaining in the bottle; 3mL missing. On (continued on next page)		

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/22/2026 at 12:27 PM Staff D Certified Medication Aide (CMA) stated there was an issue about a month ago when Resident #3 had her call light on and asked for something for pain. Staff D saw she got something 30 minutes prior and let her know she already had something for pain. Resident #3 denied receiving any pain medications with her morning medications. Staff D stated when Resident #3 has pain, she will ask her what she wants. Resident #3 will request Tylenol. Staff D stated Staff A is the only staff member that signs out Resident #3's oxycodone as given. Staff D stated Resident #3 would be reliable, could rate her pain on the pain scale and would be able to tell staff which pain medication she wants. She believed Resident #3 would be a good historian. Staff D stated about two weeks prior to the surveyors coming in to the building, she had passed medications on both Long-Term Care and Skilled residents. Staff A approached her wanting the keys for the medication room on the skilled side. Staff A did labs and just assumed that's why she was asking for the medication room key. Staff D needed to start her medication pass so she went to the medication room, knocked on the door to get her keys back. She saw Staff A had the skilled side tool box that had narcotics in it. Staff A stated Resident #20 wanted something for pain. She had pulled oxycodone from the box. These kinds of concerns had been reported so many times. There were suspicions of Staff A being the only nursing signing out Resident #1's PRN oxycodone, back dating the time when she would sign out narcotics on days she came in late. She would sign out the narcotics when she was not even in the building at that time. On 1/23/2026 at 2:00 PM Staff Y Certified Nursing Assistant (CNA) stated in December she heard Resident #3 had asked for a pain pill and Staff A stated she was not eligible for one. The resident told her she had not had a pain pill all day. Staff Y stated she heard Resident #20 had requested a pain medication and it was signed out by Staff A as given. But the resident denied receiving the pain medication. Staff A then found the pain pill in a medication cup by her drinking cup. The ADON was made aware of this and told Staff A to give Resident #20 her pain medication. On 1/28/2026 at 10:45 AM Staff H Licensed Practical Nurse (LPN) stated she has never given Resident #3 a PRN for pain. When she does her pain assessments, Resident #3 would say no. If she did have pain, she would rate it 5 of 6. She denied ever giving Resident #3 a oxycodone for pain. She added, she would never go with that medication first because she would be unsure how she would react to it. She would start with her Tylenol PRN. When she started to complain of left shoulder pain, they got orders for a PRN cream/gel but would always start with Tylenol when she needed/requested something for pain. On 1/28/2026 at 12:47 PM Staff J RN stated on the first day he trained Staff A, she was passing medications on the Long-Term Care side of the building. When she went to pass Resident #3 her morning medications and Staff A signed out her oxycodone. He was not sure if it was the same day they did her wound vac change but she never took oxycodone. Resident #3 always said Tylenol was enough. That morning Staff A signed out the medication in the narcotic book but never got in the drawer on the medication cart to retrieve the medication. From that point on he did not leave her alone while passing medications. The same thing happened with Resident #1; Staff A signed out the oxycodone medication but did not see her give the medication to the resident nor did he see her get in the drawer to get the medication out. He noticed any other medication that required to be signed out in the narcotic book, she obtained the medication and administered it to the resident, except the oxycodone. Staff J stated Resident #1 was [AGE] years old and with the amount of oxycodone Staff A had signed out as being given to her, one would think that resident would be sedated but when you would assess her, she was awake and fine. On 1/29/2026 at 10:05 AM Staff DD LPN laughed when asked if Resident #3 experienced a lot of pain. She stated no, every once in a while, but not all the time. She would usually give her Tylenol or her PRN gel if she did have pain and when she would follow up for effectiveness it would help. When she did have pain, she would report pain to her left shoulder or her neck and back some times; rating it between 3 and 6. Staff DD stated Resident #3 had not asked for anything stronger and she would always offer Tylenol first. She indicated when she would come in for her 2:00 PM-10:00 PM shift after Staff A worked, Resident #3 would ask for a Tylenol. Staff DD stated Resident #11 has scheduled Tylenol. This morning, he rated (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, document review, staff interview, and policy review the facility failed to obtain bed hold notifications for 2 of 3 residents (Resident #5 and #29) reviewed. The facility reported a census of 28 residents. Findings include: 1. According to the discharge-return anticipated Minimum Data Set (MDS) assessment tool with a reference date of 8/13/2025 documented Resident #5 was discharged to a short-term general hospital on 8/13/2025. Record review revealed the following progress note: a) On 8/13/2025 at 12:45 PM shortly after he was assisted to recliner for therapy, resident experienced hypotension, increased weakness, dizziness, nausea and requested to go back to hospital, b) On 8/13/2025 at 4:54 PM resident was admitted to the hospital due to declining renal function. Record review revealed it lacked a bed hold form completed by Resident #5 and/or his representative. On 1/23/2025 at 10:39 AM via email communication the Administrator acknowledged facility was unable to locate Resident #5's bed hold form when he was sent to the hospital on 8/13/2025. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) indicated she was not sure who would be responsible for completing and obtaining the bed hold forms but would think Social Services would be. She was unsure of the timeline they need to be completed but would assume a couple days. 2. The Minimum Data Set (MDS) dated [DATE] documented Resident #29 had a Brief Interview for Mental Status (BIMS) of 15 indicating no cognitive impairment. Review of Resident #29's Electronic Health Record (EHR) dated 1/5/26 titled, Progress Notes documented by Staff M, Licensed Practical Nurse (LPN) at 4:10 PM Resident #29 left the facility at 4:10 PM transported to hospital Emergency Department (ED) related to elevated pulse, increased pain and nausea. Progress note further documented Bed hold policy was given to Resident #29. Review of Resident #29's document dated 1/5/26 titled, Discharge Summary documented Resident #29 entered the hospital ED on 1/5/26 at 4:40 PM. Review of Resident #29's EHR dated 1/12/26 titled, Progress Notes documented at 4:13 PM Resident #29 was admitted back to the facility. On 1/26/26 at 7:58 AM an email from the Administrator indicated the facility did not have a bed hold form completed for Resident #29 for 1/5/26 hospitalization. Review of undated policy titled, Bed Hold and Returns documented Residents and/or representatives are informed (in writing) of the facility and state (if applicable) bed-hold policies. All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents, regardless of payer source, are provided written notice about these policies at least twice: notice 1: well in advance of any transfer (e.g., in the (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admission packet); and notice 2: at the time of transfer (or, if the transfer was an emergency, within 24 hours). The written bed-hold notices provided to the residents / representatives explain in detail: the duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the facility; the reserve bed payment policy as indicated by the state plan (for Medicaid residents); the facility policy regarding bed-hold periods; the facility per-diem rate required to hold a bed (for non-Medicaid residents), or to hold a bed beyond the state bed-hold period (for Medicaid residents); and the facility return policy.