STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pioneer Ridge Retirement Community	4851 Harvard Road Lawrence, KS 66049

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility reported a census of 62 residents. The Sample included 17, with two residents reviewed for dignity. Based on observations, record review, and interviews, the facility failed to ensure a dignified care environment for Resident (R) 1 and R21 during meal service. Findings Included:- On 12/02/25 at 12:22 PM, an observation was completed in the main dining room for meal service.R1 (a cognitively impaired resident who was physically dependent on staff assistance) sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) at the table closest to the kitchen entry door. R1 had a Foley catheter (an indwelling urinary catheter with a tube inserted into the bladder to drain urine into a collection bag). R1's urinary collection bag was hung directly under his wheelchair. R1's urinary collection bag was visible and was one-third full with bright yellow urine. R1 had no privacy cover on his urinary collection bag.R21 (a cognitively intact resident who was physically dependent on staff for assistance) sat at the dining room table closest to the kitchen serving window. R21 sat in her wheelchair with her Foley catheter tubing and collection bag attached to the bottom right side of her wheelchair. R21's urinary collection was half full of yellow urine with bag had no privacy barrier in place. On 12/03/25 at 02:15 PM, Certified Nurse's Aide (CNA) M stated all the wheelchairs had bags in the bottom to place the urinary collection bags. She stated urine in the bag should not be visible.On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated all the residents had dignity/privacy bags for the Foley catheters. She stated staff were expected to place them in the bags when transferring the residents to their wheelchairs.On 12/03/25 at 02:43 PM, Administrative Nurse D stated the resident's urine collection bags were to never be placed directly on the wheelchairs without having a dignity bag in place. He stated it was the staff's responsibility to ensure resident dignity.The facility's Urinary Catheter Usage policy, revised 11/2017, indicated staff were to ensure the appropriate placement and functionality of the catheters each shift. The policy indicated staff were responsible for maintaining the catheters with placement below the resident's bladder and ensuring sanitary practices. The policy noted that staff were to provide privacy barriers or covers.The facility's Resident Rights policy, revised 11/2017, indicated the facility was to ensure all residents were treated in a dignified manner. The policy indicated the facility was to provide ongoing education and In-service.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. The facility identified a census of 62 residents. The sample included 17 residents. Based on interviews, observation, and record review, the facility failed to post the previous state inspection information in a location accessible to residents and visitors. Findings included:- On 12/02/25 at 03:30 PM, review of the state agency results book that was available in the lobby area lacked the Statement of Deficiencies, which included citations from a complaint survey conducted on 10/25/25. On 12/03/25 at 10:21 AM, Administrative Staff A stated the survey binder that was available for the residents, families, and visitors did not contain the previous state inspection results. The facility's Resident Rights policy, dated 04/27/18, documented the resident had the right to self-determination.

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. The facility identified a census of 62 residents. The sample included 17 residents, with one reviewed for privacy. Based on observation, record review, and interviews, the facility failed to secure protected health information (PHI) for Resident (R) 62. Findings Included:On 12/01/25 at 07:15 AM, an inspection of the Red Hall revealed an unsecured and unsupervised treatment cart outside R62's room. The cart contained stock medications, treatment supplies, and insulin for residents on the hall. The cart laptop was open and contained R62's picture and protected health information (PHI) within direct view.On 12/01/25 at 07:18 AM, Licensed Nurse (LN) J opened R62's door and exited the room into the hallway. LN J stated she was not sure if the medication carts were supposed to be locked, but would lock them during the survey inspection. She stated the PHI should not be left open on the computers when not in use.On 12/03/25 at 02:43 PM, Administrative Nurse D stated that staff have been educated to ensure the computers were locked or placed in hidden mode when staff walk away from them to protect the resident's PHI.The facility's Resident Rights policy, revised 11/2017, indicated the facility would ensure each resident's privacy and ensure all residents were educated and informed of their rights.

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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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility identified a census of 62 residents. The sample included 17 residents, with five reviewed for abuse and/or neglect. Based on the record review and interview, the facility failed to ensure Resident (R) 37, R58, R61, R67, and R73 were free from abuse when their medication was misappropriated from the facility's medication cart.Findings included: - The Facility Incident Report 2599012 completed on 08/27/25 indicated R37, R58, R61, R67, and R73's pain medication showed errors in medication that occurred at the times when Licensed Nurse (LN) K worked and had possession of the narcotic keys.A record review of R37 (resident with intact cognition) documented R37 had had pain from a fracture. R37 was a long-term care resident who recently suffered a left femur fracture and underwent surgery for fixation. R37 had documented decline in her functional mobility and decline in her ability to assist in her self-care tasks.A record review of R58 (resident with moderately impaired cognition) documented R58 needed moderately/maximal assistance with activities of daily living (ADL).A record review of R61 (a resident with moderately impaired cognition) documented R61 needed staff assistance with functional abilities and balance impairments, a history of falls, and takes pain medication.A record review of R67 (resident with intact cognition) documented R67 had a subarachnoid hemorrhage (a life-threatening type of stroke caused by bleeding into the space between the brain and the thin tissues (meninges) that cover it) and a T12 compression fracture (fracture of the last vertebra in the lower back).A record review of R73 (a resident who was severely impaired) documented R73 needed partial/moderate assistance with ADLS. R73 was on hospice and received pain medication.Review of the Complaint Investigation Witness Statement dated 08/23/25, while checking for medications to reorder, a pattern was noticed on the Red Hall that had multiple oxycodone 2.5 milligram (mg) and 5 mg notations that did not appear on the Electronic Medical Record but were logged out on the medical paper Medication Administration Record (MAR). The review found several residents' MARs that were checked had inconsistencies.A Review of the Corrective Actions taken in response to the incident dated 08/23/25 documented that LN K was immediately suspended and has since been terminated. Re-education of