STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175298	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interviews, record review, and observation, the facility failed to ensure a safe, clean home-like environment for the residents. Findings Included:- During an observation on 05/05/26 at 08:10 AM on the second floor of the facility, the ice room revealed a dirty towel underneath the door into the room. A tray of clean cups was next to a tray on the counter with multiple cups, plates, and food from a previous meal, and dirty towels were on the sink next to the tray of clean cups. The bottom of the cabinet underneath the handwashing sink was sunken and had multiple wet & soiled towels and a black substance on the floor of this cabinet. The cabinet doors had water damage at the top of the door. The sink was soiled with food debris. A fan full of dust on the screen and blades was blowing and oscillating and blew directly onto the tray of clean cups on the counter. An ice scoop was lying on a stained & dirty lid of an ice chest. Ice water inside the ice chest had debris floating in the water.An observation on 05/05/26 at 08:30 AM on the second floor of the facility in the soiled utility room revealed nine sharps containers overfilled with syringes, needles, and other used sharps, with one container missing a lid and another container with the lid in the open position. A dirty and rusty file cabinet with a mop in a bucket leaned against in front of the sink. The interior bowl of the hopper was dirty with debris and had a brown & black substance on it. The corner of the floor next to the hopper had a brown substance on it.An observation on 05/05/26 at 0842 AM in the activity room on the second floor of the facility in front of the piano the floor revealed numerous small pieces of small glass pebbles. The window to the left of the piano had a torn screen with sharp metal pieces exposed in two places on the screen. One tear to the middle of the screen was approximately eight inches in length by two inches wide. The other tear to the bottom right corner of the screen in a circular pattern was approximately two inches in circumference. The thermostat in the room had no cover, the inside of the thermostat was exposed. In the dining area of the activity room, there was food debris on the bottom of a cabinet. The floor had a white liquid and food debris on it. A shelf in a cabinet underneath the television in the dining room had a mound of a sawdust substance in the center of the cabinet's bottom shelf.Observation on 05/05/26 at 08:30 AM, next to the vestibule area on the second floor, there was a drinking fountain with a bandage tape lying in it, a glass partially filled with water sat on the drain, and the fountain had black substance in the well. The area was soiled all around and near the drain. In the vestibule, there were three wheelchairs that were visibly soiled with dirt and food. There were three lifts that the base was soiled with debris, food, and dirt. The surface of a red and black crash cart in the cart egress area was visibly soiled; the suction machine was not covered. There were staff personal items located next to the uncovered suction machine.Observation on 05/05/26 at 08:37 AM, in a hallway next to a resident dining/activity/gathering room was a light green cart with the top edge cracked open, exposing sharp edges, the edges pulled away from the tray at the corner. The sink for handwashing in the gathering room had no hot water, the sink was visibly soiled and stained. A shelf on the wall next to the sink had three bowls and a plate sitting on it.Interview on 05/07/26 at 10:50 AM, Administrative Nurse D reported the sharps containers should be filled to the marked fill line in the container, and the lid should be secured to the base. Sharps containers should be stored in the biohazard room in the basement. Interview on 05/07/26 at 11:07 (continued on next page)

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 - Some	Provide and implement an infection prevention and control program. Based on interviews, record reviews, and observation, the facility staff failed to implement adequate infection control practices related to lack of hand hygiene, cleaning of shared equipment, and sanitary storage of respiratory equipment. Findings included:- Observed on 05/06/26 at 07:40 AM, Certified Medication Aide (CMA) R obtained Resident (R) 6's blood pressure and pulse with the vital machine; CMA R took the vitals machine from the neighboring room. CMA R did not sanitize the vitals machine before taking it into R6's room. Licensed Nurse (LN) G asked for the vitals machine, stated she would bring the vitals machine back. LN G did not sanitize the vitals machine before taking the machine from R6's room, who was on EHB. LN G took the vitals machine down the hall and obtained vitals from a resident sitting next to her medication cart. LN G did not sanitize the vitals machine after obtaining vitals. LN G returned the vitals machine to CMA R. CMA R did not sanitize the vitals machine before taking it to the next resident's room.Observed on 05/05/26 at 08:12 AM, R100's CPAP mask and nebulizer laid on her bedside table; R100's CPAP and nebulizer mask were not stored in a sanitary container. Observed on 05/06/26 at 09:11 AM R 100's CPAP mask and nebulizer mask laid on her bed side table, R100's CPAP mask and nebulizer mask. R100's CPAP mask and nebulizer mask were not in a sanitary container. R100 stated she did not have bags or containers for her CPAP mask and nebulizer mask.Observed on 05/06/2026 at 09:45 AM, Certified Nurse Aide (CNA) SS and CMA S donned gowns and gloves outside of R3's room without handwashing or sanitizer used prior to donning personal protective equipment (PPE). R3 was incontinent of bladder, and her brief was changed in bed. CNA SS removed