STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165601	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony West Des Moines	5010 Grand Ridge Drive West Des Moines, IA 50265

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident and staff interviews and record review, and policy review, the facility failed to provide adequate supervision, failed to follow policy and failed to utilize adequate assistive devices to prevent accidents or further injuries for 3 out of 4 residents reviewed (Res #2, #89 & #116). The facility reported a census of 101 residents. Findings include:1.The Minimum Data Set (MDS) dated [DATE] for Resident #116 revealed diagnoses of diabetes mellitus, stroke, heart failure and required substantial assistance for transfers and moderate assistance for toileting and personal hygiene. Walking 10 or more feet did not occur due to a medical condition or safety concerns and a manual wheelchair was normally used for mobility. The MDS identified Resident #116 had an impairment of upper or lower extremities and use of a walker was not identified for a mobility aid. The MDS did not identify Resident #116 as having negative behaviors such as rejection of care and wandering did not occur. Resident #116 had a Brief Interview for Mental Status (BIMS) score of 3 that suggested severe cognitive problems with thinking and memory without signs of delirium. The MDS did not document that the resident was on a restorative program.The Care Plan for Resident #116 identified a brain injury due to a brain bleed and directed staff to offer cues, direction, redirect as needed, explain the task to be completed as she is impulsive with movements and non-compliant with directions. The Care Plan identified a risk for falls and directed staff to assist Resident #116 to ambulate with a gait belt and a front wheeled walker (initiated date [DATE]) and transfer using a non-mechanical lift (initiated date [DATE]). Restorative care: walk to dine & ambulate in facility resolved on [DATE]. A document titled incident report revealed on [DATE] at 5:20 pm, Staff B, RN was notified by Staff A, CNA that Resident #116 had lost her balance and fell to the floor while ambulating to the bathroom. Resident #116 was screaming Please help me up!. The Nurse Practitioner was notified and Resident #116 was sent to the hospital. The Progress Notes for Resident #116 revealed:1. On [DATE], Resident #116 was examined by Nurse Practitioner (NP) and documented Resident #116 was stable sitting in her wheelchair, alert, oriented, no distress, cooperative, frail, with a weight of 100 pounds. Resident #116 musculoskeletal condition was documented as limited range of motion with muscle weakness.2. On [DATE], Staff B, Registered Nurse (RN) documented that Staff A, CNA alerted that Resident #116 had a fall and upon entering Resident #116's room, she was on the floor, near the wall, laying on her right side, screaming Please help me up! Staff A stated she was taking Resident #116 to the bathroom, using her walker, and she lost her balance, falling to her right side. Resident #116 was assisted to her bed by Staff A and Staff B. Resident #116 was continuously screaming, complaining of pain in her right arm and shoulder. The Nurse Practitioner was notified and ordered to send Resident #116 to the hospital. The daughter was aware of the hospital transfer. 3. On [DATE] at 10:03 am, the hospital update was that Resident #116 fractured the right shoulder and elbow and due to the multiple comorbidities, a conservative management of a sling instead of surgery. The trauma services were providing pain management.A document titled [NAME] Des Moines Emergency Medical Services (EMS) dated [DATE] for Resident #116 revealed:a. The primary impression listed as acute pain due to trauma and injury of shoulder from fall from chair. b. At 5:40 pm EMS arrived to find Resident #116 (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	alert and oriented to place, time, event complaining of pain to her right shoulder. Resident#116 slid out of her wheelchair and landed on her right shoulder and had pain 10/10 on scale 0-10. c. An IV access and Fentanyl was administered.d. At 5:37 pm, Resident#116 was moved to the ambulance via stretcher.A document titled ED (Emergency Department) Provider Notes dated [DATE] for Resident #116 revealed:a. The chief complaint was right arm injury.b. History: Arrived via EMS (Ambulance) from her care facility following mechanical fall. The patient was getting out of the shower, when tried to use her wheelchair for support, causing her to fall. The patient reported hitting her head and is on anticoagulation. The patient complains of right shoulder and elbow pain. c. A physical exam of musculoskeletal revealed signs of injury present, tenderness and bruising. d. Preliminary result: Impacted right humeral (upper arm) fracture and a comminuted olecranon fracture (a severe elbow injury, breaks into multiple pieces) and elbow joint effusion (fluid buildup from trauma). e. Recommend admission to trauma for possible surgical repair. Posterior long-arm splint and slingDuring an interview on [DATE] at 1:40 pm, Resident #116's daughter stated her mother was in bed mostly as it was very hard for her to get up. The daughter stated she visited on [DATE], the resident had some memory loss but feeling normal for herself, no pain. The daughter stated she's been trying to figure out what happened and she was not ok with this. Staff B, RN told her that the CNA was following her mom with a wheelchair as she walked to the bathroom. The daughter stated she visited her mother multiple times before the fall and her mother could not walk.During an interview on [DATE] at 10:29 am, Staff B, RN stated she had been employed for two years at this facility and had provided care for Resident #116. Staff B stated Resident #116 tried to get up by herself, required the assistance of one staff, with a walker, and walked to the bathroom a long while ago. Staff B stated currently, the CNAs would change Resident #116 in bed before assisting her into the recliner. Staff B stated Staff A, CNA had provided care for Resident #116 a few times had 2 different stories of the incident on [DATE] so she questioned truthfulness. Staff B stated Staff A she was taking [NAME] to the bathroom and while she was getting things ready by opening the bathroom door, Resident #116 fell and the second report was that Staff A was following Resident #116 with the wheelchair. Staff B stated that was what she documented on the incident report. Staff B stated when she entered [NAME]'s room, she was on the floor, laying on her right side without a gait belt a few feet from the bed. Staff B stated it was about 50 feet to the bathroom and the wheelchair was by the bathroom wall, and the walker was on the floor tipped over near Resident #116 who was screaming in pain. Staff B stated Resident #116 was a few feet from the bed so they tried to stand her, but she was not able to bear weight, so they grabbed her pants and slid her on her feet, lifted and put her on the bed. Staff B stated Resident #116 was screaming, complained of shoulder pain and it appeared swollen at the shoulder. Staff B stated Staff Z, CNA responded, stayed with Resident #116 as she notified the Nurse Practitioner and called 911. Staff B stated she did not notify the administration about her concerns involving the fall. Staff B stated the DON (Director of Nursing) called her 2-3 days after the incident to ask if they used the mechanical lift to get Resident #116 off the floor, which she replied no, then had a one-on-one talk about using the mechanical lift to get residents off the floor after a fall, if they cannot get up on their own. Staff B stated no one questioned her about the incident except for asking if a mechanical lift was used to put Resident #116 into the bed. During an interview on [DATE] at 12:51 pm, Staff A, CNA stated she was hired in [DATE] and had worked both the upper and lower levels of the facility. Staff A stated she received training and felt it was good enough to know the people. Staff A stated she utilized the Therapy book for resident changes with ambulation and transfers. Staff A stated she provided care for Resident #116 a few times but was unable to recall the last time she provided her care but she usually walked to the bathroom. Staff A stated on [DATE], Resident #116 was in the recliner during walking rounds at the beginning of her shift and could not recall the other CNA reporting anything. Staff A stated she would change her while she's in the bed. Staff A stated Resident #116 was eating, activated her call light, and assisted her up from the recliner, using a gait belt and walker. Staff A stated she had the wheelchair because sometimes Resident #116 would get (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	weak in the bathroom. Staff A stated Resident #116 might have taken 10 steps, then leaned to the right and went over, it happened so fast. Staff A stated she activated the call light and radioed for assistance. Staff A stated Staff B, RN was in the hall, responded and helped get her up with the mechanical lift into bed. Staff A stated the ambulance came and could not remember if other staff had entered the room. During an interview on [DATE] at 3:12 pm, Staff Z CNA stated last year Resident #116 could get into a recliner with assistance but did not ambulate to the bathroom as she was incontinent and CNAs changed her in bed. Staff Z stated Staff A CNA told her she could walk Resident #116 to the bathroom. Staff Z stated Resident #116 did not ambulate due to balance issues but was able to pivot transfer with assistance. Staff Z stated on [DATE] she responded to someone's screams, checked the rooms, and found Staff B, RN and Staff A, CNA placing Resident #116 in her bed without a gait belt and there was no mechanical in the room, Staff Z stated when Staff B left the room to notify the doctor and call 911, Staff A told her Resident #116 fell during assistance to the bathroom. Staff Z stated Resident #116 was crying and did not want to be alone.During an interview on [DATE] at 10:29 am, Staff BB, CNA stated she had provided care for Resident #116, who was declining but would sit in her recliner to eat. Staff BB stated she worked on [DATE], 6-2pm shift, providing care for Resident #116 and needed two CNA's, with a gait belt, to transfer her to the recliner. Staff BB stated Resident #116 was not stable, and was too weak to walk to the bathroom so staff would check and change while she was in bed. A document provided by the Administrator verified to be investigative notes for Resident #116's fall on [DATE] which revealed: 4. Staff A, CNA entered the room to respond to the call light. Resident #116 told her she needed the bathroom, Staff A told Resident #116 she needed to get a gait belt. Resident #116 said no I'm going to the bathroom, stood up to her walker and began walking to the bathroom. Staff A grabbed Resident #116's wheelchair, unsure what else to do, bring wheelchair up behind Resident #116 who lost her balance and fell onto her right side.5. Staff B, RN was told Resident #116 fell as she was getting things ready to use the bathroom. Resident #116 had a walker and no gait belt and hasn't gotten up by self in a long time.6. Staff Z, CNA responded to a scream, staff already got Resident #116 up in bed. 7. Resident #116 reported to be impulsive, doesn't always follow directions or wait for staff. 