all nurses on documentation of administration of pain and other as-needed (PRN) medications, including narcotics. One-on-one re-education of the same nurses identified as having errors in the documentation of PRN medication. The facility would conduct an audit of all PRN-controlled medications weekly over a four-week period and would present the findings in the Quarterly Quality Assurance report.A review of training presented and signed by all nursing staff documented immediately upon the discovery or suspicion of discrepancy, suspected loss, or diversion, the Director of Nursing and Pharmacist were consulted, and an investigation was conducted. If any discrepancy was found, the pharmacy and the Director of Nursing were to be contacted.On 12/03/25 at 10:45 AM, Administrative Nurse D stated that it was brought to his attention from a floor nurse that there were discrepancies in the MAR for missing narcotics. An immediate investigation was conducted with the Pharmacy Consultant. Administrative Nurse D stated that all narcotics that were discontinued, or the resident had left the facility, should be given to the Director of Nursing, who would lock them up in a two-key lock and be destroyed with the pharmacist's consultation and the Director of Nursing. Administrative Nurse D stated that training on discrepancies of medication and narcotic counts was done with all nursing staff, as a group and one-on-one. Administrative Nurse D stated he felt the breakdown in the medication misappropriation was that narcotics were not taken out of the cart immediately after the medication had been discontinued.On 12/03/25 at 01:52 PM, LN I stated it required two nurses at the end of the shift and the start of the shift to verify narcotics. LN I stated the facility does in-services on misappropriation of narcotics and the importance of narcotic counts.The facility's Abuse, Neglect, and Exploitation policy, revised 11/28/17, documented misappropriation of a resident meant the deliberate misplacement, exploitation, or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent. The resident has a right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, involutory seclusion, neglect, exploitation, misappropriation of resident property, and injury of unknown origin.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents, with one resident reviewed for hospitalization. Based on observation, record review, and interviews, the facility failed to provide a written notice of transfer/discharge as soon as practicable, and the facility also failed to provide a bed hold notice with the required information for Resident (R) 50. Findings included:- R50's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypotension (low blood pressure) and Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness). The admission Minimum Data Set (MDS) dated 11/17/25 documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. R50's Falls Care Area Assessment (CAA) dated 11/25/25 documented she triggered for falls related to impaired balance and history of falls. R50's Care Plan dated 10/31/25 documented: 10/31/25 - R50 planned to return home. On 11/03/25 at 08:00 AM a Communication Note documented R50 was found on the floor by her bed. R50 was transferred by ambulance to the hospital. On 12/02/25 at 08:33 AM, R50 sat upright in her wheelchair at the dining room table. R50 visited with other residents at the dining room table. R50's hair was combed. On 12/03/25 at 10:21 AM, Administrative Staff A stated there was no written notification or bed hold provided to R50 or her legal representative for her facility-initiated transfer to the hospital on [DATE]. She stated was to provide the bed hold information to the resident or their legal representative at the time of transfer. Administrative Staff A stated the nursing staff would notify the social service of the transfer. She stated that social services was responsible for providing the written notification and follow-up on the bed hold. The facility's Discharge Criteria policy dated 11/28/17 documented residents were permitted to remain in the facility and not be transferred or discharge unless appropriate discharge criteria was met.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents with five reviewed for care plan. Based on observation, record review, and interviews, the facility failed to implement a comprehensive care plan for Resident (R) 54 related to his activities of daily living (ADL).Findings Included: - R54's Electronic Medical Records (EMR) noted diagnoses of Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion).R54's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. The MDS noted he had impairments in both legs. The MDS noted he required supervision during meals but was dependent on staff for toileting, dressing, oral hygiene, bathing, bed mobility, and transfers. The MDS noted he was frequently incontinent of bladder and always incontinent of bowel. The MDS noted he was at risk for falls but had none since his admission.R54's Dementia Care Area Assessment (CAA) completed 07/09/25 indicated he usually would understand others, but instructed staff to anticipate his needs. The CAA noted he worked with speech therapy services to improve cognition.R54's Urinary Incontinence CAA completed 07/09/25 indicated he was at risk for skin breakdown and incontinence related to his cognitive impairment and limited mobility. The CAA noted he worked with occupational and physical therapy services to improve his functional abilities. The CAA instructed staff to anticipate his needs and assist with toileting as indicated.R54's CAA did not trigger for his functional abilities. R54's Care Plan initiated 06/30/25 indicated the following interventions:06/30/25 - The facility was to follow his advanced directives and indicated he was a Full Code (term used to indicate the desire to receive resuscitative measures in the event of cardiac arrest).06/30/25 - He took medications with Black Box Warnings (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration)10/31/25 - He had nutritional concerns, and staff were expected to offer feeding assistance during mealtimes.R54's Care Plan did not acknowledge his identified incontinence needs, his activities of daily living preferences or required level of assistance, and that he required a Hoyer lift (total body mechanical lift) with two staff member assistance for transfers.On 12/02/25 at 11:03 AM, R54 sat in his Broda Chair (specialized wheelchair with the ability to tilt and recline) in his room. R54's Hoyer lift sling was underneath him. R54's resident representative sat next to him. She stated the facility continually lacked communication between the management and direct care staff related to how and when cares were performed on the residents. She stated she attended the care plan meetings and felt the care was not being completed as discussed in the meetings. She stated she continually had to remind the facility to provide bathing and toileting care.On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated that the nurses used report sheets but had access to the care plans for review. She stated R54 required full assistance from staff and was transferred with a Hoyer lift. She stated the care plans should reflect the resident's current or changing needs. She stated R54 was incontinent and required frequent checks and care.On 12/03/25 at 02:15 PM, Certified Nurse's Aide (CNA) M stated that only the nurse had access to the care plans. She stated that direct care