STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	165612	A. Building B. Wing	12/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Trinity Center at Luther Park	1555 Hull Avenue Des Moines, IA 50316

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety 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, record review, staff and Iowa Department of Public Health (IDPH) interviews, facility policy review, and Centers for Disease Control and Prevention (CDC) guidelines. The facility failed to do the following; ensure staff followed proper infection control practices during resident's cares and transmission based precaution procedures to prevent the spread of COVID-19 by failing to follow facility policy and CDC guidelines, to test residents who had been exposed to other residents positive for COVID-19, separate COVID-19 positive residents from roommates, to wear proper personal protective equipment (PPE) and to properly handle contaminated linens for 20 of 20 residents reviewed (Resident #2, #6, #11, #12, #27, #32, #36, #42, #59, #68, #74, #75, #85, #91, #96, #97, #100, #118, #126, #127). The facilities failure to protect their residents from exposure to high risk infections put the residents at a serious likelihood of harm. The facility reported a census of 109 residents. The State Agency informed the facility of the Immediate Jeopardy (IJ) on December 26, 2025 at 4:59 p.m. The IJ began on November 29, 2025. The facility staff removed the immediacy on December 16, 2025 by implementing the following actions;a. Residents exposed to a resident with covid positive results will be tested immediately, and residents will be tested on a section of the building that had a high rate of positive testing resultsb. All residents who have been positive will be reviewed on 12/16/25 to determine whether they need to be put back to transmission based precautions for 10 days.c. All residents on the second floor will be tested on [DATE]. d Residents in the room with covid positive resident will be moved to a different room as soon as the room is available.e. Education will be completed to All staff on mask wearing and linen handling beginning 12/16/25 and on-going shifts.f. Staff working on the highly positive COVID unit will be tested beginning 12/16/25 and on-going shiftsThe scope was lowered from K to H at the time of the survey. Findings include: On 12/15/25 at 8:45 AM, Staff B, Licensed Practical Nurse (LPN) and Staff C, LPN were observed on a unit with Covid positive residents sitting at the nurses' station without masks. They both placed the mask over their mouths and noses when the state surveyor approached. During an observation on 12/15/2025 10:45 AM, Staff BB, CNA is observed exiting a residents room, wearing gloves, pushing a patient transfer device (EZ stand), parking along the wall in the hallway and entering a resident's room across the hall while wearing the same gloves. On 12/15/2025 at 10:52 AM, observation revealed droplet precaution sign outside of Resident #59's door with Personal Protective Equipment (PPE) supplies bin outside of room. Resident's room door is open, with resident #59 laying in bed. On 12/15/25 at 10:53 AM, Staff D, Certified Nurse Aide (CNA) was observed on the same unit with with her ear loop mask tucked under her chin. On 12/15/25 at 11:00 AM, Staff E, contracted Physical Therapy Assistant (PTA) was observed on the (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	same unit with her ear-loop mask tucked under her chin while she searched for a N95 mask. She stated the facility had been using N95 masks for Covid positive droplet precaution residents. On 12/15/2025 at 3:20 PM, observed droplet precaution sign and PPE supplies bin outside of Resident #74's room, with resident's room door open. Observation on 12/16/2025 at 1:25 PM, revealed Resident #59's room door open, resident is on TBP for positive COVID, Staff GG, CNA, outside of room donning PPE to include a gown and gloves. Stuff GG, CNA currently wearing a standard surgical mask and enters resident's room. Staff GG, CNA provides cares for Resident #59, the room door is open and the curtain is pulled a quarter of the way across the room, while roommate is on the other side of the room. At 1:30 PM another staff member approaches doorway and asks Staff GG, CNA to assist in another room when done caring for Resident #59. 1:35 PM, Staff GG, CNA exits Resident #59's room, gown, gloves and mask are removed. Leaving resident's door open and carrying unbagged linens with bare hands, stops at PPE drawer in the hallway and gets a new standard surgical mask and puts it on. Staff GG, CNA then proceeds to carry unbagged linen to the soiled laundry bin halfway down the hallway and drops items in. Uses hand sanitizer and enters another room to assist as requested earlier. On 12/16/2025 3:10 PM, Staff HH, CNA is observed carrying personal care supplies from hall B to hall C, wearing a mask, pulled down below her nose only covering her mouth. After delivering supplies to storage cart on hall B, Staff HH, CNA is observed at the entrance to hall B pulling her mask down and drinking out of a water bottle, replacing her mask to cover her mouth and sets water bottle back on hand railing and walks away. On 12/16/2025 at 5:20 PM, DON provided a spreadsheet she stated is used for reporting positive COVID-19 cases to CDC's National Healthcare Safety Network (NHSN) (healthcare-associated infection tracking system) and to Iowa Department of Public Health (IDPH). Review of this document indicated residents who had been tested for influenza and/or COVID-19, resident's symptoms and date reported, the date the test was administered with results, and the date resident was removed from isolation/TBP. On 12/16/25 at 8:17 AM, Staff F, RN was observed in the dining room on the same unit wearing her mask below her nose. She raised it above her nose when the state surveyor approached her. On 12/16/25 at 3:28 PM, Staff G, LPN was observed on the unit with mask requirements at the nurses' station with his mask hanging off of his right ear. On 12/17/25 at 11:02 AM, Staff H, contracted Registered Occupational Therapy (OTR) exited a resident's room wearing a PPE gown and gloves and carrying a green pair of pants. She rolled up the pants, placed it in the laundry bin, and returned to the resident's room wearing the same PPE. At 11:09 AM, she exited the resident's room wearing PPE gown and gloves carrying a clear plastic bag of laundry. She threw it in the laundry bin and returned to the resident's room. At 11:12 AM, Staff H stated she received infection prevention education but didn't remember receiving education about exiting EBP with PPE. She stated when she's providing services to a resident on EBP, she changes gloves after touching the resident, exits the resident's room to place any linen into the laundry bin, then returns to the resident's room. She stated the residents' rooms do not have disinfectant wipes, so she takes the gait belt to the office to clean it. Observation on 12/18/2025 at 11:30 AM, Facility Nurse Practitioner, observed standing at nurses (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #11's Care Plan, initiated 9/24/2025, included the following focus and interventions: a. Altered cardiopulmonary functioning, potential for shortness of breath, lung congestion, chest pain, decrease in level of consciousness, acute heart failure. Administer cardiac medications as ordered, blood pressure monitoring, use of anticoagulants (blood thinner), observe for signs and symptoms of cardiac decompensation and report to provider. Daily weights for cardiac monitoring as ordered, notify provider of 3 pound weight gain in 1 day or 5 pounds in one week. b. Resident #11 requires the use of diuretics related to congestive heart failure and bilateral lower extremity edema. Administer medications as ordered, notify provider of increase in edema and lung congestion. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #11's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #12 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #11's Nursing Progress notes revealed the following:11/30/2025 at 7:42 AM, Staff AA, RN, documented, Resident #11 exhibits cold symptoms; congestion and cough. Reports a sore throat, denies any malaise (feeling discomfort or illness), BP 110/65, P 85, SpO2 94% on room air. Rapid COVID test completed with negative results at this time. On call provider made aware with orders for Guaifenesin (medication used to relieve chest congestion and make coughs more productive) 400mg every 4 hours as needed x 10 days. 12/2/2025 9:10 PM, Staff B, LPN, documented, Resident #11 tested positive for COVID. 