her PPE to leave the room to obtain the Hoyer lift. No handwashing or hand sanitizer was used after removing her gown and gloves. CMA S removed her gloves and reapplied gloves after providing personal care to R3 but did not use sanitizer or wash her hands. CNA SS returned to the room with the lift and donned new gloves in the room but did not use sanitizer or wash hands.During an interview on 05/07/26 at 08:42 AM, CNA M stated respiratory equipment should be placed in bags when not in use. She stated that it was a nurse's duty.During an interview on 05/07/26 at 08:45 AM, CNA N stated she was unsure when the respiratory equipment should be placed in a bag that was in the rooms. She stated normally the nurse would place the equipment in the bags in the room.During an interview on 05/07/26 at 8:51, LN H stated respiratory equipment not in use should be stored in a clean bag with the date written on the bag. She stated the respiratory equipment could be placed in a drawer after the equipment was cleaned. She stated normally that would be the nurse's duty, but the CNAs or CMAs could also place the respiratory equipment that was not in use. LN H stated the vitals machine was cleaned before each shift. She stated staff should not take the vitals machine into rooms with EHB precautions. She stated she would take a handheld blood pressure cuff into rooms that were EHB precautions. LN H stated she did not think the equipment needed to be cleaned between each resident. During an interview on 05/07/26 at 10:13 AM, Administrative Nurse D stated the nurses were responsible for placing the respiratory equipment in bags after the equipment was cleaned. She stated placing the respiratory equipment in bags was placed on the nursing TAR. Administrative Nurse D stated all equipment should be sanitized between residents, and especially after the equipment was used in an EHB precautions room. She stated all staff have been educated on the sanitation of shared equipment.The facility's Infection Control Policy dated 05/2007 documented it was the policy of this facility to provide supplies and equipment that are adequately cleaned and disinfected.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R) 76 was assessed for the ability to safely self-administer oral medications before staff left medications in a medication cup in the resident's room. Findings included:- R76's Electronic Medical Record (EMR) documented diagnoses of gastro-esophageal reflux disease (GERD - backflow of stomach contents into the esophagus), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), chronic pain syndrome, seizures (violent involuntary series of contractions of a group of muscles), muscle weakness, dysphagia (swallowing difficulty), vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), chronic kidney disease (CKD), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and hypertension (HTN - elevated blood pressure). R76's Annual Minimum Data Set (MDS) dated [DATE] documented she had a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderately impaired cognition. She used a walker or a wheelchair for mobility. R76's Care Plan dated 03/23/25 documented R76 had an alteration in self-care related to bowel and bladder incontinence and was at risk for complications due to her decreased functional mobility, pain, seizures, weakness, and dementia. R76 required one staff member to assist her with activities of daily living (ADLs), including bed mobility, dressing, bathing, and personal hygiene. R76's Assessments tab of the EMR lacked evidence the facility assessed R76's ability to safely administer her medications. R76's clinical record lacked a physician's order to keep medications at bedside. On 05/05/26 at 10:12 AM, observation revealed a small plastic cup containing four different medications (two round and two oblong tablets) labeled with R76's first name and last initial sat on R76's breakfast tray. The tray also contained partially eaten breakfast and cups. R76 laid in bed with her eyes closed, facing away from the tray. On 05/07/26 at 09:45 AM, Licensed Nurse (LN) L stated no resident on the second floor of the facility was able to self-administer their medications. LN L said if a resident could self-administer the medications, it would be on the resident's Care Plan. On 05/07/26 at 09:46 AM, Certified Medication Aide (CMA) S stated medications should never be left unattended because it was unknown whether or not the resident would take them or throw them away. On 05/07/26 at 11:50 AM, Administrative Nurse D stated a resident must be assessed to determine whether or not they were permitted to self-administer medications, and that would be documented in their care plan. Administrative Nurse d stated she was not sure which residents were able to self-administer their medications. A policy on Self-Administration of Medications dated 01/2026 documents resident will be assessed to determine if they can safely administer their prescribed medications and will then be documented in the resident's EMR.