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews the facility failed to accurately code the type of assessment for 1 of 2 discharge Minimum Data Set (MDS) assessments (a federally mandated, standardized, comprehensive clinical assessment tool used in nursing homes to evaluate functional, medical, and psychological status, it identifies resident problems, strengths, and preferences to guide care planning and determine reimbursement) (Resident #5). The facility also failed to accurately code medications taken when reviewing unnecessary medications for 2 of 3 residents (Resident #5 and #23). The facility reported a census of 28 residents. Findings include: 1. The MDS Entry assessment dated [DATE] for Resident #5 documented this was not the first assessment since his most recent reentry to the facility. The MDS admission assessment dated [DATE] for Resident #5 documented this was the first assessment since his most recent reentry to the facility. The MDS Discharge assessment dated [DATE] for Resident #5 documented this was not the first assessment since his most recent reentry to the facility. Review of the Census tab in the resident's Electronic Health Record (EHR) revealed a discharge return not anticipated MDS was completed on 2/2/2024. The EHR documented an entry MDS was completed on 8/7/2025. On 1/27/2026 at 11:02 AM the Director of Nursing (DON) stated the MDS Coordinator is who, she was told, that overlooks the MDS assessments to ensure their accuracy. On 1/27/2026 at 11:45 AM the MDS Coordinator stated this issue sounded like it's a census issue with the Business Office Manager (BOM). 2. Review of a physician order for Resident #23, dated 2/7/25, revealed an order for Rexulti (type of atypical antipsychotic medication used to treat symptoms associated with agitation from dementia). Review of the MDS assessments, dated 2/11/25, 5/9/25, 8/1/25, and 10/24/25, revealed a diagnosis for Alzheimer's dementia. The MDS included assessment information that inaccurately identified the resident did not take an antipsychotic medication. Review of the Care Plan, last revised 1/8/26, revealed, in part, the resident used a antipsychotic/psychotropic medications r/t (related to) behavior management. On 1/22/26 at 12:32 PM, in an interview, the MDS Coordinator, reported she was responsible for completing the MDS assessment on all residents. The MDS Coordinator reviewing physician orders and the resident's medication administration record to determine if the resident was taking an antipsychotic. The MDS Coordinator reported she was unsure how she missed identifying the resident took an antipsychotic. The MDS Coordinator reported the resident's annual MDS assessment was due now and she would update the assessment to identify the resident took an antipsychotic medication. On 1/22/26 at 2:56 PM, in an email response, the Administrator reported the facility did not have an MDS Assessment policy.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and policy review the facility failed to develop and implement a Baseline Care Plan for 2 of 10 residents (Residents #17, #42) reviewed. The facility failed to develop and involve the resident and/or resident representative in the development of the Baseline Care Plan within 48 hours of admission. The facility reported a census of 28 residents. Findings include: 1. The Minimum Data Set (MDS) dated [DATE] for Resident #17 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 indicating moderate cognitive impairment. The document disclosed diagnoses of atrial fibrillation (A-fib), heart failure, Non-Alzheimer's Dementia and Chronic Obstructive Pulmonary Disease (COPD). The resident utilized oxygen while a resident. The Care Plan dated 1/20/26 revealed a focus area related to oxygen therapy revised 1/20/26 with staff interventions of providing medications as ordered, oxygen as ordered by the physician, and monitor/document/report signs and symptoms of respiratory distress dated 1/20/26. The document also included an impaired cognitive function focus area created 1/20/26 with staff interventions of monitoring medication side effects, yes/no questions, re-orient and supervise and monitor change in cognitive function dated 1/20/26. The Electronic Medical Record (EMR) Clinical Census revealed the resident was admitted on [DATE]. The EMR did not contain documentation in the Progress Notes regarding the Baseline Care Plan being completed or involvement of the resident and/or representative in a Baseline Care Plan development. The EMR did not contain a Baseline Care Plan signed by the resident or the resident's representative. On 1/20/26 at 10:37 AM Resident #17 stated she did not know what a Care Plan Conference was or remember talking to staff in a meeting about her Care Plan. On 1/28/26 at 1:10 PM Staff N, Interim Director of Social Services, stated a Baseline Care Plan Conference had not been held for Resident #17 until this date. The staff stated it was a short term notice for the completion of the conference; therefore no additional interdisciplinary team (IDT) members were present. The staff stated she contacted therapy and nursing for input prior to the conference. Staff N stated the daughter was contacted by phone for input into the Care Plan and provided a copy of the document with verbal consent by the resident's representative dated 1/28/26. 2. Resident #42's MDS dated [DATE] revealed a BIMS score of 12/15 indicating moderate cognitive impairment. The document provided the resident had diagnoses of urinary tract infection (UTI) in the past 30 days, diabetes mellitus, history of falling, fainting and collapse and a personal history of strokes without residual deficits. The resident's Care Plan dated 1/13/26 revealed a focus area of needing assistance with Activities of Daily Living (ADL's) initiated on 1/13/26 with staff interventions of assistance of 1 staff for transfers using a gait belt, walking with a walker and transfers with supervision/touching assistance dated 1/13/26. A focus identified an order for therapy dated 1/13/26 with interventions for occupation and physical therapy to evaluate and treat dated 1/13/26. A discharge focus area for discharge to destination of choice dated 1/13/26 provided an intervention for plan to discharge to home with family initiated on 1/13/26. The EMR Clinical Census revealed the resident admitted to the facility on [DATE]. Review of the EMR Progress Notes disclosed no entry related to a Baseline Care Plan Conference or providing the Baseline Care Plan to the family and/or representative. The EMR Baseline Care Plan revealed no signature by the resident and/or representative. The electronic document indicated it was signed/closed on 1/15/27. On 1/20/26 at 12:52 PM Resident #42 stated she did not know anything related to a Care Plan or a Care Plan Conference. On 1/22/26 at 1:40 PM Staff H, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist, stated she did not plan the Care Plan Conferences. On 1/22/26 at 1:49 PM Staff N stated that the Baseline Care Conference for Resident #42 had not