12/8/2025 at 5:34 PM, Staff S, LPN, documented, Resident #11 removed from droplet isolation precautions due to resolved active COVID signs and symptoms at this time. 3. Review of Resident #12's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] to a semi-private room (shared with one roommate R#75). A BIMS of 14 (cognitively intact), diagnoses of Multiple Sclerosis, contractures, neurogenic bladder, hypertension, and anxiety disorder. Resident #12 is dependent on staff assistance for mobility in her wheelchair and assistance with the use of a mechanical lift for transfers. Review of Resident #12's Care Plan revised on 8/27/2025 failed to indicate Resident's risk for COVID. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #12's symptoms started on 12/3/2025, COVID-19 testing on 12/3/25 with positive results and TBP initiated. Resident #12 was removed from TBP on 12/12/2025 after 9 days of isolation/TBP. Review of Resident #12's Nursing Progress notes revealed the following:12/2/2025 at 12:38 AM, Staff Y, LPN, documented, resident able to express self to staff, body temperature warm to touch, dry and intact. In bed, head elevated per resident's desires, call light in reach. 12/3/2025 at 8:47 PM, Staff Z, LPN, documented, resident noted coughing, rapid COVID test completed, results positive, BP 121/68, P 118, T 98 and O2 95%. On call provider notified and received an order for mucinex 600mg twice daily x 10 days. 12/8/2025 at 2:46 PM, Staff A, RN, documented, vital signs (T)98.5, (P)108, (R)18, (BP)113/61, SpO2 95% on room air. Lung sounds diminished in the bases bilaterally and expiratory rhonchi in the right upper lobe. Loose, non-productive cough. Resident is alert. No other signs and or symptoms (s/sx) of COVID. 4. Review of MDS dated [DATE], revealed Resident #27's admission to the facility on 7/31/2024 to a semi-private room (Roommate with Resident #12), BIMS of 15 (cognitively intact) and diagnoses of non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, depression, and psychotic disorder. Review of Resident #27's Care Plan initiated 7/31/2024 failed to indicate Resident's risk for COVID. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #27's nursing progress notes, failed to provide documentation related to Resident #27's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, provide COVID testing and monitoring for symptoms. 5. Review of MDS dated [DATE], revealed resident #32 was admitted to the facility 10/21/2025 in a private room, BIMS 13 (cognitively intact) and diagnoses of atrial fibrillation (A-fib), heart failure, hypertension, and unspecified toxic encephalopathy. (brain dysfunction caused by unknown toxins, can cause confusion, memory loss, personality changes, poor concentration or seizures). Resident #32 is independent with the use of a walker. Review of Care Plan, initiated 11/3/2025, revealed the following focus and interventions for Resident #32:a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis related to congestive heart failure, A-fib, and hypertension. Avoid overexertion, requiring frequent rest periods during completion of activities. Notify nursing staff of any shortness of breath, chest pain, or irregular heartbeat. Observe for signs and symptoms of cardiac decompensation and report to provider. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #32's symptoms started on 12/1/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #32 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #32's Nursing Progress notes revealed the following:11/17/2025 at 6:37 PM, Staff U, RN, documented, Nurse Practitioner is here and new order received, cough drops mouth/throat lozenge every 2 hours as needed, may have at bed side per resident's request. 12/1/2025 at 2:26 PM, Staff B, LPN, documented, called Resident #32's family and notified about Vaseline under the nose for redness.12/2/2025 at 12:39 PM, late entry created 12/3/1015 at 3:41 PM, Staff B, LPN noted, Resident #32 was tested positive for COVID, family and manager notified. Isolation precautions put in place. 12/2/2025 at 12:44 PM, Staff T, ADON, documented, positive for COVID, isolation in place. 12/3/2025 at 1:04 PM, Staff T, ADON, documented, symptoms started on Sunday (11/30/2025) with a runny nose and increased tiredness. On 12/2/2025 resident #32 was tested with a rapid COVID test and tested positive. 12/8/2025 at 5:12 PM, Staff T, ADON, documented new orders for Tussin (medicine to relieve symptoms of cough and chest congestion cause by the common cold, flue, allergies, or minor bronchial irritations) 15mg every 6 hours as needed. Rapid COVID test completed, results negative. 12/8/2025 at 5:32 PM, Staff S, LPN, documented, resident #32 removed from droplet isolation precautions due to resolved signs of active COVID signs or symptoms at this time. 6. Review of MDS dated 11/12025, revealed Resident #36's admission to the facility on [DATE] to a semi-private room (roommate with Resident #59), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of A-fib, hypertension, kidney disease, type 2 diabetes mellitus, aphasia (language disorder, impairing language, understanding speech, reading and writing), hemiplegia, seizure disorder, and history of stroke. Resident #36 requires maximal assistance for transfers and is independent with a wheelchair for mobility. Review of Resident #36's Care Plan initiated 12/5/2024 failed to indicate Resident's risk for COVID. Review of Resident #36's nursing progress notes, failed to provide documentation related to Resident #36's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident #36's Medication Administration Record (MAR) indicated an order dated 12/11/2025 for COVID MONITORING: monitor for new cough, sore throat, new shortness of breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. See nurses notes and progress notes findings every shift for 10 days. Vitals were obtained and documented each shift. The ordered nursing progress notes linked to three times daily COVID monitoring provided the following two nursing documentations:12/11/2025 at 4:50 PM, Staff AA, RN, documented, no cough or difficulty breathing noted. 12/13/2025 at 1:07 AM, Staff Z, LPN, noted, Resident #36 resting quietly with no complaints of discomfort, NO breathing difficulty. On 12/16/2025 at 1:18 PM, Resident #36 was observed self propelling in his wheelchair, exiting his room. Outside of resident #36's room, a three drawer bin with PPE, had a folded blanket, shirt on a hanger, and underwear sitting on top. Resident #36, unmasked, retrieved laundry and blanket and returned to the room. During an interview on 12/16/2025, Staff G, LPN stated in this room, Resident #59 is COVID positive, Resident #36 is not. LPN stated Resident #36 had been tested with negative results. When LPN was asked about facility's procedure for separating roommates when one is COVID positive and the other is negative, LPN stated Resident #36's roommate had a full assessment, nursing staff will monitor Resident #36 with basic vitals. LPN stated Resident #36 had been tested again and was negative, the results for these tests would be documented in the nurses progress notes in Resident #36's records. An interview on 12/16/25 at 3:12 PM, Staff F, RN stated, she has encouraged Resident #36 to spend time outside of his room and encouraged to wear a mask. Nurses are monitoring for signs and symptoms of COVID. Staff F, RN stated she was not sure if Resident #36 had been tested for COVID, at this time Staff F, RN called Staff S, the Infection Preventionist for more information. Staff F, RN continues by stating I haven't been on the floor in awhile, to know what we're doing. After communicating with Staff S, Infection Preventionist, Staff F, RN stated right now we are focusing on alert charting and monitoring for COVID symptoms, if symptoms start then the resident is tested for COVID. In an interview on 12/16/25 at 3:24 PM, Staff T, ADON, acknowledged Resident #36 cohorting (an infection control strategy where patients with the same contagious condition are grouped together in a specific area to prevent spread to others) with Resident #59 who is COVID positive and stated questions related to the cohorting would need to be redirected to the facility's Infection Preventionist Staff S, for further clarification. 