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to verify the advanced directive (legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves) displayed in Resident (R) 16's clinical record accurately reflected her advanced directives for Do Not Resuscitate Directive (DNR- a legal document or order that means the person does not desire resuscitative measures in the event of cardiac arrest). Findings included: - R16's Electronic Health Record (EHR) included diagnoses of cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hemiplegia (paralysis of one side of the body), hypertension, anxiety disorder, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).R16's Quarterly Minimum Data Set (MDS), dated [DATE] documented a BIMS of 12, which indicated moderate cognitive impairment. The MDS documented that R16 utilized a wheelchair for mobility. R16 required set-up/clean/up assistance for eating and oral hygiene but was dependent on staff for all other activities of daily living (ADL).R16's Care Plan, dated 01/13/25, did not document R16's advanced directive wishes.R16's EHR, under the scanned documents section, revealed a Do-Not-Resuscitate Directive signed by the resident, with a date of 01/21/25.On 05/05/26 at 01:18 PM, R16's EHR Home tab documented R16's code status (full code or DNR) as full code (indicating full resuscitative measures).R16's EHR had a Physician's Order, dated 02/02/26, that R16 was a full code. This order was discontinued on 05/06/26.R16's EHR had a Physician's Order, with an active date of 05/06/26, that documented R16 was a DNR.On 05/05/26 at 01:18 PM, R16 stated that she was a DNR.On 05/06/26 at 08:28 AM, Certified Medication Aide (CMA) R said that if a resident was a DNR or full code, it showed on the EHR with capital letters. She verified that R16 showed full code. CMA R then verified that R16 had a signed DNR in her EHR.On 05/06/26 at 08:33 AM, Licensed Nurse (LN) G stated that R16's code status showed as full code. She then verified that R16 had a DNR in her EHR that was signed and dated for 01/21/25.On 05/06/26 at 08:41 AM, Administrative Nurse D said that chart audits were performed daily, and the record reviews were performed quarterly, annually and when a significant change occurred. She then verified that R16's chart showed her as full code and that she had an order for Full Code. She then verified that R16 had a signed DNR in the EHR dated 01/21/25.On 05/06/26 at 08:59 AM, Administrative Nurse E said that LN G had notified her earlier that the code status for R16 was wrong. Administrative Nurse E said she then verified that R16 had an order for full code, in conflict with her signed DNR that was in the EHR. She said she then reviewed the EHR and changed R16's code status to DNR to reflect the resident's wishes and DNR documentation. The facility policy Advance Directives, dated 11/2016, documented that a resident's choice about advance directives would be recognized and respected. The policy further documented that the facility recognized and respected the resident's right to choose his/her treatment and make decisions about care received at the end of his/her life.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, record review, and interview, the facility failed to ensure that residents were free from all forms of abuse when Resident (R) 132 grabbed R127 by the neck on 04/13/26. Findings included:- R132's Electronic Medical Record (EMR) documented diagnoses of bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), major depressive disorder (MDD - a major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).R132's Annual Minimum Data Set (MDS), dated 02/11/26, documented he had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS documented that R132 utilized a walker for mobility.R132's Functional Abilities Care Area Assessment (CAA), dated 02/26/26, documented he was at risk for alterations in self-care related to occasional bowel and bladder incontinence, and required assistance with activities of daily living (ADL) and was at risk for complications as evidenced by decreased functional mobility, MDD, dementia, and bipolar disorder.R132's Care Plan dated 03/04/26, documented that he had verbal behaviors toward staff. R132, when agitated, had verbal or physical altercations and attempted to assist other residents requiring redirection. R132 would insert himself into other resident situations and was easily excitable with loud noise or voices. Staff were directed to intervene when he became agitated before the agitation escalated; staff were to guide him away from the source of distress and engage him calmly in conversation. If R132's response was aggressive, staff were to walk calmly away and approach him later. Staff was directed to assess his understanding of the situation and allow him time to express himself and his feelings toward the situation. The plan further directed staff to document the observed behavior and attempted interventions.A facility report dated 04/13/26, from Administrative Staff A, documented on 04/13/26, at approximately 07:01 PM, R127 was standing at the nurse's station talking with Certified Nurse Aide (CNA) PP. R127 turned to go to her room. As she turned to walk away from the nurse's station, R127 was met by R132 as he walked with his walker out of the dining area toward the nurse's desk. He started to curse aloud stating, This is my walker, this is my walker. R132 then grabbed R127 by her neck and caused a small scratch near her left eye. The residents were immediately separated without incident. Licensed Nurse (LN) G immediately notified R127's representative. The facility provider was notified of the incident; orders were received, and R132 was immediately placed on one-on-one (1-on-1) supervision by facility staff. R132's guardian was notified of the incident. R132 remained on a 1-on-1 for 72 hours without further incident. Speech therapy completed a new BIMS, St. Louis University Mental Status (SLUMS - screening tool used by clinicians to detect mild cognitive impairment and dementia), and a Brief Cognitive Assessment Tool (BCAT - a multi-factorial test used by health professionals to measure cognitive functioning, specifically executive function and contextual memory in older adults) on R132. The results of these assessments indicated significant cognitive impairment and mild stage dementia. A psychiatric assessment was completed on R132, and he stated that he did not recall the event, expressed remorse, and said that if he did act in that manner, he was truly sorry and did not understand why he would have done so. Social services met with R127, who had no recollection of the event