8. Resident #116 noted to be non-compliant and has been caught ambulating on her own. During an interview on [DATE] at 2:15 pm, Staff L, CNA/Restorative Aide stated she had been employed at this facility for 11 years and remembered seeing Resident #116, most of the time in bed. Staff L stated she had never provided care for [NAME] nor restorative care for her.During an interview on [DATE] at 12:29, Staff JJ, Physical Therapy (PT) stated she had worked at the facility for 16 yrs. Staff JJ stated the last time she had provided treatment for Resident #116 was [DATE] through 10/3//25 for syncope due to low blood pressure. Staff JJ stated Resident #116 was ambulatory with a front wheeled walker and stand by assistance and participation varied due to her cognition and if she wanted to participate. Staff JJ stated she did not see Resident #116 in [DATE] nor [DATE]. Staff JJ stated she then saw Resident #166 after her return from the hospital on [DATE] for a PT evaluation and one evaluation before her death on [DATE]. Staff JJ stated she provided an update form in a PT transfer binder for the staff and the ADON or MDS nursing staff would place the changes in the care plan. Staff JJ stated the facility had a restorative program but Resident #116 was not in a program due to her lack of participation. Staff JJ stated she would be made aware of changes from nursing or aides, that the resident was not doing as well, and we might look in the Point Click Care update to see if a resident had a fall or hospital visit, QAPI or daily meetings. Staff JJ stated Resident #116 did not want to do a lot of activity but would get up to the recliner. Staff JJ stated the staff should have notified her if a change of condition occurred. Staff JJ stated Resident #116 needed heavy coaxing to get up and to do any walking, it was more behavioral then medical at the time she saw Resident #116 last on [DATE]. Staff JJ stated when she saw Resident #116 on [DATE], she was very weak, unstable, reduced balance and had a fear of falling. Documents titled Physical Therapy for Resident #116 involved: 5. On [DATE], skilled interventions focused on training in turning from back to side to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	sitting at the edge of bed with a minimum of one person to assist and sit to stand at front wheeled walker. Resident #116 demonstrates extreme fatigue (weakness) with increased time needed to complete tasks. Toilet transfers with assistance and verbal cues for safety and turning completely before sitting. Resident #116 was able to perform peri cares with assistance to complete putting off and on of undergarment/pants. Electronically signed by Staff JJ, Physical Therapist (PT)6. On [DATE], gait (walk) training focused on adjustment of center of mass over base of support and directional changes using a front wheeled walker, CGA (contact guard assist where the therapist maintains hands-on physical contact with the patient using a gait belt to provide safety, stability, and balance) for 7 feet with slow gait and decreased step length. Assist needed for management of walker during turn as Resident #116 was unable to maneuver around a tray table with verbal cues. Resident #116 required increased length and amount of rest breaks due to complaints of fatigue. Electronically signed by Staff JJ, PT.7. On [DATE]. gait training focused on adjustment of center of mass over base of support and directional changes using a front wheeled walker and CGA for 10 feet and for 5 feet with verbal cues for directions. Resident #116 required extensive time to complete each task and extensive rest breaks between each task due to complaints of extreme fatigue. Skilled interventions focused on training in turning from back to side to sitting at the edge of bed with a minimum of one person to assist and moderate verbal cues for encouragement. Resident #116 had complaints of dizziness upon sitting (BP cuff unavailable during time). The dizziness subsided after 3 minutes of sitting. Sit to stands with minimum assistance of 1 staff with maximal verbal and visual cues for hand placement. Resident #116 was educated on the importance of drinking more fluids and eating in order to increase energy and strength. Electronically signed by Staff JJ, PT.8. On [DATE], Patient and Caregiver Training: Instructed Resident #116 and caregiver (CNA) in safe transfer techniques, use of assistive device RW (rolling walker) and proper body mechanics specifically, in order to increase functional mobility skills and increase safety and decrease need for assistance with 100% return demonstration provided during session. Electronically signed by Staff KK, PT Assistant on [DATE] and electronically co-signed by Staff JJ, PT on [DATE]. A document provided by the Administrator verified to be investigative notes for Resident #116's fall on [DATE] which revealed the following: 9. Staff A, CNA entered the room to respond to the call light. Resident #116 told her she needed the bathroom, Staff A told Resident #116 she needed to get a gait belt. Resident #116 said no I'm going to the bathroom, stood up to her walker and began walking to the bathroom. Staff A grabbed Resident #116's wheelchair, unsure what else to do, bring wheelchair up behind Resident #116 who lost her balance and fell onto her right side.10. Staff B, RN was told Resident #116 fell as she was getting things ready to use the bathroom. Resident #116 had a walker and no gait belt and hasn't gotten up by self in a long time.11. Staff Z, CNA responded to a scream, staff already got Resident #116 up in bed. 12. Resident #116 reported to be impulsive, doesn't always follow directions or wait for staff. 13. Resident #116 noted to be non-compliant and has been caught ambulating on her own. A document verified by the Administrator to be the 5 day and root cause analysis submitted to the Department of Inspections and Appeals (DIAL) on [DATE] revealed the following: j. On [DATE] at 4:30 pm the Administrator was notified by the hospital that Resident #116 was to be admitted following the fall on [DATE] due to a comminuted and impacted right humeral (upper arm) fracture and a proximal radial ulnar (elbow) fracture. k. On [DATE] at 4:20 pm Resident #116 was assisted by Staff A, CNA to the bathroom when she lost her balance and fell onto her right side. Resident #116 was sent to the emergency department for imaging (x-rays).l. An interview with Staff A, CNA stated she answered Resident #116's call light and she needed to use the bathroom. Staff A stated she told Resident #116 she needed to get a gait belt, but Resident #116 got up, stood herself to her walker and began walking to the bathroom. Staff A grabbed the wheelchair, brought it up behind Resident #116 and witnessed her lose balance and fall to her right side. Resident #116 began to scream in pain, calling out for help to get up. Staff A requested assistance from Staff B, RN and they assisted Resident #116 into bed utilizing a mechanical lift. m. Interview with Staff B, RN stated Resident #116 (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	was not wearing a gait belt on when she entered the room, the walker and wheelchair was nearby. Staff B completed her assessment, assisted Resident #116 off the floor and contacted the on-call provider who gave the order to transfer resident to the hospital for further evaluation due to complaints of pain in right arm and shoulder. The emergency medical services were contacted and Resident #116 was sent at 5:45 pm. n. Other staff interviewed stated Resident #116 had a normal day, used her call light, did not like to wait for staff, could be impulsive per the care plan. Resident #116 was toileted at 3 pm. Resident #116 directed her cares most of the time, ate in her room, had dinner and put on her call light. Staff answered the call lights timely per reports. o. Resident #116's daughter commented, these things happen. p. The Medical Director was informed.q. Care plan followed 1. The wheelchair was locked at bedside. 2. The walker was at bedside. 3. A picture sign to call for assistance was in place. 4. Staff were providing appropriate supervision and attempted to meet her needs. 5. Her environment was quiet and calm. Resident #116 had been eating with her television per her preference. r. Based on these findings the staff adhered to the resident care plan, no evidence of staff culpability, interventions were implemented and staff responded promptly. Root cause appeared to be the resident's need for the bathroom and her impulsivity and preference for directed care. No symptoms of frequency or urinary tract infection (UTI). The lack of a gait belt at the time was not a contributing factor, as the resident was impulsive and did not wish to wait for assistance. A document titled Physical Therapy referral dated [DATE], Reason for Referral: Resident #116 was referred to therapy services due to fall from hyperglycemic (high blood sugar) episode that resulted in a right humerus (upper arm fracture) along with elbow joint effusion. Pt presents with impaired transfers and mobility at this time. Clinical Impressions: Patient referred to PT due to new onset of compromised physical exertion level during activity, decrease in functional mobility (moderate to dependent), decrease in strength in lower extremities, decreased skin integrity (large amount of bruising to right side, right arm in sling with ace wrap and splint to elbow), recent fall with Right humeral fracture (upper arm), functional limitation with ambulation (unable at this time), increased need for assistance from others, dependent with mobility, increased physical exertion during daily living tasks, reduced dynamic balance and reduced static balance. Electronically signed by Staff JJ, PT on [DATE]. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #2 revealed the diagnoses of weakness, unsteadiness on feet, required the assistance of one staff for supervision with ambulation and maximal assistance for hygiene and toileting. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 suggesting an intact cognition.The Care Plan for Resident #2 dated [DATE]. The Care Plan identified a risk for falls and directed staff to assist with ambulation and transfers with moderate assistance of one staff with a gait belt and front wheeled walker and as needed.The Progress note dated [DATE], the Nurse Practitioner (NP) documented a visit for Resident #2 following the fall on [DATE]. Resident #2 described the incident as a slide as she attempted to stand up with the assistance of a care giver who did not use a gait belt and despite informing the care giver she was slipping; she was reassured multiple of times that she will not fall. The NP documented Resident #2 slid down and became stuck between the toilet and the wheelchair and had to be assisted by multiple of caregivers to get back to bed. Following the incident, x-rays revealed an acute fracture of her ankle and had to be transported to the hospital where she received Fentanyl for pain management and additional x-rays. The NP documented the hospital stabilized the fracture with a soft cast and potentially transition to a boot and Resident #2 reported ongoing pain from the fracture.The Falls with Injury report dated [DATE] for Resident #2 revealed:a. The incident occurred in the resident's bathroom room.b. Staff CC, CNA tried to assist resident #2 from the toilet to wheelchair, due to weakness to her legs, she sat on the floor.c. Staff I, LPN noted resident had a gait belt on and an open area to right shin and left lateral lower leg.d. Resident #2 stated her legs gave out as Staff CC, CNA performed peri care, reported pain to right lower leg and hip. e. Resident #2 refused ER prefer mobile x-ray. Notified the Nurse Practitioner, ordered x-ray to right femur and right lower leg after a witnessed fall. f. Resident #2 was alert and ambulatory with assistive device. g. No injuries observed (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	post incident. h. Person preparing the incident report: Staff GG, LPN Statement titled Incident [DATE] for Resident #2 revealed: a. At 11:45 am 2 cna's reported resident #2 fell during transfer from toilet to wheelchair. b. Resident #2 was found in bathroom in a wheelchair.c. CNAs stated they got her up prior to getting the nurse. d. Resident #2 was complaining of pain to her right lower extremity.e. Resident #2 had a gait belt on in wheelchair. f. Resident #2 assessed with vital signs then assisted to bed by two staff members. g. Signed by Staff I, LPN on [DATE] Form signed by Staff HH, Former DON on [DATE] at 11am revealed: a. Resident #2 sustained a Tri malleolar fracture of right ankle on [DATE] at 11:29am.b. Cause of accident as Resident #2 used bathroom with staff assist, staff assisting with peri care when resident legs became weak, lowered to the floor. c. Previous functional ability: 1 assist with gait belt and front wheeled walker. d. Checked as injury not a major injury and signed by Staff II, Doctor of Osteopathic Medicine on [DATE] at 1500. During an interview on [DATE] at 11:42 am, Resident #2 stated on [DATE] she had walked with her walker into the bathroom and when finished she activated the call light. Resident #2 stated she required the assistance of staff to provide peri care and had waited for a while until the Certified Nursing Assistant (CNA) arrived. Resident #2 stated usually when she was assisted by facility staff and she would say she's slipping, the staff would sit her back down on the toilet. Resident #2 stated she began to slip and said that to the CNA who replied with I've got you. Resident #2 stated she went down to the floor because her legs were weak from sitting so long waiting for assistance. Resident #2 stated the CNA that was assisting her was an agency staff who said she should not even be here providing care for her as she had not been trained. When inquired if she fainted, Resident #2 laughed and replied, I've never fainted in my life. Resident #2 stated the CNA had her by the arm and not a gait belt. Resident #2 stated another CNA came into the room, who also was new agency CNA, and helped to get into the wheelchair. Resident #2 stated it was hard, they had her by the arms and her right leg hurt so she was unable to stand. Resident #2 stated then the nurse came in to help.During an interview on [DATE] at 3:15 pm, Staff CC, CNA verified her work at this facility was through an agency. Staff CC stated on her first day, she was asked to come in ahead of her start time to receive a code for the Point Click Care (PCC) computer system to chart, then failed to show her how to use it. Staff CC stated she was unaware of how to look up resident information since they did not give her details and they were aware it was her first time in the facility. Staff CC stated the staff was not helpful. Staff CC verified she had worked on [DATE], working with another new agency CNA and termed the day as Hectic as staff were sick, went home and the two were on their own with 2 halls of residents. Staff CC stated the call lights were going off and the nurse yelled at her for using the radio to