7. Review of MDS dated [DATE] revealed Resident #42's admission to the facility on 4/7/2025 to a private room, BIMS of 12 (moderate cognitive impairment) and diagnoses of hypertension, kidney disease, type 2 diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, asthma, and sarcopenia (age related progressive loss of muscle mass, strength and function). Resident #42 is dependent on staff for transfers and mobility in her wheelchair. Review of Resident #42's Care Plan, initiated 4/7/2025, included the following focus and interventions:a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to hypertension and asthma with wheezing. Avoid overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hypertension, kidney disease, type 2 diabetes mellitus, and respiratory failure with hypoxia (critical condition where lungs fail to get enough oxygen into the blood). Review of Resident #68's Care Plan, initiated 11/26/2025 included the following focus and interventions:a. Resident #68 requires assistance of 1 with a gait belt and walker for ambulation and transfer. b. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to heart failure and acute respiratory failure. Avoid overexertion, requiring frequent rest periods during completion of activities. Instruct resident to notify nursing staff of any complaints of shortness of breath, chest pain, irregular heart rate. Observe for signs and symptoms if resident is unable to report symptoms and notify provider if signs and symptoms exist. c. Oxygen at 2 lpm via nasal cannula as needed. d. Observe for signs and symptoms of cardiac decompensation and report to provider. e. Enhanced Barrier Precautions (EBP) due to chronic wounds, gowns and gloves to be worn with all direct care. Proper hand washing before and after all cares. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #68's symptoms started on 11/29/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #68 was removed from TBP on 12/9/2025 after 7 days of isolation/TBP. Review of Resident #68's Nursing Progress notes revealed the following:11/28/2025 at 10:50 AM, Staff L, RN documented a Skilled Evaluation note stating, no signs of difficulty breathing, no shortness of breath noted. No cough, no signs of respiratory distress or discomfort noted at this time. 11/29/2025 at 8:09 AM, Staff AA, RN documented a Skilled Evaluation note stating, no signs of difficulty breathing, no shortness of breath noted. Right and left lung clear, no oxygen. Cough present with moist/loose non-productive cough noted. Reports cough not new, denies concerns at this time. 11/30/2025 at 8:37 AM, Staff AA, RN documented a Skilled Evaluation note stating, no signs of difficulty breathing. Shortness of breath noted, Resident #68 reported shortness of breath upon exertion. Right and left lung clear. No oxygen, head of bed elevated at 30 degrees. Cough present with moist/loose non productive cough noted. Small amount of thin secretions. Residual cough. 11/30/2025 at 5:33 PM, Staff AA, RN documented an Administration note, Albuterol sulfate inhalation nebulation, 3 ml inhaled orally via nebulizer every 6 hours as needed for shortness of breath, SpO2 94% on room air, no respiratory distress observed or reported. 12/1/2025 at 10:07 AM, Staff BB, Certified Medication Aide (CMA) document an Administration note, Albuterol sulfate inhalation nebulation, 3 ml inhaled orally via nebulizer every 6 hours as needed for shortness of breath, wheezing. Resident #68 requested Albuterol nebulizer for shortness of breath and wheezing. Nurse was notified. 12/1/2025 at 10:40 AM, Staff U, RN documented a Skilled Evaluation note stating, SpO2 90% on room air, no signs of difficulty breathing or shortness of breath noted. Right lung upper lobe wheezes on auscultation, lung sounds present on exhalation. Left lung upper lobe wheezes on auscultation, lung sounds present on exhalation. Moist/Loose non-productive cough present with small amounts of clear moderate consistency secretions. As needed nebulizer treatments administered, Nurse Practitioner here and notified of noted wheeze and cough. 12/1/2025 at 11:05 AM, Staff U, RN documented wheezing and shortness of breath noted this morning, as needed nebulizer treatment administered. Nurse Practitioner is here and saw resident. New order received; Mucinex 600mg by mouth twice daily x 7 days. 2 view chest x-ray today. Continue as needed nebulizer treatments. X-ray scheduled with portable x-ray services. 12/1/2025 at 11:59 AM, Staff U, RN documented Nurse Practitioner is here and saw Resident #68; verbal order received for rapid COVID test. Rapid COVID test administered and positive results noted. Nurse Practitioner and ADON aware, Resident #68 in droplet precaution, will continue to monitor. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	10. Review of MDS dated [DATE] revealed Resident #74's admission to the facility on 5/5/2025 in a private room, BIMS of 15 (cognitively intact) and diagnoses of hypertension, polyneuropathy (nerve damage in extremities causing weakness, numbness, tingling and burning pain affecting sensory and motor functions), aortic valve stenosis (serious heart condition, aortic valve narrows causing obstructive blood flow), and weakness, Resident #74 is independent with transfers and mobility with the use of a wheelchair. Review of Resident #74's Care Plan revised 11/10/2025 indicated the following focus and interventions:a. Altered cardiovascular status related to hypertension. Assess for chest pain, enforce the need to call for assistance if pain starts. Monitor, document and report any signs or symptoms of coronary artery disease.b. Initiated 12/14/2025, require care isolation precautions specifically related to the COVID-19 infection. Observe for signs and symptoms and inform provider if worsening. Ensure resident stays in room, away from other people as much as possible (contact and droplet precautions). Monitor vitals and notify provider of abnormalities. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #74's symptoms started on 12/13/2025. Review of Resident #74's Nursing Progress notes revealed the following:12/13/2025 at 9:30 AM, Staff AA, RN, documented, Resident #74 with complaints of loss of taste, also presents with nasal congestion. Denies any cough or s

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review the facility failed to appropriately provide consistent and thorough assessments for COVID positive residents and residents exposed to COVID, for the ordered 10 days, also failed to complete a neurological assessment for a resident with an unwitness fall for 17 of 21 residents reviewed. (Resident #11, #12, #18, #27, #32, #36, #42, #59, #68, #74, #75, #85, #91, #96, #97, #100, #118) Facility reported a census of 109 residents. Findings include:1. Review of Resident #11's admission MDS dated [DATE] revealed, resident was admitted to the facility on [DATE] to a private room. A BIMS of 15 (cognitively intact), diagnoses of coronary artery disease, deep vein thrombosis, heart failure, peripheral vascular disease, type 2 diabetes mellitus, and pleural effusion (excess fluid builds up in the space between the lungs and chest wall, restricting lung expansion, causing shortness of breath, chest pain, and cough). Resident #11 requires moderate assistance (helper does less than half the effort, lifts or holds trunk or limbs but provides less than half the effort) with transfers and mobility with the use of a walker or wheelchair. Review of Resident #11's Care Plan, initiated 9/24/2025, included the following focus and interventions: a. Altered cardiopulmonary functioning, potential for shortness of breath, lung congestion, chest pain, decrease in level of consciousness, acute heart failure. Administer cardiac medications as ordered, blood pressure monitoring, use of anticoagulants (blood thinner), observe for signs and symptoms of cardiac decompensation and report to provider. Daily weights for cardiac monitoring as ordered, notify provider of 3 pound weight gain in 1 day or 5 pounds in one week. b. Resident #11 requires the use of diuretics related to congestive heart failure and bilateral lower extremity edema. Administer medications as ordered, notify provider of increase in edema and lung congestion. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #11's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #11 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #11's December 2025 Medication Administration Record/Treatment Administration Record (MAR/TAR) revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/2/2025, Discontinue (D/C) date 12/8/2025 The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #11's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.2. Review of Resident #12's MDS dated [DATE] revealed the resident was admitted to the facility on [DATE] to a semi-private room (shared with one roommate). A BIMS of 14 (cognitively intact), diagnoses of Multiple Sclerosis, contractures, neurogenic bladder, hypertension, and anxiety disorder. Resident #12 is dependent on staff assistance for mobility in her wheelchair and assistance with the use of a mechanical lift for transfers. Review of Resident #12's Care Plan revised on 8/27/2025 failed to indicate Resident's risk for COVID.Review of facility provided COVID-19 tracking spreadsheet indicated Resident #12's symptoms started on 12/3/2025, COVID-19 testing on 12/3/25 with positive results and TBP initiated. Resident #12 was removed from TBP on 12/12/2025 after 9 days of isolation/TBP. Review of Resident #12's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/3/2025, Discontinue (D/C) date 12/12/2025. The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #12's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.3. Review of MDS dated [DATE], revealed Resident #27's admission to the facility on 7/31/2024 to a semi-private room (Roommate with Resident #12), BIMS of 15 (cognitively intact) and diagnoses of non-Alzheimer's dementia, Parkinson's disease, anxiety disorder, depression, and psychotic disorder. Review of Resident #27's Care Plan initiated 7/31/2024 failed to indicate Resident's risk for COVID.Review of Resident #27's December 2025 MAR/TAR, failed to indicate COVID monitoring assessment due to resident's exposure and cohorting with COVID positive roommate. Review of Resident #27's nursing progress notes, failed to provide documentation related to Resident #27's exposure and cohorting with COVID positive roommate.Review of facility provided COVID-19 tracking spreadsheet lacked documentation of Resident #27 being tested for COVID.4. Review of MDS dated [DATE], revealed resident #32 was admitted to the facility 10/21/2025 in a private room, BIMS 13 (cognitively intact) and diagnoses of atrial fibrillation (abnormal heart rhythm) , heart failure, hypertension, and unspecified toxic encephalopathy. (brain dysfunction caused by unknown toxins, can cause confusion, memory loss, personality changes, poor concentration or seizures). Resident #32 is independent with the use of a walker. Review of Care Plan, initiated 11/3/2025, revealed the following focus and interventions for Resident #32:a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis related to congestive heart failure, atrial fibrillation (A-Fib), and hypertension. Avoid overexertion, requiring frequent rest periods during completion of activities. Notify nursing staff of any shortness of breath, chest pain, or irregular heartbeat. Observe for signs and symptoms of cardiac decompensation and report to provider.Review of facility provided COVID-19 tracking spreadsheet indicated Resident #32's symptoms started on 12/1/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #32 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP. Review of Resident #32's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/2/2025 at 2:00 PM, Discontinue (D/C) date 12/8/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered.Resident#32's Medication Administration Record documented that the resident received Tussin Cough oral syrup 15milligrams per 5 milliliters by mouth on December 9, 2025 at 7:42 p.m., the medication was classified as a PRN medication (given to resident upon request).Review of Resident #32's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.5. Review of MDS dated 11/12025, revealed Resident #36's admission to the facility on [DATE] to a semi-private room (roommate with Resident #59), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of A-fib, hypertension, kidney disease, type 2 diabetes mellitus, aphasia (language disorder, impairing language, understanding speech, reading and writing), hemiplegia, seizure disorder, and history of stroke. Resident #36 required maximal assistance for transfers and is independent with a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	wheelchair for mobility. Review of Resident #36's Care Plan initiated 12/5/2024 failed to indicate Resident's risk for COVID.Review of Resident #36's December 20025 MAR/TAR indicated an order dated 12/11/2025 for COVID MONITORING: Monitor for new cough, sore throat, new Shortness of Breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes findings every shift for 10 days.Review of Resident #36's Nursing Progress notes failed to provide complete monitoring assessments indicating assessed symptoms, new cough, sore throat, new shortness of breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose every shift (three times daily) for complete 10 days as ordered. 6. Review of MDS dated [DATE] revealed Resident #42's admission to the facility on 4/7/2025 to a private room, BIMS of 12 (moderate cognitive impairment) and diagnoses of hypertension, kidney disease, type 2 diabetes mellitus, Alzheimer's disease, non-Alzheimer's dementia, anxiety disorder, depression, bipolar disorder, asthma, and sarcopenia (age related progressive loss of muscle mass, strength and function). Resident #42 is dependent on staff for transfers and mobility in her wheelchair. Review of Resident #42's Care Plan, initiated 4/7/2025, included the following focus and interventions:a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to hypertension and asthma with wheezing. Avoid overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of cardiac decompensation and report to provider.Review of facility provided COVID-19 tracking spreadsheet indicated Resident #42's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #42 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP.Review of Resident #42's December 20025 MAR/TAR indicated an order dated 12/11/2025 for COVID MONITORING: Monitor for new cough, sore throat, new Shortness of Breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes findings every shift for 10 days. Start date 12/3/2025, D/C 12/9/2025. The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered. Review of Resident #42's Nursing Progress Notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.7. Review of Resident #59's MDS dated [DATE] revealed resident #59 was admitted to the facility on [DATE] to a semi-private room (roommate with Resident #36), BIMS of 14 (cognitively intact) with diagnoses of coronary artery disease, heart failure, cardiomegaly (enlarged heart), hypertension, type 2 diabetes mellitus, anxiety disorder, depression, COPD, chronic respiratory failure, obstructive sleep apnea, disease of spinal cord, and requires oxygen. Resident #59 is dependent for transfers with assistance of a mechanical lift and uses a power wheelchair for mobility.Review of Resident #59's Care Plan revised 12/4/2025 provided the following focus and interventions:a. Resident #59 has an altered cardiovascular status related to hypertension, heart failure, and coronary artery disease. Administer cardiac medications as ordered. Daily weights, if 5 pounds gain in one week, administer additional lasix that day. Monitor and report any signs or symptoms of coronary artery disease, chest pain or pressure with activity, shortness of breath, excessive sweating, and dependent edema. Oxygen at 2 liters via nasal cannula continuous. b. Resident #59 is at risk for signs and symptoms of COVID-19. Follow facility protocol for COVID-19 screening and precautions. Observe for signs and symptoms of COVID-19, document and promptly report fever, coughing, sneezing, sore throat, and/or respiratory/breathing issues. c. Initiated 12/11/2025, Resident #59 requires isolation precautions, specifically related to the COVID-19 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection. Observe effectiveness of medications; observe for signs and symptoms and inform provider if worsening. Intervention initiated 12/16/2025; Carry on conversations with Resident #59 during care so that he does not feel isolated; Resident #59 is receiving antibiotics for COVID associated respiratory infection, observe for potential side effects and report to the provider; notify provider of any worsening COVID symptoms; isolation per policy. d. Resident #59 has altered respiratory status, difficulty breathing related to heart failure, respiratory failure, and COPD exacerbation. Assess lung sounds as needed and notify provider of abnormal findings. Monitor for signs and symptoms of respiratory distress and report to provider. Continuous oxygen at 2 liters per minute via nasal cannula. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #59's symptoms started on 12/11/2025.Review of Resident #59's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/11/2025, end date 12/21/25 Review of Resident #59's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.8. Review of MDS dated [DATE], revealed Resident #68 was admitted to the facility on [DATE] to a private room, BIMS of 15 (cognitively intact) and diagnoses of cancer, A-fib, heart failure, hypertension, kidney disease, type 2 diabetes mellitus, and respiratory failure with hypoxia (critical condition where lungs fail to get enough oxygen into the blood).Review of Resident #68's Care Plan, initiated 11/26/2025 included the following focus and interventions:a. Resident #68 requires assistance of 1 with a gait belt and walker for ambulation and transfer. b. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to heart failure and acute respiratory failure. avoid overexertion, requiring frequent rest periods during completion of activities. Instruct resident to notify nursing staff of any complaints of shortness of breath, chest pain, irregular heart rate. Observe for signs and symptoms if resident is unable to report symptoms and notify provider if signs and symptoms exist. c. Oxygen at 2 liters per minute via nasal cannula as needed. d. Observe for signs and symptoms of cardiac decompensation and report to provider. e. Enhanced Barrier Precautions (EBP) due to chronic wounds, gowns and gloves to be worn with all direct care. Proper hand washing before and after all cares. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #68's symptoms started on 11/29/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #68 was removed from TBP on 12/9/2025 after 7 days of isolation/TBP.Review of Resident #68's December 20025 MAR/TAR indicated an order for COVID MONITORING: Monitor for new cough, sore throat, new Shortness of Breath or difficulty breathing, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes findings every shift for 10 days. Start date 12/2/2025, D/C 12/9/2025. The MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered.Review of Resident #68's Nursing Progress Notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.9. Review of MDS dated [DATE] revealed Resident #74's admission to the facility on 5/5/2025 in a private room, BIMS of 15 (cognitively intact) and diagnoses of hypertension, polyneuropathy (nerve damage in extremities causing weakness, numbness, tingling and burning pain (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	affecting sensory and motor functions), aortic valve stenosis (serious heart condition, aortic valve narrows causing obstructive blood flow), and weakness, Resident #74 is independent with transfers and mobility with the use of a wheelchair. Review of Resident #74's Care Plan revised 11/10/2025 indicated the following focus and interventions:a. Altered cardiovascular status related to hypertension. Assess for chest pain, enforce the need to call for assistance if pain starts. Monitor, document and report any signs or symptoms of coronary artery disease.b. Initiated 12/14/2025, require care isolation precautions specifically related to the COVID-19 infection. Observe for signs and symptoms and inform provider if worsening. Ensure resident stays in room, away from other people as much as possible (contact and droplet precautions). Monitor vitals and notify provider of abnormalities. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #74's symptoms started on 12/13/2025.Review of Resident #74's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/13/2025 at 2:00 PM, Discontinue (D/C) date 12/23/2025. The residents MAR/TAR lacked documentation of all COVID assessments being completed as ordered.Review of Resident #74's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.10. Review of Resident #75 MDS dated [DATE] revealed admission to the facility on 5/17/2024 to a semi-private room (roommate Resident #12), BIM of 3 (severe cognitive impairment) and diagnoses of hypertension, chronic kidney disease, A-fib, and other specified signs and symptoms involving cognitive functions and awareness (brain fog, memory lapses, difficulty concentrating, altered mental status), stenosis of carotid artery, arterial fibromuscular dysplasia, hypertensive heart disease Resident #75 requires maximal assistance with transfers and mobility with the use of a gait belt and walker. Review of Resident #75's Care Plan revised 9/11/2025 indicated the following focus and interventions: a. High risk for COVID exposure due to communal living. Observe for signs and symptoms of COVID. Obtain rapid COVID test as indicated and report results to provider, should Resident #75 have a positive test, isolate per CMS/CDC guidelines. b. Resident #75 has altered cardiovascular status related to stenosis of carotid artery, arterial fibromuscular dysplasia, hypertensive heart disease. Administer medications as ordered. Monitor, document, and report any changes in lung sounds on auscultation, edema and changes in weight as needed. Review of Resident #75's December 2025 MAR/TAR failed to indicate monitoring for symptoms due to exposure to COVID positive roommate. Review of Resident #75's nursing progress notes and orders, failed to provide documentation related to Resident #75's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, and ordered monitoring for COVID symptoms. 11. Review of MDS dated [DATE] revealed Resident #85 was admitted to the facility on [DATE] to semi-private room (roommate with Resident #100), BIMS of 11 (moderate cognitive impairment) and diagnoses of kidney failure, history of rhabdomyolysis (breakdown of damaged muscle tissue), malnutrition, spondylosis lumbosacral region (degenerative changes in lower back), metabolic encephalopathy (condition causing brain dysfunction leading to confusion, seizures, or coma), bed confinement status, and weakness. Resident #85 is dependent on all transfers and mobility with the use of a mechanical lift and wheelchair. Resident #85's Care Plan, initiated 8/8/2024 indicated the following focus and interventions:a. Resident #85 requires enhanced barrier precautions (EBP) due to an extensive pressure area. Infection Preventionist to educate staff on donning (putting on) and doffing (removing) of equipment. Proper handwashing before and after all cares. Review of facility provided COVID-19 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	tracking spreadsheet indicated Resident #85's symptoms started on 12/2/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #85 was removed from TBP on 12/8/2025 after 6 days of isolation/TBP.Review of Resident #85's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/2/2025 D/C date 12/8/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered.Review of Resident #85's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.12. Review of Resident #91's MDS dated [DATE] revealed Resident #91 was admitted to the facility on [DATE] to a semi-private room (roommate Resident #118), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of history of a stroke, hypertension, type 2 diabetes mellitus, arthritis, and aphasia. Resident #91 requires maximal assistance for transfers and mobility with use of a wheelchair. Review of Care Plan revised on 12/16/2025 