STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175433	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Parkview Heights Nursing and Rehabilitation Center	101 N Pine Street Garnett, KS 66032

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS) for four residents: Resident (R) 3, R2, R14 and R30, related to anticoagulant medication (medication used to prevent clotting).Findings included:1. R3's Electronic Medical Record (EMR) recorded a Minimum Data Set (MDS), dated [DATE], which documented R3 received an anticoagulant medication (medication used to prevent clotting) during the assessment look-back period.R3's EMR under the Orders tab, revealed the following Physician's Order:Plavix (an antiplatelet medication), 75 milligrams, by mouth, every day, for a diagnosis of atherosclerosis arteries of extremities (when fatty plaque builds up in the arteries that supply blood to your limbs), ordered 01/19/19.2. R14's Electronic Medical Record (EMR) recorded a Minimum Data Set (MDS), dated [DATE], which recorded R14 received an anticoagulant medication (medication used to prevent clotting) during the assessment look-back period.R14's EMR under the Orders tab revealed the following Physician's Order:Plavix, 75 milligrams, by mouth, every day, for a diagnosis 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), ordered 11/24/22.3. R30's EMR recorded a Minimum Data Set (MDS), dated [DATE], which recorded R30 received an anticoagulant medication (medication used to prevent clotting) during the assessment look-back period.R30's EMR under the Orders tab, revealed the following Physician's Order:Plavix, 75 milligrams, by mouth, every day, for a diagnosis of atherosclerotic heart disease (chronic inflammatory process where plaque builds up inside the arterial walls), ordered 04/24/25.4. R2's EMR recorded a admission MDS, dated [DATE], which recorded R2 received an anticoagulant medication during the assessment look-back period.R2's EMR under the Orders tab, revealed the following Physician's Order: Plavix 75 mg, by mouth, every day, for a diagnosis of atherosclerosis arteries of extremities, ordered 12/28/2025.On 05/21/26 at 12:26 PM, Licensed Registered Nurse (LRN/MDS) B confirmed she had coded the MDS incorrectly regarding the Plavix. LRN/MDS B confirmed Plavix was not an anticoagulant.On 05/21/26 at 02:09 PM, Administrative Nurse C stated it was the expectation for the MDSs to be completed accurately.The facility utilized the Resident Assessment Instrument for completion of accurate MDSs.

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

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

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(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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident (R) 7 received assistance with activities of daily living (ADL) of cleansing off her face. Findings included:- R7's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and weakness.R7's Significant Change Minimum Data Set (MDS), dated [DATE], documented R7 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. R7 MDS revealed she had no behaviors and R7 required moderate assistance with personal hygiene. R7's Falls Care Area Assessment (CAA), dated 03/25/25, documented R7 required assistance with mobility and hygiene. R7's Care Plan, dated 10/11/23, instructed staff that R7 was dependent on staff for personal hygiene. R7's Physician Orders, documented Valtrex (is a prescription antiviral medication used to treat and manage viral infections like cold sores), give 1 gram, 1 tablet, by mouth three times a day for sore in mouth until 05/23/26, date ordered 05/19/26. On 05/19/26 at 10:12 AM, R7 was seated in a recliner in lounge area with her eyes closed and a brown colored film of dried food that looked like chocolate pudding noted on her lower lip. On 05/19/26 at 12:53 PM, R7 was seated in the recliner in lounge area with her eyes closed and a dry brown colored film noted on her lower lip.On 05/20/26 at 07:31 AM, R7 sat in her wheelchair at a table near the nurse station she reported she was ok, observed the dried on brown film on her lower lip she reported that she did not know what was wrong with her lip as she tried to wipe it off with a tissue and it did not wipe off.On 05/20/26 at 10:30 AM, staff assisted R7 from activities in her wheelchair to the lounge area. R7 sat there for a little while in her wheelchair. R7 self-propelled around independently, and staff brought her over to the table next to the nurse station and encouraged R7 to fold a basket of towels. She remained with the brown film on lower lip. On 05/21/26 at 08:10 AM, R7 was seated in the dining room with the dried brown film on her lower lip. On 05/21/26 at 08:38 AM, Certified Nurse Aide (CNA) H reported that he was told not to touch R7's mouth/lips as the brown film was dried blood. On 05/21/26 at 01:22 PM, Licensed Nurse (LN) F reported that the CNAs should wipe off R7's lips and the nurse should make sure they are doing that. LN F reported she was unsure what R7 had on her lip, that it was sore and it would bleed. On 05/21/26 at 12:50 PM, Administrative Nurse D revealed she was unsure why R7 was on Valtrex, she reported that she expected the staff to assist R7 with wiping off her lip. The facility's policy Activities of Daily Living (ADLs), dated 06/01/25, documented a resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to identify and implement resident-centered fall interventions for Resident (R) 7, R2, and R13 who were at risk for falls.Findings included:- R7's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and unsteadiness on feet. R7's Significant Change Minimum Data Set (MDS), dated [DATE], documented R7 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. R7 required supervision and touching for transfers, standing, and walking 150 feet; no falls documented. R7's Falls Care Area Assessment (CAA), dated 03/25/25, documented R7 had experienced falls during the lookback window; fall on 03/14/26 resulted in an intra-thalamic bleed (thalamic hemorrhage is a type of stroke