call for assistance. Staff CC stated she answered a bathroom call light and she did not know the resident. Staff CC stated when the leaving, staff conduct the walking round at the beginning of the shift, they didn't give details. Staff CC stated during the peri care, the resident was starting to fall. Staff CC stated she called for the other CNA who came in immediately and they tried to get the resident into her wheelchair, describing it as very hard. Staff CC stated a 2nd nurse came into the room to helped them. Staff CC stated when she left at 2pm, no one asked her what happened, no one called her and she did not go back to this center.During an interview on [DATE] at 10:41 am, Staff DD, Agency CNA verified she worked through an agency and that [DATE] was her first day to work at this facility. Staff DD stated it was complete chaos as the staff did not tell her anything, no direction and it was the first time working with the mechanical lifts that this facility utilized stating she had no idea how to run it. Staff DD stated she was assigned to work on a hall with a staff member who went home and she was unaware that she was working alone. Staff DD stated another agency CNA (Staff CC) was down the next hall and from 10am to 2pm they were on their own. Staff DD stated they assisted each other with the residents that required two assist and was in a room when Staff CC stated she needed to go across the hall as that call light had been activated for a while. Staff DD stated her resident was on the toilet and could not be left alone but Staff CC was absent for a really long time so she secured her resident and found Staff CC with her resident on the floor in front side of the toilet. Staff DD stated Staff CC asked what (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	do I do? and it's routine if someone falls to call the nurse, used the radio for a nurse and helped to get the resident up. Staff DD stated she did not remember what happened next. Staff DD stated there were many residents, multiple two assist and both Staff CC and herself had no idea what was going on. Staff DD stated she had been trained as a CNA, worked for 8 years, and referred to that as the craziest day of her life and she would never go back as it was unsafe. Staff DD stated no one called her and she did not return to work for them.During an interview on [DATE] at 2:09 pm, Staff I, Licensed Practical Nurse (LPN) stated she was not sure how the facility on-boards agency staff, she had seen a packet but have not reviewed the content, and the staff that are leaving for the day completed a walking round. Staff I stated the agency staff can look in the computer for the Kardex but they have to navigate to the care plan. Staff I stated most of the agency staff ask to look at the therapy communication binder. Staff I stated she had good communication with the staff CNA's but there have been multiple agency CNA's and she didn't know their base line knowledge. Staff I stated she remembered a little about Resident #2's fall, it happened in the bathroom and there was an issue with the agency CNA's getting her off the floor.During an interview on [DATE] at 1:48 pm, Staff G LPN ADON stated she was unaware of any training for the agency staff as human resources (HR) and the scheduler placed them onto her unit and was not aware of who it will be until she arrives for the day. Staff G stated she was unable to remember who the agency staff were that had worked on [DATE], day shift, but when she was made aware that they were low on staffing, she notified Staff FF, Staff Scheduler and did not receive further assistance. Staff G stated the nurse on duty had responded to some activated call lights but personally no one approached her to assist. Staff G stated administration schedules staffing according to census. Staff G stated she was not aware there were new agency staff or that they were not oriented to PCC, it was a busy day. During an interview on [DATE] at 2:15 pm, Staff FF, Staff Scheduler stated the facility utilized two staff agencies, the CNAs were independent then make a post on the clipboard account so they may pick up the shifts. Staff FF stated the moment she was aware of the individual's acceptance for a shift then requests their documentation. Staff FF stated there was a packet at the nurse station they will utilize for orientation that was created in [DATE]. The agency staff will sign the four pages in the binder when they come in for their first day and leave it in the binder. Staff FF stated she would assume the staff CNA would orient and train them as it was the responsibility of the ADON's and DON to have that done. Staff FF stated Staff CC, agency CNA accepted work starting [DATE] and Staff DD, agency CNA picked up her first shift on [DATE]. Staff FF verified both agency CNAs worked on [DATE] and a staff CNA had left at 9:30 am. Staff FF stated a staff CNA was to come upstairs to work 11 am to 6 pm but was unsure if that occurred. Policy titled Fall Occurrence dated 2/2024 revealed interventions are implemented and placed on care plan based on fall risk assessment. The resident will be assessed by a licensed nurse prior to being moved after a fall. Policy Gait belts (transfer belts)When to use: Patient is weak but can bear some weight. Fall risk is present. Assisting with sit to stand or ambulation. Policy mechanical lifts (powered or hydraulic lifts)Used for patients who cannot bear weight or require full assistance. When to use: non-weight bearing patients. Total or extensive assist transfers. Staff safety concern with a manual transfer. Policy Non mechanical lifts (manual transfers) includes pivot transfers, two person lifts, and slide board transfers.When to use: patient can bear partial weight, short transfers bed to chair, patient follows commands. If a patient cannot safely bear weight, use a mechanical lift.If a patient can assist, a gait belt or non-mechanical method may be appropriate. when in doubt, get help. Safety protects both patient and caregiver.During an interview on [DATE] at 2:55 pm, the Administrator reported that he was not employed by the facility when Resident #2 had her incident. The investigations are conducted by interviewing staff and residents. The Administrator stated he would conduct interviews wi[TRUNCATED]

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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 review of Certification and Survey Provider Enhanced Report (CASPER) from the Centers for Medicare & Medicaid Services (CMS), the CMS-2567's, staff interview and policy review, the facility failed to have an effective QAPI (Quality Assurance Performance Improvement) process to address previously identified quality deficiencies to assist in the provision of quality care for residents and attain substantial compliance with Federal regulations and State rules. The facility had several repeat deficiencies identified on the facility's current recertification and complaints survey. The facility identified a census of 101 residents.Findings include:Review of CASPER report revealed repeated deficient practices identified during the facility's annual surveys 3/14/23, 12/11/25 and 2/20/25. Department of Inspections, Appeals and Licensing (DIAL) website under the facility's visit history revealed repeated deficient practices identified during the facility's recertification surveys completed 3/14/23, 12/11/23 and 2/20/25, complaint investigations 3/14/23, 6/8/23, 12/11/23 and 7/29/24, and facility-reported incident investigations 3/14/23, 6/8/23, 10/3/23, 12/11/23, 7/29/24 and 2/20/25, and the current survey and complaint investigations. The repeat deficiencies cited included: F609 cited 3/14/23,10/3/23 and during the current surveyF688 cited 2/20/25 and during the current survey. F689 cited 3/14/23, 6/8/23 and during the current survey F812 cited 6/8/23, 12/11/23, 2/20/25 and during the current survey.F865 cited 6/8/23, 2/20/25 and during the current survey.F880 cited 3/14/23, 6/8/23, 12/11/23, 7/29/24, 2/20/25 and during the current survey.In an interview on 3/4/26 at 2:15 PM, the Administrator reported the Quality Assurance (QA) Committee met monthly. The QAPI Committee had identified areas they needed to work on. The Administrator reported he had only worked at the facility since 11/2025. The facility had worked on staff scheduling and workload strategies, as well as doing audits and providing staff education. When the surveyor asked the Administrator how they were addressing repeat deficiencies cited since the past recertification survey and complaint surveys, the Administrator responded the facility had recently implemented an Infection Preventionist and a Nurse Educator role to ensure compliance and conducting audits. The facility also planned to overhaul their orientation program and do a better job before staff worked on the units. The Facility's QAPI Plan, dated 5/23/25, identified the facility is committed to standards of performance and dedicated to providing the highest quality of health care services. Regulatory outcomes are monitored and trended including licensure certification survey results, complaint survey results and focused survey results (such as infection control focus). Performance Improvement Projects (PIPs) are developed as needed and/or as determined by the QAPI Committee. Areas of opportunity identified by the QAPI Committee are corrected through the PIP process. Completion of investigations and review of the findings should demonstrate that process improvement initiatives are implemented and have been sustained.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on electronic health record review (EHR), staff interview, and guidance from the Resident Assessment Instrument (RAI) User Manual Version 1.20.1 October 2025, the facility failed to accurately complete Minimum Data Set (MDS) Assessment for 4 of 21 residents reviewed (Resident #3, #7, #8, and #61). The facility reported a census of 101. Findings include: 1.The Quarterly MDS completed on 12/17/25 indicted the presence of a feeding tube for Resident #3 by checking question K0520B. Review of Physician Orders for Resident #3 did not show any current or discontinued orders for tube feedings. The Care Plan for Resident #3 did not show any current or previous use of tube feedings. Review of Progress Notes did not identify the presence of a feeding tube, past or present. The RAI User's Manual (pages K-11 and K-13) outlined question K0520B should be checked only if a feeding tube was present during assessment period. 2.The Annual MDS completed on 10/31/25 was checked No to question A1500 . This indicated Resident #7 did not have a Level II Preadmission Screening and Resident Review (PASARR) mental illness and/or intellectual disability. Current diagnoses listed for Resident #7 include generalized anxiety disorder, major depressive disorder, recurrent, and schizoaffective disorder, bipolar type. During an interview on 2/26/26 at 2:05 PM, The MDS Coordinator noted the mental health diagnoses for Resident #7. However they were not aware question A1500 should be answered Yes. Review of PASRR Level I Screen Outcome, dated 1/28/26, confirmed the presence of a PASRR condition being a mental health disability. This included the diagnoses of schizoaffective disorder, major depression, and anxiety. The PASRR Outcome Explanation directs facilities to mark Yes on question A1500 on the MDS as well as selecting the specific PASRR condition with question A1510. 3.The MDS completed 12/10/25 indicated the use of continuous oxygen therapy for Resident #8. The MDS did not note the use of any further respiratory treatments. Review of Physician Orders for Resident #8 noted the following: a. Apply Continuous Positive Airway Pressure (CPAP) nightly with a start date of 10/3/25; b. Oxygen at 2 liters/minute at rest and 3 liters/minute with exertion with a start date of 11/7/25. The Treatment Administration Record for December 2025 indicated Resident #8 utilized CPAP for 2 days out of the 7-day look-back period. During an interview on 2/26/26 at 2:05 PM the MDS Coordinator acknowledged Resident #8's use of a CPAP machine. They believe it was an oversight that it was not identified on the most current MDS Assessment. The RAI User's Manual (page O-6) noted any type of CPAP respiratory support devices should be (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coded on question O0110G3. 4. The Annual MDS completed on 12/31/25 indicated the use of insulin for Resident #61. Question N0350 noted insulin was used 1 day and question N0415 noted the use of hypoglycemic medications. Review of Physician Orders for Resident #61 did not show current or discontinued insulin orders for December 2025. Current diagnoses for Resident #61 did not include Diabetes. The MDS completed on 12/31/25 did not list Diabetes as an active diagnosis. During an interview on 2/26/26 at 2:05 PM, the MDS Coordinator confirmed Resident #61 did not receive insulin injections and the MDS Assessment was miscoded. The RAI User's Manual (pages N-3 to N-8) note to indicate the number of days the resident received an insulin injection during the assessment period. The use of hypoglycemic medications should be checked if the medication was taken by the resident during the assessment period.