indicated the following focus and interventions for Resident #91:a. EBP required due to MDRO CRE E. Coli (multi-drug resistant organism, superbug resistant to powerful antibiotics). Gowns and gloves to be worn with all direct care, Infection Preventionist to educate staff on donning and doffing of equipment. Proper handwashing before and after all cares. b. Altered cardiovascular status related to hypertension and history of stroke. Administer medications as ordered. Monitor, document, and report any changes in lung sounds on auscultation, edema and changes in weight as needed. Review of facility provided COVID-19 tracking spreadsheet indicated Resident #91's symptoms started on 12/3/2025, COVID-19 testing on 12/2/25 with positive results and TBP initiated. Resident #91 was removed from TBP on 12/8/2025 after 5 days of isolation/TBP.Review of Resident #91's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/3/2025, D/C date 12/8/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered.Review of Resident #91's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.13. Review of MDS dated [DATE] revealed Resident #96 was admitted to the facility on [DATE] to a semi-private room (roommate Resident #97), BIMS of 0 (resident is not able to complete the assessment) and diagnoses of stroke, hypertension, hemiplegia affecting left side, emphysema, and COPD. Resident #96 requires maximal assistance with transfers and mobility. Review of Resident #96's Care Plan revised 12/8/2025 indicated the following focus and interventions:a. Initiated 10/28/2024, Potential risk for community acquired infection while living in a healthcare setting. Antibiotics as ordered, encourage oral fluids and nutrition as tolerated. Follow standards for outbreak testing and mitigation. Sanitize high touch surfaces to decrease the risk of infection. b. Initiated 12/8/2025, Resident #96 requires isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover their mouth and nose when coughing or sneezing, ensure good infection control measures and PPE are used when working with resident. Contact and droplet isolation, encourage keeping door closed. c. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Altered cardiovascular status related to hypertension and history of stroke. Assess for chest pain and shortness of breath and monitor vital signs per protocol.d. Diagnosis of COPD, give aerosol or bronchodilators as ordered monitoring for side effects and effectiveness. Monitor for signs and symptoms of acute respiratory insufficiency. Monitor, document, report any signs and symptoms of respiratory infection.Review of facility provided COVID-19 tracking spreadsheet indicated Resident #96's symptoms started on 12/7/2025, Resident #91 was removed from TBP on 12/12/2025 after 5 days of isolation/TBP.Review of Resident #96's December 2025 MAR/TAR revealed an order for Covid positive assessment: Monitor temperature, pulse ox (oxygen saturation), assess lung sounds, shortness of breath or labored breathing, for changes in resident's baseline alertness. Monitor for NEW symptoms since isolation started; cough, sore throat, loss of taste or smell, chills, fatigue, nausea, vomiting, diarrhea, muscle or body aches, headache, congestion, runny nose, every shift for 10 days. Document Y if monitored and none of the above observed. N if monitored and any of the above was observed, select chart code other/see nurses notes and enter findings of assessment in progress notes. Start date 12/7/2025, D/C date 12/12/2025. MAR/TAR failed to provide vitals and assessments for complete 10 days as ordered.Review of Resident #96's Nursing Progress notes failed to provide complete assessments indicating assessed symptoms, lungs sounds, shortness of breath, and any changes to resident's baseline alertness every shift (three times daily) for complete 10 days as ordered.14. Review of MDS dated [DATE] revealed Resident #97 was admitted to the facility on [DATE] to a semi-private room. (Roommate with Resident #96) Resident #97's BIMS 0 (Resident was not able to complete assessment) and diagnoses of heart failure, type 2 diabetes mellitus, Alzheimer's Disease, and seizure disorder.Review of Resident #97's Care Plan revised 8/27/2025 failed to indicate Resident's risk for COVID.Review of Resident #97's December 2025 MAR/TAR failed to indicate monitoring for symptoms due to exposure to COVID positive roommate.Review of Resident #97's nursing progress notes and orders, failed to provide documentation related to Resident #97's exposure to COVID positive roommate, attempt to separate from roommate or provide interventions to reduce risk of transmission, and ordered monitoring for COVID symptoms. 15. Review of MDS dated [DATE], revealed Resident #100's admission to the facility on 8/1/2024 in a semi-private room. (roommate Resident #85, who tested COVID positive on 12/2/2025), BIMS of 13 (cognitively intact) and diagnoses of hypertension, type 2 diabetes mellitus, asthma, and adult failure to thrive. Review of Resident #100's care plan, revised 12/6/2025 indicated the following focus and interventions:a. Altered cardiopulmonary status with potential for shortness of breath, lung congestion, edema, chest pain, decreased level of consciousness, cyanosis, diaphoresis, complaints of nausea and vomiting related to hypertensive heart disease and asthma. Interventions included avoiding overexertion, requiring frequent rest periods during completion of activities. Observe for signs and symptoms of cardiac decompensation and report to provider.b. Initiated 10/29/2024, Potential risk for community acquired infection while living in a healthcare setting. Follow standards for outbreak testing and mitigation and sanitize high touch surfaces to decrease the risk of infection.c. Revised 12/6/2025, resident requires care isolation precautions specifically related to the COVID-19 infection. Encourage resident to cover their mouth and nose when coughing or sneezing, ensure good infection control measures and PPE are used when working with resident. Contact and droplet isolation, encourage keeping door closed. Review of facility provided COVID-19 tracking spreadsheet indica

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and policy review, the facility failed to label food stored in the refrigerator, failed to properly thaw meat used for lunch meal service, and failed to discard delivery boxes. The facility reported a census of 109 residents.Findings include: On 12/15/25 at 8:35 AM, the following items were observed during kitchen tour:1) One (1) pack of frozen ham thawing in an aluminum pan full of standing water in the sink.2) Seven (7) packs of thawed ham in an aluminum pan of standing hot water.3) Three (3) flattened delivery boxes lying on a kettle (large machine used for making soups, etc)4) An unlabeled, clear, plastic container with sliced, white, oval items.5) An unlabeled, clear, plastic container with sliced, light green, disk shaped items.6) A unit refrigerator with a multicolored, cloth item with a resident label later identified as a coldpak. At 9:10 AM, Staff A, Registered Nurse (RN) stated she did not know who placed the item in the refrigerator. The Certified Dietary Manager (CDM) informed the unit nurse that resident healthcare items cannot be placed in the resident food storage refrigerator. Staff A stated she didn't know where to put it then. On 12/17/25 at 4:35 PM, Staff KK, Nurse Consultant stated items should be dated and labeled when stored and delivery boxes should be stored appropriately. On 12/17/24 at 4:50 PM, the CDM stated the ham located in the standing hot water pan was present because the cook placed the 7 frozen hams in the oven to speed up the thawing process. A policy titled Food Handling Policy revised 7/24/24 indicated defrosting will be done by placing the frozen item in the refrigerator until thawed or placed in a cold-water bath for defrosting. It also indicated no soiled cloths, boxes, cartons or other items that may contaminate food will be placed on food preparation surfaces. It further indicated leftover food can be stored for up to three (3) days and a label will be affixed to the container with the following information:a) Name of the food itemb) The date food was placed in containerc) Indicate if contents include a common allergen such as peanuts, tree nuts or eggsd) Check recipe card provided by main kitchene) Evening staff will discard leftover food items that have been held for over three (3) days in the refrigerator.