that occurs when a blood vessel ruptures within the thalamus) and three right side rib fractures (broken bone). R7 required assistance with mobility and hygiene, has poor safety awareness related to dementia and occasional incontinence of bowel and bladder. She was also prescribed medications that can increase risk of falls. R7's Care Plan, dated 10/01/24, instructed staff to provide call lights within reach and encourage the resident to use it for assistance as needed. R7 needed prompt responses for assistance. R7's Care Plan, dated 10/05/25, instructed staff to educate the resident on the controls of the new recliner and provide her reminders. R7's Care Plan, dated 03/22/26, instructed staff to provide toileting every two hours. R7's Care Plan, dated 03/27/26, documented the plan of care was reviewed and the resident assisted per the care plan in commons area for close observation and continue with current care plan in place. R7's Care Plan, dated 03/31/26, instructed staff to provide 30-minute checks when R7 sat in living room. R7's Care Plan, dated 04/01/26, instructed staff that R7 may rest in recliner in television lounge when feeling restless. R7's Care Plan, dated 04/15/26, documented the plan of care was reviewed in place; the resident was in the living room for close observation, seen by multiple staff five minutes prior to fall with the wheelchair next to the resident. Reinforce with resident to wait for staff assistance for tasks. R7's Care Plan, dated 05/03/26, instructed staff to ask R7 if she is tired, and would like to lay in a recliner or her bed, hourly. R7's Care Plan, dated 05/15/26, for fall on 05/07/26 staff to ensure recliner remote is placed in the pocket of the chair so resident cannot sit on it. R7's EMR under Assessments documented fall assessments, completed on 11/04/25, 12/06/25, 01/08/26, 01/13/26, 02/13/26, 03/15/26. 03/18/26, 03/23/26, 03/28/26, 04/16/26, 04/20/26, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	05/03/26, and 05/08/26 R7 were a high risk for falls. R7's Progress Note, dated 11/03/25 at 07:37 AM, documented the resident fell on the way to the bathroom in room. A nurse assessed the resident and found no visualized injury. The resident made no complaints of pain. Review of facility's unwitnessed fall report, dated 11/05/25, documented that R7 was unsteady on her feet and ambulated in room frequently without walker, staff was to encourage R7 to use her walker when ambulating. R7 was alert with confusion and is an active exit seeker. R7's Progress Note, dated 01/08/26 at 05:01 AM, R7 ambulated in hallway with staff. Red in color spots noted on her pants. R7 had a skin tear to left knee, resident had reopened it when she fell again, and the resident did not report the fall at the time of the fall. Review of facility's unwitnessed fall report, dated 01/11/26, documented that R7 was independent in her room with all transfers, refused to use call light despite frequent reminders. Continue with current care plan. R7's Progress Note, dated 03/14/26 at 10:47 AM, documented R7 was found sitting on floor, leaning back against bed; her pants were down on her hips with laundry towels on her lap. Hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) was noted on right side of forehead just above right eye. R7 reported she was at dresser and fell while turning around to move. She reports she hit her head on her floor and landed on her right side. Staff advised to send the resident to emergency room for evaluation due to blood thinner. Review of facility's unwitnessed fall report, dated 03/14/26, documented R7 was found on the floor next to her dresser with her pants not pulled up all the way, R7 was unsteady on her feet, turned and lost balance, fell and hit her head; fall intervention put in place, evening shift staff instructed to assist R7 with picking out her clothing for the next day. R7's Device Assessment on 03/18/26 at 11:28 AM documented a specialty chair was assessed and was being used by the resident; specialty chair used per recommendation for optimal positioning, safety, and pressure reduction. An ambulatory device of a cane or walker was assessed and was being used by resident. This device had been evaluated as assistance with ambulation. No injuries or adverse outcomes were noted due to the use of stated devices in facility. The resident continued to benefit from the use of stated devices in center. Devices were reassessed quarterly and as indicated with a change in resident condition. R7's Progress Note, dated 03/27/26 at 06:04 PM, noted R7 fell onto floor, trying to climb out of a reclined chair. She sustained a laceration noted to the right eyebrow, and an abrasion to the right elbow. The hospice nurse would come out to assess R7. Review of facility's unwitnessed fall report date 03/31/36 documented R7 was restless and unaware of safety needs; she did not put recliner foot down before she tried transfer self. Continue current plan of care. R7's Progress Note, dated 4/20/2026 at 04:22, noted R7 was in the recliner and attempted to get up to get out of chair to use the restroom. Staff witnessed R7 from across the living room during the incident. R7 attempted to get out of recliner while the footrest was up and fell over the footrest and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rolled onto her right side on the floor. R7 obtained skin tears to her right elbow and both knees. Review of facility's witnessed fall report dated 04/20/26 documented a new intervention for staff to toilet the resident after lunch. R7's Progress Note, dated 05/07/2026 at 04:55 PM documented staff found R7 sitting on the floor in front of the recliner in the living room. The recliner was in the highest position when the resident was found. She stated I don't know what happened, with no signs of injury. Review of facility's unwitnessed fall report dated 05/15/26 documented R7 leaned on the remote for recliner and raised the recliner to the highest position. The intervention noted staff were educated to ensure the recliner remote was placed in the pocket of the chair so R7 would not