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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, resident records, staff interviews and policy review, the facility failed to follow infection control policies, procedures and guidelines for contact precautions, enhanced barrier precautions, and standards of care. The facility reported a census of 101 residents. Findings include: 1.The Physician's Order, initiated on 2/23/26, directed the facility to place Resident #5 in isolation due to a Clostridioides difficile (C-diff) infection. A General Progress Note dated 2/23/26 at 6:09PM documented the following; Resident is positive for C-Diff and will start Vanco (antibiotic for treatment of C-diff), educated resident and wife as to what the diagnosis is and will be on isolation for 10 days. A sign outside the resident's door informed staff to follow contact precautions. This included the use of gown and gloves for any interaction with the resident and their environment and hand washing prior to exiting the room. A note indicated the use of hand sanitizer, which is alcohol-based, was not acceptable given the type of infection. During an observation on 2/26/26 at 9:15 AM, Staff R, Registered Nurse (RN), completed dialysis fistula site cares on Resident #5. This included the use of Staff R's stethoscope on the resident's arm to further assess the fistula. After all resident cares were completed, Staff R used an alcohol wipe to disinfect the stethoscope. In an interview on 2/26/26 at 3:50 PM, Staff S, Director of Clinical Education, acknowledged Resident #5's C-diff infection and the current isolation precautions. Due to the nature of the infection, the use of an alcohol wipe is not recommended as it will not adequately disinfect surfaces. Staff S explained bleach wipes or Super Sani-cloths should be used instead to disinfect. The facility stocks Super Sani-cloth disinfectant wipes. Staff S further noted the use of disposable equipment, like a disposable stethoscope, as an alternative infection control practice with C.diff infections. The facility document Infection Control Practice Guide, revised 9/2023, noted under Contact Precautions to utilize resident-specific non-disposable items that cannot be cleaned and disinfected between residents, e.g., blood pressure cuff, stethoscopes. If indicated, equipment should be disinfected between resident use with an EP-registered disinfectant or hypochlorite solution. 2. The Minimum Data Set (MDS) dated [DATE] for Resident #4 revealed diagnoses of heart disease, diabetes mellitus, Alzheimer's disease, dementia, a stroke and required partial to supervised assistance for cares. The MDS identified Resident #4 was taking antipsychotic, antidepressants, hypoglycemic, anticoagulant, antiplatelet and diuretics. Resident #4 was identified as receiving insulin injections 7out of 7 days. The MDS identified Resident #4's Brief Interview for Mental Status (BIMS) score of a 5 suggests an impaired cognition. During an observation on 2/23/2026 at 1:25 PM, Staff B, Registered Nurse (RN) came in his room after the noon meal and informed Resident #4 she had his insulin, laid his insulin pen in the bed, swabbed his left arm then picked up the syringe and administered the medication. Staff B failed to hand sanitize, put on gloves, and failed to perform hand hygiene before she left the room. During an interview on 2/25/2026 at 10:29 AM, Staff B RN stated she had been employed for two years at this facility. Staff B verified Resident #4's blood sugars were high and on 2/23/26 she administered (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin according to the sliding scale ordered for Resident #4. Staff B was not sure if she had hand sanitized or wore gloves but verified laying the syringe on his bed and should have used a barrier. Staff B stated she did leave the cap on it but should have used a barrier. During an interview on 3/4/26 at 1:43 pm, the Director of Nursing (DON) stated she was new to her position and at this time she could not express her expectations for the nurses. 3. During an observation on 2/25/26 at 8:01 AM, Staff U, Licensed Practical Nurse (LPN) failed to provide barrier while checking Resident #54's blood glucose. Staff U placed the glucometer on top of Resident #54's books sitting at her bedside. 4. On 2/25/26 at 10:59 AM, during observation of medication administration, Staff U, LPN, failed to put on Personal Protective (PPE) while administering Resident #6's medication via g-tube. 5. Review of Resident #9's Treatment Administration Record (TAR) for February 2026, revealed an order dated 2/19/26 to cleanse abdominal (abd) wounds with cleanser, apply Medihoney topically to wound and cover with silicone super absorbent dressing daily and as needed. On 2/26/26 at 3:00 PM, a sign outside Resident #9's room indicated Enhanced Barrier Precautions (EBP) and a bin of drawers inside Resident #9's room stocked with Personal Protective Equipment (PPE) was observed. Continued observation, Staff J, LPN and Staff X, Assistant Director of Nursing (ADON) failed to don appropriate EBP PPE for wound care/dressing change on Resident #9's lower abd wounds. 6. Review of Resident #97's TAR for February 2026, revealed an order dated 2/18/26 to cleanse right thigh with normal saline, apply Bactroban ointment, cover with silicone super absorbent dressing daily and as needed. An observation on 2/26/26 at 2:50 PM failed to indicate Resident #97's need for EBP with wound care. During observation Staff J, LPN failed to wear EBP while providing wound care treatment for Resident #97. During an interview on 2/26/26 at 3:18 PM Staff G, ADON and Staff X, ADON acknowledged the failure to don EBP for Resident #9 and Resident #97's wound treatments. On 2/26/26 at 3:52 PM, Staff S, RN Director of Clinical Education, stated expectations for all staff to wear EBP PPE during wound care and g-tube care and g-tube medication administration. Review of facility provided Enhanced Barrier Precautions Policy, revised 3/2024, stated the following: Purpose: To minimize risk of transmission of novel or targeted Multi-Drug Resistant Organisms (MDROs) during high contact resident care activities for residents requiring Enhanced Barrier Precautions (EBP).1. EBP will be used in conjunction with standard precautions for residents with any of the following:a. Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply. b. Wounds and/or indwelling medical devices. (wounds generally include chronic wounds but not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. Not to include shorter-lasting wounds, such as skin breaks or tears. Indwelling medical devices include central lines, urinary catheters, feeding tubes, and/or tracheostomy.) In an email dated 2/26/26 at 2:45 PM, Facility Administrator communicated he was not able to find a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility policy related to disinfecting equipment and shared medical devices and stated we follow standard of care.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interview the facility failed to obtain informed consent for psychotropic medications that have black box warnings (the most serious safety warning the Food and Drug Administration (FDA) uses and requires the healthcare provider to have a comprehensive discussion with the resident/representative about the risks, benefits and alternatives for use) for 2 of 5 resident reviewed for psychotropic medications (Residents #4 & #110). The facility reported a census of 101 residents.The Findings include:1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #110 had diagnoses of Alzheimer's Disease, dementia, anxiety disorder and depression. The resident had impaired short and long-term memory and severely impaired decision-making skills. The MDS indicated the resident did not have any behaviors. The MDS documented the resident took an antidepressant medication. The MDS assessment dated [DATE] revealed Resident #110 took an antipsychotic and an antidepressant medication. The MDS indicated the resident had no behaviors. The Care Plan initiated 5/21/24 revealed the resident had behavioral problems related to sexually inappropriate behaviors in public areas, physical aggression and combativeness with cares at times. He took psychotropic medications (sertraline) related to anxiety, and trazadone for insomnia and agitation. The Care Plan directed staff to administer medications as ordered and assess for side effects and complications of the medications such as tremors, pacing, lip/tongue movement or rigidity, poor balance, urinary retention, constipation and dry mouth. The Order Summary revealed orders for Resident #110 for the following: Sertraline (psychotropic) 200 milligrams (mg) by mouth (PO) daily for depression started on 6/18/25, Trazodone (psychotropic)12.5 mg PO three times a day (TID) related to anxiety disorder and 25 mg PO at bedtime related to insomnia started on 6/20/25, Risperdal (psychotropic) 0.25 mg PO two times a day for agitation and restlessness started on 9/22/25, and Olanzapine (psychotropic) 5 mg PO TID for aggression started on 1/5/26. An Encounter Note / Progress Note dated 2/4/26 at 12:00 AM revealed risperidone, olanzapine, sertraline, and trazodone for symptom and behavior management. A Psychotropic Medication Monthly Review created on 1/30/26 lacked a consent for the psychotropic medications. The Electronic Health Record (EHR) revealed under the Assessment tab, a document titled Psychotropic Medication Evaluation. The Psychotropic Medication Evaluation assessment dated [DATE] was created / completed on 2/26/26. Section D of the Psychotropic Medication Evaluation revealed education to the resident and/or representative on the risks, benefits, and alternative options prior to starting the psychotropic medications. The record lacked a consent for the psychotropic medications the resident was prescribed. In an interview 2/26/26 at 4:40 PM, the Regional Nurse reported she had worked with the facility for a year. The facility had a few DON's (Director of Nursing) in the past year. She reported she knew there were forms about the psychotropic medications the residents were on. She found a binder with some forms but no consents found as of this date. She will continue to look to see if she can find consents for the use of psychotropic medications for Resident #110. The Regional Nurse reported they had recently added a section about the education provided to the resident /representative on a Psychotropic Medication Evaluation on-line. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview on 3/4/26 at 11:30 AM, the Regional Nurse reported she found information about psychotropic medication education on Resident #110. The Psychotropic Medication Evaluation assessment is located under the assessment tab in the computer. Surveyor reviewed the Psychotropic Medication Evaluation for Resident #110. The Evaluation was completed on 2/26/26 (the date the surveyor requested it). A Usage for Psychotropic Medications Guidance policy revised 3/2025 revealed each resident's drug regime will be free from unnecessary psychotropic drugs. Psychotropic drugs include antipsychotics, antidepressants, antianxiety and hypnotics. Underlying causes of the resident's behavior will be assessed prior to initiation of psychotropic medications. The benefits, risks and treatment goals will be assessed and documented. The facility will obtain informed consent from residents and/or their representatives of the benefits, risks and alternatives before initiating or increasing psychotropic medications. 2. admission Minimum Data Set (MDS) for Resident #4 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 5 indicating severe cognitive impairment. The MDS further revealed the resident had a diagnosis of depression and behavioral disturbance and received an antidepressant and antipsychotic medication during the 7 days look back period. Resident #4's clinical physician orders revealed orders for antidepressant medications and antipsychotic medication. The Electronic Health Record (EHR) for Resident #110 lacked documentation in regards to psychotropic consents. Response to an e-mail on 2/26/26 at 2:38 pm, the Administrator stated he looked for the original paper copies of the consents due to the change over to electronic system but at this time the facility did not have the signed consents for psychotropic medications requested for Residents #4 and #110.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, employee timecard review and policy review the facility failed to take appropriate steps to protect residents from potential abuse by not separating staff from residents when an allegation of suspected abuse was reported for 2 of 3 residents reviewed for abuse (Residents #89 & #116). The facility reported a census of 101 residents. Findings include: 1.The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 had diagnoses of arthritis and a right hand contracture. The MDS documented the resident had a Brief Interview for Mental Status (BIMS) score of 2 indicating severely cognition. The MDS revealed the resident had impaired range of motion (ROM) to the upper and lower extremities. The MDS also revealed the resident had dependence on staff for bed mobility and transfers. The Care Plan initiated 4/26/24 revealed the resident had arthritis and limited mobility and required assistance with activities of daily living (ADL's). The resident also had a risk for falls. The Care Plan directed staff to use a Hoyer (mechanical lift) and assistance of two staff for transfers. An Incident Report dated 2/17/26 at 1:00 PM revealed Staff G, Assistant Director of Nursing (ADON) notified by Staff I, LPN, on 2/17/26 that Resident #89 complained of right arm pain. Resident #89 was unable to give a description. The Nurse Practitioner (NP) ordered an x-ray of the right upper extremity (RUE). Resident #89 was later sent to the Emergency Department (ED) for further evaluation. The Progress Notes revealed the following: On 2/17/26 at 1:22 PM, resident with increased pain to her right arm and shoulder with movement and palpation. Resident unable to state cause. On 2/17/26 at 6:15 PM, x-ray results received. Findings show an age-indeterminate acute or subacute sub capital fracture of the right humeral neck, and diffuse osteoporosis. Information provided to the administrator. No previous records available for comparison. In an interview on 2/24/26 at 8:00 AM, Resident #64 reported a concern with how an aide handled her roommate one day last week. The certified nursing assistant (CNA) did not use the mechanical lift or any kind of device to get Resident #89 into bed. Resident #64 stated she heard the door to the room open and she heard someone wheel Resident #89 into the room. She then heard a sound like the resident was thrown into bed. Resident #89 cried out. The only time she had ever heard Resident #89 cry is when she was in pain. Resident #64 said she normally heard the staff wheel her roommate into the room, staff bring the mechanical lift into the room, and then staff get Resident #89 into bed, but that evening she did not hear the lift being brought in. She heard the CNA. She did not know the CNA's name but she was African-American, short stature, and had a stocky build. The CNA did not have a name tag on. Resident #64 reported she talked to Staff I, LPN, and let her know. She did not know the day this incident happened but it was around 8 PM when the CNA put Resident #89 in bed. The MDS assessment dated [DATE] revealed Resident #64 had a BIMS score of 15, which indicated cognition intact. In an interview on 2/25/26 at 9:40 AM, Staff G, LPN, reported she was working the floor doing wound rounds and going to meetings in-between nursing tasks/duties on 2/17/26. Later in the afternoon, she found out Resident #89 had a fracture. Staff I, LPN, had informed her about Resident #89. Staff G notified the Administrator about it. In an interview 2/25/26 at 1:48 PM, Staff K, certified medication aide (CMA), confirmed she worked on Monday (2/16) on the 2 PM to 10 PM shift and was off on (continued on next page)