staff received their instructions from the nurses during daily meetings.On 12/03/25 at 02:43 PM, Administrative Nurse D stated that the direct care staff and nurses relied more on the report sheets than the care plans. He stated the plans should reflect the resident's needs or care requirements. He stated the report sheet information was pulled directly from the care plans. He stated the care plans were reviewed quarterly, annually, and when changes occurred by the interdisciplinary team.The facility's Comprehensive Care plan policy, revised 03/2024, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated that the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents with five reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 38 and R27's care plans to reflate changes in their care.Findings Included: - R38's Electronic Medical Records (EMR) noted diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), limited mobility, muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R38's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS noted she could independently complete bathing, dressing, bed mobility, and transfers. The MDS noted she was at risk for developing pressure ulcers but had no current injuries. The MDS noted she had pressure-reducing devices in place for her bed and wheelchair. R38's Pressure Injuries Care Area Assessment (CAA) completed 06/06/25 indicated she was at risk for skin breakdown and pressure injuries. The CAA noted she had pressure-reducing devices for her wheelchair and bed. The CAA indicated she was taken off hospice services on 05/25/25. R38's Care Plan initiated 06/05/24 indicated the following interventions: 06/06/24 – The plan indicated she needed prompts and stand-by assistance to complete personal hygiene, oral hygiene, dressing, showering, and toileting. 06/17/24 - The plan noted she was at risk for skin breakdown. The plan noted she had a pressure-relieving mattress in place. The plan indicated she had low air-loss (specialized air mattress used to prevent pressure-related injuries) mattress and instructed staff to ensure the correct settings according to her weight. 10/30/24 - The plan instructed staff to perform weekly skin checks. On 12/02/25 at 07:30 AM, R38 sat up in her bed and ate her breakfast. Her bed was in the medium height (waist high) position. She had a pressure-reducing mattress, but it was not a low air-loss mattress. She stated her bed changed once she came off hospice service because she didn't need the air mattress. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated she had a pressure-reducing bed but didn't think she had a low air-loss mattress. She stated the care plan should be updated once the resident's needs changed, and old interventions should be removed. On 12/03/25 at 02:43 PM, Administrative Nurse D stated the care plans were reviewed quarterly and updated as needed. He stated R38 was on hospice services, and the bed was changed out once she was taken off hospice. He stated the plan was not updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care plan policy, revised 03/2024, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated that the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs. - R27's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS) dated 10/09/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented that R27 had received respiratory treatment during the observation period. R27's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 04/29/25 documented he required staff assistance with his functional abilities. Other risk factors included limitations in mobility, incontinence, and a diagnosis of dementia. R27's Care Plan dated 07/07/25 documented the following interventions: 07/07/25 - Staff would assist him with repositioning at least every two hours. R27's plan of care lacked direction to the nursing staff for oxygen therapy. R27's EMR under the Orders tab revealed the following physician orders: Oxygen per nasal cannula as needed daily. Monitor oxygen saturation and notify physician if below 90 percent, dated 04/16/25. The physician order lacked a diagnosis for administration. On 12/02/25 at 08:30 AM, R27 sat upright at the dining room table asleep his wheelchair. There was an empty medication cup and a plastic drinking cup on the table in front of him. R27's lower extremities were on his wheelchair pedals. On 12/03/25 at 02:15 PM, Certified Nurse's Aide (CNA) M stated that only the nurse had access to the care plans. She stated that direct care staff received their instructions from the nurses during daily meetings. She stated direction for oxygen administration should be included on the resident's care plan. She stated usually the nurse would tell the CNAs how many liters per minute to set the oxygen at. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated that the nurses used report sheets but had access to the care plans for review. She stated a resident's care plan should include directions to staff for oxygen administration and monitoring. She stated she would modify a resident care plan when needed. She stated everyone had access to the resident plan of care, but did not have the time to review or read them. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/25 at 02:43 PM, Administrative Nurse D stated that the direct care staff and nurses relied more on the report sheets than the care plans. He stated the plans should reflect the resident's needs or care requirements. He stated the report sheet information was pulled directly from the care plans. He stated the care plans were reviewed quarterly, annually, and when changes occurred by the interdisciplinary team. He stated only the administrative staff could modify the resident's care plans, and the CNAs did not have access to review the resident's plan of care. The facility's Care Plan policy, revised 03/2024, indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated that the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. The facility identified a census of 62 residents. The sample included 17 residents, with one reviewed for quality of care. Based on observation, record review, and interviews, the facility failed to ensure the physician order was followed for a daily weight for R45 to monitor for congestive heart failure (CHF - a condition with low heart output and the body becomes congested with fluid). Findings included:- R45's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypotension (low blood pressure), CHF, and atrial fibrillation (rapid, irregular heartbeat). The admission Minimum Data Set (MDS) dated 11/10/25 documented a Brief Interview for Mental Status (BIMS) score of 11, which indicated intact moderately impaired cognition. The MDS documented R45 had received diuretic (a medication to promote the formation and excretion of urine) medication during the observation period. R45's Dehydration Care Area Assessment (CAA) dated 11/16/25 documented he had triggered for dehydration related to constipation. The nursing staff would monitor for signs or symptoms of dehydration. R45's Care Plan dated 11/14/25 documented:11/14/25 - R45 received medications that had black box warnings, and the nursing staff would monitor for any adverse reaction and notify the physician. R45‘s EMR under the Orders tab revealed the following physician orders: Weigh daily to monitor for signs of CHF, dated 11/04/25. Lasix (Furosemide- diuretic) tablet 40 milligram (mg), give one tablet by mouth two times a day for edema (swelling resulting