and said she was safe and doing well with her peers. Social services completed interviews with three alert residents on the same floor, each resident expressed no concerns, and each felt safe.A witness statement dated 04/13/26 from CNA PP documented that on 04/13/26, while sitting at the nurse's station talking with R127, R132 walked up behind R127 yelling this is my walker and he his hands on R127. CNA PP came from behind the nurse's station and separated the two.A witness statement from LN K, dated 04/13/26, documented she was doing the nighttime insulin (a hormone that lowers the level of glucose in the blood) when she heard staff telling residents to separate from each other. She documented that by the time she got to the incident, the residents were separated, and staff told her what had occurred.A witness (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	statement dated 04/14/26 from CNA QQ documented that on 04/13/26, she was sitting in the sensory room when she heard CNA PP yell hey stop and CNA PP ran around the nurse's desk, and CNA QQ got up and followed CAN PP, and she saw R132 and R127 standing face to face, and CNA QQ observed R132 hands on R127's neck. CNA PP and CNA QQ separated R132 and R127.A Nursing Progress Note dated 04/20/26 at 03:20 PM from Administrative Nurse KK, documented that approximately 01:30 PM, Administrative Nurse KK heard loud yelling in the hallway while standing in the medication room. Administrative Nurse KK then opened the door and ran out of the medication room and saw R132 pushing a female resident down. Administrative Nurse KK redirected R132 and noted that he was bleeding from a scratch to the left side of his face, on his nose. The nurse on duty assisted and then took over assessing the female resident that was on the floor. Administrative Nurse KK helped R132 back to his room, where vitals were taken, and first-aid was applied to the scratch on his face. A staff member was assigned to this resident for 1-on-1. The progress notes then documented the administrator, director of nursing (DON), provider, and resident representative were notified.A Social Services Progress Note in the EMR dated 04/21/26 at 09:15 PM documented R132 had been seen on 04/20/26 by psychiatry services due to his recent behaviors. The progress notes further documented that the assessment had been unable to be completed because the more questions asked, the more agitated the R132 became and he was unable to answer. It was documented that R132's impairment in judgement and decision making was severe and due to cognitive impairment, treatment was unable to be carried forward.A Social Services Progress Note in the EMR dated 04/21/26 at 11:33 AM, documented the psychiatric hospital intake called and advised they had accepted R132. The progress notes further documented that the R132's guardian had been notified that he had been accepted to the psychiatric hospital.On 05/07/26 at 10:52 AM, CNA N stated the facility provides abuse and dementia training often but could not recall when the most recent training had occurred. CNA N further stated that when there was an altercation with residents, they were immediately separated, and staff made sure everyone was safe. The nurse would be notified if they were not present and staff would keep the residents separated.On 05/07/26 at 10:57 AM, LN H stated the residents would immediately be separated, then assessed to check for any injuries if an altercation had occurred between them and taken to safety. The director of nursing, administrator, physician, and resident representatives would have then been notified. LN H said the initiator of the incident would have been placed on 1-on-1 with staff until all necessary assessments had been completed and doctor orders received.On 05/07/26 at 11:39 AM, Administrative Nurse D stated R132 had not had any previous incidents with any residents before the incident on 04/13/26. Administrative Nurse D said R132 was followed by psychiatry and had some adjustments made to his medications, and was not aware that another incident had occurred with him. Administrative Nurse D also said the provider was in the facility six out of seven days of the week. Administrative Nurse D further stated R132 was sent out of the facility on 04/21/26 due to increased behavior and agitation.The facility's Abuse: Prevention of and Prohibition Against policy, revised on 04/2025, documented it was the policy of the facility that each resident had the right to be free from abuse, neglect, misappropriation of resident property, exploitation, and mistreatment. It was also the policy of the facility to recognize the resident's right to personal privacy and confidentiality of their physical body, personal care, and personal space or accommodations. This included, but was not limited to, freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms. This also included taking, keeping, using, or distributing photographs or video recordings of residents in any manner that would demean or humiliate them, regardless of consent provided or the resident's cognitive status.