sit on remote. R7's EMR lacked any further Device Assessment completed after any of her falls from the recliner. On 05/19/2026 at 10:12 AM R7 sat in a recliner in the lounge with her eyes closed. She had dried food on her lower lips. The recliner remote lay on the floor. On 05/19/26 at 03:00 PM R7 sat in the recliner in the lounge. R7 eyes were closed and the recliner remote lay on her chair on her left side near her hip. On 05/19/26 at 03:28 PM R7 attempted to get up from the recliner; staff intervened and assisted her up to her wheelchair. On 05/20/26 at 10:30 AM staff assisted R7 from activities in her wheelchair to the lounge area. R7 sat there for a little while in her wheelchair. R7 self-propelled around independently, and staff brought her over to the table next to the nurse station and encouraged R7 to fold a basket of towels. On 05/21/2026 at 07:52 AM R7 laid in bed. She reached up and pulled her light switch to her over bed light on. On 05/21/26 at 12:10 PM Certified Nurse Aide (CNA) M reported that if residents were to fall, staff would call the nurse over their microphone. CNA M reported there was usually an intervention completed right after a fall, and it was communicated during report. CNA M reported that the intervention was documented on the care plan, and the staff are trained to look at EMR on the Kardex for interventions. On 05/21/26 at 12:13 PM Licensed Nurse (LN) F reported that an intervention was discussed after a resident had a fall. LN F reported that Administrative Nurse D would update the care plan. LN F reported the staff would discuss an intervention change verbally during report so the staff would know. LN F revealed usually we would change an intervention for a fall. On 05/21/2026 at 02:09 PM, Administrative Nurse C stated R7 had the right to fall, and 30-minute checks would ensure the staff saw R7 at least every 30 minutes to ensure her safety. Administrative Nurse C reported that intervention one on one for R7 was not documented in EMR, and the staff know they have to complete the one on one when R7 was restless. Administrative Nurse C had no reply when asked how a resident with a BIMS of 4 could remember when reminded to call for assistance, use her walker or wait for assistance. Administrative Nurse C reported that a device assessment was completed for residents with a lift chair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy for Incidents and Accidents, revised 06/01/2025, included: The facility shall ensure appropriate and immediate interventions are implemented to prevent reoccurrences and improve the management of resident care. - R2's Electronic Medical Record (EMR) revealed diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain), and weakness and unsteadiness on feet. R2's admission Change Minimum Data Set, (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. R2's MDS revealed he required maximal assistance with transfers, and he was non-ambulatory. R2 was independent with wheelchair mobility. R7's MDS revealed he had falls before he was admitted in the last 2-6 months prior to admission but no falls since he was admitted . R2's Falls Care Area Assessment (CAA), dated 01/15/26, documented R2 was admitted from a rehabilitation hospital with reports of falls on provided documentation. His fall score of 65 reflected a high risk for falls related to history of falls, diagnoses, and weakness, and the BIMS of seven reflected severe cognitive impairment, with poor safety awareness. Staff will anticipate R2's needs in minimizing risk of falls. R2's Care Plan, dated 12/28/25, instructed staff to have call light is within reach and encourage me to use it for assistance as needed. I need prompt responses to all requests for assistance. R2's Care Plan, date initiated 01/11/26, instructed staff to have R2 on close observation related to known wandering behaviors and known poor sleep habits. Continue with current POC in place. R2's Care Plan, date initiated 01/23/26, instructed staff to keep wheelchair pedals in bag on back of wheelchair and not on the side of the wheelchair to reduce another fidget and getting caught on items when self-propelling. R2's Care Plan, date initiated 01/25/26, instructed staff to provide one on one observation overnight when R2 was awake. R2's Care Plan, date initiated 02/24/26, instructed staff to assist R2 with toileting around 03:00 to 04:00 PM. R2's EMR under Assessments documented fall assessments, completed on 01/08/26, 01/11/26, 01/23/26, 02/18/26, 03/04/26, and 04/05/26 R2 were a high risk for falls. R2's Progress Note, dated 01/06/26 at 01:38 PM, documented R2 was admitted to the facility. R2's Device Assessment, on 01/07/26 at 08:13 AM documented a specialty chair was assessed and was being used by the resident. Specialty chair used per recommendation for optimal positioning, safety, and pressure reduction. An ambulatory device of a cane or walker was assessed and was being used by resident. This device had been evaluated as assistance with ambulation. No injuries or adverse outcomes were noted due to the use of stated devices in facility. The resident continued to benefit from the use of stated devices in center. Devices were reassessed quarterly and as indicated with a change in residents' condition. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's Progress Note, dated 01/10/2026 at 05:10 AM, documented R2 was lying in recliner in living area, staff had just assisted R2 to the bathroom, R2 scooted self to the end of the footrest, chair tipped, and resident fell out of recliner onto floor, onto his right side of his face on the floor. R2 received a skin tear to the right elbow, left thumb, abrasion to right eye. Review of facility's unwitnessed fall report dated 01/11/26 documented R2 does not sleep well and required constant staff supervision for safety; R2 sleeps in recliner in living room; Continue with current care plan. R2's Progress Note, dated 01/23/2026 12:13 AM, documented R2 was in recliner with legs elevated, eyes were closed. The staff observed him in recliner while the staff walked past to go check on another resident. Staff called on walkie that R2 was on the floor, no noted injuries. R2 is a one on one, as R2 does not sleep well, resident tries to get out of recliner, when he wakes up. R2 is alert to self only. R2 forgets he cannot stand or ambulate by himself. Review of facility's unwitnessed fall report dated 01/25/26 R2 is a one-on-one observation overnight when awake. On 05/20/26 at 10:39 AM Certified Nurse Aide (CNA) M and CNA O assisted R2 to his wheelchair they used a gait belt and communicated well with R2. He had difficulty standing up well and kept his knees bent. CNA O propelled R2 in his wheelchair down the hallway to his room approximately 75 feet. No foot pedals were placed on the wheelchair, and his feet hit the floor three times once with a jerking motion of the wheelchair, while she propelled him down the hallway after the third time R2's foot hit the floor CNA O told the resident to keep his feet up. CNA M and CNA O assisted R2 to the toilet and he struggled to stand up well for the staff. CNA M and CNA O completed hands on care and assisted R2 up from the toilet, he struggled to stand, knees were bent, and he had a hard time holding onto the bar on the wall. CNA O reported that she had to bear full weight with the transfer. R2 family member was in the room during care and reported that he had done much better with standing in the past. On 05/20/26 at 01:25 PM R2 sat in his wheelchair self-propelling around in the TV lounge area. On 05/20/26 at 03:30 PM R2 sat in his wheelchair with his feet propped up on a chair and had his eyes closed. On 05/21/26 at 10:38 AM Certified Medication Aide (CMA) I propelled R2 out of his room in his wheelchair and pushed R2 in his wheelchair from his room to nurse station approximately 75 feet with no foot pedals on the wheelchair. On 05/21/26 at 10:40 AM CMA I reported that R2 could not use foot pedals as he had received a bad skin tear on his left leg when he was transferred to the wheelchair, and the foot pedal latch was then covered with a pool noodle cover. CNA H reported that R2 was able to keep his feet up by himself. On 05/21/2026 10:42 AM Licensed Nurse (LN) F reported that R2 should probably use foot pedals when being transported in the wheelchair by the staff. LN F reported that foot pedals are left in the bag hung off the back of a resident's wheelchair when they propel themselves. On 05/21/2026 at 02:09 PM, Administrative Nurse C stated R2 had the right to fall, Administrative Nurse C reported that intervention one on one for R2 was not documented in EMR, that the staff know they must complete the one on one when R2 was awake. Administrative Nurse C reported that a (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	device assessment was completed for residents with a lift chair. The facility policy for Incidents and Accidents, revised 06/01/2025, included: The facility shall ensure appropriate and immediate interventions are implemented to prevent reoccurrences and improve the management of resident care. - R13's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion). R13's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. She required partial to moderate staff assistance with standing from a sitting position and used a walker and a wheelchair for mobility. She had one fall with injury (except major) since the prior assessment. R13's Fall Care Area Assessment (CAA), dated 11/27/2025, documented R13 had one fall resulting in a minor injury during the lookback assessment period. R13's Quarterly MDS, dated [DATE], documented she had a BIMS score of three, indicating severe cognitive impairment. She was dependent on staff with standing from a sitting position and used a walker and a wheelchair for mobility. She had one fall with injury since the prior assessment. R13's Care Plan, revised 05/01/26, included staff instruction that she was at risk for falls. Staff were to keep a sign on her bedside table to remind her to call for assistance when she needed to get up and to do hourly rounds to ensure her safety. R13's EMR under the Assessments tab, revealed a fall assessment which placed her at a low risk for falls on 04/19/2026. Further fall assessments, dated 02/23/2026, 01/27/2026, 11/13/2025, and 08/23/2025, placed R13 at a high risk for falls. A Fall Report, dated 04/18/2026, provided by the facility documented R13 had an unwitnessed fall in her room at approximately 02:45 PM. Staff discovered R13 on her back on the floor of her room. R13 was able to move all extremities per normal, and her vital signs (VS) were within normal limits (WNL). Staff assisted her up from the floor and assisted her to sit in her recliner. Staff implemented a fall intervention for staff to do hourly rounds to ensure R13's safety. A Fall Report, dated 01/17/2026, provided by the facility documented R13 had an unwitnessed fall in her room at 08:00 PM. Staff discovered R13 on her back on the floor of her room in front of her recliner. She was able to move all extremities per normal, and her VS were WNL. Staff assisted her up from the floor and assisted her to sit in her recliner. Staff implemented a fall intervention to place a sign on her bedside table reminding her to call staff for assistance before getting up on her own. On 05/19/2026 at 10:35 AM, R13 sat in her recliner in her room. Her call light rested on the floor next to her chair and her bedside table lacked a sign reminding her to call for staff if she needed assistance getting up. On 05/20/2026 at 10:45 AM, R13 sat in her recliner in her room. Her call light rested on the floor next to her chair and her bedside table lacked a sign reminding her to call for staff if she needed assistance getting up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/20/2026 at 01:52 PM, Certified Nurse Aide (CNA) J stated R13 was confused and requires staff assistance with most of her ADLs. CNA J was unaware of fall interventions for R13 but stated she should have her call light within reach when she was in her recliner. On 05/29/2026 at 01:52 PM, CNA H stated R13 was able to walk at times but required staff assistance. CNA H confirmed