from an excessive accumulation of fluid in the body tissues), dated 11/04/25. Review of R45's EMR under the Vitals tab, the Medication administration Record (MAR), the Progress Notes, and the Treatment Administration Record (TAR) from 11/04/25 to 12/01/25 (27 days) lacked evidence staff measured and recorded R45's weight on following seven dates 11/06/25, 11/10/25, 11/12/25, 11/15/25, 11/16/25, 11/19/25, and 11/20/25. R45's clinical record lacked documentation of any refusals of any daily weights and any physician notification of daily weights that had not been obtained. On 12/02/25 at 12:56 PM, R45 sat upright on his bed. R45's bedside table was pulled across his lower extremities, which had three cups of fluid on the table. R45 was awake and watched his TV. On 12/03/25 at 01:45 PM, Licensed Nurse (LN) I stated it was ultimately the nurse's responsibility to ensure daily weights were obtained and documented. LN I stated if the resident refused to be weighed, she would notify the physician and document the refusal on the TAR and in the progress notes. On 12/03/25 at 02:24 PM, Certified Nurse Aide (CNA) M stated the nurse would write on the report sheet if a resident was a daily weight and the expectation was to obtain their weight before breakfast. CNA M stated she would then notify the nurse of the resident's weight. CNA M stated if the resident refused to be weighed, she would notify the nurse. On 12/03/25 at 02:45 PM, Administrative Nurse D stated he would expect the physician order to followed. Administrative Nurse D stated if the resident was to refuse be weighed then the nurse would notify the physician and write a progress not in the residents' EMR.The facility's Physician Orders policy dated 09/21/21 documented physician orders would be followed related to the care needs of individual residents.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents, with two residents reviewed for treatment/services to prevent/heal pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on observation, record review, and interviews, the facility failed to ensure pressure-reducing measures were placed on Resident (R) 2, and further failed to ensure R2's Low air loss (LAL) mattress (medical device that uses continuous airflow through small holes in the surface to reduce moisture, keep skin cool and dry, and redistribute pressure to prevent and treat pressure ulcers) was set at the proper weight. Findings Included:- R2's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), senile degeneration of brain (a progress degeneration of the brain with age), and dementia (a progressive mental disorder characterized by failing memory and confusion).The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R2 was dependent on the staff for bathing and toileting. The MDS documented R2 had one Stage 3 (full-thickness pressure injury extending through the skin into the tissue below), and two unstageable (depth of the wound is unknown due to the wound bed being covered by a thick layer of other tissue and pus) pressure wounds. The MDS documented R2 had a pressure-reducing mattress in her chair and on her bedThe Pressure Ulcer/Injury Care Area Assessment (CAA) dated 09/22/25 documented R2 triggered CAA due to risk for skin breakdown related to incontinence and impaired bed mobility. The CAA documented multiple pressure injuries were noted, and treatment orders were in place per provider orders. The CAA documented staff would assist R2 with repositioning as needed, and a pressure-relieving mattress and cushion were in use for prevention. R2 was admitted to Hospice services on 09/15/25.R2's Care Plan documented the following:09/29/23 - staff to apply protective barrier to R2's skin after incontinence.12/02/24 - Licensed Nurse (LN) was to check R2's skin weekly for any injury and report to the physician with any skin injury.R2's plan of care lacked staff direction and interventions for pressure injuries/ulcers on the heels and coccyx.R2's plan of care lacked staff direction for monitoring of R2's LAL mattress.R2's physicians' Orders documented the following:Ensure heel protectors are on patients' feet/heels to reduce the risk of pressure sores every shift, dated 1028/25. Magic Butt (paste compound formula) two times a day for wound care to the coccyx, dated 10/28/25.Wound care to left heel: cleanse left heel with normal saline, pat dry with gauze, and apply skin-prep (liquid skin protectant) to left heel, dated 11/05/25. Wound care to the right heel, cleanse right heel with normal saline, pat dry with gauze, apply skin-prep to right heel would apply Calcium alginate (a gel-like substance derived from seaweed that is commonly used for medical dressings), to wound bed with ABD (thick dressing) pad then Kerlix (stretchy gauze bandage) and change daily and prn every day shift, dated 11/18/25.R2's EMR lacked direction for staff monitoring of her LAL mattress.R2's EMR under 'Weights and Vitals documented a weight of 121.2 on 11/17/25.On 12/01/25 at 08:32 AM, R2 laid on her back in her bed with her eyes closed. R2's heels were wrapped with kerlix and laid on a pink chuck directly on the mattress. R2 did not have boots on her heels, and R2's heels were not offloaded. R2's LAL mattress, which was controlled with a dial, was set at 180 pounds.On 12/02/25 at 10:17 AM, R2 laid in her bed with her head elevated and eyes open. R2 did not have boots to her heels. R2's heels were wrapped with kerlix and were offloaded on a pillow covered with a pink chuck. R2's LAL mattress, which was controlled with a dial with pre-set weights, was set at 180 pounds.On12/03/25 at 01:52 PM, LN I stated the facility had a provider that takes care of checking the LAL mattresses, and the settings were set at the correct settings. LN I stated she did believe the facility had requested R2's boots. R2 stated it was the floor nurse and the Certified Nurse Aides' (CNAs)responsibility to ensure boots were applied to a resident's heels, or heels were floated.On 12/02/25 at 12:10 PM, Administrative Nurse D stated he had made calls to R2's hospice provider to request R2's boots. He stated the facility had requested the boots for R2 a couple of times and had not received the boots. He stated staff should be offloading R2's heels while she was in bed. Administrative Nurse D stated, Breathe A provider sets the LAL mattress; he stated the mattress dial was set by weight. He stated the only time the staff would touch the mattress was if the mattress was not working.The facility's Wound Assessment, Prevention and Treatment policy, revised 11/28/17, documented a resident who enters the facility without pressure ulcers would not develop them unless the individual. The

