

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175245	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/05/2026
NAME OF PROVIDER OR SUPPLIER Edwardsville Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 751 Blake Street Edwardsville, KS 66111	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to ensure dietary staff appropriately stored, labeled, and dated foods after the original storage container was opened. Findings included:- During the initial tour of the facility kitchen on 08/03/2026 at 08:13 AM, observation revealed the stand-alone refrigerator had a gallon jug of 2% milk that was half full did not have an open date on it. A half-gallon jug of chocolate milk was opened and did not have an open date on it. In the walk-in refrigerator, there were five-pound containers of ham salad, pasta salad, and potato salad that had been opened but lacked an open date. There was a gallon container of creamy Italian dressing that had been opened but lacked an open date. The dry storage area had an opened two-pound bag of powdered sugar that was opened and not in a sealed bag, which lacked an open date. All these food items were removed by the kitchen staff. On 08/03/2026 at 08:25 PM, Dietary CC stated that all foods should be labeled open or use by date and be stored in a sealed container or bag. On 08/05/2026 at 10:55 AM, Dietary BB stated that dietary staff should be labeling all foods with an open or use by as well as in a sealed container or bag. A policy for food storage was requested by the facility on 08/05/2026 but was not provided.		

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 - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement a water management program for Legionella disease (Legionella is a bacterium spread through mist, such as from air-conditioning units for large buildings. Adults over the age of 50 and people with weak immune systems, chronic lung disease, or heavy tobacco use are most at risk of developing pneumonia caused by Legionella). Findings Included:- On 04/06/2026 at 11:51 AM, Maintenance Supervisor (MS) U verified the facility had no water management program. MS U stated he tested water temperatures daily in the laundry room and resident rooms but did not document them. MS U stated he had the testing material for Legionella but had not used it. Maintenance Staff U stated he was unaware of how to establish a water management program but would get with the facility's corporation to find out. On 04/06/2026 at 12:00 PM, Administrative Staff A stated he was unaware the facility was required to develop a water management program and verified they did not have one. The facility's Water Management, Legionella Testing Policy, revised 03/2026, documented the facility would handle and maintain its water supply in accordance with recommendations of the Centers for Disease Control (CDC), the Healthcare Infection Control Practices Advisory Committee, and the Federal Drug Administration (FDA) guidelines approaches to controlling waterborne microorganisms (tiny living things). The policy documented the facility would conduct Legionella testing, complete the review of the water system annually, and document the infection control committee minutes and the findings. Cultures may be recommended based upon potential outbreaks. The policy documented that hot water distribution systems serving resident care areas would be continuously recirculated.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on record review, interview, and observation, the facility failed to provide care for Resident (R) 4 and R1 in a manner that protected and promoted their dignity. Findings included:- On 08/04/2026 at 07:32 AM, observation in the commons area revealed Licensed Nurse (LN) G pulled R4's shirt up on his left arm and cleansed the area with an alcohol wipe and administered an insulin injection subcutaneous (applied under the skin), in his right upper arm, with two surveyors, multiple facility employees and numerous other residents in full view of the procedure from the four halls and dining room area. On 08/04/2026 at 07:40 AM, observation in the commons area revealed LN G pulled R1's shirt up on his left arm and cleansed with an alcohol wipe, and administered an insulin injection subcutaneous, in his right upper arm in full view of two Surveyors, multiple facility employees, and numerous other residents. On 08/05/2026 at 08:10 AM, Administrative Nurse D verified LN G should not administer insulin injections in the public area; they should take the residents to their rooms or a private area. The facility's Respect and Dignity; Right to Personal Property, policy, dated August 2026, documented resident have the right to be treated with respect and dignity, including the right to retain and use personal possessions, including furnishings, and clothing, as space permits unless to do so would infringe upon the rights and safety of other residents.		