R13's bedside table lacked a sign reminding her to call for staff if she needed assistance getting up. CNA H stated R13 should have her call light when she was in her room and stated he was unaware of her fall interventions. On 05/20/2026 at 09:37 AM, Licensed Practical Nurse (LPN) E stated staff were to implement a new fall intervention following each fall. The intervention would then be added to the care plan and communicated to the staff. On 05/21/2026 at 02:09 PM, Administrative Nurse C stated the resident had the right to fall. Hourly rounds would ensure the staff saw R13 at least every one hour to ensure her safety. Administrative Nurse C stated she would expect staff to ensure a sign was on R13's bedside table to remind her to call for assistance when she needed to get up. The facility policy for Incidents and Accidents, revised 06/01/2025, included: The facility shall ensure appropriate and immediate interventions are implemented to prevent reoccurrences and improve the management of resident care.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R)2 received the necessary nutritional support when staff failed to provide a breakfast meal for several days in May 2026. Findings include:- R2's Electronic Medical Record (EMR) revealed diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by decreased blood flow to the brain) and dysphagia (swallowing difficulty). R2's admission Change Minimum Data Set, (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of seven, indicating severely impaired cognition. R2's MDS revealed he required touching assistance for eating; he had no weight loss and was on a therapeutic diet.R2's Nutritional Status Care Area Assessment (CAA), dated 01/15/26, documented R2 was participating in speech therapy services at a skilled level of care due to dysphagia. R2 received a regular diet of mech soft texture and thin consistency. R2 typically eats 76-100% of meals and snacks. Chart review reflects a stable weight of approximately 130 pounds. Staff would monitor and document oral intake and nutritional changes. Any changes will be addressed with the dietician and physician. R2's Care Plan, dated 12/28/25, staff instructed R2 required supervision or touching assistance when eating. R2's Care Plan, dated 02/03/26, staff were instructed to weigh R2 at the same time of day and record: weekly and as needed with bath scale. Staff were instructed to notify Registered Dietician (RD) and provider of weight loss greater than five pounds (Lbs.). R2's Care Plan, dated 02/04/26, staff were instructed to monitor/record/report to R2's provider as needed signs or symptoms of malnutrition, muscle waste, significant weight loss: greater than 5% in one month, greater than 7.5% in three months, and greater than 10% in six months. Consultant Staff U (RD) to evaluate and make diet change recommendations as needed. R2's Physician Orders, documented regular diet, mechanical soft consistency, and thin liquid consistency, and double protein at meals for wound healing, date ordered 12/30/25.R2's Physician Orders, documented weights weekly with bath days Tuesday or Thursday eveningone time a day, date ordered 12/30/25. R2's Weights, reviewed 04/11/26 through 05/13/26 documented in EMR documented:04/11/26 at 01:28 PM weighed 137.5 Lbs.04/15/26 at 01:50 PM weighed 138.1 Lbs.04/18/26 at 01:57 PM weighed 139.5 Lbs.04/22/26 at 01:41 PM weighed 138.9 Lbs.04/29/26 at 08:51 AM weighed 132.0 Lbs.05/06/26 at 01:22 PM weighed 130.0 Lbs.05/09/26 at 01:56 PM weighed 132.6 Lbs.05/13/26 at 01:42 PM weighed 126.6 Lbs.R2's Registered Dietician Note, dated 05/04/26 03:43 weight on 04/2926 of 132 Lbs. was an unplanned seven Lbs. weight loss in one week. Does not trigger for significant weight loss. R2 is sleeping more and thus not eating as well. Discussed this with interdisciplinary team today. Provider notification would be prepared today notifying him of weight loss. R2 started on 15 milligrams of Remeron (an antidepressant a class of medications used to treat mood disorders) for mood disorder. Remeron can have side effects of increasing appetite. R2's Registered Dietician Note, dated 05/19/26 at 04:02 PM documented, weight on 05/13/26 of 127 Lbs. was a significant, unplanned 8% & 7.5% weight loss in one and three months. R2 continued to sleep throughout the day, thereby making it difficult to eat. Recommend discontinue the double portion entree' due to not eating well. The past week, on average, consumed 33% of his meals. Start an 8-ounce house supplement at bedtime today. R2's Nutrition Amount Eaten, documented in tasks on EMR reviewed from 05/03/26 through 05/21/26 revealed for breakfast meal intake documented on 05/03/26, 05/10/26, 05/13/26, and 05/14/26 lacked a breakfast meal percentage. The breakfast meal intake documented the resident unavailable on 05/04/26, 05/11/26, 05/15/26, 05/20/26 and 05/21/26. The breakfast meal intake documented the resident refused on 05/08/26, and 05/18/26. On 05/20/26 at 07:32 AM R2 was seated in the recliner in the television lounge his eyes were closed, and his upper denture was very dry and stuck to his upper lip. On 05/20/26 at 09:05 AM R2 remained in the recliner in lounge with eyes closed and dry denture remained stuck to his upper lip place. R2 was not observed in the dining room. Resident sat in the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	recliner under direct observation from 09:05 AM through 10:39 AM. Certified Nurse Aide (CNA) M and CNA O assisted R2 for AM care in his room. On 05/20/26 at 10:50 AM CNA O reported that R2 had just woken up and did not have breakfast. On 05/20/26 at 11:00 AM No breakfast was observed given to R2. After AM care on 05/20/26 he was assisted back into his recliner by CNA M and CNA O. On 05/20/26 at 12:00 PM R2 was in the dining room with his family drinking fluids. At 12:30 PM R2's family member reported that he was so much more awake and ate some of his lunch. On 05/20/26 at 01:25 PM R2 was seated in his wheelchair self-propelling around in the TV lounge area. On 05/20/26 at 03:30 PM R2 sat in his wheelchair with his feet propped up on