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents, four residents were sampled for accidents and hazards. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 2's fall interventions as directed by her care plan.Findings included:- R2's Electronic Medical Record (EMR) documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), senile degeneration of brain (a progress degeneration of the brain with age) and dementia (a progressive mental disorder characterized by failing memory and confusion).The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R2 was dependent on the staff for bathing and toileting. The MDS documented R2 had falls since admission or reentry or the prior assessment. The MDS documented R2 had two or more falls with injury during the observation period.The Falls Care Area Assessment (CAA) dated 09/22/25 documented R2 triggered for falls CAA due to the risk for falls related to impaired balance. The CAA documented other risk factors, including cognitive (impaired thought process) impairments, incontinence, limitations in mobility, opioid (use for pain), dementia, and senile degeneration of the brain. The CAA documented R2 had clear speech and was often able to understand others. The CAA documented R2 was admitted to hospice on 09/15/25.R2's Care Plan documented the following fall interventions:06/24/2025 - nonskid strips placed in front of the recliner to help keep my feet from sliding out from under me.06/24/25 - Place call light within reach.09/22/25 - Place a fall mat next to the bed.09/22/25 - Bed in the lowest position.08/25/25 - Staff to check R2 every 2 hours.10/03/25 - Staff to provide non-slip socks.On 12/03/25 at 02:22 PM, Certified Nurse's Aide (CNA) M stated she did not have access to the care plan. CNA M stated she would know who needed a fall mat by the daily CNA report and the nursing report. CNA M stated the fall mats should be placed on the side of the bed, and if the resident was a fall risk, the bed should be in a low position. On 12/03/25 at 01:52 PM, Licensed Nurse (LN) I stated she was unsure if everyone had access to the care plan. LN I stated the expectation was that the CNA would put the fall mat down when putting the resident to bed. She stated she was unsure if beds should be in a low position, as it was different for each resident. On 12/02/25 at 10:22 AM, Administrative Nurse D stated that fall mats should be on the side of the bed that R2 would roll out of bed on. Administrative Nurse D stated the fall mat should not be under the bed. He stated the last staff member to leave a resident's room should ensure the fall mat was in place, and the bed was in the lowest position. Administrative Nurse D stated that all staff would know if a resident needed a fall mat or bed, which should be in the lowest position on the daily report sheet. Administrative Nurse D removed R2's fall under her bed and placed it on the side of her bed.The facility's Falls policy, revised 04/27/18, documented the facility would implement systems to reduce the risk of falls based on resident assessment. An individualized care plan intervention would be developed for residents identified through assessment as being at risk of falls. The interventions would be reviewed and updated on a regular basis when a fall occurred.

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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 identified a census of 62 residents. The sample included 17 residents, with one resident reviewed for respiratory care. Based on interviews, observation, and record review, the facility failed to ensure there was physician indication for oxygen administration for Resident (R) 27. Findings included:- R27's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The Quarterly Minimum Data Set (MDS) dated 10/09/25 documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented that R27 had received respiratory treatment during the observation period. R27's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 04/29/25 documented R27 required staff assistance with his functional abilities. Other risk factors included limitations in mobility, incontinence, and a diagnosis of dementia. R27's Care Plan dated 07/07/25 documented the following interventions:07/07/25 - Staff would assist him with repositioning at least every two hours.The plan of care lacked direction for the nursing staff related to R27's oxygen therapy. R27‘s EMR under the Orders tab revealed the following physician orders: Oxygen per nasal cannula as needed daily. Monitor oxygen saturation and notify the physician if below 90 percent dated 04/16/25. The physician's order lacked a diagnosis for administration. On 12/02/25 at 08:30 AM, R27 sat upright at the dining room table, asleep in his wheelchair. There was an empty medication cup and a plastic drinking cup on the table in front of him. R27's lower extremities were on his wheelchair pedals. On 12/03/25 at 01:45 PM, Licensed Nurse (LN) I stated oxygen was a medication and required a diagnosis for any medication. LN I stated she would call the physician to obtain a diagnosis. On 12/03/25 at 02:45 PM, Administrative Nurse D stated he would expect that all medication would have an indication for administration. He stated he would expect the nurse to call and get a diagnosis. The facility's Oxygen Safety and Management policy dated 03/22/19 documented oxygen would be administered in a safe manner to residents who require it. Oxygen would be provided to residents based on their physician's orders. Concentrators and oxygen tanks would be available for resident use. Physician orders for oxygen use would include the rate of oxygen flow (liters/minute), the route of administration, the mask, and the frequency of administration.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents, with one resident reviewed for dialysis (a procedure where impurities or wastes are removed from the blood), and end-stage renal disease (ESRD- a terminal disease of the kidneys). Based on observation, record review, and interviews, the facility failed to provide standards of care related to Resident (R) 7's dialysis.Findings included:- R7's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid) and end stage renal disease (the final stage of chronic kidney disease, where the kidneys have permanently stopped working and can no longer function at a level needed to sustain life).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R7 was impaired on one side of his body. The MDS documented R7 required dialysis during the observation period.R7's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 08/14/25 documented R7 admitted to the facility following hospitalization. The CAA documented R7 was admitted for therapy services. The CAA documented R7 required additional assistance with his activities of daily living (ADL). The CAA documented R7 received dialysis on Monday, Wednesday, and Friday.R7's Care Plan documented the following:08/12/25 - R7 wanted to remain safe during his stay in the facility.08/12/25 - R7 planned to return home after therapy.08/12/25 - R7 needed help obtaining the services and resources to be able to go home.R7's plan of care lacked direction for staff to care for his dialysis treatments.R7's EMR under the physicians' Orders tab lacked direction for nursing to care for R7, who needed dialysis.The EMR lacked a physician order for R7's dialysis.The EMR lacked direction for staff to access R7's dialysis shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) in his left arm.The EMR lacked direction for staff for R7's dialysis location, transportation provider, and the date and times that R7 received dialysis.On 12/03/25 at 02:22 PM, Licensed Nurse (LN) I stated the process to ensure a resident's standard of care for dialysis would be to check the Treatment Administration Record (TAR), nursing report, and the care plan for specific orders for dialysis. LN I stated nursing staff do not check the residents' shunt, she stated dialysis takes care of the residents' dialysis needs. LN I stated the facility ensured residents had a lunch to take with them to dialysis.On 12/03/25 at 02:43 PM, Administrative Nurse D stated the nurses would know a resident was on dialysis by the nursing report sheet and nurse-to-nurse communication. Administrative Nurse D stated he did not know who had access to the care plans; he thought just the administrative staff. He stated he could see where having direction for nursing in the TAR, and the care plan would be good, along with the nursing report sheet.The facility's Dialysis policy, revised 11/28/17, documented dialysis services would be provided for residents with end-stage renal disease. A physician's order would be obtained at the time of admission for the provision of dialysis treatment. The facility would arrange for dialysis services and transportation to and from the dialysis unit for any resident who required them.