STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175418	A. Building B. Wing	12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Providence Living Center	1112 SE Republican Avenue Topeka, KS 66607

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility identified a census of 67 residents. The sample included 17 residents. Based on interview and record review, the facility failed to ensure adequate staffing levels on the weekends to meet the needs of the residents. Findings included: - A review of the Centers for Medicare and Medicaid Services (CMS) Payroll-Based Journal (PBJ) for Fiscal Year (FY) 2025 Quarter 1, FY 2025 Quarter 2, FY 2025 Quarter 3, and FY 2025 Quarter 4 revealed the facility triggered for excessively low weekend staffing. Review of the Facility Assessment dated 01/01/25 documented the specific needs of each resident would be identified and adjusted as necessary. This included staffing needs for each shift, such as day, evening, night, and weekend. Day shift staffing would include two nurse shifts, four Certified Nurse Aide (CNA) shifts, and two Certified Medication Aide (CMA) shifts (eight total staff). Night shift would include two nurse shifts, two CNA shifts, and two CMA shifts (six total staff). The assessment documented there would be no change in staffing patterns during weekend and/or holiday shifts. The facility's schedule data documented the day shift was defined as 06:00 AM to 06:00 PM and the night shift was defined as 06:00 PM to 06:00 AM. Review of the facility's historical payroll data revealed the following: On 10/12/24 (Saturday), the day shift had four CNA staff on shift, but CNA Y clocked out at 06:10 AM and CNA AA clocked out at 01:20 PM, which left two CNA staff on the clinical floor. Three CMA staff on shift and two nurses, but Licensed Nurse (LN) LN G clocked out at 03:34 PM (six staff members for the full shift). Night shift had four CNA staff; however, CNA T and CNA DD clocked out at 09:35 PM, and CNA JJ clocked out at 12:00 AM, which left one CNA on the clinical floor. Two CMA staff, but CMA II, clocked out at 09:33 PM, and CMA EE clocked out at 09:42 PM, which left zero CMA staff on the clinical floor. Two nurse staff, but LN K, clocked out at 12:00 AM, which left one nurse on the clinical floor (two staff members for the full shift). On 02/08/25 (Saturday) day shift had three CNA staff on shift, two CMA staff on shift but the agency (contracted worker) CNA clocked out at 06:18 AM which left one CMA staff on the clinical floor, two nurse staff on shift from 06:00 AM to 07:00 AM, three nurse staff on shift from 07:00 AM to 02:00 PM, two nurse staff on shift from 02:00 PM to 02:30 PM, three nurse staff on shift from 02:30 PM to 04:00 PM, and two nurse staff on shift from 04:00 PM to 06:00 PM (five staff members for the full shift). Night shift had one CNA staff on shift from 06:04 PM, but CNA KK clocked out at 12:00 AM, which left zero CNA staff on the clinical floor. One CMA staff was on shift, but the agency CMA clocked out at 10:33 PM, which left zero CMA staff on the clinical floor. Two nurse staff on shift (two staff members for the full shift). Review of the facility's historical payroll data revealed on 04/26/25 (Saturday), the day shift had four CNA staff on shift, one CMA staff on shift, and two nurse staff on shift (seven staff members total). Night shift had zero CNA staff on shift, two CMA staff on shift, but CMA R clocked out at 09:13 PM, which left one CMA staff on the clinical floor and two nurse staff on shift (three staff members total for the full shift). On 07/06/25 (Sunday), the day shift had three CNA staff, but CNA S clocked out at 01:47 PM, and CNA O clocked in at 04:03 PM, which left one CNA staff on the clinical floor from 01:47 PM to 04:03 PM. One CMA staff shift and two nurse staff (four staff members total for the full shift). Night shift had two CNA staff, three CMA staff, and zero nurse staff on shift (five total staff members for the full shift). On 10/12/25 (Sunday), the day shift had four CNA staff on (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shift, but CNA Y clocked out at 06:10 AM and CNA AA clocked out at 01:20 PM, which left two CNA staff on the clinical floor. Three CMA staff on shift and two nurses, but Licensed Nurse (LN) LN G clocked out at 03:34 PM (six staff members for the full shift). Night shift had four CNA staff; however, CNA T and CNA DD clocked out at 09:35 PM, and CNA JJ clocked out at 12:00 AM, which left one CNA on the clinical floor. Two CMA staff, but CMA II, clocked out at 09:33 PM, and CMA EE clocked out at 09:42 PM, which left zero CMA staff on the clinical floor. Two nurse staff, but LN K, clocked out at 12:00 AM, which left one nurse on the clinical floor (two staff members for the full shift). During an interview on 12/18/25 at 11:40 AM, CMA T said that if the facility is short-staffed, the care team works together to get tasks done. Occasionally, if tasks go unperformed, it is the resident's showers that do not get done. CMA T revealed there are other staff in the building who are also CNAs who seldom help with tasks when the staffing is low. During an interview on 12/18/25 at 11:55 AM, CNA Q said that weekend staffing tends to run short of the required number of staff. CNA Q reported that when staff call off for a shift, it normally happens on nights and weekends, which makes caring for the residents hard. During an interview on 12/18/25 at 12:10 PM, CMA L said the facility does not utilize agency staff for CNAs anymore, just nurses. CMA L stated that low staffing is a problem at the facility, but would not address the subject further. The facility's Nursing Services F725, F726 policy, dated 04/2025, documented the facility provided adequate staffing to provide services to assure resident safety and attain or maintain the well-being of each resident. The facility would maintain adequate staffing on each shift to ensure that the residents' needs and services were met.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 67 residents. Based on observation, interview, and record review the facility failed to provide the services of a full-time certified dietary manager for the residents who resided in the facility and received their meals from the kitchen. Findings included:- On 12/15/25 at 12:35 PM, observation revealed Dietary Staff BB cleaning up the kitchen after meal service. On 12/16/25 at 11:30 AM, Dietary Staff BB stated she had recently completed a certified dietary management course and would be scheduling her test soon. Dietary Staff BB was unable to provide proof of completion of the course upon request. On 12/18/25 at 01:35 PM, Administrative Staff A verified the facility should have a certified dietary manager. Administrative Staff A verified she was unable to provide proof of Dietary Staff BB's completion of the Dietary Management course, certification, or evidence Dietary Staff BB had the required experience for the position. The facility's Food Service Staffing policy, dated 10/2023, stated a Food Services Manager would oversee the production, storage, and delivery of food. If the dietician is not full-time, the facility would employ a nutritional professional to serve as the dietary manager. The person must meet one of the following qualifications: Certified dietary manager, certified food service manager, similar certification in food service management and safety from a national certifying body, an associate's degree or higher in food services management from an accredited institution of higher learning, two or more years of experience in the position of dietary manager and has completed a course of study in food safety and management by 10/01/23, or meets the state established standards.