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and policy review the facility failed to ensure staff documented the non-pharmacological interventions attempted prior to the administration of anti-anxiety medication for one of five residents reviewed for unnecessary medications (Resident #39). The facility reported a census of 109 residents.Findings include:A significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #39 had diagnoses of non-traumatic brain dysfunction, Alzheimer's disease, dementia and anxiety. The MDS revealed the resident had impaired short-term and long-term memory and severely impaired cognitive skills for daily decision making. The MDS also indicated the resident had inattention and disorganized thinking present, and rejected care 4-6 days during the look-back period. The MDS indicated the resident took an antipsychotic medication. The Care Plan revised 2/25/25 revealed the resident required use of an antipsychotic medication due to behaviors of anxiety and aggression related to senile degeneration of the brain. The behavioral triggers included physical aggression (pushing away) and combativeness toward staff during cares, resistance to cares, pacing and wandering. The care plan directed staff to administer medications as ordered at the lowest therapeutic dosage, and observe for any side effects of the medications. The Treatment Administration Record (TAR) dated 2/2025 and 6/2025 revealed to monitor for antipsychotic medication side effects. The Progress Notes revealed Lorazepam (Ativan) (an antianxiety medication) 0.5 mg (milligrams) given by mouth (PO) as needed (PRN) for anxiety and/or restlessness on the following dates and times: a. On 2/19/25 at 11:10 AM, the resident had on the same shirt for the past two days. Nurse approached resident to change clothing. Resident was restless and anxious. Lorazepam medication administered.b. On 6/30/25 at 9:55 AM, food given. No other non-pharmacological interventions were documented prior to administration of the PRN lorazepam. In an interview 12/22/25 at 11:35 AM, Staff U, Registered Nurse (RN) reported she documented nonpharmacological intervention in the progress notes prior to giving a PRN medication and documented the nonpharmacological interventions that were not effective. In an interview 12/22/25 at 11:45 AM, Staff G, Licensed Practical Nurse (LPN) reported when she signed out an antianxiety medication, she added a note at that time of the interventions that were attempted. He also entered a progress note with the things that were tried but didn't work before he administered an antianxiety medication. Staff G stated he had been told to try three things before he gave a PRN medication, and then document if the nonpharmacological interventions were effective or not. In an interview 12/22/25 at 2:31 PM, Staff A, RN, reported whenever she gave a PRN medication, she clicked on the PRN medication in the electronic health record, and she had to document the reason for the PRN medication. At that time, she typed a note with what things she did before she gave the PRN medication. Staff A stated she could also put in a progress note to document the interventions that staff had done or tried. In an interview 12/22/25 at 2:47 PM, Staff V, LPN, reported she documented the nonpharmacological interventions in the progress notes whenever she gave a PRN antipsychotic or antianxiety medication. In an interview 12/23/25 at 12:34 PM, Staff T, Assistant Director of Nursing (ADON), reported she expected staff to document nonpharmacological interventions before a PRN medication administered. She expected the nonpharmacological interventions documented in the progress note on the EMAR as the staff gave the medication. The listing of 1-2-3 on the MAR should be where the staff documented the interventions that were done prior to the PRN medication administration. An undated Psychotropic Medication Monitoring policy revealed psychotropic medications include antianxiety medications. The facility supported the appropriate use of psychopharmacologic medications that are therapeutic and enabling for residents suffering from mental illness. The use of psychopharmacologic medications for dementia-related behaviors is inappropriate in most cases but rather the use of non-pharmacological interventions based on (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individual resident needs, preferences and routines is the most appropriate and first-line treatment for dementia-related behaviors. The goal was to determine the underlying cause of residents having difficulty sleeping so the appropriate treatment of environment or medical interventions that could be used prior to psychopharmacologic medication use.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on clinical record review, staff interviews, and policy review, the facility failed to notify the resident's representative in writing of a transfer to the hospital and a policy for bed hold including reserve bed payment for 1 of 3 residents reviewed for hospitalization (Resident #3). The facility reported a census of 109 residents.Findings include: The Minimum Data Set (MDS) for Resident #3 dated 11/01/25 indicated Resident #3 had a Brief Interview for Mental Status (BIMS) score of 05 out of 15 which indicated severely impaired cognition. It included diagnoses of kidney failure, non-Alzheimer's dementia, Alzheimer's disease, a hip fracture, and traumatic brain injury. It revealed the resident required setup assistance with eating, maximal assistance with toileting, toilet transfers, dressing, and personal hygiene, and was independent with oral hygiene and all other forms of mobility. The Care Plan revised 9/24/24 included impaired cognitive function/impaired thought processes related to unspecified dementia with confusion and directed staff to discuss concerns about confusion, dementia disease progression, nursing home placement with the resident's family members' names listed. The Progress Notes dated 8/03/25 indicated the resident fell and sustained right hip pain and was transferred to the Emergency Department. It included a progress note at 11:24 AM that indicated a family member was notified of the transfer and a bed hold. The Medical Record did not include a signed or dated, written notification of transfer notification or bed hold policy with reserve payment. On 12/18/25 at 9:35 AM, the Social Services Worker (SW) stated the bed hold was documented in progress notes but the form was not completed. On 12/18/25 at 12:06 PM, Staff F, Registered Nurse (RN) stated the bed hold and representative notification of transfer form were not completed. The facility did not have a policy available for bed hold and transfer notification. A Bed Hold Policy effective 12/2025 revealed the facility shall inform residents or their representative prior to transfer to the hospital of the bed hold policy. The bed hold policy will be provided to the resident or representative within twenty-four hours of an emergency transfer to the hospital.