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility had a census of 62 residents. The sample included 17 residents. Five Certified Nurse Aides (CNA) were reviewed for yearly performance evaluations and in-service training. Based on record review and interview, the facility failed to ensure one of the five reviewed CNA staff had the required yearly performance evaluations completed. This placed the residents at risk for inadequate care.Findings included: - Review of the facility's performance evaluation and in-service records revealed the following:CNA N, hired 09/30/23, had no yearly performance evaluations provided upon request.On 12/03/25 at 09:30 AM, Administrator A stated the facility did not have a performance evaluation for CNA N.On 12/03/25 at 02:43 PM, Administrative Nurse D stated that yearly evaluations were completed on all direct care staff. He stated the evaluations were used to gauge performance and identify areas of needed improvement for direct care staff.The facility's Staffing policy, dated 06/2017, indicated performance reviews will be conducted on each employee at least annually to identify employee strengths and goals. The policy noted that the evaluation would be utilized to determine training needs for the employee.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility reported a census of 62 residents. The Sample included 17 residents. Based on observations, record review, and interviews, the facility failed to ensure safe medication storage of three of its six medication carts. Findings Included:- On 12/01/25 at 07:08 AM, an inspection of the Blue Hall revealed an unlocked and unsupervised medication cart next to the medication storage room. The cart contained prescription medications, stock medications, insulin (a hormone that lowers the level of glucose in the blood), and treatment supplies for the residents on the hall. An inspection of the Blue Hall also revealed an unsecured, smaller treatment cart that contained stock medication and treatment supplies next to the medication cart. At 07:11 AM, Certified Medication Aide (CMA) M entered the hallway and secured both carts. She stated staff were expected to lock the carts when not directly supervising them.On 12/01/25 at 07:15 AM, an inspection of the Red Hall revealed an unsecured and unsupervised treatment cart outside Resident (R) 62's room. The cart contained stock medications, treatment supplies, and insulin for residents on the hall. The cart laptop was open and contained R62's picture and protected health information (PHI) within direct view. At 07:18 AM, Licensed Nurse (LN) J opened R62's door and exited the room into the hallway. LN J stated she was not sure if the medication carts were supposed to be locked, but would lock them during the survey inspection. She stated the PHI should not be left open on the computers when not in use.On 12/03/25 at 02:43 PM, Administrative Nurse D expected the medication carts to be supervised or locked when not in use. He stated that staff received annual training related to resident safety and medication storage expectations.The facility's Storage of Medications policy, revised 01/2021, indicated that drugs and biological agents were expected to always be stored in a locked compartment or area. The Policy indicated staff were expected to supervise all medications and biologicals during times of administration or use.

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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 identified a census of 62 residents. The facility had one main kitchen and two dining areas. Based on observation, interview, and record review, the facility failed to ensure that staff members properly tested the dishwashing sanitization chemicals documented freezer and refrigerate temperatures. The facility also failed to staff donned hairnets and beard guards and maintain dairy food at the appropriate temperature. Findings included:- During the initial tour of the kitchen and dining room area on 12/01/25 at 07:10 AM, an open undated gallon of milk sat in a brown tub without ice. Dietary Staff EE tempted the open milk, which was 46 degrees. The Milk was discarded. Dietary Staff EE lacked a hairnet when setting up the breakfast serving line. Dietary Staff CC carried two juice glasses, touching the tops of the glasses where the resident would drink from. On 12/01/25 at 07:45 AM, review of the Low Temperature Sanitizing Dish Machine Log, Refrigerator Temperature Log, and the Freezer Temperature Log for November 2025 revealed the following ten days lacked documentation on 11/21/25, 11/22/25, 11/26/25, 11/27/25, 11/28/25, 11/29/25, and 11/30/25. On 12/02/25 at 12:45 PM, Dietary Staff DD failed to don (put on) a beard guard as he worked in the food prep area. On 12/03/25 at 10:01 AM, Dietary Staff BB stated staff should always wear a hairnet and facial hair net when in the kitchen food prep area. She stated that staff should hold the glasses at the base of the cup and not touch the part of the glasses where the resident would drink from. Dietary Staff BB stated the temperatures for the dishwashing machine, refrigerators, and freezers should be recorded daily. Dietary Staff BB stated dairy products should always be kept on ice to ensure they do not spoil.The facility's Food Storage policy, revised 04/06/20, documented food would be stored on shelves in a clean, dry area, free from contaminants. Food would be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Check refrigerator temperature regularly. Conduct random temperature checks of food items.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 62 residents. The sample included 17 residents, with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to ensure collaboration between the nursing home and hospice services to identify hospice-supplied services, supplies, medication, and equipment for Resident (R) 3 and R1. Findings included:- R3's Electronic Medical Records (EMR) noted diagnoses of heart failure, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), overactive bladder, and morbid obesity (severely overweight). R3's Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 12, indicating mild cognitive impairment. The MDS noted she could independently complete bathing, transfers, showering, dressing, personal hygiene, toileting, and footwear. The MDS noted she reported she had little interest in doing things and had feelings of hopelessness. The MDS indicated she was on hospice services. R3's Functional Abilities Care Area Assessment (CAA) completed 09/12/25 indicated she required assistance with her functional abilities and impaired balance. The plan instructed staff to anticipate her needs. The plan noted she was admitted to hospice services on 08/27/25. R3's Care Plan initiated 11/11/24 indicated the following interventions: 12/10/24 - The plan indicated she was often independent with her activities of daily living but may need help