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	165601	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/17/26. She only worked with Resident #89 once that day. The other staff person assigned asked her to help reposition and change her. Staff K stated she only helped get Resident #89 up but did not help to lay her down. The CNA she worked with was Staff C. Staff K again stated she had only helped Staff C with Resident #89 one time that day. In an interview on 2/25/26 at 2:13 PM, Staff L, Restorative Aide, confirmed she worked last week on 2/16/26 from 8 AM to 2 PM on the [NAME] back hall. Staff E, CNA, was assigned to the front (South) hall. Staff L stated she helped Staff E lay Resident #89 down with the mechanical lift. At that time, Resident #89 was ok, she did not complain of pain. She did not notice any bruising or anything at that time. Staff L said she left at 2 PM. Resident #89 was fine. In an interview 2/25/26 at 3:10 PM, Staff I, LPN, reported she worked upstairs on 2/17/26 but was not assigned to Resident #89. Staff I stated she was passing medications on Tuesday (2/17/26) when Resident #64 came out around 8 or 9 AM and said she was worried. Resident #64 said she thought people were not doing things safely. Then Resident #64 asked if she could tell Staff I something. Resident #64 said she was really worried and proceeded to tell her that last night (2/16) she heard the door to her room open and she heard the CNA wheel Resident #89 through the door, but she did not hear her bring the mechanical lift in like staff usually did. She then heard Resident #89 cry and heard a thud on the bed. The CNA left the room. Resident #89's (Broda) chair was by the bed. Resident #89 was oddly positioned on the bed, she was way down toward the end of the bed and had her legs over on the bed. Resident #64 thought Resident #89 was going to fall off the bed. Staff I asked Resident #64 the name of the CNA, and Resident #64 said she did not know. Staff I stated she told the Administrator about the accusation. In an interview 2/25/26 at 4:34 PM, Staff M, LPN, confirmed he worked on 2/17/26 from 6 PM to 6 AM. When he got report at shift change, Staff J, LPN, shared concerns about Resident #89's shoulder/arm. Staff J said the vendor came and got an x-ray on Resident #89. After report, he received a fax with the x-ray results showing Resident #89 had a right humeral neck fracture. He was told by multiple nurses and multiple CNA's they heard from Resident #89's roommate it may be due to an improper transfer. He spoke with the Administrator and the provider. Staff M stated he was not aware of any injury. Resident #89 did not complain of any pain or anything the night before when he worked (on 2/15/26 or 2/16/26). He did not think anything at the time, but after he got the x-ray report he wondered if something had happened. The previous night when he worked on 2/16/26, Resident #64 (Resident #89's roommate) came up to him. He was by the medication cart. Resident #64 is particular about time and getting her medications. He usually gave her medications at 7:30 PM. Resident #64 forgot to take her nutrition drink and came back to get it. At that time, Resident #64 asked him if he had done Resident #89's medications yet. Staff M said he had not. Resident #64 proceeded to tell him an aide came in the room and she kind of lifted Resident #89 into bed. Resident #89 had been crying and seemed in pain. Staff M stated he did not blow Resident #64 off. He went in the room to check on Resident #89. Resident #89 was not crying out. He noticed Resident #89 was a little askew in bed. Her feet were caddy wampus by the baseboard (on the bed) and it looked like she needed to be boosted up in bed. He did not think anything of what Resident #64 said until the next day when Staff J said they were getting an x-ray, and then the x-ray report showed a fracture. Surveyor asked Staff M what he meant by askew. When he saw Resident #89 lying in the bed askew her body was kind of at an angle on the bed, her feet were closer to the baseboard or end of the bed than usual, like she needed a boost up in bed. He thought the CNA's transferred the resident with the mechanical lift weird or something. He went out to the desk and asked the CNA's to go in and boost her up in bed. He did not recall the CNA's names that were working that night but when he asked the CNA's to do something, they were pretty good about doing things. In an interview on 2/26/26 at 8:21 AM, Staff F, CNA, reported she was assigned as Resident #89's CNA one day last week (the week of 2/16/26). She was in Resident #89's room with two other CNA's (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after the nurse had done wound rounds. The staff discussed that Resident #89 was in a lot of pain when they rolled her and were getting her dressed. Staff F stated she mentioned this observation to Staff G, LPN. Staff G said during wound rounds, Resident #89 was acting like she was in a lot of pain. That AM (on 2/17/26), the roommate told Staff F the night before (Monday) the aide came in to do things with Resident #89, the curtain was pulled, she heard a bunch of hassling and heard Resident #89 scream and stuff but said she did not see what happened. Resident #89 is noncommunicative and not able to tell them if something happened. Staff F reported Staff G came in and asked the roommate questions. The roommate said the aide came in the room without the mechanical lift. She did not see anything but heard something. It was reported to the Administrator. An x-ray of Resident #89's arm showed her arm was broken. Staff F stated when someone was on hospice and had a broken arm, it did not make sense to her. Staff F reported that Staff C was assigned to Resident #89 the night before (on 2/16/26). In an interview 2/26/26 at 12:35 PM Staff C, CNA, confirmed she worked on 2/16/26 on the 3-10 PM shift. She was assigned to Resident #89. Staff K was her hall partner that she worked with. Staff C stated she believed it was Staff K who helped her get Resident #89 up and put Resident #89 to bed that night. When the Surveyor questioned if she was sure it was Staff K. Staff C said 'yes. Staff C reported they use the mechanical lift to transfer Resident #89. Staff C reported she also made rounds on the resident with Staff H, CNA. Resident #89 seemed ok during rounds. In an interview on 2/26/26 at 1:18 PM, the Administrator reported he was at a conference out of town on 2/17/26 when he got a phone call from Staff I, LPN. Staff I told him she was not assigned to Resident #89 but she was working down that hall. Resident #64 told Staff I she had a concern with Resident #89 in the evening the other day and a concern with the aide and how the aide transferred Resident #89. The Administrator asked for the phone numbers of the CNA's that worked that night (2/16/26) and he contacted the CNA's. Staff C and Staff K stated they had worked with Resident #89. He talked to Staff C first and asked her what happened. Staff C said she put Resident #89 to bed around 7:30 - 8 PM. Resident #89 was mechanically lifted into bed. He asked Staff C who helped her. Staff C said Staff K helped her. Staff C told him Resident #89 says ow ow ow. Staff K took the mechanical lift out of room. Staff C then rolled the resident and changed her, then left the room. The Administrator reported he then called Staff K immediately and asked her the same questions. He asked if Staff K had assisted with Resident #89. Staff K said Resident #89 was transferred around 8 PM. Resident #89 said ow, ow, ow. Staff C was there. Staff K said she took the mechanical lift and left the room. Staff C stayed in the room and changed Resident #89. That was the end of Staff K's interaction. The Administrator reported he got a call from Staff I, LPN, at 1 PM that day that Resident #89 was still crying with pain. The Administrator asked Staff I to see if she could get an order for an x-ray from the NP. X-ray came around 2 or 3 PM, and they got the x-ray results around 6 PM. One x-ray report showed age indeterminate, and the other x-ray report showed subacute fracture. Staff M, LPN, followed up with x-ray about the reports. Staff M said the acute subacute was the correct indication. The Administrator reported he discussed the causes with the NP and ruled out abuse. In an interview on 3/2/26 at 2:55 PM, the Administrator reported when he conducted the investigation of Resident #89's incident, he spoke with the evening and overnight shift staff who last worked with the resident and asked if they noticed any changes. He would separate the staff person from the residents whenever he suspected abuse. A document titled New Report (timecard) dated 1/1/26 to 3/3/26 revealed Staff C continued to clocked in/out from the time an allegation of concern/abuse was made until the surveyor investigation and notification to the facility of the alleged abuse. Staff C worked: 2/16/26 2:05 (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	– 10:09 PM2/17/26 2:40 – 10:00 PM2/18/26 2:00 – 10:04 PM2/19/26 2:40 – 10:00 PM2/20/26 2:40- 10:05 PM2/21/26 2:45 – 10:00 PM2/23/26 2:58 – 10:00 PM2/24/26 2:40 – 10:00 PM2/25/26 2:42 – 10:00 PM2/26/26 2:36 – 10:00 PM 2. The Minimum Data Set (MDS) dated [DATE] for Resident #116 revealed diagnoses of diabetes mellitus, stroke, heart failure and required substantial assistance for transfers and moderate assistance for toileting and personal hygiene. Walking 10 or more feet did not occur due to a medical condition or safety concerns and a manual wheelchair was normally used for mobility. The MDS identified Resident #116 had an impairment of upper or lower extremities and use of a walker was not identified for a mobility aid. The MDS did not identify Resident #116 as having negative behaviors such as rejection of care and wandering did not occur. Resident #116 had a Brief Interview for Mental Status (BIMS) score of 3 that suggested severe cognitive problems with thinking and memory without signs of delirium. The Care Plan for Resident #116 identified a brain injury due to a brain bleed and directed staff to offer cues, direction, redirect as needed, explain the task to be completed as she is impulsive with movements and non-compliant with directions. The care plan identified a risk for falls and directed staff to assist Resident #116 to ambulate with a gait belt and a front wheeled walker and transfer using a non-mechanical lift. A document titled incident report revealed on 1/21/2026 at 5:20 pm, Staff B, RN was notified by Staff A, CNA that Resident #116 had lost her balance and fell to the floor while ambulating to the bathroom. Resident #116 was screaming Please help me up!. The Nurse Practitioner was notified and Resident #116 was sent to the hospital. The Progress Notes for Resident #116 revealed:1. On 1/20/26, Resident #116 was examined by Nurse Practitioner (NP) and documented Resident #116 was stable sitting in her wheelchair, alert, oriented, no distress, cooperative, frail, with a weight of 100 pounds. Resident #116 musculoskeletal condition was documented as limited range of motion with muscle weakness.2. On 1/21/26, Staff B, Registered Nurse (RN) documented that Staff A, CNA alerted that Resident #116 had a fall and upon entering Resident #116's room, she was on the floor, near the wall, laying on her right side, screaming Please help me up! Staff A stated she was taking Resident #116 to the bathroom, using her walker, and she lost her balance, falling to her right side. Resident #116 was assisted to her bed by Staff A and Staff B. Resident #116 was continuously screaming, complaining of pain in her right arm and shoulder. The Nurse Practitioner was notified and ordered to send Resident #116 to the hospital. The daughter was aware of the hospital transfer. 