a chair and had his eyes closed. On 05/21/26 at 07:35 AM R2 was seated in the recliner in the TV lounge with his eyes closed and his dry upper denture hung out of his mouth. On 05/21/26 at 08:51 AM R2 remained in his recliner as above and he had not been offered breakfast. On 05/21/26 at 09:30 AM CNA H reported that R2 would sometimes get up for breakfast, but he stays up late he does not get up for breakfast if he was sleeping that was the family request. CNA H reported that R2 should be getting him up soon and there was breakfast saved for him. On 05/21/26 at 10:38 AM Certified Medication Aide (CMA) I propelled R2 out of his room in his wheelchair and pushed R2 in his wheelchair from his room to nurse station approximately 75 feet with no foot pedals on the wheelchair. On 05/21/26 at 10:43 AM CAN H Provided R2 with a cup of coffee and no breakfast at the table near the nurse station. On 05/21/26 at 10:58 AM Licensed Nurse (LN) F and CNA H weighed R2 on chair scale in spa room, weight of 123.6. On 05/21/26 at 11:05 AM LN F reported that R2 had lost three Lbs., and she would let the charge nurse know. LN F reported that R2 should have been given breakfast. On 05/21/26 at 11:30 AM Dietary Staff P reported that she was involved with weight loss, and Consultant Staff U (RD) had been at the facility for the past two days. Administrative Staff A was also present and reported that the family did not want him woken up to eat and that is charted in the progress notes. Dietary Staff P reported that Consultant Staff P made a recommendation for a house shake on 05/19/26. Dietary Staff P revealed that R2 should have been offered something to eat when he is woken up and was not aware that he had missed meals. On 05/21/26 at 12:27 PM Consultant Staff P revealed that R2 had been sleepy and had started to have a weight loss. She expected the staff to offer R2 something to eat if it was not too close to the lunch meal that was served at 11:30 AM. She reported that R2 started on Remeron on 05/04/26 and that it should help his appetite. On 05/21/26 at 12:50 PM Administrative Staff A gave me the tasks nutrition documentation and some progress notes about R2's weight loss. She reported she could not locate progress notes in EMR before 05/19/26 of the family requests not to wake R2 up for meals. The facility's policy Frequency of Meals dated 01/25/26, documented the facility would ensure that each resident receives at least three meals daily without extensive time lapses between meals.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record and interview, the facility failed to ensure all residents were free from significant medication errors when a staff member administered 30 units of insulin to Resident (R)13, who was not a diabetic.Findings included: - R13's Electronic Medical Record (EMR) documented a diagnosis of dementia (a progressive mental disorder characterized by failing memory and confusion).R13's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. She did not have a diagnosis of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) and did not receive insulin during the seven-day lookback period.R13's Cognitive Loss/Dementia Care Area Assessment, dated 11/27/25, documented R13 had severe cognitive limitations.R13's Quarterly MDS, dated [DATE], documented she had a BIMS score of three, indicating severe cognitive impairment. She did not receive insulin during the lookback period.R13's Care Plan, revised 05/01/26, instructed staff to administer her medications, as ordered.R13's EMR under the Progress Notes tab, dated 05/06/26, documented Licensed Practical Nurse (LPN) G administered 30 units of Lantus insulin (a long-acting insulin used to control high blood sugar (BS) to R13, who was not diabetic, into her left upper arm. LPN G immediately noticed she had administered the insulin to the wrong resident and notified the on-call physician. R13's BS at the time of the insulin administration was 162 milligrams per deciliter (mg/dL). The on-call physician ordered BS to be taken every hour for four hours and if BS were stable to take BS every two hours. If R13's BS went below 70 ml/dL, staff were to administer Glucagon (a hormone produced by the pancreas that raises blood sugar levels) and send her to the emergency room. R13's BS remained stable throughout the night with the lowest BS reading 115 ml/dL at 03:45 AM; the facility staff continued to obtain R13's BS until 10:45 AM when the physician stated the resident was stable and they could stop.On 05/21/2026, LPN G stated she had administered the insulin to the wrong resident and immediately notified the on-call physician. The resident had no negative outcome from the medication error and R13's BS did not go below 70 ml/dL. LPN G stated she monitored R13 throughout the night.On 05/21/2026 at 02:09 PM, Administrative Nurse C stated it was the expectation for the staff to administer medications, as ordered.The facility policy for Medication Administration, revised 04/01/2026, included: Medications are to be administered, as ordered, by the physician.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff provided cognitively impaired Resident (R) 7 with her prescribed nectar thickened (liquid with slightly higher viscosity that pour easily but leave a coating on the glass or spoon, they slow down the swallowing process to prevent fluids from entering the lungs) liquids. Findings included:- R7's Electronic Medical Record (EMR) revealed diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and weakness.R7's Significant Change Minimum Data Set (MDS), dated [DATE], documented R7 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. R7's MDS revealed she was independent with eating. R7's Nutritional Status Care Area Assessment, dated 03/25/25, documented R7 had a prescribed regular diet of regular texture and thin liquids. Consumes 76-100% of meals and snacks of most meals but eating has become more sporadic. Resident has selected hospice care; therefore, comfort eating is encouraged. R7's Care Plan, dated 09/25/25, documented staff to serve diet as ordered, monitor intake and