from staff. The plan indicated she could dress herself, perform oral hygiene, and personal hygiene with set-up assistance. The plan indicated she wanted to bathe twice a week and needed assistance washing her back. 12/10/24 - The plan indicated she was at risk for skin breakdown. The plan indicated she had a pressure reducing mattress and her wheelchair. A review of R3's Care Plan revealed no entries related to her hospice services that she admitted to on 08/27/25. On 12/01/25 at 07:00 AM, R3 sat in her bed in her room. Her bed had a pressure-reducing mattress. Her call light was within reach. R3 stated she had not felt well for the last few days and had been on hospice services. She stated that hospice comes in twice weekly to see her. On 12/03/25 at 01:55 PM, Licensed Nurse (LN) G stated the facility's care plan should have indicated which hospice service provider, what services were provided, and what equipment hospice covered. She stated staff should be able to review this information if needed for care. On 12/03/25 at 02:43 PM, Administrative Staff A stated the facility's care plan should identify hospice and the services provided. (continued on next page)

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	175445	A. Building B. Wing	12/03/2025

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Hospice policy, revised 11/2017, noted the facility would ensure coordination between the resident, representative, and hospice services providers to ensure effective end-of-life care. The policy indicated that the facility would identify the responsibilities of each party and engage in ongoing communication. - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiparesis (muscular weakness of one half of the body), and hemiplegia (paralysis of one side of the body) following cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), and dysphagia (swallowing difficulty). The Significant Change Minimum Data Set (MDS) dated [DATE] documented R1 had a Brief Interview for Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R1 had an impairment on one side of his upper and lower body. The MDS documented R1 needed the assistance of staff for all activities of daily living (ADL). The MDS documented R1 received hospice services during the observation period. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 11/06/25 documented R1 triggered for the CAA due to his requiring assistance with functional abilities. R1's CAA documented other risk factors for R1 were incontinence, limitations in mobility, and impaired cognition (impaired thought process). The CAA documented R1 was admitted to hospice services on 10/30/25. R1's Care Plan documented the following interventions: 12/30/21- R1 always needs his palm protector on. 04/23/25 - R1 wanted to receive the proper assistance with my ADLs. 07/11/25 - R1 needs assistance with his showers in the morning and would like a shower two times a week. R1's plan of care lacked an indication of hospice care or hospice provider services. R1's hospice- provided communication binder was unavailable upon request. R1's EMR under physician Orders documented: Admit to hospice for late effect cerebrovascular accident (CVA- stroke- sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) with prognosis of less than 6 months, dated 10/31/25. On 12/01/25 at 08:15 AM, R1 sat in his Broda chair (specialized wheelchair with the ability to tilt and recline) in his room, watching TV with his feet elevated. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/03/25 at 02:22 PM, Certified Nurse's Aide (CNA) M stated she did not have access to the care plan, but she would know who was on hospice by her nursing report or by asking her nurse. She stated the nurse reported to the CNA's all information about a resident. She stated residents have their hospice supplies in their rooms. CNA M stated if she was unsure, she would be able to look in the resident's binder. On 12/03/25 at 01:52 PM, Licensed Nurse (LN) I stated she would know a resident was on hospice, the resident would have a binder provided by hospice, she would be able to look at the facility's care plan. LN I was unsure if what the provider provided for supplies would be on the care plan. She stated when the hospice nurse or bath aides were in the facility would be documented in the resident's binder. She stated hospice supplies were marked in the resident's room, specifically for that resident. LN I stated if she noticed a resident did not have a binder she would immediately call the hospice provider. On 12/03/25 at 11:11 AM, Administrative Nurse D stated he had just noticed R1 did not have a binder. He stated he had called the hospice provider and requested one. He stated he had a good repour with the hospice provider, and usually he could just text him if the facility saw any changes in the resident. Administrative Nurse D stated staff would know when a resident was on hospice with their nursing report sheet; he stated he put all pertinent information about a resident on the nursing report sheet. Administrative Nurse D was unsure if all hospice information needed to be on the care plan. The facility's Hospice/End of Life policy, revised 11/28/17, documented hospice/end of life services would be provided according to resident needs and preferences. Upon the decision to elect hospice services, the physician would be contacted to obtain orders, and social services would coordinate with hospice.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility identified a census of 62 residents. The facility identified nine residents on 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). The facility failed to identify Resident (R) 74, who had a percutaneous endoscope gastrostomy tube (PEG- a tube inserted through the wall of the abdomen directly into the stomach), and R1, R21, R48, and R6, who had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). Based on record review, observations, and interviews, the facility failed to implement signage or indicators within the physical environment to alert staff and visitors of the required EBP. The facility further failed to store oxygen nasal canula in a sanitary manner, the facility further failed to ensure staff performed adequate hand hygiene, and further failed to ensure Accu-check (blood glucose monitoring test) had a barrier placed prior to being laid down in a resident's room. Findings included:- An initial walkthrough of the facility was completed on 12/01/25 at 07:13 AM. An inspection of the Red hall revealed R6's oxygen nasal cannula laid in her wheelchair. At 07:14 AM, R20's oxygen concentrator sat next to the piano in the main dining room. R20's nasal cannula laid directly on the floor next to the piano bench. On 12/01/25 at 08:25 AM, R47's oxygen nasal cannula and tubing was tightly wrapped around the handles of his wheelchair.On 12/02/25 at 07:44 AM, Licensed Nurse (LN) H gathered supplies for R21's Accu-check monitoring, insulin (a hormone that lowers the level of glucose in the blood) pen, two blue gloves, an insulin pen needle, and an alcohol wipe. LN H read the order in R21's chart, and LN H laid supplies on the counter at the nurse's station. LN H went to the dining room to retrieve R21 and take her to her room to check her glucose reading and give insulin, holding all supplies in her hand. LN H touched R21's hair and glasses and pushed her back to R21's room. LN H laid the Accu-Chek monitor on R21's bedside table without a barrier, and LN H donned gloves without hand hygiene. LN