3. On 1/26/26 at 10:03 am, the hospital update was that Resident #116 fractured the right shoulder and elbow and due to the multiple comorbidities, a conservative management of a sling instead of surgery. The trauma services were providing pain management with narcotics every four hours, along with ice therapy, . During an interview on 2/26/26 at 1:40 pm, Resident #116's daughter stated her mother was in bed mostly as it was very hard for her to get up. The daughter stated she visited on 1/20/26, she had some memory loss but feeling normal for herself, no pain. The daughter stated she's been trying to figure out what happened and she was not ok with this. Staff B, RN told her that the CNA was following her mom with a wheelchair as she walked to the bathroom. The daughter stated she visited her mother multiple times before the fall and her mother could not walk. During an interview on 2/25/2026 at 10:29 am, Staff B, RN stated she had been employed for two years at this facility and had provided care for Resident #116. Staff B stated Resident #116 tried to (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	get up by herself, required the assistance of one staff, with a walker, and walked to the bathroom a long while ago. Staff B stated currently, the CNA's would change Resident #116 in bed before assisting her into the recliner. Staff B stated Staff A, CNA had provided care for Resident #116 a few times had 2 different stories of the incident on 1/21/26 so she questioned truthfulness. Staff B stated Staff A she was taking [NAME] to the bathroom and while she was getting things ready by opening the bathroom door, Resident #116 fell and the second report was that Staff A was following Resident #116 with the wheelchair. Staff B stated that was what she documented on the incident report. Staff B stated when she entered [NAME]'s room, she was on the floor, laying on her right side without a gait belt a few feet from the bed. Staff B stated it was about 50 ft to the bathroom and the wheelchair was by the bathroom wall, and the walker was on the floor tipped over near Resident #116 who was screaming in pain. Staff B stated Resident #116 was a few feet from the bed so they tried to stand her, but she was not able to bear weight, so they grabbed her pants and slid her on her feet, lifted and put her on the bed. Staff B stated Resident #116 was screaming, complained of shoulder pain it appeared swollen at the shoulder. Staff B stated Staff Z, CNA responded, stayed with Resident #116 as she notified the Nurse Practitioner and called 911. Staff B stated she did not notify the administration about her concerns involving the fall. Staff B stated the DON (Director of Nursing) called her 2-3 days after the incident to ask if they used the mechanical lift to get Resident #116 off the floor, which she replied no, then had a one-on-one talk about using the mechanical lift to get residents off the floor after a fall, if they cannot get up on their own. Staff B stated no one questioned her about the incident except for asking if a mechanical lift was used to put Resident #116 into the bed. During an interview on 2/25/26 at 3:12 pm, Staff Z CNA stated last year Resident #116 could get into a recliner with assistance but did not ambulate to the bathroom as she was incontinent and CNAs changed her in bed. Staff Z stated Staff A CNA told her she could walk Resident #116 to the bathroom. Staff Z stated Resident #116 did not ambulate due to balance issues but was able to pivot transfer with assistance. Staff Z stated on 1/21/26 she responded to someone's screams, checked the rooms, and found Staff B, RN and Staff A, CNA placing Resident #116 in her bed without a gait belt and there was no mechanical in the room, Staff Z stated when Staff B left the room notify the doctor and call 911, Staff A told her Resident #116 fell during assistance to the bathroom. Staff Z stated Resident #116 was crying and did not want to be alone. During an interview on 2/26/26 at 10:29 am, Staff BB, CNA stated she had provided care for Resident #116, who was declining but would sit in her recliner to eat. Staff BB stated she worked on 1/21/26, 6-2pm shift, providing care for Resident #116 and needed two CNA's, with a gait belt, to transfer her to the recliner. Staff BB stated Resident #116 was not stable and was too weak to walk to the bathroom so staff would check and change while she was in bed. A document provided by the Administrator verified to be investigative notes for Resident #116's fall on 1/21/26 which revealed: 1. Staff A, CNA entered the room to respond to the call light. Resident #116 told her she needed the bathroom, Staff A told Resident #116 she needed to get a gait belt. Resident #116 said no I'm going to the bathroom, stood up to her walker and began walking to the bathroom. Staff A grabbed Resident #116's wheelchair, unsure what else to do, bring wheelchair up behind Resident #116 who lost her balance and fell onto her right side.2. Staff B, RN was told Resident #116 fell as she was getting things ready to use the bathroom. Resident #116 had a walker and no gait belt and hasn't gotten up by self in a long time.3. Staff Z, CNA responded to a scream, staff already got Resident #116 up in bed. 4. Resident #116 reported to be impulsive, doesn't always follow directions or wait for staff. 5. Resident #116 noted to be non-compliant and has been caught ambulating on her own. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A document titled New Report (timecard) dated 1/1/26 to 3/3/26 revealed Staff A, CNA continued to clocked in/out from the time an allegation of concern/abuse was made until the surveyor investigation and notification to the facility of the alleged abuse. Staff A worked: 1/21/26 1:57pm-10:09pm /22/26 1:59pm-10:05pm 1/23/26 9:02pm-2:24pm1/26/26 5:53pm-9:48pm 1/27/26 1:58pm-10:15pm 1/28/26 1:59pm-10:19pm 1/29/26 1:49pm-10:02pm 1/30/26 2:02pm-10:01pm 1/31/26 2:05pm-9:51pm 2/1/26 2:10pm-10:05pm2/2/26 2pm-10pm 2/3/26 2pm-10pm 2/4/26 2pm-10pm 2/5/26 2pm-10:08pm2/6/26 6am-10pm 2/8/26 6pm-10pm 2/9/26 2:05pm-10pm 2/9/26 2:05pm-10pm 2/10/26 2pm-10:08pm 2/11/26 2:10pm-10pm 2/12/26 1:47pm-10pm 2/13/26 12:23pm-10:01pm 2/14/26 2:06pm-10:01pm 2/15/26 2:04pm-10:03pm 2/18/26 2:08pm-10:01pm 2/19/26 1:51pm-10:11pm 2/20/26 6:19pm-10:10pm 2/23/26 2:00pm-10:01pm 2/24/26 2:13pm-10:00pm 2/28/26 1:58pm-10:46pm 3/1/26 2:04pm-10:09pm 3/2/26 12:41pm-missed punch The facility policy titled Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation policy revised 9/2025 revealed the facility provided care and services in an environment that is free from abuse and neglect. The facility shall immediately implement measures to prevent further potential abuse of residents while the investigation is in progress. When an allegation of abuse by an employee, the accused employee will be separated from all residents.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, observation, resident and staff interviews and policy review the facility failed to report an injury of unknown origin, and an allegation of abuse to the Iowa Department of Inspections, Appeals and Licensing (DIAL) within the required timeframe (within 2 hours) for one of three residents reviewed for possible abuse (Resident #89). The facility reported a census of 101 residents. Findings include: The Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #89 had diagnoses of arthritis and a right hand contracture. The MDS documented the resident had a Brief Interview for Mental Status score of 2 indicating severely impaired cognition. The MDS revealed the resident had impaired range of motion (ROM) to the upper and lower extremities. The MDS also revealed the resident had dependence on staff for bed mobility and transfers. The MDS documented the resident had no skin issues. The Care Plan initiated 4/26/24 revealed the resident had arthritis and limited mobility and required assistance with ADL's (activities of daily living). The Care Plan directed staff to use a Hoyer (mechanical lift) and assistance of two for transfers. A sling to the right upper extremity as needed for comfort was added to the care plan on 2/23/26. A Nurse Practitioner (NP) Encounter Note dated 2/17/26 revealed Resident #89 had a history of osteoporosis, tremors and impaired mobility. Resident seen for increased right shoulder pain and limited ROM in the right arm and shoulder area with movements. X-ray of the right arm ordered to rule out any underlying fractures or injuries.An X-ray Report of the right humerus on 2/17/26 revealed an acute or subacute subcapital fracture of the right humeral neck and diffuse osteoporosis. An x-ray of the right shoulder on 2/17/26 revealed age-indeterminate subcapital fracture of the right humeral neck and diffuse osteoporosis. The Order Summary revealed an order on 2/18/26 to send the resident to the Emergency Department (ED) for evaluation of a humeral neck fracture. An ED Provider Note dated 2/17/26 at 8:53 PM revealed the resident had a right humerus fracture of unknown cause. Resident is bed bound and uses a mechanical lift to transfer. Staff at the facility not aware of any injury to the resident and no witnessed falls. Resident had pain in her right shoulder. Resident cannot recall the incident. Resident on hospice. Nursing home does not want any additional workup performed but is just requesting a sling and to discharge her back to the facility. She was diagnosed with a closed nondisplaced fracture of the right proximal humerus. Resident discharged from the ED on 2/17/26 at 11:38 PM (with EMS).Medication Administration Record (MAR) dated 2/1/26 to 2/28/26 documented an order for Morphine Sulfate 5 milligrams (mgs) every 4 hours as needed for pain. The MAR did not document use of this medication until 2/17/26 at 7:06AM. Additional 5mg doses were given as follows; 2/17/26 at 8:00PM, on 2/18/26 at 5:55AM and 10:07AM, on 2/19/26 at 4:26AM and 6:17PM, on 2/20/26 at 2:23AM and 10:32AM, and 3:34PM, on 2/21/26 at 8:51AM, and at 3:23PM, on 2/22/26 at 4:23AM, at 9:30AM, at 3:19PM, and at 8:59PM, and on 2/23/26 at 12:20PMThe Progress Notes revealed the following: a. On 2/17/26 at 1:22 PM, resident with increased pain to her right arm and shoulder with movement and palpation. Resident unable to state cause. Morphine given twice this shift. New order to obtain portable 2-view x-ray to right shoulder, humerus, and forearm due to pain and decreased ROM. b. On 2/17/26 at 6:15 PM, x-ray results received. Findings show an age-indeterminate acute or subacute subcapital of the right humeral neck, and diffuse osteoporosis. Information provided to administrator. Resident calls out ow with any movement of unaffected arm.c. On 2/17/26 at 7:00 PM, on-call provider notified of x-ray results. Provider is concerned about possible severity of fracture especially with level of resident's debility and contractures and need for mechanical lift. Provider stated to send resident to the ED for further evaluation and an immobilization device. Provider informed resident on hospice.d. On 2/17/26 at 8:30 PM, ambulance called to transport resident. Resident's pain at 9 out of 10. ED nurse contacted and expressed ambivalence and asked why resident had a fracture without recent fall. e. On 2/18/26 at 12:12 AM, resident returned to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility with a sling on the affected arm/shoulder. Observations revealed on 2/25/26 at 9:30 AM, a sling to Resident #89's right arm. The right upper arm (above the elbow) had a faded yellow bruise with a faded dark purple bruise to the inner area. In an interview on 2/24/26 at 8:00 AM, Resident #64 reported she had a concern with how the aide handled her roommate one day last week. The certified nursing assistant (CNA) did not use the mechanical lift or any kind of device to get Resident #89 into bed. Resident #64 stated she heard the door to the room open and she heard someone wheel Resident #89 into the room. She then heard a sound like the resident was thrown into bed. Resident #89 cried out. The only time she had ever heard Resident #89 cry is when she was in pain. Resident #64 said she normally heard the staff bring her roommate in, then staff brought the mechanical lift into the room, and staff got Resident #89 into bed, but that evening she did not hear the lift being brought in. She did not know the CNA's name but she was African-American, short and had a stocky build. The CNA did not have a name tag on. Resident #64 reported she talked to Staff I, LPN, and let her know. She did not know the day this incident happened but it was around 8 PM when the CNA put Resident #89 in bed. The MDS assessment dated [DATE] revealed Resident #64 had a Brief Interview for Mental Status score of 15, which indicated cognition intact. In an interview on 2/25/26 at 9:40 AM, Staff G, Licensed Practical Nurse (LPN), reported she was working the floor doing wound rounds and going to meetings in-between nursing tasks/duties on 2/17/26. Later in the afternoon, she found out Resident #89 had a fracture. Staff I had informed her about Resident #89. Staff G notified the Administrator about it. In an interview 2/25/26 at 3:10 PM, Staff I, LPN, reported she was passing medications on Tuesday (2/17/26) when Resident #64 came out around 8 or 9 AM and said she was worried. Resident #64 said she thought people were not doing things safely. Then Resident #64 asked if she could tell Staff I something. Resident #64 said she was really worried and proceeded to tell her that last night (2/16) she heard the door to her room open and she heard the CNA wheel Resident #89 through the door, but she did not hear her bring the mechanical lift in like staff usually did. She then heard Resident #89 cry and heard a thud on the bed. The CNA left the room. Resident #89's (Broda) chair was by the bed. Resident #89 was oddly positioned on the bed, she was way down toward the end of the bed and had her legs over on the bed. Resident #64 thought Resident #89 was going to fall off the bed. Staff I asked Resident #64 the name of the CNA, and Resident #64 said she did not know. Staff I stated she told the Administrator about the accusation. The Administrator had her write a statement. She wrote a statement and it should have the date on it. The CNA told her the resident was complaining of shoulder pain that day when they got her out of bed. Staff I stated she thought it was her left shoulder that had pain. Staff I spoke with Staff J who was assigned to Resident #89. Staff J, LPN had no idea about an incident. In an interview 2/25/26 at 4:34 PM, Staff M, LPN, confirmed he worked on 2/17/26 from 6 PM to 6 AM. When he got report at shift change, Staff J, LPN, shared concerns about Resident #89's shoulder/arm. Staff J said the vendor came and got an x-ray on Resident #89. After report, he received a fax with the x-ray results showing Resident #89 had a right humeral neck fracture. He was told by multiple nurses and multiple CNA's they heard from Resident #89's roommate it may be due to an improper transfer. He spoke with the Administrator and the provider. The provider was very concerned about the x-ray report, and thought it would be best to send Resident #89 to the ED for an evaluation and to get an immobilizer. He spoke with hospice and the family. He did not share any details with the family other than that there was a concern about a fracture. Staff M reported Resident #89 was completely immobile and had contractures. She required assistance of two staff and a mechanical lift for transfers. Staff M stated Resident #89 did not complain of any pain or anything the night before when he worked (on 2/15/26 or 2/16/26). Staff M stated it's hard to place a wrist cuff on Resident #89's arm to get a blood pressure due to her contractures. Resident #89 was in a Broda chair or in bed when he saw her and she was not crying out or tearful, however she complained of pain when she was transferred. He did not hear staff in the resident's room or when she was transferred. He didn't think anything at the time but after he got the x-ray report he wondered if something had happened. The previous night when he worked on 2/16/26, (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #64 (Resident #89's roommate) came up to him. He was by the medication cart. Resident #64 is particular about time and getting her medications. He usually gave her medications at 7:30 PM. Resident #64 forgot to take her nutrition drink and came back to get it. At that time, Resident #64 asked him if he had done Resident #89's medications yet. Staff M said he had not. Resident #64 proceeded to tell him an aide came in the room, and she kind of lifted Resident #89 into bed. Resident #89 had been crying and seemed in pain. Staff M stated he did not blow Resident #64 off. He went in the room to check on Resident #89. Resident #89 was not crying out. He noticed Resident #89 was a little askew in bed. Her feet were caddy wampus by the baseboard (on the bed) and it looked like she needed to be boosted up in bed. He did not think anything of what Resident #64 said until the next day when Staff J said they were getting an x-ray, and then the x-ray report showed a fracture. Surveyor asked Staff M what he meant by askew. When he saw Resident #89 lying in the bed askew her body was kind of at an angle on the bed, her feet were closer to the baseboard or end of the bed than usual, like she needed a boost up in bed. He thought the CNA's transferred the resident with the mechanical lift weird or something. He went out to the desk and asked the CNA's to go in and boost her up in bed. He did not recall the CNA's names that were working that night but when he asked the CNA's to do something, they were pretty good about doing things. In an interview on 2/26/26 at 8:21 AM, Staff F, CNA, reported she was assigned as Resident #89's CNA one day last week (the week of 2/16/26). She was in Resident #89's room with two other CNA's after the nurse had done wound rounds. The staff discussed that Resident #89 was in a lot of pain when they rolled her and were getting her dressed. Staff F stated she mentioned this observation to Staff G. Staff G said during wound rounds, Resident #89 was acting like she was in a lot of pain. That AM (on 2/17/26), the roommate told Staff F the night before (Monday) the aide came in to do things with Resident #89, the curtain was pulled, she heard a bunch of hassling and heard Resident #89 scream and stuff but said she did not see what happened. Resident #89 is noncommunicative and not able to tell them if something happened. Staff G came in and asked the roommate questions. The roommate said the aide came in the room without the mechanical lift. She did not see anything but heard something. It was reported to the Administrator. An x-ray of Resident #89's arm showed her arm was broken. In an interview on 2/26/26 at 1:18 PM, the Administrator reported he was at a conference out of town on 2/17/26 when he got a phone call from Staff I, LPN. Staff I told him she was not assigned to Resident #89 but she was working down that hall. Resident #64 told Staff I she had a concern with Resident #89 in the evening the other day and a concern with the aide and how the aide transferred Resident #89. He then contacted the Social Worker and HR and asked them to get a statement from Resident #64 on what took place. The Administrator also asked for the phone numbers of the CNA's that worked that night (2/16/26). He contacted the CNA's. Staff C and Staff K stated they had worked with Resident #89. He talked to Staff C first and asked her what happened. Staff C said she put Resident #89 to bed around 7:30 - 8 PM. Resident #89 was mechanically lifted into bed. He asked Staff C who helped her. Staff C said Staff K helped her. Staff C reported nothing odd took place. Staff C told him Resident #89 says ow ow ow. Staff C then rolled the resident and changed her, then left the room. The Administrator reported he then called Staff K. Staff K said Resident #89 was transferred around 8 PM. Resident #89 said ow, ow, ow. Staff C was there. Staff K said she took the mechanical lift and left the room. Staff C stayed in the room and changed Resident #89. That was the end of Staff K's interaction. The Administrator reported he got a call from Staff I at 1 PM that Resident #89 was still crying with pain. The Administrator asked Staff I to see if she could get an order for an x-ray from the NP. X-ray came around 2 or 3 PM, and they got the x-ray results around 6 PM. The facility got one x-ray report that showed age indeterminate, and the other x-ray report showed subacute fracture. Resident #89 had diffuse osteoporosis. She is on hospice, has brittle bones, has contractures and tremors. The Administrator stated he focused on the facts of what took place and he felt he could rule out abuse. The Administrator confirmed he did not report Resident #89's fracture or injury of unknown origin to DIAL because it was a spontaneous fracture and spontaneous fractures are not reportable to the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	State. In an interview on 3/2/26 at 2:55 PM, the Administrator reported he would report to DIAL if he suspected abuse. A Patient Protection Guidelines Abuse Prevention, Reporting, and Investigation policy revised 9/2025 revealed the facility provided care and services in an environment that is free from abuse and neglect. An injury of unknown source is when the source of the injury was not observed by any other person, or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of the injury. The Administrator is responsible for reporting any alleged or suspected abuse regardless of the source of the concern. The staff are required to notify the charge nurse and Abuse Prevention Coordinator immediately for any suspicion of abuse, neglect and injuries of unknown origin. Injuries of unknown origin and allegations of abuse need to be reported to the Iowa Department of Inspections, Appeals and Licensing Reports immediately and not later than two (2) hours after the allegation is made if there is bodily injury.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident record review, staff interview, and Resident Assessment Instrument (RAI) manual review, the facility failed to submit a significant change in status for 1 of 2 residents reviewed for a significant change of condition. The facility reported a census of 102 residents.The Quarterly Minimum Data Set (MDS) dated [DATE] for Resident #2 revealed the diagnoses of weakness, unsteadiness on feet, required the assistance of one staff for supervision with ambulation and maximal assistance for hygiene and toileting. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 suggesting an intact cognition. The Quarterly MDS dated [DATE] for Resident #2 was totally dependent on staff for transfers and toileting with no ambulation. The Progress note dated 9/18/25, the Nurse Practitioner (NP) documented a visit for Resident #2 following the fall on 9/11/15. Resident #2 described the incident as slide/fall incident, x-rays revealed an acute fracture of her ankle and had to be transported to the hospital where she received fentanyl for pain management and additional x-rays. The NP documented the hospital stabilized the fracture with a soft cast and potentially transition to a boot and Resident #2 reported ongoing pain from the fracture. During an interview on 3/3/26 at 3pm, Staff EE, MDS Coordinator stated she completed the resident's assessment for the MDS submissions. Staff EE stated Resident #2 did qualify and there should have been a significant change MDS submitted due to her change of condition after her fall in September 2025. Resident Assessment Instrument (RAI) 3.0 User's Manual requires the facility to submit a significant change within 14 days of a major decline in a resident's health status.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on electronic health record review (EHR), observations, resident interview and staff interview, the facility failed to offer and apply a hand splint for 1 of 2 residents reviewed for positioning (Resident #7). The facility reported a census of 101. Findings include: 1.The Quarterly Minimum Data Set (MDS) Assessment, completed 1/30/26, revealed Resident #7 with a Brief Interview for Mental Status score of 9, indicating moderate cognitive impairment. Diagnoses included the following; hemiplegia (paralysis of one side of the body) and stroke. The MDS noted the need for splint assistance under the restorative nursing programs section. The Care Plan, with a Target Date of 5/25/26, listed the use of a right-hand splint as an intervention for Activities of Daily Living. The intervention directed staff as follows; right resting hand splint; assist with application every am until bedtime as tolerated.The Physician Order, initiated 8/3/23, direct staff to assist Resident #7 with putting on a right resting hand splint in the morning and taking off at night. The Treatment Administration Record (TAR) documented staff applied right hand splint every morning and removed it every night from 2/1/26 to 2/26/26. There was no documentation on the TAR that the resident refused for the splint to be placed. During an observation on 2/23/26 at 12:30 PM, Resident #7 was not wearing a right hand splint. The resident acknowledged not wearing one. During an observation on 2/25/26 at 10:25 AM and then again at 4:30 PM, Resident #7 was not wearing a right hand splint. A blue splint, with the resident's name, was seen sitting on top of a bedside dresser during the morning observation. During the afternoon observation, the splint was seen in the same location untouched. During an observation on 2/26/26 at 9:45 AM, Resident #7 did not wear a hand splint. The blue splint remained in the same position on top of the bedside dresser untouched. In an interview on 2/25/26 at 4:30 PM, Resident #7 noted staff did not offer or put the splint on in the morning. Resident #7 did not feel they could put on or take off the splint independently since they are unable to move the right arm. Resident #7 then lifted up their right hand, with their left arm, to indicate which hand the splint goes to. In an interview on 2/26/26 at 4:45 PM, the Assistant Director of Nursing (ADON), acknowledged Resident #8 had orders for a splint. Nursing staff should offer to put it on daily and document accordingly.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews the facility failed to have an action plan in place to ensure new agency staff receive a timely orientation and were able to demonstrate competency in skills and equipment use before the expectation to work independently. The facility reported a census of 101 residents. Findings include: The Minimum Data Set (MDS) dated [DATE] for Resident #2 revealed the diagnoses of weakness, unsteadiness on feet, required the assistance of one staff for supervision with ambulation and maximal assistance for hygiene and toileting. Resident #2 had a Brief Interview for Mental Status (BIMS) score of 15 suggesting an intact cognition. The Care Plan for Resident #2 dated 7/24/25. The Care Plan identified a risk for falls and directed staff to assist with ambulation and transfers with moderate assistance of one staff with a gait belt and front wheeled walker and as needed. The Progress note dated 9/18/25, the Nurse Practitioner (NP) documented a visit for Resident #2 following the fall on 9/11/15. Resident #2 described the incident as a slide as she attempted to stand up with the assistance of a care giver who did not use a gait belt and despite informing the care giver she was slipping; she was reassured multiple of times that she will not fall. The NP documented Resident #2 slid down and became stuck between the toilet and the wheelchair and had to be assisted by multiple of caregivers to get back to bed. Following the incident, x-rays revealed an acute fracture of her ankle and had to be transported to the hospital where she received fentanyl for pain management and additional x-rays. The NP documented the hospital stabilized the fracture with a soft cast and potentially transition to a boot and Resident #2 reported ongoing pain from the fracture. During an interview on 3/3/26 at 11:42 am, Resident #2 stated on 9/11/25 she had walked with her walker into the bathroom and when finished she activated the call light. Resident #2 stated she required the assistance of staff to provide peri care and had waited for a while until the Certified Nursing Assistant (CNA) arrived. Resident #2 stated usually when she was assisted by facility staff and she would say she's slipping, the staff would sit her back down on the toilet. Resident #2 stated she began to slip and said that to the CNA who replied with I've got you. Resident #2 stated she went down to the floor because her legs were weak from sitting so long waiting for assistance. Resident #2 stated the CNA that was assisting her was an agency staff who said she should not even be here providing care for her as she had not been trained. When inquired if she fainted, Resident #2 laughed and replied, I've never fainted in my life. Resident #2 stated the CNA had her by the arm and not a gait belt. Resident #2 stated another CNA came into the room, who also was new agency CNA, and helped to get into the wheelchair. Resident #2 stated it was hard, they had her by the arms and her right leg hurt so she was unable to stand. Resident #2 stated then the nurse came in to help. During an interview on 3/3/26 at 3:15 pm, Staff CC, CNA verified her work at this facility was through an agency. Staff CC stated on her first day, she was asked to come in ahead of her start time to receive a code for the Point Click Care (PCC) computer system to chart, then failed to show her how to use it. Staff CC stated she was unaware of how to look up resident information since they did not give her details and they were aware it was her first time in the facility. Staff CC stated the staff was not helpful. Staff CC verified she had worked on 9/11/25, working with another new agency CNA and termed the day as hectic as staff were sick, went home and the two were on their own with 2 halls of residents. Staff CC stated the call lights were going off and the nurse yelled at her for using the radio to call for assistance. Staff CC stated she answered a bathroom call light and she did not know the resident. Staff CC stated when the leaving staff conduct the walking round at the beginning of the shift, they didn't give details. Staff CC stated during the peri care, the resident was starting to fall. Staff CC stated she called for the other CNA who came in immediately and they tried to get the resident into her wheelchair, describing it as very hard. Staff CC stated a 2nd nurse came into the room to helped them. Staff CC stated when she left at 2pm, no one asked her what (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	happened, no one called her and she did not go back to this center. During an interview on 3/3/26 at 10:41 am, Staff DD, Agency CNA verified she worked through an agency and that 9/11/25 was her first day to work at this facility. Staff DD stated it was complete chaos as the staff did not tell her anything, no direction and it was the first time working with the mechanical lifts that this facility utilized stating she had no idea how to run it. Staff DD stated she was assigned to work on a hall with a staff member who went home and she was unaware that she was working alone. Staff DD stated another agency CNA (Staff CC) was down the next hall and from 10am to 2pm they were on their own. Staff DD stated they assisted each other with the residents that required two assist and was in a room when Staff CC stated she needed to go across the hall as that call light had been activated for a while. Staff DD stated her resident was on the toilet and could not be left alone but Staff CC was absent for a really long time so she secured her resident and found Staff CC with her resident on the floor in front side of the toilet. Staff DD stated Staff CC asked what do I