been held yet as she had been out with the flu since 1/19/26. The staff stated the MDS Coordinator could hold the meetings in her absence. When asked about the delay in the holding of the Baseline Care Plan Conference as the resident had been admitted on (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[DATE] and the meeting was to be held within 48 hours, Staff N responded that the meeting had not been scheduled and she had a lapse in judgement. The staff stated she did not have a consultant or someone at the corporate level to provide education and guidance. The staff stated what she knows she learned from the previous Social Services Director. On 1/26/26 at 10:12 AM the Director of Nursing (DON) and the Administrator stated he would expect in normal circumstances the IDT would be present for a Care Plan Conference. The DON and Administrator stated they were knowledgeable in the frequency of Care Plan Conferences. The Administrator stated there was no one at the corporate level with skilled expertise related to social services. On 1/27/26 at 8:50 AM Staff CC, Physical Therapist Assistant/ Director of Rehabilitation (DOR) confirmed that Resident #42 received skilled therapy services. The staff stated neither he nor another member of the Physical Therapy Department had not been to Care Plan Conference for Resident #42. Staff CC stated a Baseline Care Plan Conference was an important piece of the discharge planning process as that begins on Day 1. The staff stated that meeting should happen within the first week of admission 4-5 days of admission. On 1/27/26 at 9:28 AM Staff G stated she had not been involved in a Care Conference/Care Plan meeting while working in this facility. On 1/28/26 at 11:14 AM in a discussion with the Administrator and DON, the DON stated Baseline Care Plan Conferences need to be held with involvement of the resident and/or family representative otherwise how would a person centered Care Plan include the resident's preferences with examples of bathing (type and time), when the resident wanted to get up, food. The facility's Care Plans - Baseline, undated, revealed it must contain initial goals based on admission orders and discussion with the resident/representative. The Baseline Care Plan must be developed within 48 hours of admission, a written copy provided to the resident and/or representative in a language they understand and provision of the summary to the resident and/or representative is documented in the medical record.		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, interviews and policy review the facility failed to provide resident centered activities that incorporated the resident's interests, hobbies to maintain and/or improve a resident's physical, mental and psychosocial well-being and independence for 1/10 residents (Resident #21) reviewed. The facility failed to create opportunities for the resident to have a meaningful life by supporting her domain of wellness (autonomy, connectedness, joy and meaning). The facility reported a census of 28. Findings include: Resident #21's MDS dated [DATE] Significant Change export ready revealed a BIMS score of 8/15 indicating moderate cognitive impairment. The document disclosed the resident did not have a catheter, was incontinent of bowel and bladder, and dependent for bed mobility and transfers. The document indicated the resident's diagnoses included heart failure, atrial fibrillation (A-fib) and impaired brain function. The MDS revealed the resident had (1) Stage 2 pressure ulcer, partial thickness loss of skin presenting as a shallow open ulcer with a red or pink wound bed, at the time of admission. The resident's Care Plan dated 12/30/25 revealed a focus area of impaired cognitive function/dementia related to short term memory loss initiated 12/30/25 with staff interventions of medications as ordered and to monitor for side effects, provide yes/no questions, cue, re-orient and supervise as needed dated 12/30/25. The Care Plan failed to identify person centered activities for the resident. Observed on 1/20/26 at 9:45 AM the resident seated in her wheelchair (w/c) in the day room with other residents with no stimulus in the room (music, TV). Observed Resident #21 on 1/20/26 at 12:18 PM with another resident seated in her w/c with a full body dependent lift sling under her. The resident was positioned at a table without an activity facing a blank TV screen and wall. A staff member transported the resident from the living room to the dining room. Observed staff return Resident #21 on 1/20/26 at 1:00 PM to the living room and positioned her at the table with no activities present. Observed the resident seated in her w/c on 1/20/26 at 1:25 PM in the living room at the table without activities, facing the blank TV. On 1/20/26 at 1:35 PM observed Resident #21 sleeping in her w/c at the living room table. On 1/20/26 at 1:56 PM observed the resident awake in the living room seated in her w/c with no activities for engagement. On 1/21/26 at 7:46 AM observed Staff H, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist, walk into the living room and notice the residents, including Resident #21, without activities or stimulus. The staff attempted to turn on the TV with multiple remotes without success. The staff then left the room without providing any other type of activity for the residents. On 1/21/26 at 8:28 AM observed Resident #21 taken to the dining room for breakfast. On 1/21/26 at 9:26 AM staff returned the resident from the dining room to the living room, placed at the table, facing the blank TV without any activity or stimulus. On 1/21/26 at 9:36 AM the resident requested a drink of water and Staff D, Certified Medication Aide (CMA) provided a glass with a straw for the resident. On 1/21/26 at 9:47 AM Staff C, Certified Nurse Assistant (CNA), assisted the resident to her room to reposition her in a recliner. On 1/22/26 at 12:27 PM Staff C stated there were activities available for residents in the living room including the TV, coloring books, and an activity board. The staff stated the TV was not currently working as she attempted to use it for the residents on 1/21/26. The staff stated Staff A, Registered Nurse (RN), told her the TV had not worked for several days. Staff C stated maintenance managed the repairs for the TV and was unaware if maintenance knew about the TV not working. The staff stated she had not notified anyone regarding the TV not working. On 1/22/26 at 3:50 PM Staff Z, Director of Plant Operations, stated he was not aware of the TV not working in the living room. The staff stated the facility utilized an electronic communication system for notifications/tracking of work orders. On 1/27/26 at 11:01 AM the Director of Nursing (DON) stated she had been in the position for almost 1 month. The staff stated residents when seated in the living room should always be provided with activities, not be positioned at a table or facing a blank wall/TV without an activity. The staff stated it was not acceptable. The DON stated the facility utilized an (continued on next page)		

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic work order system and anyone should be able to place a work order. The staff stated she was aware of the TV not working and maintenance had been working on it in coordination with the cable provider. The DON stated on 1/23/26 a member of the Activities Department figured out how to make videos play on the TV. On 1/28/26 at 11:14 AM the Administrator agreed residents should not be sitting without activities or something to engage with. On 1/29/26 at 11:13 AM the Administrator stated the facility did not have a policy related to activities for residents.		