H took a glucose reading and gave insulin in the abdomen. LN H removed gloves and performed hand washing.An inspection of R74's room revealed no protective equipment (PPE) readily available for EBP. R74 had no signage or indicators R74 was on EBP. R74 had a percutaneous endoscope gastrostomy tube.An inspection of R21's room revealed no PPE readily available for EBP. R21 had no signage or indicators R21 was on EBP. R21 had a urinary catheter.An inspection of R48's room revealed no PPE readily available for EBP. R48 had no signage or indicators R48 was on EBP. R48 had a urinary catheter.An inspection of R66's room revealed no PPE readily available for EBP. R66 had no signage or indicators R66 was on EBP. R66 had a urinary catheter.On 12/02/25 at 08:00 AM, LN H stated she would place a barrier on R21's bedside table before the Accu-check monitor was laid down. She stated she would wash her hands when entering a resident's room, leaving a resident's room, or when her hands were soiled. LN H stated she would sanitize before putting on gloves, after monitoring blood sugar, and giving the insulin.On 12/03/25 at 02:22 PM, Certified Nurse's Aide (CNA) M stated oxygen cannulas not in use should be placed in a bag or just changed if they are found on the floor. CNA M stated she was not aware of enhanced barrier precautions for residents with urinary catheters and peg tubes. She stated there were residents with the enhanced barrier supplies in multiple rooms.On 12/03/25 at 01:52 PM, LN I stated Breathe an oxygen provider, checks all oxygen canisters, and changes nasal cannulas. She stated oxygen nasal cannulas should be placed in a bag when not in use. LN I stated the facility uses the standard of practice for urinary catheters and peg tubesOn 12/03/25 at 12:05 PM, Administrative Nurse D stated the facility does not need to use enhanced barrier precautions for residents with urinary catheters or ped tubes. He stated the facility used the standard of care and expected residents to wear gloves when doing residents cares. Administrative Nurse D stated oxygen tubing should be kept off the floor, and staff should put oxygen nasal tubing in the bag the tubing came out of if not in use. Administrative Nurse D stated there should be a barrier placed when an Accu-check monitor was laid down in a resident's room. He stated staff should wash their hands when entering a room, leaving a room, or whenever their hands were soiled. He stated hands should be washed or sanitized before applying gloves, and after using the Accu-check monitor, and again before giving residents insulin.The facility's Oxygen Safety and Management policy, revised 03/22/19, documented equipment used for oxygen administration (nasal cannula, mask, tubing) would be replaced every two weeks. The equipment should be marked with the name of the resident and the date it was put into use. Oxygen cannulas and masks should not be allowed to come in contact with the floor or other potentially dirty surfaces. If that occurred, they should be replaced. The cannulas or mask should be stored in plastic bags to prevent contamination The facility's

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility identified a census of 62 residents. The sample included 17 residents. Based on interviews, observation, and record review, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program including antibiotic stewardship for the residents of the facility. Findings included:- On 12/02/25, requested the infection control log for tracking and trending infections from December 2024 through October 2025. The facility was unable to provide an infection control log for the following months December 2024, June 2025, July 2025, August 2025, September 2025, and October 2025 that included evidence of tracking and identifications of possible infection outbreaks at the facility, lacked consistent identification of infection, the antibiotic administration and the of continent documentation of the infection control surveillance. On 12/02/25 at 02:25 PM, Administrative Nurse D stated he is responsible for tracking and trending for the antibiotic use in the facility. He stated he had not completed the monthly tracking of the antibiotic use since May 2025. He stated he would review if the physician ordered antibiotic had met the criteria for administration at the end of each month to educate himself. The facility's Antibiotic Stewardship policy dated 04/27/19 documented the use of antibiotics would be reserved for those conditions that meet clinically approved indications for their use. Education would be provided to nursing staff, clinical providers, residents, and their representative on proper antibiotic use and antibiotic resistance.

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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 identified a census of 62 residents. The sample included 17 residents. Based on interviews, observation, and record review, the facility failed to designate a staff member with the required qualification and certification as the Infection Preventionist, who was responsible for the facility's Infection Prevention and Control Program. Findings included:- On 12/02/25 at 02:25 PM, Administrative Nurse D stated the nurse listed as the Infection Preventionist was a corporate nurse who would answer questions and give advice as needed, but was not at the facility. Administrative Nurse D stated he was responsible for the Infection Prevention and Control Program. He stated he had not completed a specialized education for the monitoring of the Infection Preventionist. The facility was unable to provide a policy related to the Infection Preventionist as requested on 10/03/25.

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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 62 residents. The sample included 17 residents, with five residents reviewed for immunizations. Based on interviews, observation, and record review, the facility failed offer or obtain informed declinations or a physician-documented contraindication for the Pneumococcal Conjugate Vaccine (PCV20 - vaccination for bacterial infections), and pneumococcal (type of bacterial infection) vaccination for Resident (R) 2, R4, and R8. Findings included:- Review of R2's clinical record lacked documentation of PCV20 being offered, obtained informed declination, or a physician-documented contraindication prior to surveyors entering the facility.Review of R4's medical record lacked documentation of PCV20 being offered, obtained informed declination, or a physician-documented contraindication prior to surveyors entering the facility.Review of R8's clinical record documented not eligible for PCV20; the medical record lacked documentation of PCV20 being offered, obtained informed declination, or a physician-documented contraindication prior to surveyors entering the facility. An Immunization report from the facility documented PVC 13 on 09/28/16 and Pneumococcal Polysaccharide Vaccine (PPSV23) on 08/02/19.On 12/02/25 at 02:25 PM, Administrative Nurse D stated he was responsible for tracking and monitoring the resident's immunizations. He stated that he would have to check the CDC guidelines if the residents were eligible to receive the PCV 20. He stated the facility had not offered the PCV 20 at this time. The facility's Immunization Pneumococcal policy, revised 11/28/17, documented pneumococcal vaccinations would be offered to all residents per Centers for Disease Control and Prevention (CDC) guidelines.