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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. The facility reported a census of 67 residents, and one kitchen. Based on interviews, observations, and record review, the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food-borne bacteria. Findings included:- Observation of the kitchen and food storage areas on 12/15/25 at 09:46 AM with Dietary BB, revealed the following areas of concern:The bottom shelf of the heat table was visibly dirty with caked-on grease.There were empty boxes (not broken down) stacked in the large trash can, near the handwashing sink. The boxes and a wire rack were on the step-to-open trash can, next to the handwashing sink, making it inaccessible. Several different buckets of two types of dishwasher sanitizer were under the dishwasher area, grey and brown dirt built up against the baseboards of the wall, and visible rust on pipes under the dishwasher. There was a large plastic dishwashing pan on the floor in the back sink area under an unused triple-basin sink to catch leaking water, as well as warm water on the floor in the area. The triple-basin sink had dried, caked on substances, as well as a white residue. There was one non-slip floor mat folded up under the unused triple-basin sink. There were no other floor mats in use in the kitchen.The back of the cook station was covered entirely with a thick, black, greasy substance.The exhaust hood above the dishwasher had visible dirt and grease. Three blackened muffin tins lay with their food surfaces right side up on top of a warmer. The warmer had debris noted inside and out. There was a box of rotted sweet potatoes on the floor near the double-door oven.The microwave in the food preparation area was greasy, inside and out. There was a large stack of coffee filters on the lower shelf of the spice rack. There was debris on the filters that appeared to be coffee grounds, as well as a liquid stain which appeared to have come from the tipped bottle of vanilla extract stored above the filters on the rack. Four out of seven large containers of spices were undated. There were five bags of moldy buns, and one unopened loaf of bread had visible gnat-like insects within the wrapper. There was one package of tortillas, which was opened and ripped across the top of the package, making it unable to be sealed.One oven mitt was frayed with its inner stuffing exposed. There was an open box of cookies on the bread rack, unsealed, open to air, and undated. The top of the dishwasher has dust what appeared to be wood shavings. There were soiled towels in a pile under the dishwasher. There was an open partial sleeve of Styrofoam cups on the floor, between two rolling plastic carts.The steam table had old, discolored water at the bottom of it. There was a large container of dry oats open and undated. The glass plate storage rack in the corner to the right of the steam table held plates stored with the eating surface upwards and uncovered. On a wire rack near the food prep table, a large metal colander was observed with several dents, a large rectangular pan had bent corners, and a black substance coated the bottom and outside surfaces. Observation of the cooler storage area revealed the following concerns:A bag of lettuce was open to the air and undated. Several packages of sliced turkey, opened and undated. A jug of Italian salad dressing was half full and undated. Observation of and around the dry storage area revealed the following concerns:The floor was unclean and had large food particles, dust, and dirt present.There were open snacks belonging to staff on the shelf in the dry storage area.A bulk bag of unlabeled cereal (closed) and an unopened bag of popcorn were on the floor, under the steel shelving. An individually wrapped snack was also on the floor. In an interview with Dietary BB on 12/16/25 at 10:12 AM, she stated the triple-basin sink was not currently in use due to a major leakage issue. This leak has caused loosened, dirty floor tiles, which were attempted to be tarred or glued back into place. Dietary BB stated that items should be dated when opened, and items in the freezer that were undated were labeled with a yellow sticker, which identified when they were received by the facility. Dietary BB confirmed the above-identified concerns and discarded the items in the trash. Dietary BB identified the items that belonged to staff, stated they should not be stored with resident food items, and discarded the items that belonged to staff. The facility's Food Safety Requirements F812 policy, dated 10/2025, documented foods would (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	be received and stored in a manner that complied with safe food handling practices. Staff would always maintain clean food storage areas. Non-refrigerated foods would be stored and kept clean and free of insects. All foods would be labeled and dated. The facility's Sanitation F812 policy, dated 10/2025, documented the food service area would be maintained in a clean and sanitary manner. Utensils, counters, shelves, and equipment would be kept clean, maintained in good order, and would be free from defects that may affect correct use or cleaning. Damaged or broken equipment that cannot be repaired would be discarded. Kitchen and dining surfaces not in contact with food would be cleaned regularly to prevent the accumulation of grime. Management would be responsible for scheduling staff for regular cleaning of the kitchen and dining areas, which included maintaining cleanliness through the work areas during all tasks, after each task, and before proceeding to the next task.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility reported a census of 67 residents; the sample included 17 residents. Based on record review and interview, the facility failed to ensure the Medical Director (or designee) attended Quality Assurance Performance Improvement (QAPI) meetings at least quarterly.Findings included:-Review of the facility's QAPI attendance binder noted the following: Upon request, the facility was unable to provide evidence of the quarterly attendance of the Medical Director (or designee) completed within the last year. During an interview on 12/18/25 at 01:53 PM, Administrative Staff A reported the quarterly attendance signature sheets lacked detailed signatures, which indicated the Medical Director attended the QAPI meetings only twice in the 12-month look-back period. Administrative Staff A reported he expected the Medical Director to be in attendance quarterly. The facility's policy Providence QAPI Plan 2025, dated 01/01/24, documented the QAPI Committee reports to the Governing Body and meets monthly, or at additional times when deemed necessary. The Administrator may delegate the necessary authority to a QAPI Coordinator.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. The facility had a census of 67 residents. Based on record review and interview, the facility failed to ensure the staff member designated as the Infection Preventionist (IP), who was responsible for the facility's Infection Prevention and Control Program, completed the specialized training in infection prevention and control and possessed the required certification. Findings included:- The Department Heads form completed by the facility on 12/15/25 listed Administrative Nurse E as the designated IP. Upon request, the facility could not provide documentation of a certification for the designated IP. On 12/18/25 at 07:57 AM, Administrative Nurse E confirmed she was the designated IP but was not currently certified. She stated she shared some of the duties with Administrative Nurse D, but she was not sure if Administrative Nurse D was certified. The facility's Infection Prevention and Control Program F 880 policy, revised 01/2024, stated the IP would report monthly to the Quality Assurance and Performance Improvement committee.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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** The facility census totaled 67 residents. Based on observation, interviews and record review, the facility failed to maintain the building in good condition and provide a safe and hazard free environment for the residents, visitors and staff. Findings included:- On 12/15/2025 at 11:00 AM, observation revealed the sidewalk was cracked in several areas and uneven in the courtyard that connected the north and south sides of the facility. The sidewalk that connected the east and west sides of the facility courtyard was missing a large piece of concrete and was uneven. On 12/15/25 at 11:13 AM in the north hallway, observation revealed a large hole in the ceiling; the tiles surrounding the large hole were discolored brown. There was pink insulation that was discolored black in some areas; the discolored insulation hung from the large hole. During an observation on 12/16/2025 at 11:20 AM, the clean laundry room area had a barrel in the doorway. Further observation of the ceiling above the barrel revealed an unintended black substance, and there were brown, dried, discolored areas indicating water damage. One tile was damaged. During a walkthrough on 12/18/25 at 11:30 AM of the facility with Maintenance U, the following areas were identified as needing repair:In the north hallway, a large crack in the ceiling between rooms [ROOM NUMBERS] and between rooms [ROOM NUMBERS] was present.In the south hallway, a large crack in the ceiling was present between rooms [ROOM NUMBERS] and between rooms [ROOM NUMBERS].During an interview on 12/15/2025 at 11:16 AM, Certified Nurse Aide (CNA) S reported the large hole in the north hallway ceiling had been like that since 12/14/25. During an interview on 12/16/2025 at 11:20 AM, Laundry Staff V revealed the ceiling dripped water when the shower room in the north hallway was used, and that was why the barrel was placed in the doorway. During an interview on 12/18/25 at 07:20 AM, Administrative Staff A reported the environment of the facility as a whole needed repair, and the facility was aware and planned for improvements. During an interview on 12/18/25 at 11:30 AM, the hole in the ceiling was identified by Maintenance U, which had developed on 12/12/25 from a frozen fire sprinkler line. Maintenance U revealed the attic access holes in the ceiling were open throughout the building to allow heat from the building to escape into the attic to prevent the fire sprinkler lines from freezing. He reported that the facility had obtained a bid for repairs but did not provide the survey team with proof that an attempt at repairs had been initiated. The facility policy Other Environmental Conditions dated 10/2025 documented the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility reported a census of 67 residents. Based on observation, interview and record review, the facility failed to maintain a clean, comfortable, sanitary and homelike environment in the facility. Findings included: - During a walkthrough of the facility on 12/18/25 at 05:30 AM, the combined dining and common area floor was dirty and had several areas of spilled popcorn and empty soda cans. Several tables had food containers and various spilled liquids, and on the floor as well, where no residents were seated. No staff members were present in the combined dining and common room. During an observation on 12/18/25 at 06:45 AM in the combined dining and common area, the tables were rearranged but had not been cleaned. The litter had been removed, but food debris remained on the floor. During an observation on 12/18/25 at 07:05 AM in the combined dining and common area, residents were being served breakfast on tables that still had food debris and spilled liquids. During a walkthrough of the facility on 12/18/25 at 11:30 AM with Maintenance U, the following areas were identified as being in need of repair:The windows in Resident (R) 46 and R12's room had plastic covering the windows. Maintenance U identified the plastic as being in place to minimize drafts caused by leaky windows.The walls in R17 and R63's room had gouges in the drywall material.The walls of R26's room had writing and various other marks on the paint.The floor of R19 and R11's room had missing floor tiles on the transition to the bathroom.The walls of R34's room had scrapes and gouges in the drywall material.The walls of R7's room had a hole in the drywall material.The walls of R29's room had multiple holes in the drywall material that were covered with blue duct tape. Additionally, R29 identified a hole in the closet wall that he kept covered with clothing to hide the hole.The wall of R1's room had scratches in the drywall materialThe walls of R64 and R62's room had scratches in the drywall material. Additionally, R62's side of the room had writing and various other marks on the paint.The walls of R25's room had scratches in the drywall material.The floor of R67 and R56's room had drag marks on the linoleum material with exposed sub-floor material.The walls of R35's room had scratches in the drywall material.The walls of R21's room had gouges in the drywall material.The closet door of R66's room had a hole in the door.The closet door of R32's room had a hole in the door.The closet door of R20's room had a hole in the door.The walls of R49 and R33's room had writing and various other marks on the paint.The elevator in the south hallway from the first floor to the basement was out of order.The wall in the north hall tub room had an area of drywall that was repaired but not repainted. During an interview on 12/16/25 at 03:35 PM, Administrative Staff B stated that residents used to use the activity area in the basement, but haven't been able to use it for activities since the elevator broke down. During an interview on 12/18/25 at 05:55 AM, Licensed Nurse (LN) H said staff should clean up the common and dining area during the night shift, but residents leave trash and spill food and drinks throughout the night. LN H said if something were broken, she would send a message to the maintenance department for repairs. During an interview on 12/18/25 at 06:15 AM, Certified Nurse Aide (CNA) O reported staff would normally clean up the common and dining area, but some residents just like to make messes. CNA O reported if something needed repair, the nurse was notified and would put a work order in the computer for the maintenance department. During an interview on 12/18/25 at 06:36 AM, Maintenance FF said each morning, the floors in the common and dining area were always dirty and had food debris from the previous day's evening meal service and snacks. Maintenance FF said that staff have asked residents to properly dispose of their trash. Maintenance FF said that the floors are the worst on Monday mornings. During an interview on 12/18/25 at 07:10 AM, Dietary BB said she had cleaned off the tables prior to the residents being served breakfast. Dietary BB identified debris that remained on the tables and reported she cleaned the tables in a darkened room. During an interview on 12/18/25 at 07:20 AM, Administrative Staff A said he expected the common and dining area to be clean before and after each meal service. Administrative Staff A toured the common/dining area and identified debris on the floor (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and tables that were from the previous day's evening meal service that was present where residents were currently dining, and said that conditions were unacceptable. During an interview on 12/18/25 at 12:30 PM, Maintenance U stated the identified areas were not consistent with a home-like environment for the residents. Additionally, Maintenance U stated that the elevator had been out of order for over a year. Further, Maintenance U stated the activity room in the basement that residents used to use daily is now inaccessible to residents since the elevator is inoperable. During an interview on 12/18/25 at 12:00 PM, Activity Z revealed the residents used to spend a lot of time in the activity room in the basement doing various activities that included playing billiards pool and watching TV in a more private setting in the activity area in the basement; however, the residents have not been able to participate in these activities since the elevator broke and has been out of order. The facility's Safe, Clean, Comfortable, Homelike Environment F584 policy, dated 11/2017, documented residents have the right to a safe, clean, comfortable, and homelike environment. The facility staff and management would maximize the characteristics of the facility to reflect a personalized, homelike setting, which included cleanliness and order.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 67 residents. The sample included 17 residents with four residents reviewed for hospitalization. Based on observation, interview, and record review, the facility failed to provide a written bed hold policy and failed to issue written notification as soon as practicable for transfers for Resident (R) 1, R33 R52 and R70. Additionally, the facility failed to notify the Ombudsman for transfers.Findings included1.R1's Electronic Medical Record (EMR) recorded R1 was transferred to the hospital on 7/14/25, 8/17/25, and 9/14/25. R1's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R1 and/or his representative. Upon request, the facility was unable to provide the documentation. 2. R33's EMR recorded R33 was transferred to the hospital on 7/03/25. R33's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R33 and/or her representative. Upon request, the facility was unable to provide the documentation. 3. R52's EMR recorded R52 was transferred to the hospital on [DATE] and 11/20/25. R52's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R52 and/or her representative. Upon request, the facility was unable to provide the documentation. 4. R70's EMR recorded R70 was transferred to the hospital on [DATE]. R70's EMR lacked evidence the facility provided a bed hold notice or written notification of the transfer to R70 and/or her representative. Upon request, the facility was unable to provide the documentation. During an interview on 12/16/25 at 03:22 PM, Licensed Nurse (LN) J reported when a resident was transferred to the hospital, a bed hold form should be in the transfer packet, and the nurse on duty should obtain the signature from the resident or phone consent from their representative, then the bed hold was placed in the Administrative Nursed D's door-mailbox. LN J reported Administrative Nurse D would then give the bed holds to Medical Records to scan to the EMR. During an interview on 12/16/25 at 03:26 PM, Certified Nurse Aide (CNA) S, who completed medical records, reported the bed holds and written notifications were routed to Administrative Nurse D, then to Social Service Designee (SSD) X or maybe Administrative Staff B to be filed and or scanned to the residents' EMR. During an interview on 12/16/25 at 03:35 PM, Administrative Staff B reported all bed holds and written notifications were held by SSD X and then filed or scanned to the EMR. During an interview on 12/18/25 at 11:00 AM, SSD X reported when a resident was transferred to the hospital, the nurse would complete the bed hold form during the non-business hours. SSD X reported she would complete a bed hold through email with the representatives, and all the bed holds would go to medical records to be uploaded into the residents' EMR. SSD X revealed she was unaware until 12/17/25 that she was responsible for notifying the Ombudsman of transfers. During an interview on 12/18/25 at 03:00 PM, Administrative Nurse E reported she expected the bed holds to be completed upon transfer to the hospital by the nurse; if unable to complete the bed hold due to an emergency, she expected SSD X to complete the bed hold the next business day. The facility's policy Bed Hold dated 06/25 documented the community staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed hold policy. The bed-hold information would include any charges that the resident may incur, as well as the time limit established by the State Medicaid Plan for which the facility will reserve the resident's bedspace.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility reported a census of 67 residents; the sample included 17 residents sampled with five residents reviewed for unnecessary medications. Based on interview and record review, the facility failed to acknowledge the Consultant Pharmacist's monthly medication regimen review (MRR) and failed to ensure the MRR recommendations were filed in the clinical record for Resident (R) 1, R7, R9, R13, and R30. Findings included:1. R1's Electronic Medical Record (EMR) recorded the following Medication Regimen Review (MRR):R1's Pharmacy Consultant Note on 07/21/25 documented MRR completed, irregularities noted, see report. R1's Pharmacy Consultant Note on 10/13/25 documented MRR completed, The Consultant Pharmacist requested a vitamin level, but no results were found until the facility provided lab results dated 12/18/25. R1's Pharmacy Consultant Note on 11/13/25 documented MRR completed, irregularities noted, see report. R1's clinical record lacked the actual recommendations made and lacked evidence the facility and physician acknowledged and responded. 2. R7's EMR recorded the following MRR:R7's Pharmacy Consultant Note on 07/21/25 documented MRR completed, irregularities noted, see report.R7's Pharmacy Consultant Note on 08/19/25 documented MRR completed, irregularities noted, see report.R7's Pharmacy Consultant Note on 11/13/25 documented MRR completed, irregularities noted, see report.R7's clinical record lacked the actual recommendations made and lacked evidence the facility and physician acknowledged and responded. R7's Pharmacy Consultant Note on 10/13/25 documented MRR completed, The Consultant Pharmacist requested a magnesium level, but no results were found until the facility provided lab results dated 12/17/25. 3. R9's EMR recorded the following MRR:R9's Pharmacy Consultant Note on 07/21/25 documented MRR completed, irregularities noted, see report.R9's Pharmacy Consultant Note on 08/18/25 documented MRR completed, irregularities noted, see report.R9's Pharmacy Consultant Note on 09/08/25 documented MRR completed, irregularities noted, see report.R9's clinical record lacked the actual recommendations made and lacked evidence the facility and physician acknowledged and responded. 4.R13's EMR recorded the following MRR:R13's Pharmacy Consultant Note on 07/21/25 documented MRR completed. The Consultant Pharmacist documented R13 had diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and recommended considering monitoring hemoglobin A1c (HbA1c-blood test used to evaluate the level of glucose control over the past 90 days) on the next lab day and every 6 months.R13's Pharmacy Consultant Note on 09/08/25 documented MRR completed, Pharmacist documented R13 had diabetes mellitus and recommended to consider monitoring hemoglobin A1c on the next lab day and every 6 months.R13's EMR lacked any results or evidence the physician reviewed and declined as of 12/17/25.R13's Pharmacy Consultant Note on 11/13/25 documented MRR completed, irregularities noted, see report. The Consultant Pharmacist requested a review of the listed psychoactive medication for gradual dose reductions including Depakote (an anti-convulsant) sprinkles 500 milligrams daily, haloperidol (antipsychotic medications used to treat major mental conditions that cause a break from reality) 2 mg twice daily, quetiapine (antipsychotic) 500 mg at bedtime, lithium (mood stabilizer) extended release 300 mg at bed time and citalopram (an antidepressant a class of medications used to treat mood disorders) 20 mg daily. R13's EMR lacked any responses from the physician corresponding to the 11/13/25 report. 5. R30's EMR recorded the following MRR:R30's Pharmacy Consultant Note on 08/18/25 documented MRR completed, irregularities noted, see report. R30's Pharmacy Consultant Note on 09/08/25 documented MRR completed, irregularities noted, see report.R30's Pharmacy Consultant Note on 11/13/25 documented MRR completed, irregularities noted, see report.R13's clinical record lacked the actual recommendations made and lacked evidence the facility and physician acknowledged and responded. During an interview on 12/16/25 at 01:11 PM, Administrative Nurse D reported that she only received the gradual dose reduction reports, not the entire reports. She reported she would not receive a full (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	report with all the residents' names on it, and she was not aware every resident every month was assessed by the pharmacist for an MRR. During an interview on 12/16/25 at 01:40 PM, Administrative Nurse D reported she was responsible for the process of receiving and follow-up for the MRR. During an interview on 12/18/25 at 12:50 PM, Consultant GG and Consultant HH revealed the facility/physician response to the MRR should be completed and returned to the pharmacy within a reasonable time frame, defined as 30 days or less. The facility's policy Pharmacy Services Overview dated 10/2025 documented 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. Help establish procedures for conducting the monthly medication regimen review for each resident in the facility.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 67 residents. The sample included 17 residents with five residents reviewed for vaccinations. Based on record review nad interview, the facility failed to ensure the residents were offered and received the pneumococcal vaccine or informed declinations for the vaccine were obtained for Resident (R) 13, R5, R6 and R34. Findings included:R13's Electronic Medical Record (EMR) documented a signed declination for the influenza vaccine on 10/03/25. The EMR lacked evidence of administration of the pneumovax and lacked evidence of an informed declination signed by the resident or her representative. R5's EMR recorded the resident received the influenza vaccine on 10/08/25, but refused the pneumovax. The EMR lacked evidence of an informed declination signed by the resident or his representative. R6's EMR recorded the resident received the influenza vaccine on 10/08/25 but refused the pneumovax. The EMR lacked evidence of an informed declination signed by the resident or her representative. R34's EMR recorded the resident received the influenza vaccine on 10/08/25 but refused the pneumovax. The EMR lacked evidence of an informed declination signed by the resident or his representative. On 12/18/25 at 10:25 AM, Consultant GG confirmed the facility was not able to provide the informed declinations for the pneumovax vaccines for the above-listed residents. The facility policy F883 F884 F887 Vaccination of Residents, Including Influenza, Pneumococcal., revised 09/2023, noted prior to receiving vaccinations, the resident or legal representative would be provided information and education regarding the benefits and potential side effects of the vaccinations, and provision of such education would be documented in the resident's medical record. The residents would be offered the flu, pneumovax, and COVID-19 vaccinations per the Centers for Disease Control and Prevention and Centers for Medicare and Medicaid guidelines. The policy noted if vaccinations were refused, the refusal would be documented in the resident's medical record.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. The facility reported a census of 67 residents. The sample included 17 residents. Based on observation, record review, and interviews, the facility failed to provide a safely secured handrail in the stairwell corridor leading to the basement. Findings include:- During an observation on 12/15/25 at 12:30 PM, the handrail to the stairwell on the north side of the courtyard was wobbly and not secured. Resident (R) 62 sat at the bottom of the stairway near the secured basement door. During an interview on 12/16/25 at 11:00 AM, Administrative Staff A observed the loose, wobbly handrail in the stairwell corridor leading to the basement and reported he had not been aware of the loose handrail. Administrative Staff A moved the railing, observed the base was out of the hole in the concrete, and reported it would need to be fixed. The facility policy Other Environmental Conditions dated 10/2025 documented the facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Equip corridors with firmly secured handrails on each side.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 67 residents, the sample included 17 residents. Based on interview and record review, the facility failed to inform Resident (R) 1 and R13 and/or their representative regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included: - Review of both Electronic Health Record (EHR) and paper records revealed the following:1.R1's EHR under the Orders tab revealed orders for the following:Fluphenazine HCl (an antipsychotic [a class of medications used to treat major mental conditions that cause a break from reality] medication), five milligrams (mg) to be given orally two times daily for schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), dated 11/19/25.Mirtazapine (antidepressant medication used to treat mood disorders), 15 mg to be given orally at bedtime for depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), dated 11/15/25.Lorazepam (an antianxiety [a class of medications that calm and relax people] medication), one mg to be given two times daily for anxiety, dated 10/28/25.Escitalopram oxalate (an antidepressant medication) 20 mg to be given orally once daily for depression, dated 10/06/25.Quetiapine fumarate (an antipsychotic medication) 50 mg to be given orally twice daily for psychosis, dated 07/16/25. R1's scanned document revealed Informed Consents for Use of Psychotropic Medication consents, which listed the medications and potential risks but lacked R1's signature indicating he received the information. During an interview on 12/16/25 at 02:40 PM, Administrative Nurse D revealed R1 made his own decisions and did not have a durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) or a guardian on file. Administrative Nurse D and Consultant GG stated that R1 should have signed the forms. 2. R13's EHR Orders tab revealed orders for the following:Clonazepam (an antianxiety medication), 0.5mg to be given every 12 hours as needed for anxiety, dated 05/59/25.Quetiapine fumarate, 300 mg to be given orally each day at bedtime for schizoaffective disorder, dated 07/16/25.Quetiapine fumarate, 200 mg to be given orally each day at bedtime for schizoaffective disorder, dated 01/21/25.Citalopram hydrobromide (an antidepressant medication), 20 mg to be given orally once per day for depression, dated 01/21/25.Lithium (a mood stabilizer), 300 mg to be given orally at bedtime for mood/depression, dated 05/02/25. R13's EHR scanned documents did not contain consent forms for the above-listed medications and lacked evidence of informed consent. Upon request, the facility could not provide evidence of informed consent by the resident and/or representative. On 12/18/25 at 11:45 AM, Consultant GG revealed that signed consents should be completed if a new psychotropic medication is prescribed or if there is a change in the dose. The facility's F605 Use of Psychotropic Drugs (Formerly F 758 policy, dated 04/2025, documented residents would only receive psychotropics or other approved medications that affect brain activity when necessary to treat specific conditions, and residents and/or their representative(s) have the right to refuse such treatment. Resident(s) and/or their representative(s) would be informed of new or change orders that included benefits, risks, and alternatives prior to the mediation(s) being initiated or increased. Staff would obtain the consent for the new or changed order, add it to the record, and document the conversation in the clinical record.

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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. The facility identified a census of 67 residents. The sample included 17 residents with one resident reviewed for advanced directives. Based on observation, record review, and interviews, the facility failed to accurately identify Resident (R) 30's advanced directives for a Do Not Resuscitate (DNR-expressed desire to not receive cardiopulmonary resuscitative measures in the event of cardiac or respiratory arrest). Findings included:- R30's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R30's Significant Change Minimum Data Set [MDS] dated 11/10/25 documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R30 received hospice (palliative) care. R30's Care Plan dated 09/19/18 documented she wished to have a DNR. R30's EMR under the MISC tab revealed an outside-of-hospital DNR signed by the resident and other required parties. R30's profile information in her EMR documented she was a Full Code (desires full cardiopulmonary resuscitative measures). On 12/16/25 at 11:00 AM, R30 was in her room attempting to put her pants on. R30 requested assistance, and staff arrived to assist the resident. On 12/16/25 at 02:00 PM, Administrative Nurse D confirmed R30's profile in the EMR showed R30 was a Full Code. Administrative Nurse D confirmed R30 had a signed DNR advance directive in the scanned documents. Administrative Nurse D said if the resident had a change in code status, regarding an advance directive related to DNR, the change should be reflected in the EMR, and the information would also be relayed to other staff during both verbal and written reports. The facility policy, revised on 11/2023, F578 Advance Directives, recorded each resident had the right to formulate advance directives. The policy noted the information about whether the resident had executed an advance directive would be displayed prominently in the medical record.

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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. The facility reported a census of 67 residents. The sample included 17 residents with one resident reviewed for activities of daily living (ADLs). Based on observation, interviews, and record review the facility failed to offer and provide assistance with nail care for Resident (R) 9, who participated in her hygiene activities but needed staff assistance. Findings included:- R9's Electronic Medical Record (EMR) revealed diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and a need for assistance with personal care. R9's 07/22/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated moderate cognitive impairment. The MDS documented R9 required moderate assistance with bathing, dressing, and personal hygiene. R9's 08/05/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R9 was at risk for falls. The plan of care would be reviewed and revised to ensure proper interventions were in place to prevent falls. The CAA lacked information related to functional abilities and self-care. R9's Care Plan, revised on 03/26/24, directed staff to provide set-up assistance with prompts to complete personal hygiene. During an observation on 12/15/25 at 01:18 PM, R9's fingernails were very long; nail polish was chipped on some of her nails. Observation revealed brown residue underneath several of R9's fingernails. During an observation on 12/16/25 at 11:16 AM, R9's fingernails were very long. The nail polish was unchanged from the 12/15/25 observation. R9 continued to have brown residue underneath several of her fingernails. R9 reported she liked her fingernails long. During an interview on 12/18/25 at 01:07 PM, Certified Nurse Aide (CNA) Q reported the nurses would cut R9's nails, but the CNAs should make sure her nails were clean. CNA Q reported that R9 liked her nails long. During an interview on 12/18/25 at 01:10 PM, Licensed Nurse (LN) I reported the CNAs should clean residents' fingernails. LN I reported that R9 would refuse to have her nails cut as she liked them long, but stated R9's fingernails should be clean and polished. During an interview on 12/18/25 at 03:00 PM, Administrative Nurse E reported she expected the staff to provide fingernail care to the residents who could not complete that task independently. The facility did not provide a policy for ADLs.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. The facility reported a census of 67 residents; the sample included 17 with one resident reviewed for prevent decrease in range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) and mobility. Based on observation, interview, and record review, the facility failed to provide a palm guard to prevent contractures (abnormal fixation of a joint or muscle) to Resident (R) 44. Findings included:- R44's Electronic Medical Record (EMR) revealed diagnoses including acute cerebrovascular insufficiency (CVI- a sudden, temporary lack of blood flow to part or all of the brain, often due to blocked arteries or low blood pressure), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) R44's 11/25/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 99, which indicated severely impaired cognition. R44's MDS recorded impairment to both sides of her upper and lower extremities. The MDS recorded R44 required total dependence on staff for all activities of daily living (ADLs). R44's 12/16/25 Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R44 had severe immobility. She depended on the staff for ADL function. R44's Care Plan dated 09/17/24 documented she had pain in her left hand related to contractures. The plan instructed staff to apply a gel support to her left hand for 20 minutes four times a day for three days, then for 30 minutes four times a day for three days, then to the left hand at tolerated intervals for contractures. R44's Physician Orders documented to remove the palm guard protectors each shift to check for skin integrity, date ordered, 01/30/25. R44's Progress Note on 01/28/25 at 08:12 AM documented staff spoke with Hospice regarding the gel support for R44's left hand contracture and discontinued at that time. Hospice would reevaluate later that day during the visit. During an observation on 12/15/25 at 11:24 AM, R44 sat in her Broda chair (specialized wheelchair with the ability to tilt and recline). Her left hand was contracted, and she did not have a palm guard device in her left hand. R44 was unable to stretch out her left hand when asked. During an observation on 12/16 /25 at 08:49 AM, Certified Nurse Aide (CNA) N and Certified Medication Aide (CMA) R assisted R44 out of bed with the mechanical lift and into her Broda chair. Further observation revealed the staff did not place a palm guard in R44's left hand and propelled R44 out of the room towards the dining room without the palm guard. During an observation and interview on 12/18/25 at 05:35 AM, CNA O reported she had just provided ADL care to R44. CMA O walked down to R44's room, where R44 was in bed, and knocked on the door. R44 opened her eyes and smiled. She did not have a palm guard in her left hand. During an observation on 12/18/25 at 08:38 AM, R44 sat in her Broda chair without a palm guard in her left hand, which remained tight. R44 had clear mucus hanging down from her nose to her chin. During an interview on 12/18/25 at 08:40 AM, CNA T reported there was no restorative aide, and the CNA staff were responsible to complete restorative tasks. She reported that the other CNA completed ADL care for R44 and said she just assisted with R44's transfer. CNA T reported she did not realize R44 did not have her palm guard applied. During an interview and observation on 12/18/25 at 08:43 AM, Licensed Nurse (LN) I reported that she checked the skin of R44's palm every day to make sure it was intact. LN I walked down to R44's room and opened the top drawer of her nightstand. R44's palm guards were buried under personal items and pictures in that drawer. LN I reported that R44 should have the palm guard placed in her hands every shift and said she was uncertain why R44 did not have a palm guard in her hand the past few days. During an interview on 12/18/25 at 03:00 PM, Administrative Nurse E reported she expected staff to apply devices to help prevent contractures as per the physicians' orders. The facility did not provide a policy for Restorative Therapy/Splint Devices.

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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. The facility had a census of 67 residents. The sample included 17 residents, with one resident reviewed for smoking. Based on observation, record review, and interview, the facility failed to ensure a safe environment free from accident hazards for Resident (R) 33 when staff failed to assess R33 for safe smoking ability and determine if safety equipment was required. Findings included:- R33's Electronic Medical Record (EMR) revealed diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) R33's 12/20/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R33's MDS documented she had no behaviors and no depression. The MDS documented R33 did not use tobacco. R33's 01/03/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R33 received psychotropic (alters mood or thought) medications related to schizoaffective disorder. She was compliant with her current medication regimen and was followed by psychiatry and pharmacy for medication review. R33's 10/11/25 Quarterly MDS documented a BIMS score of 13, which indicated intact cognition. R33's MDS documented Patient Health Questionnaire-9 (PHQ-9, a depressive symptom scale) score of 24, which indicated severe depression. The MDS lacked information related to R33's tobacco use. R33's Care Plan, revised 03/26/24, instructed staff R33's preferred activities were bingo, music, iPad, and she was an outdoors (smoker). The plan lacked interventions regarding safe smoking practices or smoking equipment needs. R33's EMR under the Assessments tab revealed a Smoking Evaluation dated 01/22/24, which noted the resident had no cigarettes. R33 was safe to smoke. The Smoking Evaluation dated 04/05/24 documented R33 required no adaptive safety equipment for smoking. R33's EMR lacked any further Smoking Evaluation assessments. R33's Progress Note on 04/20/25 at 01:09 PM documented R33 was smoking on the patio. She attempted to smoke her cigarette but could not hold her head up. She dropped a cigarette and burned a hole in her shirt. Staff assisted the resident back inside, told her that smoking was unsafe, and reported it to the nurse. R33's Progress Note on 06/7/2025 at 08:18 PM documented during the 07:30 PM smoking period, R33 was seated and kept drooping head forward. R33 had to be told constantly to hold her head up and sit up. R33 said she could not, so staff assisted R33 up and walked with her. R33 had taken off her sock and gave it to a Certified Nursing Aide (CNA). The CNA placed the sock in the resident's pocket and, in doing so, found a vape (electronic smoking device). Staff confiscated the vape, and R33 cried and begged the CNA to give her vape back. Staff notified Administrative Nurse D and R33 lost smoking privileges for 24 hours. Staff placed R33's on her vape and placed it in the cigarette container. Review of the undated Providence Living Center Smoking List which hung at the nurses' station for the scheduled smoke breaks, revealed R33 was checked off to wear a smoke apron. During an observation on 12/16/25 at 10:05 AM, R33 was outside in a supervised smoking area. She did not have any safety equipment. During an interview on 12/16/25 at 10:10 AM, CNA N reported the smoking aprons were probably stored in the smoking storage closet, and if a resident was supposed to wear an apron, she would not know, as she had not been told. CNA N reported she had the sign-out form for cigarettes for the residents, but no list as to who was supposed to wear an apron. During an interview on 12/16/25 at 03:13 PM, Licensed Nurse (LN) J reported the smoking evaluations were completed quarterly to coincide with the MDS, and the floor nurse completed the smoking evaluations. LN J confirmed that R33 has been a smoker at the facility for over a year and verified that the last smoking safety evaluation for R33 was completed on 04/05/24. LN J reported that if a resident had burned their clothing while smoking in the past, they should wear a smoking apron. LN J was unsure who printed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	off the smoking list that was hung on the wall at each nurse station. During an interview on 12/16/25 at 03:18 PM, LN G revealed that Activity Director Z hung the Providence Living Center Smoking List at the nurses' stations. During an interview on 12/16/25 at 03:20 PM, Activity Director Z reported they typed the smoking list that was posted at each nursing station and had just hung a newly updated form the other day. Activity Director Z reported the previous MDS nurse had given her a list of the smokers and told her what to type on the form. Activity Director Z reported she would not even know where to find out if a resident required an apron or other safety equipment for smoking. During an interview and observation on 12/18/25 at 10:00 AM, R33 sat outside on a supervised smoke break with no smoking apron on. CNA Q reported that R33 was now crossed off the list and provided the updated list, which had a pink line drawn through R33's name. CNA Q reported that Activity Director Z removed R33's name. During an interview on 12/18/25 at 03:00 PM, Administrative Nurse E confirmed the most current smoking evaluation in R33's EMR was completed on 04/05/24 and reported that the evaluation had not been entered to automatically open quarterly. Administrative Nurse E reported the residents required a safe smoking evaluation quarterly and as needed. Administrative Nurse E reported if a resident had a history of burning their clothes, the resident should wear a smoking apron when smoking. The facility's policy Accident Prevention - Smoking Policy dated 08/25 documented residents who wish to smoke will be evaluated for safe smoking per community protocol. The staff would review the status of a resident's smoking privileges periodically, per community protocol.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. The facility had a census of 67 residents. The sample included 17 residents, with one resident reviewed for respiratory care. Based on observations, record reviews, and interviews, the facility failed to apply, clean, and store a continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) within the standards of practice for Resident (R) 3.Findings included:- R3's Electronic Medical Record (EMR) revealed diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and sleep apnea (a disorder of sleep characterized by periods without respirations). R3's 08/16/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) was not completed as the resident was rarely/never understood, indicating severely impaired cognition. R3's MDS documented R3 used oxygen therapy and a non-invasive mechanical ventilator (CPAP). R3's 08/28/25 Cognitive Loss/Dementia Care Area Assessment (CAA) documented R3 required comfort care due to end-of-life processes. R3 received Hospice care to optimize treatment to control physical symptoms such as pain, constipation, diarrhea, fatigue, nausea, and vomiting, and assist in activities of daily living support. R3's Care Plan, revised 03/26/24, instructed staff to apply the CPAP with auto settings of 12 centimeters (cm) to 16 cm water and Expiratory Pressure Relief 3 (EPR3, its primary function is to reduce the air pressure delivered by the CPAP machine specifically during exhalation) at bedtime and remove in the morning. Staff were instructed to elevate the head of the bed to prevent shortness of breath. R3's Physicians Orders documented clean the CPAP mask every day shift dated 04/02/22.R3's Physicians Orders documented elevate the head of the bed to prevent shortness of breath every shift for COPD dated 10/06/23.R3's Physicians Orders documented apply CPAP auto settings of 12 cm to 16 cm water EPR3, on at bedtime and off in the morning, for sleep apnea dated 03/29/24. R3's Progress Notes on 07/30/25 at 10:48 PM documented R3 used a CPAP machine at night; R3 had no cough. R3's Medication Administration Record on 12/18/25 at 05:56 AM lacked documentation from Licensed Nurse (LN) H that R3's CPAP was applied. During an observation on 12/16/25 at 08:32 AM, R3 laid in bed with her eyes closed. R3's CPAP mask laid on the dresser, open to air, attached to the CPAP machine. During an observation on 12/18/25 at 05:45 AM, R3 was in her bed with her blanket over her head; the head of her bed was flat. R3's CPAP mask laid on the dresser attached to the CPAP machine that was not plugged in. During an interview on 12/18/25 at 05:47 AM, LN H reported that R3's CPAP was not always functioning. LN H stated she was uncertain why the CPAP was not working and why the head of R3's bed was in the flat position, because she normally did not work in the south hallway. LN H reported that when the CPAP mask was not in use, it should be placed in a storage bag. LN H reported that R3 had recently moved into her current room, and all her items were not in the correct place. LN H verified that R3 had not refused the CPAP on her shift. During an interview on 12/18/25 at 03:00 PM, Administrative Nurse E reported she expected the nurse to apply a resident's CPAP machine and to make sure a resident's head of bed was elevated as per physician's orders. Additionally, she reported that she was not aware R3's CPAP machine was not working. The facility did not provide a policy for respiratory care.

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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. The facility reported a census of 67 residents; the sample included 17 residents with one resident reviewed for trauma. Based on observation, interview, and record review the facility failed to implement approaches for trauma informed care to prevent triggers that were identified for Resident (R) 33, who had a history of personal trauma.Findings included:- R33's Electronic Medical Record (EMR) revealed diagnoses of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), and schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) R33's 12/20/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R33's MDS documented no behaviors and no depression. R33's 01/03/25 Psychotropic Drug Use Care Area Assessment (CAA) documented R33 was administered psychotropic (alters mood or thought) medications related to schizoaffective disorder. She was compliant with her current medication regimen and was followed by psychiatry and pharmacy for medication review. R33's 10/11/25 Quarterly MDS documented a BIMS score of 13, which indicated intact cognition. R33's MDS documented a Patient Health Questionnaire-9 (PHQ-9, a depressive symptom scale) score of 24, which indicated severe depression. R33's Care Plan revised on 03/26/24 documented R33 had a history of trauma and directed staff to monitor for symptoms of agitation, flashbacks, anxiety, insomnia, and nightmares. Staff instructed that R33's triggers were overstimulation in the dining room and loud and crowded areas. Other triggers listed included adjusting to new places and new roommates. R33's Progress Note on 7/30/25 at 09:32 AM documented, effective that day, the resident would experience a room change within the facility. R33's Progress Note on 12/9/225 at 06:26 PM documented a room move was made, effective at that time. R33's Progress Notes lacked notification of why the room change occurred and any follow-up notes for monitoring R33's adjustment to changes. During an interview on 12/15/25 at 03:27 PM, R33 reported that the facility moved her room last week and did not explain why. R33 reported that the other resident in the room that connected with the joined bathroom was loud and would come into her room through the bathroom door. At this time during the interview, the female resident next door opened R33's bathroom door into her room and looked at R33 and then closed the bathroom door. R33 stated the other resident did that all the time and pointed at the closed door. She reported she felt anxious about that and said she had reported her concerns to the staff. During an interview on 12/16/25 at 03:18 PM, Licensed Nurse (LN) G reported that management and Social Service Designee (SSD) X completed room changes and the related documentation. LN G reported he had no knowledge that R33 had concerns with her new room. During an interview on 12/16/2025 at 11:00 AM, SSD X reported that she did not make the decisions related to room changes; Administrative Nurse D and Administrative Nurse decided and then let her know. SSD X reported she would document when a room change occurred. SSD X reported she did not realize that R33 had PTSD and that roommate changes and loud noises could trigger her PTSD. During an interview on 12/18/25 at 03:00 PM, Administrative Nurse E reported she expected documentation in the residents' EMR of why a room change occurred. Administrative Nurse E said she expected there to be a follow-up on how a resident adjusted to the room change. The facility's policy Trauma-Informed Care dated 06/2025 documented residents who are known trauma survivors will receive culturally competent trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. The facility's policy Roommate Change, Roommate Notification, Choice of Roommate, dated 06/2025, documented changes in room or roommate assignment shall be made when the facility deems it necessary or when the resident requests the change. The resident will receive a written notice, including the reason for (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the change, before their room or roommate is changed. Information regarding transfers will be documented in the resident's medical record.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 67 residents. The sample included 17 residents with two residents reviewed for bed rail safety. Based on interview, observation, and record review, the facility failed to assess Resident (R)1 and R29 for safe use and necessity of the bed rails. The facility further failed to obtain and document that risks of bed rail use were explained and informed consent from the resident and/or representative was obtained. Findings include:- 1. Review of R1's Electronic Health Record (EHR) revealed diagnoses that included morbid obesity (excessive body fat) and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), R1's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. R1 utilized a wheelchair for locomotion, required substantial/maximal assistance for rolling left to right, and was dependent on staff for transfers. The assessment documented bed rails were not used. R1's Quarterly MDS, dated 10/09/25, documented a BIMS score of nine, which indicated moderately impaired cognition. R1 utilized a wheelchair for locomotion and was dependent on staff for mobility and transfers. The assessment documented bed rails were not used. R1's Care Plan, reviewed on 12/16/25, documented on 10/11/24, R1 was at risk for falls related to poor ambulation (manner or style of walking) techniques, and staff would provide half rails to promote safe transfers and independence, initiated on 10/31/24. Review of R1's clinical record lacked evidence of a safety assessment. The clinical record also lacked evidence risks were explained, and informed consent was obtained prior to installation of the rails. During an observation on 12/15/25 at 01:37 PM, R1's bed had a quarter-length bed rail attached to both sides of the bed. R1 was able to move the bed rail side-to-side with minimal effort. During an observation on 12/16/25 at 11:20 AM, R1 rested in bed with the bed rails still attached to both sides of his bed. During an observation on 12/18/25 at 07:40 AM, R1 rested in bed. The bed continued with the bed rails attached to both sides of the bed. 2. Review of R29's EHR revealed diagnoses that included schizophrenia and generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R29's Annual MDS, dated 02/09/25, documented a BIMS score of 15, which indicated intact cognitions. R29 was independent with locomotion, mobility, and transfers. The assessment documented bed rails were not used. R29's Quarterly MDS, dated 11/12/25, documented a BIMS score of 99, which indicated the assessment could not be completed. The staff assessment for mental status indicated modified independence. R29 was independent with locomotion, mobility, and transfers. The assessment documented bed rails were not used. Review of R29's clinical record lacked evidence of a safety assessment. The clinical record also lacked evidence risks were explained, and informed consent was obtained prior to installation of the rails. During an observation on 12/16/25 at 08:20 AM, R29 rested in bed with an eighth-length bed rail attached to one side of the bed frame. During an observation on 12/18/25 at 10:15 AM, R29's bed had an eighth-length bed attached to one side of the bed frame. During a walk-through observation on 12/18/25 at 11:40 AM with Maintenance U, Maintenance U confirmed the presence of bed rails on R29 and R1's beds. During an interview on 12/15/25 at 01:37 PM, R1 revealed he utilized the bed rails for turning and repositioning in bed. During an interview on 12/15/25 at 01:39 PM, R29 was unable to explain why there was a bed rail on his bed. R29 stated that it had always been attached to his bed. R29 revealed that he was able to turn over in bed and get out of bed independently without the use of the bed rail. During an interview on 12/18/25 at 10:20 AM, Licensed Nurse (LN) I stated the presence or absence of bed rails was part of the nursing assessment evaluation in the EHR and was completed on admission to the facility and as needed. The need for bed rails was part of a physical therapy evaluation and would be recommended (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by physical therapy and placed on the beds by physical therapy personnel. During an interview on 12/18/25 at 11:40 AM, Maintenance U stated he was responsible for periodic inspection of the bed rails to ensure they were securely fastened to the bed frames, but the need for bed rails was determined by either nursing or physical therapy personnel. During an interview on 12/18/25 at 01:00 PM, Administrative Nurse E stated physical therapy assessed residents to see if they needed bed rails and that there should be a quarterly assessment performed specifically for bed rail safety. Administrative Nurse E identified eight residents in the facility with bed rails. The facility's F689 Accidents F700 F909 Bed Safety - Bed Rails policy, dated 04/2025, documented bed rails were defined as adjustable metal or rigid plastic bars attached to the bed. The policy documented staff would assess the current status of the need for any type of bed rail. Prior to applying the bed rail, staff would obtain informed consent from the resident and obtain a physician's order for the use of the bed rail. Staff would install the bed rail utilizing the manufacturer's instructions and specifications, then inspect it regularly for safety.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. The facility reported a census of 67 residents. The sample included 17 residents with two residents reviewed for bed rail safety. Based on interview, observation, and record review, the facility failed to inspect the bed rails to ensure correct and secure installation on the beds for Resident (R)1 and R29. Findings include: - Upon request for a record or log of the regular maintenance inspections of the bed rails, the facility provided the Assessment history Nursing: Side Rail Evaluation-V5 with a date range of 12/01/24 through 12/22/25. The document did not list any assessments for R1 or R29 prior to the survey event. The facility was unable to provide any evidence of regular maintenance inspections of the bed rails for R1 or R29 upon request. During an observation on 12/15/25 at 01:37 PM, R1's bed had a quarter-length bed rail attached to both sides of the bed. R1 was able to move the bed rail side-to-side with minimal effort. During an observation on 12/16/25 at 08:20 AM, R29 rested in bed with an eighth-length bed rail attached to one side of the bed frame. During a walk-through observation on 12/18/25 at 11:40 AM with Maintenance U, Maintenance U confirmed the presence of bed rails on R29 and R1's beds. During an interview on 12/18/25 at 10:20 AM, Licensed Nurse (LN) I stated bed rails were placed on the beds by physical therapy personnel. During an interview on 12/18/25 at 11:40 AM, Maintenance U stated he was responsible for periodic inspection of the bed rails to ensure they were securely fastened to the bed frames, but the need for bed rails was determined by either nursing or physical therapy personnel. Maintenance U stated he did inspections, but was unable to say how frequently they were done, when it was last done, and whether it was ever done for R1 or R29. During an interview on 12/18/25 at 01:00 PM, Administrative Nurse E identified eight residents in the facility with bed rails. Administrative Nurse E stated maintenance personnel should conduct periodic inspections to ensure the bed rails were safe for residents to use. The facility's F689 Accidents F700 F909 Bed Safety - Bed Rails policy, dated 04/2025, documented bed rails were defined as adjustable metal or rigid plastic bars attached to the bed. Staff would install the bed rail utilizing the manufacturer's instructions and specifications, then inspect it regularly for safety.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. The facility reported a census of 67 residents. Based on observations, interviews, and record review, the facility failed to maintain and / or dispose of kitchen garbage and refuse properly. Findings included: -During a tour of the kitchen on 12/16/25 at 10:10 AM, observation revealed the outside garbage receptacle had one lid open. On 12/17/25 at 05:10 PM, observation revealed two of the lids on the trash receptacle were left open. Two female staff members were observed rolling a large, uncovered trash can through the parking lot, toward the garbage receptacle in the corner of the lot. During an interview on 12/16/25 at 1020 AM, Dietary Staff BB reported that all lids to outdoor trash receptacles were to be closed. The facility's policy Food-Related Garbage and Rubbish Disposal F814, last approved 10/2025, states outside dumpsters provided by garbage pick up services will be kept closed, and free of surrounding litter, garbage containers are covered when removed from the kitchen area to the dumpster.