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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 clinical record review, provider interview, resident and family interview, staff interviews, and policy review the facility failed to appropriately assess a resident with a head injury and appropriately complete assessments / provide interventions for a diabetic ulcer for 2 of 8 residents (Resident #15, and #30). The facility reported a census of 28 residents. Findings include: 1. The MDS dated [DATE] documented Resident #15 had a BIMS of 15 indicating no cognitive impairment. On 1/20/26 at 11:49 AM Resident #15 stated she told Staff P RN / Assistant Director of Nursing (ADON) about the sore on her foot and she did nothing about it. Resident #15 stated Staff J, RN was the nurse that finally did something about it. Review of Resident #15's (Treatment Administration Record) TAR documented a physician's order with a start date of 1/15/26 to cleanse 2nd toe on left foot with wound cleanser, pat dry, apply Triple Antibiotic Ointment (TAO) and cover with band aid daily. Review of Resident #15's (Electronic Health Record) EHR dated 1/5/26 titled, Progress Note admission readmission Progress Note documented at 2:48 PM Resident #15 had an admission date of 1/5/26. The Progress Note documented reason for admission weakness post hospitalization for acute and chronic renal failure. The Progress Note documented no impaired skin integrity, no bruise, burn, deep tissue injury, diabetic ulcer, incontinence associated dermatitis, moisture associated skin damage, open areas, wound, rash, redness, skin tear or surgical incisions. Review of Resident #15's EHR dated 1/15/26 at 10:05 AM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.33 cm², length of 0.98 cm, and width of 0.5 cm. Wound note described area red with slough and Physician notified. Review of Resident #15's EHR dated 1/16/26 at 4:57 PM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.33 cm², length of 0.98 cm, and width of 0.5 cm. Review of Resident #15's EHR dated 1/23/26 at 5:27 PM entered by Staff J, RN titled, Wound Evaluation documented a diabetic ulcer on left foot second digit that was present on admission that had an area of 0.11 cm², length of 0.62 cm, and width of 0.28 cm. Review of EHR documented no physician notification or treatment completed for Resident #15's wound since admission on [DATE] until 1/15/26 when Staff J RN addressed the area. On 1/26/26 at 3:26 PM the DON stated her concern was the initial admission skin assessment for Resident #15 was completed by Staff A, RN. The DON explained Staff A completed the assessment and left without documenting the assessment. The DON stated the evening nurse went in and completed the assessment again. The DON stated she did not think Staff A made an observation of her foot / toe. The DON explained Staff J documented the area as not facility acquired because Resident #15 stated she had the area before entering the facility. The DON stated Resident #15 was a good historian. The DON stated there were a lot of balls that were dropped when it comes to wound care in the facility. The DON stated the area should have been noticed on the admission skin assessment, the physician should have been notified then and a treatment started if the physician thought it warranted. The DON acknowledged Resident #15 was at the facility for a week and the wound was not assessed and not treated. The DON stated the CNA's should have noticed the wound when cleaning Resident #15's feet. 2. The MDS dated [DATE] documented Resident #30 had a BIMS of 13 indicating no cognitive impairment. Review of Resident #30's EHR dated 12/22/25 titled, Skin Check documented no skin issues. On 1/14/26 at 7:39 AM Staff M, Licensed Practical Nurse (LPN) stated she had cared for Resident #30. Staff M stated she had reported an injury of unknown origin, a bruise to the forehead. Staff M stated on 1/4/26 she went into Resident #30's room at 7:00 AM or 7:30 AM. Staff M stated Resident #30 had a scratch on the right side of her forehead. Staff M explained Resident #30 reported she had hit the table and also said she did not know what had happened. Staff M stated that afternoon when she was going to document the injury and Resident #30's daughter came to the nursing desk. Staff M stated the area on Resident #30 had become a hematoma. Staff M acknowledged she started neuro checks and notified (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the doctor at that time. Staff M stated Resident #30's daughter notified a CNA and the CNA told her that Resident #30's daughter would like to talk to her. Staff M stated she entered Resident #30's room and the area was no longer a red mark. Staff M stated the area on the right side of her forehead was swollen. Staff M stated it looked like a goose egg and had started bruising. Staff M stated she called the on call provider at that time and he asked if the neuro had been started and if there was any altered mental status. Staff M reported Resident #30 was at her baseline. Staff M stated the daughter was at the facility late morning. Staff M stated she was going to call Resident #30's daughter and the physician but had not at that time. Staff M stated Resident #30 initially reported she hit her head on the table and then said she had fallen in her bathroom and daughter assisted her in getting into bed. Staff M stated Resident #30's daughter said she did not assist Resident #30 to get up. Staff M reported it did not look like Resident #30 had hit her head there was no induration or swelling. Staff M stated Resident #30 was a poor historian. Staff M stated they did do an initial set of vitals when the red mark was found. Staff M explained she did an assessment at the same time when she was completing her daily assessment. Staff M stated the red area was documented in the daily assessment. Staff M stated she did not know if there was a procedure for injury of unknown origin. Staff M stated she was not aware of any procedure for injury of unknown origins with injury to the head or witness / unwitnessed head injury. Staff M stated Resident #30 was wearing pants and it was difficult for her to get up and would often get agitated if the staff tried to move her. Staff M stated she did not remove Resident #30's clothes. Staff M explained she pulled Resident #30's pant legs up but did not assess the hips or buttocks. Staff M stated Resident #30 was being transferred to the ER the next day and the daughter wanted her to be seen the next day based on the general decline of the resident. Staff M acknowledged she did not initiate neuro assessments when the injury was found on the head that morning. On 1/20/26 at 1:05 PM Resident #30's Daughter / Power of Attorney (POA) stated she walked into the facility around 12:30 PM or 1:00 PM on 1/4/26. Resident #30's Daughter / POA stated she found Resident #30 with a bruise on her knee and a wound on the right side of her head. Resident #30's Daughter / POA stated her mother said she fell in the bathroom that morning. Resident #30's Daughter / POA stated the staff said her mother told them she leaned forward toward the table and hit her head. Resident #30's Daughter / POA stated she was told the staff had used a full body mechanical lift on her and possibly bumped her head. Resident #30's Daughter / POA stated she was then told her mother was combative on Saturday night and might have bumped her head. Resident #30's Daughter / POA stated she asked where the knee bruise came from. Resident #30's Daughter / POA stated she came to the facility the next day and told the DON she wanted her mother sent to the hospital. Resident #30's Daughter / POA once at the hospital there was a huge bruise noticed on Resident #30 right hip and sent a picture to the DON. Resident #30's Daughter / POA was told they would have to look into the bruise. Resident #30's Daughter / POA stated Resident #30's right shoulder blade had a huge bruise on it as well when she was rolled over in the Emergency Department (ED) where both bruises were noted. Resident #30's Daughter / POA stated the goose egg was very large on the right side of Resident #30 head. Resident #30's Daughter / POA stated the bruising was not brought to her attention at all until seen in the ED. Resident #30's Daughter / POA stated the DON stated the bruising could have happened when transferred to hospital. On 1/20/26 at 4:32 PM the DON stated there was an injury of unknown origins that had happened to Resident #30. The DON explained the facility had completed an investigation and determined the injury was no longer of unknown origins. The DON stated that Resident #30 had a red area on the right side of her forehead at approximately 7:30 AM on 1/4/26. The DON explained Staff M notified her, an assessment was completed, and the physician was notified. The DON stated she asked Staff M if Resident #30 was on a blood thinner and Staff M told her no. The DON explained she would have only started neuro assessments if the resident was on a blood thinner and had an injury to the head of unknown origins or a change in cognition. The DON explained a neuro assessment was also completed. The DON stated Resident #30's daughter was notified. The DON stated Resident #30's (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Chapters Living of Council Bluffs		STREET ADDRESS, CITY, STATE, ZIP CODE 3000 Risen Son Blvd Council Bluffs, IA 51503	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daughter had come to the facility later in the afternoon and asked about the area on Resident #30 forehead as it was now a raised area. The DON stated Resident #30's daughter must have forgotten about the earlier notification. The DON stated the raised area was only there for about a day and had decreased and was almost gone the next day. The DON stated there was no other injuries to Resident #30 from the incident. The DON stated she completed an investigation and interviewed the staff. The DON explained the staff had stated Resident #30 did have a shower the day prior but had not fallen. The DON stated Resident #30 was aggressive and combative the night prior. The DON explained Resident #30 had kicked an employee in the groin and hit an employee. The DON stated Resident #30 stated she had hit her head on the bedside table on the morning of 1/4/26. The DON stated Resident #30's cognition was enough that she felt that is where the injury had come from. The DON explained the injury probably occurred from the aggression and combativeness of the evening before. The DON explained the staff had not notified the physician or family appropriately and some writes came from that incident. The DON stated she would have expected the staff would have notified the DON at 7:30 AM on the day the injury was found when the injury was found and the staff did not. The DON stated she expected the nurse would have notified the physician of the area on the head at 7:30 AM when it was found as well and that was not completed. The DON stated she would have expected the family of Resident #30 would have been notified of the injury as well at 7:30 when the injury was noticed. The DON stated neuro assessments should have been initiated when the area was found on Resident #30 forehead at 7:30 AM and the neuro assessments were not initiated. Review of Resident #30's EHR dated 1/4/26 titled, Neurological Assessment Flow Sheet documented neurological assessments were not started at 6:00 PM on 1/4/26. Review of Resident #30's EHR dated 1/4/26 at 7:49 PM titled, Skilled Note entered by Staff M documented Resident #30 had a hematoma to the right side of the forehead. On call provider made aware, DON made aware, Resident #30's daughter in and aware. Review of Resident #30's document dated 1/4/26 at 7:27 PM titled Fax documented physician notification that Resident #30 had a 3 cm x 2.5 cm hematoma to the right forehead of unknown origin. On 1/4/26 evening propranolol was held due to blood pressure 102/50 and pulse of 53. Called to inform the on call provider with no return call at this time. On 1/13/25 at 11:29 AM the Nurse Practitioner stated she was notified on 1/4/26 of Resident #30's area on her forehead. The Nurse Practitioner stated the staff reported Resident #30 gave several conflicting stories. The Nurse Practitioner stated she was not made aware of Resident #30 goose egg after the contusion or bruising anywhere else. The Nurse Practitioner stated she would expect staff to call with any head injuries and start neuro assessments immediately.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and observation the facility failed to implement policies and procedures regarding the technical aspect of feeding tubes by pushing enteral flushes with a piston syringe into the enteral tube for 1 of 1 residents (Resident #44). The facility reported a census of 28 residents. Findings include: Review of Resident #44's Minimum Data Set (MDS) dated [DATE] revealed Resident #15 was admitted to the facility from another nursing home on 1/15/2026. The MDS then revealed a Brief Interview for Mental Status (BIMS) score of 14 indicating intact cognition. The MDS further revealed Resident #44 utilized a feeding tube while at the facility. Review of Resident #44's Electronic Health Record (EHR) page titled, Clinical Physician's Orders revealed an order to flush Resident #44's tube with 25 milliliters of water twice a day starting 1/15/2026. Observation on 1/21/2026 at 10:45 AM Staff A Registered Nurse (RN) completed hand hygiene, donned gown, gloves, and goggles. Staff A then checked for placement of Resident #44's enteral tube. Staff A then pushed 25cc of water into Resident #44's enteral tube, and did not let the water flow via gravity. Interview 1/21/2026 at 11:06 AM with the Director of Nursing (DON) revealed that staff should not be pushing medications or flushes through enteral tubes, and that the flushes and meds should be passed using gravity. Follow up interview 1/21/2026 at 4:45 PM with the DON revealed that the facility policy for enteral nutrition did not have any information related to allowing medications/water flushes to flow via gravity, but she would expect for flushes to be completed via gravity as this is standards of practice.		