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 122 received the assistance he needed with eating. Findings Included:- R122's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis (muscular weakness of one half of the body) with cerebrovascular accident (CVA-stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), hypertension (HTN-elevated blood pressure, and obesity, need for assistance with personal care, and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R122 had an impairment of the extremities on both sides of his body. The MDS documented R122 needed substantial/maximal assistance in eating.R122's Communication Care Area Assessment dated 03/25/26 documented R122 had alteration in communication and was at risk for complications following a CVA. R122 was unable to speak.R122's Care Plan documented:03/19/26-Staff to provide R122 with a regular diet with pureed texture.03/25/26-R122 was provided with a mechanically altered diet, on thickened liquids for weight loss.05/01/26-R122 needed substantial/maximal assistance of one person for oral hygiene.R122 needed substantial/maximal assistance of one person with assistance with eating.On 05/04/26 at 08:34 AM, R122 sat up in his bed. R122's breakfast tray sat on his bedside table. R122 scooped hot cereal from a white divided tray. R122 had white food dripping down his chin, the right side of his mouth, and his neck into his gown. R122 was in his room eating by himself; there were no staff in his room assisting. On 05/05/26 at 08:26 AM, R122 was in bed. R122's breakfast tray sat on his bedside table. R122 was attempting to eat hot cereal from a white, divided plate. R122 dripped the cereal down his chin onto his neck and over his gown. R122 was in his room eating by himself; there were no staff in his room to assist R122.On 05/07/26 at 08:05 AM, Certified Nurse's Aide (CNA) M stated R122 did need staff monitoring while he was eating, and said the staff just know him and know he had problems with swallowing. She stated she would know if a resident needed assistance by looking at the Kardex (nursing tool that gives a brief overview of the care needs of each resident).On 05/07/26 at 9:06 AM, Licensed Nurse (LN)H stated staff have access to the Kardex and the plan of care for each resident. LN H stated staff would look at Kardex and know if a resident needed assistance or monitoring when eating. LN H stated she normally did not work the hall R122 was on, but she would read the residents care plan and let CNAs know they should check him while he was eating.On 05/07/26 at 10:13 AM, Administrative Nurse D stated if a resident needed monitored or needed assistance that would be care planned. She stated all staff have access to the care plans and to Kardex. She stated staff would be able to look at the residents' charts to see how much assistance a resident needed. Administrative Nurse D stated if the residents care plan stated they should have one assistant while eating, the staff should assist that resident.The facility's Quality of Care dated 10/23 documented It was the policy of the facility that residents are given the appropriate treatment and services to maintain or improve his/her abilities.

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Riverbend Post Acute Rehabilitation	7850 Freeman Avenue Kansas City, KS 66112

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review the facility failed to provide Resident (R) 31 the necessary activities of daily living (ADL) cares including hygiene assistance with cleaning his fingernails. Findings:- Review of the Electronic Health Record (EHR) revealed that R31's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of the body), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, major depressive disorder (major mood disorder that causes persistent feelings of sadness), seizures (violent involuntary series of contractions of a group of muscles), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness).R31's admission Minimum Data Set (MDS), dated 07/17/25, documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognitive impairment. He required a wheelchair for mobility; he was dependent on staff for bathing and hygiene care, and all other ADL.The Functional Abilities Care Area Assessment (CAA), dated 07/17/25, documented R31 required assistance with ADLs and was at risk for complications.R31's Care Plan for ADLs, dated 07/11/225 with latest review date of 04/18/26, instructed staff he was dependent on staff assistance of one for bathing. The plan lacked instructions to staff regarding nail care.R31's EHR, under the Tasks for nails, lacked evidence R31 received nail care from 04/07/26 to 05/07/2026. There were no documented refusals from 04/07/26 to 05/07/26.R31's EHR, under the Progress notes lacked evidence R31 refused nail care.R31s EHR, under Tasks for bathing, documented he received bathing eight times in the month of April 2026 and two times in the month of May 2026.Observation on 05/06/26 at 09:19 AM, R31 had a brown substance on both right and left hands on the fingertips and underneath the fingernails.Observation on 05/07/26 at 08:19 AM, R31 had a brown substance on right and left hands, on the fingertips, and underneath the fingernails.Interviewed on 05/06/26 at 09:55 AM, R31 reported that he would not mind if staff cleaned his fingertips and fingernails. R31 reported that staff did not ask him if he wanted his nails cleaned.Interviewed on 05/06/26 at 11:03 AM, Licensed Nurse (LN) J reported R31's nail care could be provided by the support staff. LN J reported she had not been alerted by staff that R31 had refused nail care. On 05/07/26 at 08:19 AM, with Certified Medication Aid (CMA) S reported R31's nails were dirty with a brown substance that might be food. She stated that activities did nail care. CMA S verified that a resident's nails should never look like R31's nails looked.On 05/06/26 at 10:54 AM, Certified Nursing Assistant (CNA) P stated staff should clean R31's nails if he wanted them cleaned.On 05/07/26 at 08:28 AM, CNA Q stated activities staff would clean R31's nails sometimes, but it should be done during showers as that was the best time to clean nails.On 05/07/26 at 08:35 AM, Activity Staff AA stated staff did nail care for the residents every other Wednesday.On 05/07/26 at 08:40 AM, Activity Director Z stated activities staff normally did spa days every other Wednesday, which included cleaning underneath the nails and soaking nails to remove dirt and debris from underneath the nails. Activity Director Z said no one had reported that R31 needed his nails cleaned.On 05/07/26 at 09:58 AM, Administrative Nurse D stated nail care can be provided with the shower and said staff chart nail care under resident Tasks. The facility policy Nail Care of Finger and Toe, dated 05/2007, documented that it is the policy of this facility to clean the nail bed, keep nails trimmed, and prevent infections.