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on direct observation, clinical record review, staff interview, policy review and Resident Assessment Instrument (RAI) Manual the facility failed to ensure proper Minimum Data Set (MDS) coding by coding residents as having physical restraints when they did not have physical restraints present, and by not coding a residents mental illness when indicated for three of twenty-two residents reviewed for MDS assessments (Resident #4, #9, and #21). The facility reported a census of 109 residents. The Minimum Data Set (MDS) assessment for Resident's #9 and #21, last completed on 09/06/2025 for Resident #9, and 09/20/2025 for Resident #21, indicate both residents had a physical restraint in the form of a bed rail present, as denoted in question P0100. The care plan for Resident #9, last updated 11/28/2025, documented the resident prefers to have side rails on their bed as it makes them feel safer. The care plan for Resident #21, last revised 12/03/2025, documented the resident prefers to have bed rails on their bed to make them feel safer and because it enhances the residents mobility in bed. A Bed rail assessment for Resident #9, completed on 11/28/2025, documented the bed rail was present at resident request and enhanced the residents mobility in bed. A bed rail assessment for Resident #9, completed on 12/11/2025, documented the bed rail was present at resident request and enhanced the residents mobility in bed. A direct observation on 12/18/2025 revealed the bed rails to be present but noted the bed rails to be partial side-rails that did not restrict a residents ability to get in or out of bed. An interview on 12/18/2025 at 01:36 PM with Staff W, Assistant Director of Nursing (MDS), stated she took fully responsibility with the MDS coding issue. She stated she recently attended an Iowa Health Care Association training where she learned they had been coding bed rails as restraints in error. In an interview on 12/18/2025 at 01:45 PM with Staff X, MDS Coordinator, she expressed confusion on whether or not to code the bed rails as a restraint on question P0100. She stated they do not have an MDS policy but follow the State Resident Assessment Instrument (RAI Manual). The 10/2025 Resident Assessment Instrument states the following for question P0100. Physical restraints are any manual method or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot easily remove which restricts freedom of movement or normal access to one's body. The assessments present indicate the bedrails in question do not restrict movement, but enhance mobility. The annual MDS assessment dated [DATE] revealed Resident #4 had diagnoses of bipolar disorder, psychotic disorder, intermittent explosive disorder, anxiety, and depression. The MDS indicated the resident not currently considered by the state level II PASRR (Preadmission Screening and Resident Review) process to have a serious mental illness or a related condition. The Care Plan revised 5/22/23 revealed the resident had a PASRR Level I completed. The care plan also revealed the resident had diagnoses of anxiety disorder, major depression, dementia with behavioral disturbance. The care plan directed staff to do a PASRR re-evaluation if there was a change in a major mental illness condition. Resident #4's PASRR dated 10/7/25 revealed a Level II outcome. The PASRR included the resident's diagnoses of major depressive disorder, delusional disorder, bipolar disorder, anxiety disorder, and Alzheimer's dementia. In an interview 12/18/25 at 9:35 AM, Staff F, MDS Coordinator, reported she completed the residents MDS assessments at least quarterly. Staff F reported she got information to complete MDS assessments and care plans from the medical records and interviews with the resident. She reviewed (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's PASRR to see if a Level II PASRR was required, and then she marked the MDS under section A1500 yes if the PASRR directed her to mark the question for a PASRR condition. In an email 12/18/25 at 10:54 AM, Staff W, Assistant Director of Nursing, wrote they do not have a policy for MDS assessments, they followed the RAI Manual. The Long-Term Care Facility RAI User's Manual updated 10/2025 revealed the following: a. Review the Level I PASRR form to determine whether a Level II PASRR was required.b. Review the PASRR report provided by the State if Level II screening was required.c. Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD or related condition, and continue to A1510, Level II PASRR Conditions.d. Code A, serious mental illness: if resident has been diagnosed with a serious mental illness.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, staff interview, and policy review, the facility failed to use a gait belt while transferring a resident who required assistance with mobility for 1 of 22 residents (#103). The facility reported a census of 109 residents.Findings include: On 12/16/25 at 1:23 PM, Staff I, Certified Nurse Aide (CNA) was observed watching a visitor attempt to transfer Resident #103 without assistance. When the resident began losing balance, Staff I assisted the visitor with transferring the resident from a recliner to his wheelchair without using the gait belt wrapped around her waist. On 12/16/25 at 1:52 PM, J, CNA stated gait belts should be used to transfer residents who are off balance, can't stand by themselves, or for safety issues. She stated staff uses a gait belt for Resident #103 except when his friend comes. His friend gets him out of the chair himself. On 12/16/25 at 2:01 PM, Staff K, Registered Nurse (RN) stated the resident walks by himself but gets up with assistance. She stated a gait belt should be used with residents who require assistance. On 12/16/25 at 2:09 PM, Staff K, RN stated she doesn't know if the resident's friend was provided education regarding the safety importance of using a gait belt for resident transfers and didn't know where the education documentation would be.The Minimum Data Set (MDS) for Resident #103 dated 11/01/25 revealed a Brief Interview for Mental Status (BIMS) score could not be obtained due to the resident being rarely or never understood. It included diagnoses of non-Alzheimer's dementia, traumatic brain injury, age-related mental decline, visual loss, and syncope (temporary loss of unconsciousness from reduced blood flow to the brain), and collapse. It indicated he was dependent with toileting, required setup assistance with eating, moderate assistance with dressing and chair-to-chair transfers, and maximal assistance with all other Activities of Daily Living (ADLs) and forms of mobility. It also indicated the resident had a fall since admission to the facility and used a wheelchair for mobility in the previous 7-day look-back period. The Care Plan revised 5/07/25 indicated the resident required assist x 1 with FWW (front-wheeled walker) at baseline with use of wheelchair on occasions with poor balance/mobility. It also included the resident's potential for falls related to generalize weakness, decreased mobility, poor safety awareness, and non-compliance with transfer status. It did not include the resident's friend resisting staff assistance with resident transfers nor education provided to the resident's friend on the safety importance of gait belt use for resident transfers.A Resident Care Conference Summary document dated 11/12/2025 did not include educating the resident's friend on the safety importance of gait belt use for resident transfers. It also did not include the resident's non-compliance with transfersThe Progress Notes did not include any documented education provided to the resident's friend regarding the safety importance of gait belt use for resident transfers.On 12/17/25 at 8:02 AM, Staff L, RN stated a gait belt is required for residents who require staff assistance for transfers for safety. She stated staff should use a gait belt when transferring Resident #103.On 12/17/25 at 8:48 AM, Staff I, CNA transferred Resident #103 with a gait belt. On 12/17/25 at 12:43 PM, Staff M, CNA stated if a resident requires assistance with transfers, a gait belt should be used. On 12/17/25 at 12:55 PM, Staff N, CNA stated a gait belt should be used when a resident requires transfer assistance from staff. On 12/17/25 at 12:59 PM, Staff O, CAN stated a gait belt should be used for resident transfers if they require staff assistance. On 12/17/25 at 1:31 PM, Staff P, Quality Assurance (QA) stated she did not have any documentation of the resident's friend being educated on the importance of using a gait belt for resident transfers.On 12/17/25 at 1:37 PM, the Director of Nursing (DON) stated she would have to look for documentation of any education provided to the resident's friend regarding the importance of using a gait belt with resident transfers. She also stated she had not heard about the resident's friend transferring him.On 12/17/25 at 4:17 PM, the DON stated CNAs should notify charge nurse or the manager, if available. The charge nurse should report it to the manager. A policy titled Gait Belt, Transfer, Wheel Chair effective 3/07/07 indicated residents who are unable to transfer or ambulate independently shall be (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assisted by staff instructed in proper procedures. A gait belt shall be used when a resident needs assistance with balance and/or strength.