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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 observation, interview, and record review, the facility failed to ensure a 14-day stop date or a specified duration with rationale for Resident (R)47's ongoing as needed (PRN) antianxiety (class of medications that calm and relax people) medications. Findings include:- R47's Electronic Health Record (EHR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, irrational fear), restlessness, and agitation. R47's Quarterly Minimum Data Set (MDS) dated [DATE], recorded R47 had moderately impaired cognition. The MDS recorded that she required staff assistance with all activities of daily living (ADLs). The MDS documentation R47 received an antianxiety medication during the observation period. R47's Psychotropic Medication Care Plan dated 06/19/2026, documented the resident received psychotropic medication. The care plan documented staff would administer medications as ordered and staff would monitor and document side effects and effectiveness. The staff would consult with the pharmacist and physician to consider dose reduction when clinically appropriate. The care plan lacked directions related to R47's lorazepam (antianxiety medication) as needed for anxiety. R47's Physician's Order, dated 06/01/2026, directed staff to administer lorazepam 0.5 milligrams (mg) every six hours as needed for anxiety PRN. The order lacked a stop date. R47's EHR lacked documentation of specified duration with a physician documented rationale for extended use. On 08/04/2026 at 11:50 AM, R47 was at the dining room table in her Broda chair (specialized wheelchair with the ability to tilt and recline) and staff assisted her to eat lunch. On 8/05/2026 at 08:30 AM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 06/01/2026. Administrative Nurse D verified the facility had not obtained the 14-day stop date or a reason for the continued use with the appropriate rationale and failed to document a stop date to review the medication for indicated need and use. The facilities Use of Psychotropic Drugs, policy dated July 2026, documented residents would receive psychotropic or other approved medications that have an effect on the brain activity when necessary to treat specific conditions for which they are indicated and effective and will not be used for discipline or convenience of staff. The policy documented PRN orders for all classes of psychotropics; antipsychotics the facility would enter a 14 day stop date and to renew the PRN order, the attending physician or prescribing practitioner must evaluate the resident for the appropriateness to write an additional 14 days for that medication. The policy documented on all other psychotropics the facility staff would enter a 14 day stop date, there is documented rationale in the resident's medical record and indication the duration of the PRN order.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to promote an environment free of hazards for Resident (R) 6, who smoked cigarettes. R6 was assessed for smoking practices by the facility, and the facility documented she required staff assistance, the facility failed to provide her with the necessary safety equipment. Findings included:- R6's diagnoses included nicotine dependence (a chronic brain disorder where the body and mind rely on nicotine,) schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought,) diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin and unsteadiness on feet R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating intact moderately impaired cognition. The MDS documented R6 was independent with activities of daily living (ADL), used a walker to assist with mobility. The MDS documented R6 did use tobacco. R6's Cognitive Loss (CAA) dated 12/16/2025, documented the resident had disorganized thinking, wandering, inattention, and refusal of cares. R6's Smoking Care Plan dated 04/28/2026 directed staff to encourage R6 to wear a smoking apron and ensure the resident was aware of the facility's smoking policy. The care plan directed staff to show R6 where smoking was allowed and how to access the area. The care plan documented the facility would provide residents with requisitions to sign for facility to purchase cigarettes out of their resident account. R6's Smoking Evaluation assessment dated [DATE] documented R6 smoked a flame lit tobacco, could not light her own cigarettes, and required a smoking apron when smoking. The assessment lacked documentation R6 had been given and acknowledged the facility's Community Smoking Rules. On 08/03/2026 at 03:35 PM, observation revealed R6 walked out the patio door and sat on a bench. Continued observation revealed a nurse aide provided R6 with a cigarette and lit it for her. Observation revealed the resident did not have a smoking apron on while smoking her cigarette. On 08/04/26 at 03:40 PM, observation revealed R6 walked out the patio door and sat on a bench. Continued observation revealed a nurse aide provided R6 with a cigarette and lit it for her. Observation revealed the resident did not have a smoking apron on while smoking her cigarette. On 08/05/26 at 04:05 PM, Administrative Nurse D verified R6 was admitted to the facility, and staff evaluated R6 for a Smoking Evaluation assessment and assessed she required a smoking apron when she smoked. Administrative Nurse D verified on the Smoking Evaluation Assessment staff failed to document if R6 had been provided the facility Community Smoking Rules. The Smoking policy, dated September 2024, documented that the facility would establish and maintain safe resident smoking practices. Prior to, or upon admission, residents would be informed about limitations on smoking, including designated smoking areas. Smoking areas would be designated by the community and identified by signage. Smoking restrictions would be strictly enforced in all non-smoking areas, to protect the safety of residents who do not smoke. Residents who wished to smoke would be evaluated for safe smoking per facility protocol, any smoking related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to those issues, per community protocol.