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to provide consistent activities for Resident (R) 10. Findings included: - The Electronic Health Records (EHR) for R10 included diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (common motor deficits affecting one side of the body following a cerebral infarction [stroke]), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and aphasia (condition with disordered or absent language function).R10's Annual Minimum Data Set (MDS), dated 09/10/25, documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severe cognitive impairment. The MDS documented that R10 used a wheelchair for mobility and was dependent on staff for all activities of daily living (ADL). The MDS documented that R10 had an indwelling urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) and a percutaneous endoscopic gastrostomy tube (PEG - a flexible feeding tube placed through the abdominal wall directly into the stomach to deliver nutrition, fluids, and medications tube) for feeding. Further MDS documentation revealed that it was very important for R10 to listen to music she liked, not very important to do group activities, and that her primary respondent for daily and activity preferences was family or her significant other.R10's Communication Care Area Assessment (CAA), dated 09/10/25, documented R10 was rarely and never understood when she tried to express ideas and that rarely and never understood verbal expression.R10's Quarterly MDS, dated 03/13/26, documented a BIMS of one, which indicated severe cognitive impairment. The MDS documented that R10 used a wheelchair for mobility and was dependent on staff for all ADL. The MDS documented that R10 had an indwelling urinary catheter and a PEG tube for feeding. R10's Care Plan, dated 04/14/26, documented that R10 was dependent on staff for activities, cognitive stimulation, and social interactions. An intervention, dated 04/21/26, instructed staff that her preferred activities included listening to country music, old rock and roll from the 1980's, being outdoors, parties, getting her nails done, watching television, and pets. An intervention dated 04/21/26 instructed staff to record prior level activity involvement and interests by talking with R10, caregivers, and family on admission and as necessary. Other interventions, dated 04/21/26, instructed staff to provide one to one bedside/in-room visits and activities if R10 was unable to attend out of room events, and staff were to provide a program of activities that was of interest and empowered her by allowing choice, self-expression, and responsibility.The One-to-One lists, dated 04/12/26 to 05/02/26, I R10 was to receive activity three times weekly. It was documented that R10 received activity on 04/14/16, 04/22/26, and 04/29/26. There was no documentation of activity refusal recorded.R10's EHR Activity Progress Note, dated 04/14/26, documented R10 had no changes since the last report and that she was offered one to one room visits for sensory stimulation. The note also documented that R10 would not wake up for visits and did not want to be bothered. The progress notes further documented that R10 enjoyed people-watching at times and observing some group activities when she was awake and out of bed. Observed on 05/05/26 at 09:36 AM, R10 rested in her bed and had the television on. A sign on the wall read that staff were to get R10 up and into her wheelchair three times weekly with the Hoyer lift.Observed on 05/06/26 at 09:10 AM, R10 was lying in bed with her television on, there were no staff present. A bible study activity was performed in the facility common area.Observed on 05/06/26 at 02:37 PM, R10 remained in her room, in bed with the television on.On 05/07/26 at 08:02 AM, Licensed Nurse (LN) I stated that one-to-one activities were provided by the activity staff, and she was unsure when or how often this was provided.On 05/07/26 at 09:17 AM, Activity Z said that the one-to-one residents were assigned an activity person, and those individuals were responsible for performing the one-to-one activity. She then said that the activity person recorded the activity performed on a one-to-one document sheet, if the resident refused an activity that was also to be documented. Activity Z then verified that R10 had been offered activities once weekly, 04/12/26 to 05/02/26, and there was no refusal documented, and she then said that the activity staff had not (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	been documenting refusals. Activity Z then stated that if the resident required a Hoyer lift transfer and wanted to participate in a group activity, then the activity staff would coordinate with the nursing staff to get the resident up for the activity.On 05/07/26 at 09:22 AM, Certified Nurse Aide (CNA) O said that CNAs and activity personnel provided a joint effort when offering and getting Hoyer residents up for activities. She said if it was an activity person, then that person notified the CNA or nurse staff to get the resident up for an activity. CNA O then said that if the resident refused to attend or get up, there was no real way for it to be charted.The facility policy Activities Programming, dated 04/2025, documented that it was the policy of this facility to ensure that activities are available to meet resident needs and interests that support the physical, mental, and psychosocial well-being of the resident. The policy also documented that activities may be facility-sponsored group or independent.

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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** The facility census totaled 126 residents. Based on observation, interview, and record review, the facility failed to ensure a safe environment free from accidents and hazards when staff left a cognitively impaired resident by herself in the shower, resulting in a fall with injury. (Resident 127) Findings included:- Review of the Electronic Health Record (EHR) for Resident (R) 127 revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, cognitive communication deficit (an impairment in organization, sequencing, memory and attention, memory, planning, problem-solving and safety awareness), and iron deficiency anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues). The 03/19/26 Annual admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The Care Plan dated 03/12/26 for R127 revealed due to the alteration in self-care due to her unsteadiness on her feet, and her decrease in functional mobility and dementia, R127 required one staff to assist with Activities of Daily Living (ADLs). The 03/19/26 Falls Care Area Assessment (CAA) documented R127 was a risk for falls related to bowel and bladder incontinence; she also required staff assistance with ADLs and was at risk for complications because of her decreased functional mobility, unsteadiness on her feet, and dementia. The Progress Note on 05/06/26 at 03:17 PM by Administrative Nurse D documented the facility's fall investigation, revealing Certified Nurse Aide (CNA) NN left R127 unattended in the shower on 05/04/26. CNA NN returned from retrieving supplies and found R127 lying face down in the shower. Staff notified the second-floor nurse, who noted R127 had a pulse, blood was noted from the left side of her face, as well as emesis (vomit) from her mouth. The staff called Emergency Medical Services (EMS), and the resident was responsive at the time of EMS' arrival on scene, per documentation by the Fall Committee Interdisciplinary Team (IDT) Progress Note. R127 transferred to a local hospital, where she was evaluated and treated for the fall sustained in the shower. R127 required one stitch to close her lower lip laceration due to the fall. During an interview on 05/07/26 at 10:48 AM, CNA Q stated she did not think any resident on the second floor should be left alone in the shower, but especially not R127. During an interview on 05/07/26 at 11:32 AM, CNA MM stated R127 should not be left alone in the shower. CNA MM stated he gets along with R127 well, and R127 let him assist with the washing processes without any difficulty. R127 was observed walking slowly to the nurse's station at 11:36 AM. She was smiling and had a bruised and swollen lower lip with a stitch visible to the left side of her lip. R127 stated her lip was tender, but she wasn't sure why. During an interview on 05/07/26 at 12:44 PM, Licensed Nurse (LN) J stated R127 was a resident who should not be left alone, even if R127 or any other resident insisted on being left alone for privacy. The facility's Providence Policy revised on 10/2023, documents residents unable to carry out ADLs will receive assistance in good nutrition, grooming, personal, and oral hygiene. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R56's Electronic Medical Record (EMR) from the Diagnoses tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS document R56 needed set up or cleanup for eating and substantial/maximal assistance with bathing and oral care, and was dependent on staff for toileting. The MDS documented R56 had one fall without injury during the observation period. The Falls Care Area assessment dated [DATE] documented R56 was at risk for falls related to bowel and bladder incontinence and required assistance with activities of daily living (ADLs). The CAA documented R56 was at risk for complications due to decreased functional abilities and Alzheimer's disease. R56's Care Plan documented the following: 06/22/23- Staff was to ensure R56's call light was within her reach and to encourage her to use the call light. 12/01/25- R56 would have nonskid strips on the left side of her bed. 01/07/26- R56 would have a toilet riser. On 05/05/26 at 08:40 AM, R56 laid on her bed on her back. R56 was yelling out for help. R56's call light laid curled up at the bottom of her bed. R56's call light was not within her reach. R56 did not have a toilet riser or non-skid strips to the left side of her bed as care planned On 05/06/26 at 11:10 AM, R56 sat in her wheelchair in front of her bed. R56's call light was behind her bed. R56's call light was not within her reach. R56 did not have a toilet riser and did not have non-skid strips to the left of her bed as care planned. On 05/07/26 at 08:42 AM, Certified Nurse Aide (CNA)M stated call lights should be within the reach of the resident. She stated the call light should not be at the bottom of the bed, out of reach of the resident. CNA M stated she would know what fall interventions were in place for any resident, by looking at the resident's care plan or Kardex (nursing tool that gives a brief overview of the care needs of each resident). She verified the nonskid strips were not in place, and there was not a stool riser anywhere in the resident's room. On 05/07/26 at 09:06 AM, Licensed Nurse (LN) H stated call lights should be within the reach of the resident. LN H stated if the care plan stated a resident should have a stool riser, and skid strips, they should be in place. She stated she was unsure who would get the stool riser, or who would place the skid strips. LN H stated any staff could report to the Director of Nursing to let her know fall interventions were not in place or available. On 05/07/26 at 10:13 AM, Administrative Nurse D stated all nursing staff have access to the resident's care plan. She stated R56 had moved rooms, and her fall interventions were not moved with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	her. Administrative Nurse D stated it was all nursing staff's responsibility to ensure each resident had what they needed, and what was care planned for each resident. The facility's Falls Management System dated 04/25 documented It was the policy of the facility to provide an environment that remains as free of accident hazards as possible. It was also the policy of this facility to provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs.