do? and it's routine if someone falls to call the nurse, used the radio for a nurse and helped to get the resident up. Staff DD stated she did not remember what happened next. Staff DD stated there were many residents, multiple two assist and both Staff CC and herself had no idea what was going on. Staff DD stated she had been trained as a CNA, worked for 8 years, and referred to that as the craziest day of her life and she would never go back as it was unsafe. Staff DD stated no one called her and she did not return to work for them. According to 9/11/25 clock-in and clock-out documentation the following occurred; with these times one CNA according to previous interviews was providing assistance to two halls from 10:19AM to 10:58AMStaff CC, CNA worked from 6:02AM to 2:37PM (breaktime 10:19AM - 10:49AM)Staff DD, CNA worked from 6:30AM to 2:27PM (breaktime 10:25AM - 10:58AM)Staff LL, CNA worked from 11:16AM to 5:12PM (breaktime 2:44PM - 3:14PM)During an interview on 3/3/26 at 2:09 pm, Staff I, Licensed Practical Nurse (LPN) stated she was not sure how the facility on-boards agency staff, she had seen a packet but have not reviewed the content, and the staff that are leaving for the day completed a walking round. Staff I stated the agency staff can look in the computer for the Kardex but they have to navigate to the care plan. Staff I stated most of the agency staff ask to look at the therapy communication binder. Staff I stated she had good communication with the staff CNA's but there have been multiple agency CNA's and she didn't know their base line knowledge. Staff I stated she remembered a little about Resident #2's fall, it happened in the bathroom and there was an issue with the agency CNA's getting her off the floor. During an interview on 3/3/26 at 3pm, Staff EE, MDS Coordinator stated she completes the resident assessment for the MDS submission and helps on the unit at times. Staff EE stated she was unaware of any training for the agency staffing and hopes the nurse would make sure they can get into the Point Click Care (PCC) and the electronic medication administration (EMAR) record. During an interview on 3/4/26 at 1:48 pm, Staff G LPN ADON stated she was unaware of any training for the agency staff as human resources (HR) and scheduler placed them onto her unit and was not aware of who it will be until she arrives for the day. Staff G stated she was unable to remember who the agency staff were that had worked on 9/11/25, day shift, but when she was made aware that they were low on staffing, she notified Staff FF, Staff Scheduler and did not receive further assistance. Staff G stated the nurse on duty had responded to some activated call lights but personally no one approached her to assist. Staff G stated administration schedules staffing according to census. Staff G stated she was not aware there were new agency staff or that they were not oriented to PCC, it was a busy day. During an interview on 3/4/26 at 2:15 pm, Staff FF, Staff Scheduler stated the facility utilized two staff agencies, the CNAs were independent then make a post on the clipboard account so they may pick up the shifts. Staff FF stated the moment she was aware of the individual's acceptance for a shift then requests their documentation. Staff FF stated there was a packet at the nurse station they will utilize for orientation that was created in June 2025. The agency staff will sign the four pages in the binder when they come in for their first day and leave it in the binder. Staff FF stated she would assume the staff CNA would orient and train them as it was the responsibility of the ADON's and DON to have that done. Staff FF stated Staff CC, agency (continued on next page)

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	165601	A. Building B. Wing	03/05/2026

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Harmony West Des Moines	5010 Grand Ridge Drive West Des Moines, IA 50265

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA accepted work starting 8/24/25 and Staff DD, agency CNA picked up her first shift on 9/11/25. Staff FF verified both agency CNAs worked on 9/11/25 and a staff CNA had left at 9:30 am. Staff FF stated a staff CNA was to come upstairs to work 11 am to 6 pm but was unsure if that occurred. The Facility Assessment with effective date 8/2/2024 documented that the facility did utilize contracted staffing for the nursing department. The facility assessment did not address specific orientation for agency staff, but did include the following for nursing assistant orientation; Clinical orientation for nursing assistants is conducted after General Orientation. Clinical orientation is coordinated by the Director of Nursing/designee and facilitated through use of a preceptor model. Topics include but are not limited to dignity, choices, privacy, abuse, customer service, role/responsibilities of interdisciplinary team members, shift routines, quality assurance and performance improvement, clinical practice guides, documentation , change in condition, emergency management, activities of dialing living, transfers, weight/vital signs, meal service and infection control.During an interview on 3/4/26 at 1:43 pm, the Director of Nursing (DON) stated she was new to her position and at this time she could not express her expectations for the nurses. The DON was not aware of any training or orientation process for onboarding agency staff.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, clinical record review, staff interview, and facility policy review, the facility failed to assure a medication error rate of less than 5%. Medication administration was observed for a total of five residents, with three errors being observed for 2 of 5 residents (Resident #6 and #106). A total of 42 ordered medications were reviewed with three errors, an error rate of 7.14%. The facility reported a census of 102 residents. Findings include:1. On 2/25/26 at 10:59 AM, the observation of the medication pass began. Staff U, Registered Nurse (RN) prepared a total of 6 medications for Resident #6. Among the medications observed, Staff U prepared Esomeprazole (also known as Nexium, proton pump inhibitor (PPI), stomach acid reducer). Staff U administered the medications to the resident at 11:17 am. The Medication Administration Record (MAR) for February 2026 for Resident #6 failed to indicate an order for Esomeprazole and included an order for Zegerid (combination of Omeprozole (PPI) and antacid). 2. On 2/25/26 Wednesday) at 8:20 AM, the observation of the medication pass began. Staff U, RN prepared a total of 7 medications for Resident #106. Among the medications observed, Staff U prepared 65 units of Tresiba (long acting insulin) and Tums chewable tablets. While administering medications to Resident #106, Staff U, RN stated she needed to review Resident #106's Lyumjev (short acting insulin) due to blood glucose reading of 98. The MAR for February 2026 for Resident #106 indicated the following orders:a. Lyumjev Insulin, inject 5 units subcutaneously one time in the morning every Mon, Wed, Fri for Diabetes Mellitus.b. Calcium Carbonate (Tums) chewable 500 MG tablet, give 2 tablets by mouth at bedtime for low Calcium.On 2/25/26 at 1:15 PM Review of Resident #106's nursing progress notes failed to indicate follow up documentation related to resident's AM blood glucose level and if Lyumjev insulin had been administered or held. On 2/26/26 at 9:25 AM, a review of the medication administration observation was provided with Staff S, RN, Director of Clinical Education, who stated these errors would be reviewed and follow up would be provided. 2/26/26 at 11:15 AM, Staff S, RN, Director of Clinical Education confirmed Lyumjev insulin had not been administered to Resident #106 as ordered and acknowledged the Tums that had been administered in the morning should have been administered at bedtime per Physician's order. Staff S, stated she would expect the Physician to be notified of concerns related to blood glucose levels for recommendations and to notify of any missed medication doses.In an email dated 2/26/26 at 2:45 PM, Facility administrator communicated he was not able to find a facility policy related to medication administration and stated we follow standard of care.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, staff interviews, and policy review, the facility failed to administer insulin and provide Velphoro (a phosphate binder that controls high serum phosphorus in patients with chronic kidney disease) per Physician's order for 1 of 5 residents (Resident #106) reviewed for medications, resulting in a significant medication error. The facility reported a census of 101 residents.Findings include:Review of Resident #106's Quarterly Minimum Data Set (MDS) dated [DATE], identified a Brief Interview for Mental Status (BIMS) score of 15, indicating cognitively intact. Resident #106's diagnoses include end stage kidney disease, diabetes mellitus, coronary artery disease, heart failure and receiving dialysis. Review of Resident #106's Care Plan, provided a focus, initiated 1/1/24, of Resident's end stage kidney disease requiring dialysis on Mondays, Wednesdays and Fridays. A focus initiated 5/11/23, Resident's diagnosis of Diabetes Mellitus with interventions to provide diabetes medications as ordered by Physician.On 2/25/26 Wednesday) at 8:20 AM, the observation of the medication pass began. Staff U, RN prepared a total of 7 medications for Resident #106. While administering medications to Resident #106, Staff U, RN stated she needed to review Resident #106's Lyumjev (short acting insulin) due to blood glucose reading of 98.Review of Medication Administration Record (MAR) for February 2026 revealed orders for Resident #106 to receive Velphoro 500mg tablets, 2 tablets by mouth with meals and to send noon dose with Resident #106 dialysis days and Lymjev insulin, 5 units subcutaneously every morning on Mondays, Wednesdays, and Fridays. On Wednesday 2/25/26, MAR indicated Resident #106 had not received a noon dose of Velphoro due to being out of the facility. On 2/25/26 at 1:15 PM Review of Resident #106's nursing progress notes failed to indicate follow up documentation related to resident's AM blood glucose level and if Lyumjev insulin had been administered or held. Review of Velphoro Pharmaceutical Prescribing Information revealed Velphoro is a phosphate binder indicated for the control of serum phosphate levels (phosphate blood levels). The recommended starting dose for adults is one 500mg tablet three times daily with meals and to adjust dose by one 500mg tablet per day as needed until an acceptable serum phosphorus level is reached, with regular monitoring afterwards (lab work). On 2/26/26 at 11:15 AM, Staff S, RN, Director of Clinical Education confirmed Lyumjev insulin had not been administered to Resident #106 as ordered and the Velphoro noon dose had not been sent with Resident #106 to dialysis as ordered. Staff S, stated she would expect the Physician to be notified of concerns related to blood glucose levels for recommendations and to notify of any missed doses.In an email dated 2/26/26 at 2:45 PM, Facility administrator communicated he was not able to find a facility policy related to medication errors and Physician notification and stated we follow standard of care.

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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. Based on electronic health record review (EHR), observations, and staff interview, the facility offered inappropriate candy to residents on altered textured diets for 2 of 2 residents observed (Resident #14 & #58). The facility reported a census of 101. Findings include: During an observation on 2/25/26 at 4:20 PM, Staff P, maintenance, asked Resident #14 if they wanted another Snickers. The resident indicated yes and Staff P gave them a fun-sized Snickers candy bar. Staff P then offered the same to Resident #58 who accepted. Review of Physician Orders noted Resident #14 and Resident #58 are both on a mechanical soft diets. This diet consists of moist, tender, ground, or finely chopped foods that need minimal chewing for residents with swallowing or chewing difficulties. The Minimum Data Set (MDS) Assessment, completed on 12/22/25, revealed Resident #14 with a Brief Interview for Mental Status (BIMS) score of 4 indicating severe cognitive impairment. Diagnoses include dysphagia (difficulty swallowing), dementia, and stroke. The MDS Assessment, completed on 2/6/26, revealed Resident #58 with a BIMS score of 4 indicating severe cognitive impairment. Diagnoses include dementia and dysphagia. In an interview on 2/26/26 at 8:45 AM, Staff P acknowledged providing the Snickers candy bars to Resident #14 and Resident #58. They were not aware the residents were on specialized diets. Staff P noted they had seen other staff members give these residents candy before, including Snickers. In an interview on 2/26/26 at 1:00 PM, the Dietary Manager explained a list of acceptable snack items for residents on specialized diets, like a mechanical soft or puree, are kept on each nursing station for staff reference. In an email response dated 3/3/26 at 10:00 AM, the Registered Dietitian (RD) stated Snickers candy bars would not be allowed on a mechanical soft diet. These would be too sticky and the nuts would be difficult to chew. The Simplified Diet Manual, Thirteenth edition, noted foods allowed on a Level 5 Minced and Moist diet, which resembles a mechanical soft diet, should require minimal chewing (with no biting) and can be easily mashed with little pressure from a fork. [NAME] which has nuts and/or is chewy and sticky should be avoided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and policy review, the facility failed to apply appropriate food handling practices when assisting residents to eat for 2 of 4 residents during breakfast. The facilty reported a census of 101. Findings include:During a continuous breakfast observation on 2/26/26 at 8:10 am, the following occured: a. Staff Q, Certified Nursing Assistant, reached over the table to assist a resident pick-up food from the plate. A fork & the Staff's bare hand were used to place toast in the resident's hand; b. Staff Q folded over a piece of toast and gave it to another resident using their bare hands. In both cases no hand hygiene was performed prior to handing the toast to residents. A box of gloves was visualized in the Dining Room next to the table where Staff Q was assisting residents. In an interview on 2/26/26 at 5:30 PM, the Corporate Regional Nurse acknowledged staff should not be handling resident food with their bare hands. The policy Food Handling, revised 10/2023, outlined the following: 1.Employees perform hand hygiene prior to handling food and maintain safe food handling practices; 2.Ready-to-eat food must not be touched with bare hands; 3.Disposable gloves, tongs, or other dispensing devices must be used properly in accordance with safe food handling practices