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to identify trauma-based triggers related to Resident (R) 21's post-traumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) when staff failed to implement individualized interventions to prevent re-traumatization to R21. Findings included:- R21's Electronic Medical Record (EMR) documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), PTSD, and insomnia (inability to sleep).R21's admission Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of three, which indicated severely impaired cognition. R21 had delusions (untrue persistent belief or perception held by a person although evidence shows it was untrue). The MDS documented a diagnosis of PTSD.R21's Cognitive Care Area Assessment (CAA) dated 06/01/2026 documented he had disorganized thinking with rejection of cares. R21 was able to communicate his wants and needs. The resident refused to participate in the assessment, so the BIMS was not fully accurate.R21's Care Plan revised on 07/31/2026 directed staff he had behavior problems related to his current diagnoses. The plan directed staff to administer medications as ordered; monitor/document for side effects and effectiveness; anticipate and meet my needs; assist the resident to develop more appropriate methods of coping and interacting. Encourage the resident to express feelings appropriately; caregivers to provide opportunity for positive interaction, attention; educate R21 and his guardian on successful coping and interaction strategies; explain all procedures to the resident before starting and allow the resident to adjust to changes; if reasonable, discuss his behavior; as necessary to protect the rights and safety of others; approach/speak to him in a calm manner; minimize potential for my disruptive behaviors by offering tasks which divert attention; monitor behavior episodes and attempt to determine underlying cause; praise any indication of his progress/improvement in behavior; provide a program of activities that is of interest and accommodates the resident's status. R21's plan lacked a care area to address and identify any triggers of his PTSD. The plan lacked intervention to prevent further re-traumatization.R21's EMR documented a Trauma Informed Care Assessment dated 06/05/2026, which documented he had the diagnosis of PTSD. No further information was provided.On 08/04/2026 at 10:15 AM, R21 was in his room and did not want to be disturbed.On 08/05/2026 at 01:05 PM, Social Services X stated the Trauma Informed Care Assessment was attempted on R21, but he refused to divulge any information about any previous trauma he had experienced. Social Services X stated that his care plan should reflect that he had the PTSD diagnosis and direction for staff on things that could cause re-traumatization.The facility's Clinical Protocol: Trauma-Informed Care policy dated August 2026 documented residents, whom are known trauma survivors, will receive culturally competent, trauma informed care in accordance with professional standard of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization; assess residents upon admission and update quarterly and with change of condition. Once established that the resident may have PTSD, assess and/or review the following: triggers that may be stressors or may prompt recall of a previous traumatic event, and the history and physical from referring agency, hospital or setting; to develop the individualized care plan interventions, collaborate with the resident; their family or friends or representatives as appropriate; and any additional health care professionals, e.g. psychologist or mental health professional the (continued on next page)		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident has seen; as appropriate and available, refer the resident to local support groups, or as able allow the group to meet in the community; attempt to identify the triggers which may re-traumatize the resident and note in the care plan to minimize or eliminate the effect of the trigger on the resident; create trigger specific interventions, examples in chart below; address potential symptoms of trauma.		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 1's blood glucose (the main sugar in your blood and your body's primary energy source) level was below the physician's ordered parameter and the physician ordered insulin (a hormone that lowers the level of glucose in the blood) was not held. The facility failed to ensure the CP identified and reported when R27's physician ordered parameters for blood pressure and/or pulse were not obtained and recorded prior to the administration of his ordered antihypertensive (a class of medication used to treat high blood pressure) medications. Findings included:- 1. R1's Electronic Medical Record (EMR) recorded diagnoses of type 2 diabetes mellitus (DM -a chronic condition where the body cannot use insulin properly and sugar builds up in the blood), hypertension (HTN- elevated blood pressure), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought).R1's Annual Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 was independent with his cares. R1 received insulin injections on seven days during the lookback period. R1's Cognition Care Area Assessment (CAA) dated 02/16/2026 documented the resident had periods of disorganized thinking and inattention. R1 had a diagnosis of schizophrenia and experienced auditory hallucinations (sensing things while awake that appear to be real, but the mind created). R1 was able to make his needs known.R1's Care Plan last revised on 04/13/2026 directed staff to administer diabetes medications as ordered by the doctor. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of hypoglycemia (less than normal amount of sugar in the blood). R1's Orders tab of the EMR documented a physician's order dated 03/25/2026 for Novolog aspart (rapid-acting insulin) solution to inject 10 units subcutaneously before meals for DM. Hold when blood sugar (BS) was less than 120 milliliters (ml) per deciliter (dL). Call provider when BS less than 60 ml/dL or over 400 ml/dL.Review of the CP's Monthly Regimen Review (MRR) from January 2026 to July 2026 revealed the CP reported on 04/26/2026 that R1's Novolog was not held when his BS was below 120 ml/dL. The CP reports lacked identifying and reporting when R1's BS was below 120 ml/dL and Novolog should have been held during the months of May and June 2026.Review of R1's April 2026 Medication Administration Record (MAR) revealed his Novolog insulin was not held when his BS was below 120 ml/dL on three of 90 opportunities.Review of R1's May 2026 MAR revealed his Novolog insulin was not held when his BS was below 120 ml/dL on three of 93 opportunities.Review of R1's June 2026 MAR revealed that his Novolog was not held when his BS was below 120 ml/dL on three of 90 opportunities.On 08/05/2026 at 08:45 AM, R1 sat in his room watching tv.On 08/04/2026 at 07:58 AM, Licensed Nurse (LN) G stated the parameters for insulin should be followed and the insulin held when the BS was below the physician's parameters.On 08/05/2026 at 11:55 AM, Administrative Nurse D stated that he would expect the nurse to follow the physician's order on the insulin and when it should be held if below the parameter. 2. R27's EMR documented diagnoses of HTN, major depressive disorder (major mood disorder that causes persistent feelings of sadness) and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought).R27's Annual MDS dated 04/16/2026 documented he had a BIMS score of 11, which indicated a moderately impaired cognition. R27 required moderate assistance from staff for cares. R27 (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed inattention and disorganized thinking. R27 received hospice services.R27's Cognition CAA dated 04/29/2026 documented he had noted disorganized thinking and inattention to some conversations. R27 was at increased risk for dementia (a progressive mental disorder characterized by failing memory and confusion).R27's Care Plan last revised on 10/01/2025 directed staff to give antihypertensive medications as ordered. Staff was directed to take blood pressure as ordered.R27's Orders tab of the EMR documented a physician's order dated 06/04/2025 for the beta blocker antihypertensive (medication that lowers the blood pressure and heart rate) propranolol hydrochloride (HCl) 120 milligrams (mg) by mouth in the morning for HTN hold if blood pressure was below 110/60 millimeters of mercury (mm/Hg).R27's Orders tab of the EMR documented a physician's order dated 06/04/2025 for the antihypertensive amlodipine 10 mg daily for HTN hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 100 mm/Hg or the pulse was less than 60 mm/Hg. This order was discontinued on 06/15/2026.R27's Orders tab of the EMR documented a physician's order dated 06/15/2025 for the antihypertensive amlodipine 10 mg daily for HTN hold if systolic blood pressure was less than 100 mm/Hg or the pulse was less than 60 mm/Hg.Review of the CP MRR's from January 2026 to July 2026 revealed that the CP failed to identify and report that R27's blood pressure was not being recorded prior to the administration of propranolol. Review of the MMR's also revealed that the CP failed to report and identify when R27's pulse and blood pressure was not recorded/obtained prior to the administration of Amlodipine.Review of R27's MAR from January 2026 to July 2026 revealed no documented blood pressure or pulse reading with the administration of his amlodipine. R27's documented administration of propranolol from January 2026 to July 2026 on the MAR revealed the blood pressure was not obtained and documented when administered.On 08/04/2026 at 12:50 PM, R27 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room getting ready to receive his noon medications.On 08/04/2026 at 12:50 PM, Certified Medication Aide (CMA) S stated that the physician' parameters should be followed for blood pressure medications. CMA S could not state why R27's blood pressure and pulse was not documented for his amlodipine or propranolol, but she would ask the nurse.On 08/05/2025 at 10:15 AM, Licensed Nurse (LN) I stated that medications parameters should be followed, and she would expect the nurses and CMA's to follow them. On 08/05/2026 at 11:55 AM, Administrative Nurse D stated blood pressure medication orders should be followed as ordered by the physician. Administrative Nurse D stated he would expect the CP to identify when a blood pressure or pulse was not being documented when they should. Administrative Nurse D stated that R27's blood pressure and pulse should be documented on the MAR if there were physician's parameters and he would have to look and see why they had not been.The facility's Pharmacy Services Overview policy dated October 2025 documented the licensed Pharmacist shall collaborate with facility leadership and staff to coordinate pharmacy services within the facility, and to guide the development and implementation of pharmacy services procedures. The facility shall use only individuals authorized under state requirements to provide pharmacy services or administer medications. The facility shall contract with a licensed Pharmacist to help it obtain and maintain timely and appropriate pharmacy services that support residents' needs, are consistent with current standards of practice, and meet state and federal requirements. This includes, but is not limited to, collaborating with the facility, the Medical Director and the Attending Physician (if different) to: develop, implement, evaluate, and revise (as necessary) the procedures for the provision of all aspects of pharmacy services (including ordering, delivery and acceptance, storage, distribution, preparation, dispensing, administration, disposal, documentation, and reconciliation of all medications and biologicals in the facility; help the facility assure that medications are requested, received, and (continued on next page)		

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered in a timely manner as ordered by authorized prescribers; give the facility's Director of Nursing Services, Medical Director, and staff feedback about performance and practices related to medication administration and medication errors; collaborate with the staff and practitioners to address and resolve medication related needs or problems; help establish procedures for conducting the monthly medication regimen review (MRR) for each resident in the facility.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident (R) 1's physician ordered insulin (a hormone that lowers the level of glucose in the blood) was held when the blood glucose (the main sugar in your blood and your body's primary energy source) level was below the physician's ordered parameter. The facility failed to ensure R27's physician ordered parameters for blood pressure and/or pulse were obtained and recorded prior to the administration of his ordered antihypertensive (a class of medication used to treat high blood pressure) medications. The facility failed to ensure R86 had physician ordered parameters for his blood glucose prior to injection of insulin. Findings included: - 1. R1's Electronic Medical Record (EMR) recorded diagnoses of type 2 diabetes mellitus (DM -a chronic condition where the body cannot use insulin properly and sugar builds up in the blood), hypertension (HTN- elevated blood pressure), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R1's Annual Minimum Data Set (MDS) dated [DATE] documented he had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 was independent with his cares. R1 received insulin injections on seven days during the lookback period. R1's Cognition Care Area Assessment (CAA) dated 02/16/2026 documented the resident had periods of disorganized thinking and inattention. R1 had a diagnosis of schizophrenia and experienced auditory hallucinations (sensing things while awake that appear to be real, but the mind created). R1 was able to make his needs known. R1's Care Plan last revised on 04/13/2026 directed staff to administer diabetes medications as ordered by the doctor. Staff were directed to monitor, document, and report to the physician as needed for signs and symptoms of hypoglycemia (less than normal amount of sugar in the blood). R1's Orders tab of the EMR documented a physician's order dated 03/25/2026 for Novolog aspart (rapid-acting insulin) solution to inject 10 units subcutaneously before meals for DM. Hold when blood sugar (BS) was less than 120 milliliters (ml) per deciliter (dL). Call provider when BS less than 60 ml/dL or over 400 ml/dL. Review of R1's April 2026 Medication Administration Record (MAR) revealed his Novolog insulin was not held when his BS was below 120 ml/dL on three of 90 opportunities. Review of R1's May 2026 MAR revealed his Novolog insulin was not held when his BS was below 120 ml/dL on three of 93 opportunities. Review of R1's June 2026 MAR revealed that his Novolog was not held when his BS was below 120 ml/dL on three of 90 opportunities. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/05/2026 at 08:45 AM, R1 sat in his room watching tv. On 08/04/2026 at 07:58 AM, Licensed Nurse (LN) G stated the parameters for insulin should be followed and the insulin held when the BS was below the physician's parameters. On 08/05/2026 at 11:55 AM, Administrative Nurse D stated that he would expect the nurse to follow the physician's order on the insulin and when it should be held if below the parameter. 2. R27's EMR documented diagnoses of HTN, major depressive disorder (major mood disorder that causes persistent feelings of sadness), and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R27's Annual MDS dated 04/16/2026 documented he had a BIMS score of 11, which indicated moderately impaired cognition. R27 required moderate assistance from staff for cares. R27 showed inattention and disorganized thinking. R27 received hospice services. R27's Cognition CAA dated 04/29/2026 documented he had noted disorganized thinking and inattention to some conversations. R27 was at increased risk for dementia (a progressive mental disorder characterized by failing memory and confusion). R27's Care Plan last revised on 10/01/2025 directed staff to give antihypertensive medications as ordered. Staff were directed to take blood pressure as ordered. R27's Orders tab of the EMR documented a physician's order dated 06/04/2025 for the beta blocker antihypertensive (medication that lowers the blood pressure and heart rate) propranolol hydrochloride (HCl) 120 milligrams (mg) by mouth in the morning for HTN hold if blood pressure was below 110/60 millimeters of mercury (mm/Hg). R27's Orders tab of the EMR documented a physician's order dated 06/04/2025 for the antihypertensive amlodipine 10 mg daily for HTN hold if systolic blood pressure (SBP- top number, the force your heart exerts on the walls of your arteries each time it beats) was less than 100 mm/Hg or the pulse was less than 60 mm/Hg. This order was discontinued on 06/15/2026. R27's Orders tab of the EMR documented a physician's order dated 06/15/2025 for the antihypertensive amlodipine 10 mg daily for HTN hold if systolic blood pressure was less than 100 mm/Hg or the pulse was less than 60 mm/Hg. Review of R27's MAR from January 2026 to July 2026 revealed no documented blood pressure or pulse reading with the administration of his amlodipine. R27's documented administration of propranolol from January 2026 to July 2026 on the MAR revealed the blood pressure was not obtained and documented when administered. On 08/04/2026 at 12:50 PM, R27 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room getting ready to receive his noon medications. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/04/2026 at 12:50 PM, Certified Medication Aide (CMA) S stated that the physician' parameters should be followed for blood pressure medications. CMA S could not state why R27's blood pressure and pulse was not documented for his amlodipine or propranolol, but she would ask the nurse. On 08/05/2025 at 10:15 AM, Licensed Nurse (LN) I stated that medications parameters should be followed, and she would expect the nurses and CMA's to follow them. On 08/05/2026 at 11:55 AM, Administrative Nurse D stated blood pressure medication orders should be followed as ordered by the physician. Administrative Nurse D stated that R27's blood pressure and pulse should be documented on the MAR if there were physician's parameters and he would have to look and see why they had not been. The facility's Unnecessary Medications policy dated May 2026 documented residents drug regimen will be free from unnecessary drugs- if any drug is used in excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued or any combination of the reasons above. The facility's QAPI Plan: Failure to Follow Blood Sugar Parameters dated April 2026 documented: assess the affected resident immediately for symptoms of hypo (low) or hyperglycemia (elevated blood glucose) and document; treat as parameters indicate by order; notify physician and family as indicated; complete an audit on all residents with orders for blood sugar parameters. Document correction of any identified issues; establish a schedule for ongoing audits of adhering to blood sugar parameters; re-education to all licensed nurses or CMA's for adhering to blood sugar parameters and the documentation associated with the process. - The Electronic Medical Record (EMR) for R86 documented the following diagnoses of atrial fibrillation (rapid heart rate), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R86's Quarterly Minimum Data Set (MDS), dated [DATE], documented R86 had intact cognition. R86 was independent with all activities of daily living (ADL) and received seven days of insulin medication. R86's 06/04/2026 Care Plan documented the following interventions for R86: 4/06/2026-Blood glucose (measures the concentration of glucose in the liquid portion of the blood) levels as ordered, diabetes medication as ordered by doctor, and monitor for side effects and effectiveness. Obtain a dietary consult for nutritional regimen and ongoing monitoring and educate R86 regarding medications and the importance of compliance. The care plan directed staff to obtain fasting serum blood sugars as ordered by the physician. The Physician's Order, dated 01/30/2026, directed staff to administer insulin glargine (a long-acting insulin), 30 units, subcutaneously (beneath the skin), at bedtime for diabetes mellitus. (continued on next page)		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician's Order, dated 11/17/2025, directed staff to obtain blood sugars daily. The order lacked blood sugar parameters. On 08/04/2026 at 09:00 AM, R86 was in the hospital. On 08/05/2026 at 09:15 AM, Licensed Nurse (LN) I stated, per her nursing judgment, the insulin would be held if his blood sugars were under 60 milligrams per deciliter (mg/dL). At 09:15 AM, LN I stated she updated the EMR with blood sugar parameters. On 08/05/2026 at 09:30 AM, Administrative Nurse D stated there should be parameters for all residents who received insulin. Upon Request, a policy for obtaining blood sugar levels was not provided by the facility.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure biologicals were properly monitored for safe storage temperatures, dated upon opening, maintained within safe expiration dates, and secured to prevent unauthorized access. This deficient practice affected 1 of 1 medication room refrigerators and 4 resident-specific insulin (a hormone that lowers the level of glucose in the blood) pens, Resident (R) 13, R75, and R72. Findings included:- On [DATE] at 07:35 AM, observation of the medication cart for Hall A&B located adjacent to the nurses station revealed Resident (R) 13's Lantus (long-acting insulin) flex pen was not labeled with an opened date or an expired date, and R13's Novolog (fast -acting insulin) insulin flex pen that had a date written on the pen -but it had smeared and was not legible. On [DATE] at 07:50 AM, observation of the medication cart for Hall C located next to the nurses' station revealed R86's Lantus vial was labeled with the date opened [DATE] (44 days), and R75's Basaglar (long acting) insulin flex pen was labeled with a date opened of [DATE] (44 days). On [DATE] at 07:20 AM, Licensed Nurse G verified the nurses should label and date the insulin flex pens and insulin vials with the date opened. On [DATE] at 8:20 AM, Administrative Nurse D verified the nurse should label and date the insulin flex pens with the date opened and discard the outdated insulin. Medlineplus.gov directs open, unrefrigerated Basaglar, Lantus, and Novolog can be used within 28 days; after that time, they must be discarded. The facility's Storage of Medications policy, dated [DATE], documented the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed per state regulations. The facility's Insulin Administration policy, dated [DATE] documented when the nurse administered insulin to resident's she would check expiration date, if drawn from an open multi-dose vial, when opening a new vial, record expiration date and time on the vial, (follow manufacturer recommendations for expiration after opening). - On [DATE] at 08:39 AM, observation in the medication room revealed the temperature log for the medication refrigerator lacked daily temperatures for 12 days in July and four days in August. Administrative Nurse E stated the night shift nurse was responsible for the temperature log in the medication room and verified there were missing signatures for the days in July and [DATE]. On [DATE] at 09:30 AM, Administrative Nurse D stated that the night nurse who was responsible for (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	making sure the temperatures were taken for the medication room refrigerator had been on vacation during the days that lacked documentation, and he usually checked the temperatures also, but he had been gone during that time also. The facility's Medication Distribution policy, dated 01/204, documented that insulin and other medications requiring refrigeration should be stored separately in the medication room. Each medication should be placed in the refrigerator and stored in a zip-lock bag or plastic basket labeled with the resident's name and unit number. The refrigerator should not be used for any non-medical items. If medications stored in the refrigerator must be temporarily removed, ensure that they are maintained at the appropriate temperature. The refrigerator should have a hanging thermometer in it, and the temperature must be maintained to an appropriate level for storage of meds: 37-42 degrees F. Employees are to monitor this daily and log the temperature on the medication refrigeration temperature log form.		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R)47 and R27. Findings included:- 1. R47's Electronic Health Record (EHR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), arteriosclerotic heart disease (a condition where fatty plaque builds up inside the arteries that supply blood to the heart), and peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). R47's Quarterly Minimum Data Set (MDS) dated [DATE], recorded R47 had moderately impaired cognition. The MDS recorded that R47 required staff assistance with all activities of daily living (ADLs). The MDS lacked documentation R47 received hospice services. R47's Activities of Daily Living Care Plan dated 06/19/2026 documented R47 required extensive assistance with most ADL. R47's End of Life Care Plan dated 06/20/2026, documented R47 had chosen end of life care with another hospice. The care plan directed staff to administer medications for comfort prior to activity/care. Assist with supporting ADL function of bathing, eating, grooming and hygiene, toileting-continence- related tasks including control and hygiene, and assistance for fatigue, loss of strength, and sleep. The care plan lacked the current hospice provider, instruction on the services provided by hospice including hospice staff visits, supplies and medical equipment provided by the current hospice, and medications covered by hospice. Review of R47's medical record revealed R47 was admitted to hospice care on 08 /20/2024. On 02/18/2026, the resident chose the current hospice provider. The medical records lacked evidence of the current hospice provider and the coordination of care between hospice and the facility. On 08/04/2026 at 11:50 AM, R47 was at the dining room table in her Broda chair (specialized wheelchair with the ability to tilt and recline), and staff assisted her to eat lunch. On 08/05/2026 at 08:30 AM, Administrative Nurse D stated he expected the facility to have a hospice care plan for R47 to be able to coordinate care with hospice services. Administrative Nurse D verified the facility lacked a hospice care plan that coordinated with the facility care plan and verified the facility care plan documented the previous hospice the resident was on but acknowledged she had recently been admitted to a new hospice and that information was not in the care plan including what services the present hospice would provide for the resident. - 2. R27's EMR documented diagnoses of HTN, major depressive disorder (major mood disorder that causes persistent feelings of sadness), and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	thought). R27's Annual Minimum Data Set (MDS) dated 04/16/2026 documented he had a BIMS score of 11, which indicated moderately impaired cognition. R27 required moderate assistance from staff for cares. R27 showed inattention and disorganized thinking. R27 received hospice services. R27's Cognition Care Area Assessment (CAA) dated 04/29/2026 documented he had noted disorganized thinking and inattention to some conversations. R27 was at increased risk for dementia (a progressive mental disorder characterized by failing memory and confusion). R27's Care Plan revised on 08/20/2024 directed staff that he was on hospice services. The plan directed staff to: provide activity as tolerated; administer medications for comfort prior to activity/care (Pain medications/respiratory treatments) as ordered; Assist with supporting ADL function of bathing to the extent needed. Assist with supporting ADL function of eating to the extent needed. Assist with supporting ADL function of grooming and hygiene to the extent needed. Assist with supporting ADL function of toileting- continence-related tasks including control and hygiene to the extent needed. Assistance for Fatigue, Loss of Strength, Sleep; Keep resident comfortable to the extent possible. The plan lacked information about how often hospice staff would make visits, what supplies and medications hospice would provide, and lacked information on what durable medical equipment (DME) hospice would provide. R27's hospice provider binder lacked a plan of care (POC) with all the required information. The binder lacked the most recent recertification order and information. On 08/04/2026 at 12:50 PM, R27 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room getting ready to receive his noon medications. On 08/05/2026 at 10:02 AM, Certified Nurse Aide (CNA) M stated that usually the nurse would let staff know when a resident was on hospice and would let them know what hospice provided the resident. CNA M stated each resident had a hospice book at the nurses station. On 08/05/2026, Licensed Nurse (LN) I stated that the hospice book should have all the information on what hospice provided in the POC. The residents care plan should reflect the same information as what the POC has in it. The facility's Hospice Program policy dated December 2025 documented to obtain a physician's order for Hospice services to include diagnosis. Including physician's orders the for prognosis and the basis for prognosis that match the hospice information on the certification of terminal illness; clarify the residents advanced directives and preferences for end-of-life planning; along with the hospice provider, discuss, plan and obtain orders for preferences in pain management, symptom control, treatment of acute illness, and choices regarding hospitalization; obtain the physician certification or re-certification for hospice services; post the 24-hour access number for the resident's hospice provider; the hospice provider(s) should be set up in Point Click Care (PCC) and attached to the resident's profile within the chart; identify a member of the IDT who is responsible for working with the hospice representative. This person must have a clinical background and has the ability to assess (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident within state scope of practice or have access to someone who can complete that function. These responsibilities include collaboration and coordination of hospice care; communication with hospice representatives and other health care providers participating in the hospice care; ensuring the hospice medical director and the attending physician or other practitioners collaborate and communicate to coordinate the hospice care; ensuring the appropriate documents are readily available. The hospice provider may have access and can document in PCC the care provided. A nursing progress note stating hospice saw the resident and notes to follow etc. should be documented in the progress notes. If the hospice does not document in PCC the community may include selecting one personal to scan and upload hospice documents to the resident's electronic medical record no more than five days after documents are received as outlined below), to include; the most recent hospice plan of care; hospice election form; physician certification for terminal illness; names and contact information of hospice personnel involved for each resident; instructions for the 24 hour on call system; hospice medication and supplies specific to each resident; hospice physician and attending physician orders specific to each resident; visit notes from all hospice disciplines, nurse, chaplain, social services, and volunteer; ensuring that the community staff provides an orientation to the policies and procedures of the community, including resident rights, appropriate forms, and record keeping requirements.		

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

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many Note: The nursing home is disputing this citation.	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on interview and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ) as required. Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) Quarter1 (October 1-December 31/2025), Quarter 2 (January 1-March 31), Quarter 3 (April 1-June 30, 2025), and Quarter 4 (July 1-September 30, 2025) indicated the facility had excessively low weekend nurse staffing. Review of the facility's weekend nursing schedules and working hours for the above Quarters revealed the facility had adequate staffing. On 08/18/25 at 08:26 AM, Administrative Staff A stated the administrator and corporate staff were responsible for submitting the PBJ. The facility's PBJ Policy, revised 10/2025, documented the facility would submit PBJ data in a uniform format to CMS, including staffing community, agency, and contact staff.		