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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, electronic medical record (EMR) reviews, resident and staff interviews, and policy review, the facility failed to provide respiratory care and services in accordance with professional standards of practice for 1 of 1 residents (Resident #17) reviewed, requiring the use of oxygen. The facility reported a census of 28 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #17 revealed a Brief Interview for Mental Status (BIMS) score of 12/15 indicating moderate cognitive impairment. The document disclosed diagnoses of atrial fibrillation (A-fib), heart failure, Non-Alzheimer's Dementia and Chronic Obstructive Pulmonary Disease (COPD). The resident utilized oxygen while a resident. The Care Plan dated 1/20/26 revealed a focus area related to oxygen therapy revised 1/20/26 with staff interventions of providing medications as ordered, oxygen as ordered by the physician, and monitor/document/report signs and symptoms of respiratory distress dated 1/20/26. Resident #17's EMR Clinical Physician Orders included an order for oxygen at 2L/minute via an unspecified route dated 1/5/26. The EMR Clinical Census revealed the resident was admitted to the facility on [DATE]. On 1/20/26 at 10:37 AM observed Resident #17 seated in her recliner with the concentrator turned on set at 4L/minute, the resident's nasal cannula was not in her nose, and the end of the oxygen tubing lying on the floor not connected to the concentrator. The resident stated she was having a hard time catching her breath and the use of her oxygen had been a mess since she was admitted to the facility. The resident stated she had been using oxygen for 5 years, prior to admission, and required 2L. On 1/20/26 at 10:42 AM Staff J, Registered Nurse (RN) responded to the resident's call light. The staff untwisted the resident's nasal cannula, checked the tubing for air, and provided it to the resident. The resident checked for oxygen prior to placing it on her face. The resident stated there was no air in the tubing. Staff J observed the tubing on the floor and re-attached it to the concentrator. On 1/21/26 at 8:34 AM observed Resident #17 seated in her wheelchair (w/c) with an E-Tank (3' aluminum portable oxygen cylinder) on the w/c back and the nasal cannula in place. The resident stated I need air. The tank regulator dial appeared in the red indicating the tank was either not turned on or the tank was out of oxygen. Staff H, Licensed Practical Nurse (LPN)/MDS Coordinator/Infection Preventionist, stated to Staff A, Registered Nurse (RN) and an unidentified staff the resident's oxygen was not turned on. Staff H noted the regulator needed to be reset on the E-Tank for proper fit. Staff H requested the key to turn the E-Tank on and set the regulator. On 1/21/26 at 10:15 AM Resident #17 stated she felt better since her oxygen was turned on referencing the earlier experience when going to breakfast this morning. The resident stated it was an ongoing issue with her oxygen not being turned on when moving between her concentrator and E-Tank. Observed the resident's concentrator set at 2L/minute. On 1/26/26 at 3:38 PM Resident #17 entered the Director of Nursing (DON's) office. The DON noted the oxygen was turned on and the E-Tank was almost empty. The DON stated the regular was set at 0.5L/minute. The DON acknowledged the rate was to be 2L/minute and changed the regulator to the appropriate flow. On 1/22/26 at 12:27 PM Staff D, Certified Medication Aide (CMA), stated the nurses manage the oxygen needs for residents. On 1/26/26 at 2:39 PM Staff J stated the nurse who was assigned to the resident was responsible for changing the oxygen from the concentrator to/from the E-Tank. The staff stated the nurse hold the key for the tank closet and the black key to turn on the E-Tank. Staff J stated on 1/20/26 when he answered the resident's call light, he was not the resident's primary nurse and did not know her orders for oxygen flow. Staff J stated he was fixing the problem of the nasal cannula and the resident's complaint of lack of air. On 1/27/26 at 11:01 AM the DON acknowledged the observations made with Resident #17's oxygen and the concerns with the oxygen not set at the correct flow on both the E-Tank and the concentrator. The staff stated she had provided education following her observation on the previous day. The DON stated she questioned whether oxygen saturations were being monitored on the resident's need for oxygen and ensuring the flow met the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's needs. The DON expected the resident's oxygen needs to be managed correctly per physician orders. On 1/28/26 at 11:14 AM during an interview with the Administrator with the DON present the Administrator was informed of the concerns observed regarding Resident #17's oxygen and the resident's statements of her oxygen needs being an ongoing issue since admission with the tanks not being turned on or the concentrator/E-Tank not set to the correct flow. The Administrator stated during the course of the interview that some questions were very open ended and did not like making responses due to history of his responses being included on reports and the feeling the questions set the Administrator up. The facility's Oxygen Administration Policy, undated, included the need for a physician's order, review of the Care Plan, and ensuring proper supplies/equipment were assembled. The document included the need for assessments before and during oxygen administration for cyanosis, hypoxia, toxicity, vital signs and lung sounds. The policy disclosed the need for oxygen in use signage, monitoring the route of oxygen and tank to ensure working properly and providing the correct flow of oxygen, and documentation.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews and policy review the facility failed to prepare and serve food in a form designed to meet individual needs and according to their assessments and Care Plans for 3 of 5 residents (Residents #3, #13, #23) reviewed. The facility failed to prepare and serve 3 meals according to the residents' prescribed diet orders. The facility reported a census of 28 residents. Findings include: 1. Resident #3's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11/15 indicating moderate cognitive impairment. The document disclosed the resident received a mechanically altered diet during the last 7 days of the assessment period. The resident's Care Plan dated 8/21/25 revealed a focus area of nutritional problems or potential nutritional problems related to needing a mechanical soft diet with increased protein revised 5/19/25. Interventions for staff included downgrading to mechanical soft due to a resident request related to difficulty chewing initiated on 4/14/25. Resident #3's electronic medical record (EMR) Clinical Physician Orders disclosed an order for regular diet, mechanical soft texture, thin consistency dated 8/7/25. 2. Resident #13's MDS dated [DATE] revealed a BIMS score of 6/15 indicating severe cognitive impairment. The document disclosed the resident consumed a mechanically altered diet during the last 7 days of the assessment period. The resident's Care Plan dated 1/24/25 included the focus area of nutritional problems related to Vitamin B deficiency and dysphagia revised 12/30/24 contained an intervention to downgrade to mechanical soft diet on 4/17/24. Resident #13's EMR Clinical Physician Orders disclosed an order for a mechanical soft diet, regular texture, thin consistency dated 4/17/24. 3. Resident #23's MDS dated [DATE] revealed a BIMS score of 3/15 indicating severe cognitive impairment. The document disclosed the resident consumed a mechanically altered diet during the last 7 days of the assessment period. The resident's Care Plan dated 1/8/26 included a focus area related to a nutritional problem or potential nutritional problem related to diabetes mellitus and dementia revised 2/28/25. Interventions for staff included explaining and reinforcing the importance of maintaining the diet ordered, encouraging the resident to comply and explanation of refusals dated 2/28/25. An additional intervention identified provide, serve diet as ordered dated 2/28/25. Resident #23's EMR Clinical Physician Orders disclosed an order for consistent carbohydrate (CCHO) diet, mechanical soft texture, thin consistency dated 8/26/25. Continuous observation of the meal service on 1/21/26 beginning at 12:02 PM revealed the following: Staff F, Dietary Aide, notified Staff V, cook/Dietary Manager, (3) mechanical soft plates were required. Staff V obtained a multipurpose scraper/chopper and modified the noodles in the steam table pan by pushing aside the regular noodles for altering a portion of the noodles. The staff placed a 4 ounce (oz.) serving of the semi modified egg noodles on the plate, a 6 oz. serving of regular Chicken [NAME] on top of the noodles and a 4 oz. serving of vegetables on the plate. The staff covered the plates and placed them on the warming shelf before transferring them to the delivery cart. The staff did not utilize meal tickets/resident menus for serving the meals. Staff V and Staff F took the delivery cart to the dining room. Staff F was unable to identify the mechanical soft plates from the regular plates for distribution to the residents. Staff F removed the refrigerated [NAME] Fruit Crumble tray from the walk-in cooler and placed uncovered on the delivery cart to the dining room. All pieces were precut without differentiation for diet consistencies or therapeutic diets. The facility's menu spreadsheet for the noon meal on 1/21/26 revealed residents requiring mechanical soft diets were to be served 6 oz. ground Chicken [NAME] over 4 oz. chopped egg noodles, #8 scoop of soft chef's vegetable of choice (no corn), soft chopped #8 scoop of [NAME] Fruit Crumble, and soft dinner roll. The facility failed to modify the egg noodles, Chicken [NAME] and [NAME] Fruit Crumble per physician orders. The facility failed to provide a soft dinner roll to the residents. On 1/22/26 at 1:57 Staff HH, Registered Dietitian, stated the cook(s) were to follow the menus as (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	presented and if they were not able to complete the approved menu she needed to be contacted for approval on substitutions. Staff HH stated residents with specific diet consistencies must have their foods altered to the appropriate consistency. Staff HH stated if meal tickets were not consistently used for plating of meals and for delivery, it would be difficult to ensure Physician Orders were followed. On 1/27/26 at 1:39 PM Staff II, Chief Executive Officer (CEO) for the kitchen services contract company, stated diets must be prepared according to the orders, as well as the approved menus. The staff stated the company provided the cooks with recipes and instructions for preparing the modified diets. Staff II further disclosed the company provided on-going training for staff. The Administrator stated during a conversation regarding the concerns with meal service and wrong diets/consistencies on 1/28/26 at 11:14 AM it was difficult with some aspects of the kitchen due to using a contract company. The Administrator stated he was hopeful the new Dietary Manager would be able to correct some of the concerns. The undated kitchen policy for Menu Compliance identified all meals served to residents following the approved menu for both regular and therapeutic diets. The undated kitchen policy for Diet Order Changes and Communication disclosed to ensure all diet orders were communicated accurately, implemented promptly and documented shall originate from a physician or RD or speech language pathologist (SLP) and be communicated immediately to the Food Service Director and Nursing Leadership. The undated kitchen policy, IDDSI (the International Dysphagia Diet Standardization Initiative) Diet Framework Compliance, revealed its purpose was to ensure texture-modified foods were served to promote resident safety, reduce the risk of choking or aspiration and maintain regulatory compliance. The document identified staff responsible for food preparation shall ensure foods meet the prescribed IDDSI level prior to service. The document provided that each meal served under the IDDSI framework shall be labeled with a meal card identifying the resident name, IDDSI level and any special instructions. With the mechanical soft diets the document provided that foods shall be prepared to texture that was soft, moist and easy to chew by chopping, grinding, or mincing. Additionally noted was ground or finely chopped meats must be served with a gravy or sauce.		

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record reviews, family and staff interviews and policy review the facility failed to provide therapeutic diets as prescribed by the primary care provider for 3 of 6 residents (Resident #23, #33, #42,) reviewed. The facility failed to follow physician orders for consistent carbohydrate (CCHO) and renal diets. The facility reported a census of 28. Findings include: Findings include: 1. Resident #23's Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3/15 indicating severe cognitive impairment. The document disclosed resident diagnoses including diabetes mellitus, high cholesterol, and Alzheimer's. The document included the resident consumed a therapeutic diet during the last 7 days of the assessment period. The resident's Care Plan dated 1/8/26 included a focus area related to a nutritional problem or potential nutritional problem related to diabetes mellitus and dementia revised 2/28/25. Interventions for staff included explaining and reinforcing the importance of maintaining the diet ordered, encouraging the resident to comply and explanation of refusals dated 2/28/25. An additional intervention identified provide, serve diet as ordered dated 2/28/25. Resident #23's electronic medical record (EMR) Clinical Physician Orders disclosed an order for consistent CCHO diet (diabetic diet), mechanical soft texture, thin consistency dated 8/26/25. 2. Resident #33's 1/22/26 Export Ready MDS revealed a BIMS score of 14/15 indicating normal cognition. The document disclosed resident diagnoses including heart failure, renal insufficiency, benign prostatic hyperplasia (BPH), diabetes mellitus, Parkinson's, and complete traumatic amputation of an unspecified great toe. The document included the resident was prescribed a therapeutic diet during the last 7 days of the assessment period. The resident's Care Plan dated 1/24/26 included a focus area for a Physician's Orders for diet, end stage renal disease and dialysis revised 1/24/26. Interventions for staff included providing a diet as ordered: renal dated 1/17/26 and supplement per physician dated 1/24/26. Resident #33's EMR Clinical Physician Orders disclosed an order for a renal diet, regular texture and thin consistency dated 1/16/26. On 1/26/26 at 12:24 PM and 4:34 PM Resident #33's family stated the resident did not consistently get breakfast prior to leaving for dialysis in the morning. The family stated the resident received a shake on this date, but that was not an acceptable form of nutrition prior to dialysis. The family stated the facility did not offer a meal substitution (brown bag) for the breakfast meal as the resident left for dialysis prior to the breakfast meal being served. The family included the resident did receive cereal once but that was not part of his renal diet and the resident did not do well when he did not get breakfast. The family stated the facility may offer the resident a breakfast upon return and have it reheated but that may not be consistent either. The family disclosed the resident did not consistently receive menus prior to the meals to select options, be provided with approved alternatives for his diet and did not receive items selected from his menu that were part of his diet. 3. Resident #42's MDS dated [DATE] revealed a BIMS score 12/15 indicating moderate cognitive deficit. The document disclosed the required a therapeutic diet upon admission and during the last 7 days of the assessment period. The resident's Care Plan dated 1/13/26 contained a focus area with a Physician Order for therapeutic diet related to diabetes mellitus with an intervention of providing diet as ordered of Consistent Carbohydrate initiated 1/13/26. The electronic medical record (EMR) Clinical Physician Orders disclosed an order for CCHO diet, regular texture, thin consistency dated 1/13/26. Observation of lunch meal service on 1/21/26 beginning at 12:02 PM revealed the following: Staff F, Dietary Aide, and Staff V, Cook/Dietary Manager, did not consistently use the meal tickets when preparing and serving the meals in the dining room and for room trays. Staff V stated he did not have all of the meal tickets and did not know who had what orders or had been served. Staff F stated a renal plate was needed. Staff V prepared the plate with (2) 4 ounce (oz) servings of egg noodles, (2) 6 oz servings of Chicken [NAME] and (1) 4 oz serving of vegetables. Staff V covered the plate and handed it to Staff F. Staff F placed it on a room (continued on next page)		

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tray with pre-plated [NAME] Fruit Crumble from a large tray taken from the refrigerator. Staff did not prepare CCHO meals. The facility's menu spreadsheet for the noon meal on 1/21/26 for liberal renal diets provided the resident was to be served 6 oz. Chicken [NAME] over 4 oz. egg noodles, 4 oz. mixed vegetables, #12 scoop of [NAME] Fruit Crumble and dinner roll. The facility failed to provide the resident with a dinner roll, provided double the servings of Chicken [NAME] and noodles, and an undisclosed amount of the [NAME] Fruit Crumble as the portion sizes were indistinguishable from the regular diet portions (#8 scoop). The facility's menu spreadsheet for the noon meal on 1/21/26 for the CCHO diets provided the residents were to be served 6 oz. Chicken [NAME] over 4 oz. egg noodles, 4 oz. mixed vegetables, #12 scoop of [NAME] Fruit Crumble and dinner roll. The facility failed to provide the residents with a dinner roll and the prescribed portion of [NAME] Fruit Crumble as the portion sizes were indistinguishable from the regular diet portions (#8 scoop). On 1/22/26 at 1:57 Staff HH, Registered Dietitian, stated the cook(s) were to follow the menus as presented and if they were not able to complete the approved menu she needed to be contacted for approval on substitutions. Staff HH stated residents with therapeutic diet orders must have those diets followed. The staff stated she was not present during meal services due to schedule. Staff HH stated if meal tickets were not consistently used for plating of meals and for delivery, it would be difficult to ensure Physician Orders were followed. On 1/27/26 at 1:39 PM Staff II, Chief Executive Officer (CEO) for the kitchen services contract company, stated diets must be prepared according to the orders, as well as the approved menus. The staff stated the company provided the cooks with recipes and instructions for preparing the modified diets. Staff II further disclosed the company provided on-going training for staff. The Administrator stated during a conversation regarding the concerns with meal service and wrong diets/consistencies on 1/28/26 at 11:14 AM it was difficult with some aspects of the kitchen due to using a contract company. The Administrator stated he was hopeful the new Dietary Manager would be able to correct some of the concerns. The undated kitchen policy for Menu Compliance identified all meals served to residents follow the approved menu for both regular and therapeutic diets. The undated kitchen policy for Diet Order Changes and Communication disclosed to ensure all diet orders were communicated accurately, implemented promptly and documented shall originate from a physician or RD or speech language pathologist (SLP) and be communicated immediately to the Food Service Director and Nursing Leadership.		