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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. Based on observation, interview, and record review, the facility failed to ensure medications were labeled and stored appropriately when staff failed to properly secure a medication cart. Findings included:- Observed 05/06/26 at 08:17 AM on the second floor, a large rolling medication cart sat in the hall, unattended, with the lock partially pushed in. It contained stock bottles of medications, cards of resident-specific medication, and personal drink cups. In an interview on 05/06/26 at 08:19 AM with Licensed Nurse (LN) L, she confirmed she thought the cart was locked and stated the medication cart should always be locked when it is unattended or out of sight. The requested facility policy, Medication Labels and Storage, dated 03/2024, did not address the resident medication carts.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, record review, and interviews, the facility failed to ensure a functional call light system for Resident (R) 111 while he was on or in bed, in order to convey his needs to staff. Findings included:- R111's Electronic Medical Record (EMR) showed a diagnosis of generalized muscle weakness, difficulty walking, and unsteadiness on feet.R111's Care Plan dated 08/25/2025 stated R111 was at risk for falls related to occasional bladder incontinence and he required assistance with activities of daily living (ADL)s He was at risk for complications as evidenced by decreased functional mobility and dementia (decline in cognitive functioning The plan directed staff to be sure the call light was within reach and encourage the resident to use it to call for assistance as needed.Observed on 05/05/2026 at 10:25 AM, R111's call light was at the head of his bed. R111 sat on the edge of the bed. R111 stated he was trying to get some help, but no one was coming. A check of the call light within reach of R111's bed revealed the light did not come on at the door or at the monitor where staff watch for call lights when the button was activated. Observed on 05/06/2026 at 08:19 AM, R111 self-propelled his wheelchair to the dining area for breakfast. His call light laid on the bed, but upon further check, the call light still did not alert at the monitor or above the room door.Observed on 05/06/2026 at 01:44 PM, R111 laid in bed awake. When asked if he used the call light to summon staff, R111 picked up the call light next to his bed and pushed it. The call light still did not alert at the monitor or above the room door. During an interview on 05/06/2026 at 02:54 PM, Certified Nurse Aide (CNA)P stated that she was not aware R111's call light was not working or how long it had been like that as he did not use it very often. She said she would inform the nurse, as that is the facility protocol.During an interview on 05/06/2026 at 03:07 PM, CNA RR stated that anyone could place a work order in the computer if they needed something fixed. CNA RR placed the work order since the nurse was at lunch. During an interview on 05/06/2026 at 04:05 PM, Maintenance U stated that after a staff member placed a work order in the system, it would show up on his phone and alert him. He stated he had a work order in his system that showed up for the call light not working in R111 room. The facility did not provide a policy for a functional call light system.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record reviews, and observation, the facility staff failed to ensure a safe, sanitary, and functional environment on one of the stairwells. Findings included:- Observed on 05/07/2026 at 08:30 AM, one of the stairwells had a white, wet, organic type substance on the walls with a strong musty odor. There was dusty debris, which appeared to be flaked plaster, on the handrail and the floor at the back wall of the stairwell. There were stains which appeared to be water damage on the ceiling inside the stairwell.Interviewed on 05/07/2026 at 08:37 AM, Housekeeping Staff stated that housekeeping staff were responsible for cleaning the floors and handrails in the stairwell, but not the walls and ceilingsInterviewed on 05/07/2026 at 08:40 AM, Maintenance Staff U stated the maintenance department would be responsible for cleaning the walls of the stairwell. He said he would get a plan in place to spray the white substance on the walls with bleach to clean it.During an interview on 05/07/2026 at 08:40 AM, Administrative Staff A stated the white substance on the wall developed due to increased moisture from a leak in the roof, which had not yet been fixed. She stated that maintenance was responsible for cleaning the walls and said she submitted an order for it to be repaired. She reported she would follow up and see what is going on with the bid. During an interview on 05/07/2026 at 09:15 AM, Administrative A verified there would be someone there at noon that day to look at it around noon and get a plan of action in place. The facility's policy [NAME] 25 Safe and Homelike Environment dated 02/2022 stated it was the policy to ensure that resident's that reside here are provided the right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and supports for daily living safely.