record. Staff to monitor nutritional status. R7's Care Plan, dated 05/19/26, lacked documentation that R7 had nectar thickened liquids ordered. R7's Physician Orders, documented provide regular diet mechanical soft texture (a modified diet that consists of soft, easy-to-chew foods that require minimal chewing), nectar consistency, serve food on red plate; ground meat with gravy, date ordered 05/06/26. R7's Dietary Note, dated 05/04/26 at 12:43 PM, documented nursing reported R7 was having trouble with swallowing liquids, and nursing staff would like her to receive slightly thickened liquids; however, point click care only has nectar thick liquids available as a diet option. Facility will update care plan.On 05/20/26 at 07:31 AM, Certified Nurse Aide (CNA) O assisted R7 to the dining room in her wheelchair. R7 was assisted to her table and where she was seated observed a glass of apple juice and orange juice both glasses approximately 120 milliliters (ml.) of regular thin liquid.On 05/20/26 at 08:37 AM, R7 was served breakfast and did not try to feed herself. CNA O sat down to assist her to eat. R7 had drank a full glass of orange juice and approximately 100 ml of apple juice from 07:33 AM till 08:30 AM and an unknown staff member brought her over another glass of orange juice and sat that in front of her. R7 refused to eat despite encouragement. CNA O gave R7 some coffee and R7 reported there it is and then R7 started to eat the food offered to her only a few bites. Noted that R7 had regular thin orange juice in her cup and apple juice. CNA O confirmed that the juices were not nectar thick and reported that she did not give R7 the juice and had not seen R7 drinking those juices before she sat down, she reported that R7 was nectar thick liquids only and did not know who gave her regular thin juices. CNA O reported that R7's coffee was nectar thick as she made it for her.On 05/21/26 at 08:10 AM R7 was seated in the dining room with regular thin water approximately 240 ml in front of her.On 05/21/26 at 08:12 AM Certified Medication Aide (CMA) I pushed the cup of water away from R7's reach. On 05/21/26 08:12 AM Dietary Staff Q reported that she passed the water this morning and the residents don't always stay seated in the same spot, she reported that R7 was on nectar thick liquid and poured her a cup of nectar thick liquid, she reported she worked yesterday and could not recall giving R7 any juices. On 05/21/26 08:16 AM Dietary Staff P (Certified Dietary Manager) reported that the staff normally pass the water before the residents come into the dining room. She reported that R7 does not usually get juice because she liked coffee. Dietary Staff P reported that the staff know that she is on nectar thick liquids and did not know who or why someone would give R7 juice yesterday and expected the correct fluids to be passed. 05/21/2026 8:20 AM CMA I reported that she noted that R7 had the regular thin water in front of her and pushed the water away from R7 out of her reach. CMA I reported she made R7 her nectar thick coffee then. The facility's policy Therapeutic Diet Orders dated 06/01/26 documented the facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences. Mechanically altered diet is one in which the texture or consistency of food is altered to facilitate oral intake. Examples include soft solids, pureed foods, ground meat, and thickened liquids. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on interviews, observation, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing direct care to a Resident (R) 7 with open wounds to her knees. Additionally, the facility failed to ensure adequate hand hygiene during a dressing change for R7 and perineal care for R2. The facility failed to properly transport clean personal linens.Findings included:1. On 05/19/26 at 03:32 PM Certified Nurse Aide (CNA) L and CNA N applied gloves, neither CNA performed hand hygiene, nor did they apply any other personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) before they assisted R7 to the bathroom and transferred her to the toilet. R7 had a dressing on each of her knees. CNA N removed R7's soiled brief. CNA L then removed her gloves without performing hand hygiene and tried to find R7 a different pair of shoes to wear in her closet. CNA L then applied her gloves without performing hand hygiene. CNA L and CNA N assisted R7 to her feet, CNA L cleansed R7 and CNA L and CNA N pulled up her pants and assisted R7 to her wheelchair. CNA L and CNA N removed their gloves without performing hand hygiene. CNA N removed the gait belt from R7, and CNA L placed the gait belt on her own waist and then both CNA L and CNA N performed hand hygiene. On 05/19/26 03:55 PM CNA L reported that she did not know that R7 was on EBP. CNA L reported that R7 did have open wounds on her knees. CNA L reported that the sticker on the resident's door name tag with the three blue swirling arrows that make a circle meant EBP and confirmed R7 had that sticker on R7's door name tag. CNA L reported that she did not wash her hands when she removed the old ones and should have performed better hand hygiene. On 05/19/26 at 04:00 PM CNA N reported that she did not know that R7 was on EBP. CNA N the sticker on the resident's door name tag with the three blue swirling arrows that make a circle meant EBP and confirmed R7 had that sticker on R7's door name tag and reported she did not notice that on her door tag. CNA N reported she should have performed hand hygiene before hands on care and after she removed her gloves.2. On 05/19/26 at 03:44 PM Licensed Nurse E sanitized her hands and applied gloves and a gown as she entered R7's room. LN E removed the R7's dressing from her right knee, the left knee dressing had rolled off as she pulled up the R7's pant leg. LN E cleansed both knees open areas, LN E removed her gloves and tried to find another pair of gloves in her pocket, CNA L handed LN L a pair of gloves, no hand hygiene was performed. LN E applied the pair of gloves and finished the dressing change.On 05/19/26 at 03:51 PM LN E reported that she did not think to perform hand hygiene when she removed her gloves before applying new ones. LN E reported that R7 was on EBP and that all staff should wear PPE gowns and gloves when they assist R7 with hands on care. 3. On 05/20/26 at 10:39 AM CNA M sanitized her hands applied gloves and gown as she entered R2's room. CNA O applied gloves and gown as she entered R2's room with no hand hygiene performed. CNA M used her gloved hands to open drawers, cupboards and closet doors looking for briefs and wipes. CNA O removed R2's soiled brief, CNA M and CNA O assisted R2 with change of clothes. CNA O removed her gloves without performing hand hygiene and applied new gloves. CNA O attempted to remove R2's upper denture and R2 refused to give them to her. CNA M and CNA O assisted R2 up from the toilet, he struggled to stand, knees were bent, and he had a hard time holding onto the grab-bar on the wall. CNA M cleansed R2 and pulled up his brief and clothes and assisted R2 to his wheelchair. On 05/20/26 at 02:06 PM CNA O reported that she did not realize that she did not wash her hands before she performed care, and that she should have washed her hands when she removed her gloves each time and before applying new gloves.On 05/20/26 at 02:06 PM CNA M reported that she should not have used her gloved hands to look for items in R2's room and that she should have washed her hands when she removed her gloves each time and before applying new gloves.4. On 05/20/26 at 11:03 AM observed Laundry Staff R delivered personal clothes to the residents' rooms in the 100 hallways, The linen cart was not covered as Laundry Staff R moved the linen cart down the hallway from room to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room, Laundry Staff R also was observed pulling the clothes off the rack in hangers and hugging the clothes against her uniform.On 05/20/26 at 11:10 AM Laundry Staff R reported that she would keep the linen cart uncovered while she delivered down the entire hallway. Laundry Staff R reported she did not realize that she hugged the clothes against her uniform. 5. On 05/20/26 at 11:16 AM LN K prepared R14's insulin in the nurse station. LN K picked up a washcloth off the floor that R7 had dropped on the floor and R7 attempted to reach for the washcloth on the floor. LN K entered R14's room without performing hand hygiene before she applied gloves and administered the insulin to R14. 6. On 05/20/26 at 11:39 AM LN K prepared R22's insulin in the nurse station. LN K put a pair of gloves, alcohol prep, and insulin pen into her pocket. LN K entered the dining room and propelled R22's wheelchair out to the hallway. LN K pulled the gloves, alcohol prep and insulin pen out of her pocket without performing hand hygiene before she applied her gloves and administered the insulin to R22.On 05/20/26 at 03:25 PM LN K reported that she should have performed hand hygiene after she picked up the towel off the floor before she placed her gloves to administer R14's insulin and she should have performed hand hygiene after she moved R22 into the hallway. On 05/21/26 at 09:50 AM Administrative Staff A reported that the linen should be covered when delivered down the hallways and the clothes/linen should not be hugged by staff. On 05/21/26 at 12:50 PM Administrative Nurse D (Infection Preventionist) revealed she expected staff to wear appropriate PPE when providing direct care for residents on EBP. Additionally, she expected the staff to use clean gloves when providing care. Administrative Nurse D revealed she expected staff to perform hand hygiene before providing care and perform hand hygiene after staff removed gloves before they apply new gloves. The facility's policy Enhanced Barrier Precautions, dated 04/01/26, documented PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. High-contact resident care activities include transferring, providing hygiene, changing briefs or assisting with toileting, and wound care: any skin opening requiring a dressing. The facility's policy Infection Prevention and Control Program, dated 02/15/26, documented hand hygiene shall be performed in accordance with our facility's established hand hygiene procedures; laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection; clean linen shall be delivered to resident care units on covered linen carts with covers down.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to offer and provide or obtain an informed declination for the COVID-19 vaccine (a vaccine designed to prevent highly contagious respiratory virus) for Resident (R) 2. Additionally, the facility failed to maintain staff documentation of screening, education, offering, and current COVID-19 vaccination status. Findings included:1. R2's Electronic Medical Record (EMR) lacked documentation of a COVID-19 vaccine being offered since 2022.On 05/21/26 at 12:50 PM, Administrative Nurse D (Infection Preventiveness) reported that the facility does not maintain staff documentation of screening, education, offering, and current COVID-19 vaccination status, and that if a staff member was ill then they are told to go to their provider and to let the facility know. The facility's policy Infection Prevention and Control Program, dated 02/15/26, documented COVID-19 Immunization:Residents and staff will be offered the COVID-19 vaccines when vaccine supplies are available to the facility. If COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. Residents or resident representatives will have the opportunity to accept or refuse a COVID-19 vaccination, and change their decision based on current guidance. Staff will have the opportunity to receive the COVID-19 vaccination or apply for a religious or medical exemption to the vaccine for facility consideration as per current Equal Employment Opportunity Commission (EEOC is an independent federal agency established by the Civil Rights Act of 1964 guidelines), state requirements, and/or facility policy. The facility will maintain documentation related to staff COVID-19 vaccination that includes at a minimum, the following:That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine.