STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185131	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jordan Rehabilitation and Healthcare Center	270 E Clayton Lane Louisa, KY 41230

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview, record review, and review of the facility's policy, the facility failed to ensure each resident's right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she preferred for 6 of 28 sampled residents, Resident (R) 7, R9, R10, R28, R76, and R82.Review of each resident's document Behavior Modification Consent revealed the name of the medication, risks and benefits of the medication, and treatment alternatives/options were not specified.The findings include:Review of the facility's document Resident Rights, undated and found in the facility's admission packet, revealed the resident had a right to be informed of and participate in their treatment, which included the right to be fully informed in advance of the risks and benefits of proposed care, of treatment, and treatment alternatives.1. Review of R82's admission Record revealed the facility admitted R82 on 05/11/2012 with diagnoses of chronic obstructive pulmonary disease, anxiety disorder, and unspecified dementia. Review of R82's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/02/2026, revealed R82's cognitive function was severely impaired, and she rarely or never made decisions.Review of R82's Clinical Orders revealed an order for sertraline HCL (an antidepressant medication) that was started on 10/04/2025 and was currently still active.Review of R82's Behavior Modification Consent form, dated 07/29/2023, revealed the form authorized the use of specific behavior modification medication intervention identified in the individual plan of care but did not identify the specific medication(s) being consented to. Further review revealed the form did not include the medication name, dosage, frequency, route, diagnosis or clinical indication for use, targeted behaviors or symptoms, expected benefits, potential material risks or adverse effects specific to the medication, alternative treatment options, duration of treatment, monitoring parameters, or documentation reflecting the resident's or responsible party's opportunity to ask questions and make an informed decision regarding the proposed medication treatment.2. Review of R76's admission Record revealed the facility admitted R76 on 03/10/2026 with diagnoses of unspecified fracture of the left lower leg, anxiety disorder, depression, and abuse of other non-psychoactive substances.Review of R76's admission MDS, with an ARD of 03/20/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, indicating R76 was cognitively intact.Review of R76's, Order Summary Report, dated 04/16/2026, revealed the resident received multiple psychotropic medications including lorazepam (benzodiazepine anxiolytic), Vraylar/cariprazine (atypical antipsychotic), venlafaxine (serotonin-norepinephrine reuptake inhibitor antidepressant), trazodone (serotonin antagonist/reuptake inhibitor antidepressant often used as a sedative), Remeron/mirtazapine (tetracyclic antidepressant), and Ambien/zolpidem (sedative-hypnotic non-benzodiazepine sleep agent). Review of R76's Behavior Modification Consent form, dated 03/10/2026, revealed the form authorized the use of specific behavior modification medication intervention identified in the individual plan of care but did not identify the specific medication(s) being consented to. Further review revealed the form did not include the medication name, dosage, frequency, route, diagnosis or clinical indication for use, targeted behaviors or symptoms, expected benefits, potential material risks or (continued on next page)

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

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted R7 on 09/15/2018 with diagnoses of major depressive disorder and other specified anxiety disorder. On 09/18/2025 the resident received a new diagnosis of schizophrenia, unspecified.Review of R7's quarterly MDS, with an ARD of 01/16/2026, revealed the facility assessed the resident to have a BIMS score of 11 out of 15, indicating R7 was moderately cognitively impaired.Review of R7s Clinical Orders, revealed an order for quetiapine (an anti-psychotic medication), dated 10/01/2025, was active. R7's active orders also included aripiprazole (an antipsychotic used to treat schizophrenia, dated 02/06/2026.Review of R7's Behavior Modification Consent form, dated as signed on 09/15/2018 by R7's family member, who was also the responsible party (RP), revealed consent had been obtained for the use of specific behavior modification medication intervention. Further review revealed the signee understood the behavior modification medication was a part of a total comprehensive treatment program, and the medication intervention would only be utilized in specific instances when it had been determined to be necessary. Continued review revealed the signee understood she would be counseled by the physician or a member of nursing regarding the risk factors involved in both using and not using the ordered behavior modification intervention and agreed the benefits outweighed the risk factors. However, no specific documentation of the medication, its side effects, risks, or alternative options had been documented for either the quetiapine or the aripiprazole.During an interview with the Director of Nursing (DON) on 04/16/2026 at 10:30 AM, she stated medication consent was obtained during the admission process through a general consent form. The DON stated the admission consent was a blanket consent and did not include medication-specific information, such as the name of the medication, the reason for use, potential risks, benefits, or possible side effects. The DON stated there was no separate consent process for individual psychotropic medications when ordered.During an interview with the Administrator on 04/16/2026 at 11:30 AM, he stated the admission consent was a blanket consent and was not intended to serve as consent for specific medications. The Administrator stated medication consents should include the medication name, the reason for use, and potential side effects.During an interview with the Senior [NAME] President of Regulatory Affairs (SVPRA) on 04/16/2026 at 4:00 PM, the SVPRA stated the facility did not have a written policy for obtaining consent for psychotropic medications and instead relied on the Centers for Medicare & Medicaid Services (CMS) guidelines for medication consent practices.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, record review, information from the Centers for Disease Control and Prevention (CDC), and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 7 of 40 sampled and supplemental residents, Resident (R) 66, R77, R35, R13, R42, R71, and R33.R66 was diagnosed with a communicable skin infection on 04/10/2026 and a contact precautions order was placed by the physician. However, observation on 04/14/2026 revealed no transmission-based precaution signage posted outside R66's room, and after Contact Precaution signage was posted, staff entered the room without donning (putting on) required personal protective equipment (PPE). Observation on 04/14/2026 revealed the common sinks shared between two resident-occupied rooms by R77, R35, and R13 were completely covered in clear plastic and inaccessible for use.Observations on 04/15/2026 and 04/16/2026 revealed staff used the mechanical lift for R42, R71, and R33 without disinfecting it between resident use. The findings include:Review of the facility's policy titled, Infection Prevention and Control Program, undated, revealed the facility established and maintained an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections per accepted national standards and guidelines. The policy also indicated all staff was responsible for following the policies and procedures related to the program, and a resident with an infection or communicable disease would be placed on transmission-based precautions as recommended by the Centers for Disease Control and Prevention (CDC) guidelines. Further review of the policy revealed isolation signs were used to alert staff, family members, and visitors of transmission-based precautions. The policy also outlined that all staff would receive training, relevant to their specific roles and responsibilities, regarding the facility's infection prevention program, including policies and procedures related to their job function; all staff would demonstrate competence in relevant infection control practices; and direct care staff would demonstrate competence in resident care procedures established by the facility.Review of the facility's undated policy, Mechanical Lift Cleaning, revealed, Mechanical lifts will be cleaned and disinfected between each resident use.Review of the CDC website at www.cdc.com revealed for residents in long term care facilities diagnosed with a shingles/herpes zoster infection, standard and contact precautions should be observed until all lesions were dried and crusted. It also stated lesions should be covered completely, and gloves and gowns should be used for direct care.Review of the admission Record revealed the facility admitted R66 on 03/14/2025 with diagnoses of encounter for orthopedic aftercare following a surgical amputation and bacteremia. An additional diagnosis of herpes zoster (shingles-a painful viral infection caused by the reactivation of the virus which also caused chickenpox) without complications was added on 04/10/2026.1. Observation on 04/14/2026 at 10:45 AM revealed no transmission-based precaution signage posted outside R66's room. Observation on 04/14/2026 at 12:00 PM revealed a Contact Precaution sign had been placed on R66's door indicating everyone must clean their hands, including before entering and when leaving the room and providers and staff must also put on gloves and a gown before entering the room and discard the gloves and gown before exiting the room. Additional observation revealed Certified Nursing Assistant (CNA) 4 entered R66's room with his lunch tray without putting on gloves or a gown.During an interview on 04/14/2026 at 12:15 PM with CNA4, she stated the Contact Precaution sign was new, and she had never seen it before. She stated R66 did not need to be on precautions because he did not have anything going on.Review of R66's Clinical Orders, dated 04/10/2026, revealed an order for an antiviral medication for R66's shingles had been entered by Registered Nurse (RN) 3, but no order for contact precautions had been entered.During an interview on 04/14/2026 at 12:30 PM with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON), they stated they were not (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aware R66 did not have any transmission-based precaution signage posted outside his room and would fix it immediately.During an interview on 04/16/2026 at 4:50 PM with RN3, she stated she wrote the order for R66's antiviral medication for shingles and an order for Contact Precautions at the same time.Review of R66's Clinical Orders revealed an order for Contact Precautions due to shingles had been created by the Infection Preventionist (IP) on 04/14/2026 to begin on 04/10/2026 and end on 04/18/2026.During an interview on 04/14/2026 at 4:40 PM with the Infection Preventionist (IP), she stated residents with the shingles virus should be in contact isolation unless the rash had spread to another part of the body, and then the resident should be in airborne precautions. The IP further stated she did not know how R66 caught the virus, and the virus could possibly still be in the room.During an additional interview on 04/16/2026 at 9:13 AM with the IP, she stated she had been the IP at the facility since May 2020. The IP stated R66 was diagnosed with shingles on Friday, 4/10/2026, and she was not sure why Contact Precautions signage was not posted that same day. The IP also stated R66 was on Enhanced Barrier Precautions (EBP) for a wound on his foot, and that signage would have covered the gown and gloves precaution requirement for the contact precautions if the EBP signage had been on R66's door. The IP further stated the charge nurse that rounded with the physician was responsible for taking orders, entering them into the computer, and then following through with the order as needed. The IP stated she thought RN3 had rounded with the physician on 04/10/2026, and she would have been responsible for entering the order for any new medication and/or transmission-precautions and then placing the signage on R66's door. The IP stated she noticed R66 should have been placed on contact precautions during her general antibiotic rounds on 04/14/2026, but she was not sure if R66 had EBP signage on the resident's door at that time. The IP stated it was her expectation for staff to read the signage posted on R66's door and follow the guidance to prevent an infection from being spread to other residents. The IP stated again that R66 was already on EBP for his foot wound, so EBP signage should have been posted, and she was not sure why it was not.During an interview on 04/16/2026 at 10:00 AM with the ADON and the DON, they both stated all new orders were reviewed every morning by the clinical team which included the unit managers/charge nurses, the IP, the Minimum Data Set (MDS) nurse, the ADON, and the DON. They stated any new order for an antibiotic or antiviral would also include an order for transmission-based precautions if necessary, and they both expected the signage to be posted immediately and staff to follow the guidance as posted to prevent the spread of infection to other residents, staff, and visitors.During an interview on 04/16/2026 at 5:30 PM with the Administrator, he stated he expected any resident that required any form of transmission-based precaution to have signage on the door to safely guide staff and visitor contact with that resident.2. Observation on 04/14/2026 at 12:25 PM revealed the common sinks shared between two resident-occupied rooms were completely covered in clear plastic and inaccessible for use, which affected R77, R35, and R13.During an interview on 04/14/2026 at 3:15 PM with Certified Nursing Assistant (CNA) 7, she stated if she needed to wash her hands after caring for any of the residents in those rooms, she would have to go to the shower room down the hall. She stated the sinks in those rooms had been out of service for several days, and she thought they were clogged and needed to be fixed.During an interview on 04/14/2026 at 3:40 PM with the Maintenance Director, he stated the sinks shared a common drainpipe and had been out of order since Wednesday, 04/08/2026. He stated some parts were ordered but had not been received as of today. Observation on 04/15/2026 at 9:04 AM revealed R35, R77, and R13 were relocated to other rooms, and their previous rooms were left empty until the sinks could be repaired. 3. Observation on 04/15/2026 at 11:02 AM revealed CNA3 put the mechanical lift in an alcove in the hall on the 100 Unit. She then went into the clean linen room and got a brief. She then went into R71's room.During an interview with CNA3 on 04/15/2026 at 11:04 AM, she stated she had used the mechanical lift to get R42 out of bed. When asked how the lift was to be cleaned after use, she stated with alcohol wipes and pointed to the wipes next to the lift. When asked if she cleaned the lift after getting R42 out of bed she stated, No. When asked what could happen if the lift was not cleaned between residents, she (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated, Germs could transfer to another resident. Observation on 04/16/2026 at 10:30 AM revealed CNA10 put the mechanical lift in an alcove in the hall on the 200 Unit. She then left and walked down the hall.During an interview with CNA10 just after the observation, she stated she had just used the lift to get R33 out of bed. When asked why she did not clean the lift, she stated, I was in a hurry.During an interview with the Infection Preventionist (IP) on 04/16/2026 at 10:57 AM, she stated staff was supposed to clean the mechanical lifts before and after each use, so infection between residents could not be spread. She further stated she did periodically monitor staff to ensure they were cleaning the lifts after each use. She also stated she had not found any issues with the cleaning of the lifts because staff knew she was watching. The IP stated staff was taught on cleaning the mechanical lifts in orientation and yearly.During an interview with the Director of Nursing (DON) on 04/16/2026 at 11:11 AM, she stated staff was taught how to clean the mechanical lifts in orientation and quarterly. She stated it was important to keep the lifts clean to prevent the spread of diseases. The DON stated staff should clean the lifts after each use with the germicidal wipes.During an interview with the Administrator on 04/16/2026 at 11:31 AM, he stated staff knew how to clean mechanical lifts by training given in orientation. He stated the nurse should also reeducate the staff on cleaning the lifts to make sure residents were not exposed to germs from other residents or staff.During continued interview on 04/16/2026 at 5:30 PM with the Administrator, he stated he relied on the nursing staff and the IP to ensure the infection prevention program was implemented per the facility's policies.

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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. Based on observation, interview, record review, review of the facility's job description, and review of the facility's document and policy, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the comprehensive assessment for 3 of 9 sampled residents, Resident (R) 10, R17, and R28, related to falls.The findings include:Review of the facility's undated policy titled, Comprehensive Care Plans [CCP], revealed it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and all services that were identified in the resident's comprehensive assessment and met professional standards of quality but were not provided due to the resident's exercise of his/her right to refuse. The policy also revealed the CCP would be reviewed and revised by the IDT (Interdisciplinary Team) after each comprehensive and quarterly assessment and would include documentation of alternative interventions if needed.Review of the undated facility's document, Minimum Data Set (MDS) Coordinator, Job Description,, revealed the purpose of the MDS nurse was to conduct and coordinate the completion of the required Resident Assessment Instrument (RAI) and responsibility for the implementation and ongoing evaluation of each resident's comprehensive plan of care.1. Review of R10's admission Record revealed the facility admitted R10 on 01/16/2025 with diagnoses of dementia, post-traumatic stress disorder, and repeated falls.Review of R10's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/16/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of three out of 15, indicating R10 was severely cognitively impaired.Review of the facility's Interdisciplinary Team [IDT] Review Notes for each fall incident for R10 revealed the facility followed their process for review of the falls with identification of the root cause analysis for each fall, however resident specific interventions were not added to each resident's comprehensive care plan.Review of R10's Certified Nurse Aide (CNA) Kardex (a centralized and concise quick reference guide for daily resident care which was driven by the resident's CCP), dated 04/16/2026, revealed documented interventions as: make sure shoes were comfortable and not slippery, noting R10 preferred to wear tennis shoes; encourage R10 to use the call bell for assistance; ensure R10 had an unobstructed path to the bathroom and provide a safe environment, call light in reach, adequate low glare light, bed in lowest position with all wheels locked; avoid isolation; and R10 needed a safe environment with floors that were even and free from spills and clutter, and a call light or alarm system and personal items in reach.Review of R10's CCP, initiated on 01/31/2025, revealed R10 was at risk for falls due to confusion and wandering and had experienced actual falls. The goals for R10 included safety measures would be maintained to prevent or lessen an injury from falling and included R10 would resume usual activities without incident, and R10's injured areas would resolve without complication by the next review date. Interventions dated 02/24/2026 included: physician to evaluate, check range of motion daily, for no apparent acute injury, determine and address causative factors of the fall, monitor/document /report as needed for 72 hours to the physician for signs/symptoms: pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation, and pharmacy consult to evaluate medication.a. Review of R10's Fall Incident Report, dated 01/09/2026, revealed R10 sustained a fall with resulting redness to the jawline. Review of R10's CCP, dated 01/09/2026, revealed a documented intervention of physician to evaluate.b. Review of R10's Fall Incident Report, dated 02/04/2026, revealed R10 sustained a fall which resulted in a knot to the top of the head and had refused to put on footware.Review of R10's CCP, dated 02/04/2026, revealed a documented intervention of physician to evaluate and did not contain an intervention to address the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's refusal to wear footwear. The intervention was not addressed on the CNA Kardex.c. Review of R10's Fall Incident Report, dated 02/06/2026, revealed R10 sustained a fall with no injury.Review of R10's CCP, dated 02/06/2026, revealed a documented intervention of physician to evaluate.d. Review of R10's Fall Incident Report, dated 02/17/2026, revealed R10 sustained a fall with no injury.Review of R10's CCP, dated 02/17/2026, revealed a documented intervention of physician to evaluate.e. Review of R10's Fall Incident Report, dated 02/21/2026, revealed R10 sustained a fall resulting in red/purple discoloration to her right arm and shoulder and a knot on the right side of her head.Review of R10's CCP, dated 02/21/2026, revealed a documented intervention of physician to evaluate.f. Review of R10's Fall Incident Report, dated 02/24/2026, revealed R10 sustained a fall resulting in a laceration to the top center of her head. R10 was sent to the hospital, received five staples to the top of her head, and had a Computed Tomography (CT) scan of her head which was negative for fracture but showed progression of her Alzheimer's.Review of R10's CCP, dated 02/24/2026, revealed a documented intervention of physician to evaluate.g. Review of R10's Fall Incident Report, dated 02/27/2026, revealed R10 sustained a fall with no injury.Review of R10's CCP, dated 03/04/2026, revealed a documented intervention of physician to evaluate.h. Review of R10's Fall Incident Report, dated 03/17/2026, revealed R10 sustained a fall resulting in a knot to her right temple.Review of R10's CCP, dated 03/17/2026, revealed a documented intervention of physician to evaluate dated 03/16/2026.i. Review of R10's Fall Incident Report, dated 03/25/2026, revealed R10 sustained a fall resulting in a laceration to the top of her head above her hairline. Review of R10's CCP, dated 03/25/2026, revealed a documented intervention of physician to evaluate. j. Review of R10's Fall Incident Report, dated 04/01/2026, revealed R10 sustained a fall with no injury.Review of R10's CCP, dated 04/01/2026, revealed a documented intervention of physician to evaluate. 2. Review of R17's admission Record revealed the facility admitted R17 on 09/06/2025 with diagnoses of unspecified dementia, adult failure to thrive, and non-infective gastroenteritis. Additional diagnoses of abnormalities of gait and mobility/lack of coordination and muscle weakness were added on 11/08/2025.Review of R17's quarterly MDS, with an ARD of 12/15/2025, revealed a BIMS could not be completed because the resident was rarely/never understood.Review of R17's CNA Kardex, dated 04/16/2026, revealed no interventions for falls or safety were documented.Review of R17's CCP, initiated on 10/17/2025, revealed goals included R17 would resume usual activities without further incident through the review date and interventions dated 10/10/2025 included physician to evaluate, check range of motion, continue interventions on the at-risk plan, for no apparent acute injury, determine and address causative factors of the fall, monitor/document /report as needed for 72 hours to physician for signs/symptoms of pain, bruises, change in mental status, and new onset confusion, sleepiness, inability to maintain posture, and agitation.a. Review of R17's Fall Incident Report, dated 01/02/2026, revealed R17 sustained a fall with no injuries.Review of R17's CCP, dated 01/02/2026, revealed documented interventions of mats to the floor by the bed and physician to evaluate. However, the intervention for the mats to the floor by R17's bed did not appear on his CNA Kardex.b. Review of R17's Fall Incident Report, dated 01/10/2026, revealed R17 sustained a fall with resulting redness to right outer knee.Review of R17's CCP, dated 01/12/2026, revealed a documented intervention of physician to evaluate.c. Review of R17's Fall Incident Report, dated 03/31/2026, revealed R17 sustained a fall which resulted in a skin tear to the left outer elbow. Review of R17's CCP, dated 04/01/2026, revealed documented interventions of physician to evaluate and treatment to the skin tear to the left outer elbow per current physician order.3. Review of R28's admission Record revealed the facility admitted R28 on 12/17/2024 with diagnoses of unspecified dementia, altered mental status, and skin picking disorder. Additional diagnoses of abnormalities of gait and mobility and muscle weakness were added on 12/13/2025.Review of R28's MDS, with an ARD of 06/23/2025, revealed the facility assessed the resident to have a BIMS score of six out of 15, indicating severe cognitive impairment.Review of the facility's Falls List, dated 04/15/2026, documenting falls for the past 120 days revealed R28 had four falls.a. Review of R28's Fall Incident (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Report, dated 01/19/2026, revealed R28 sustained a fall with no injury.Review of R28's CCP, dated 01/20/2026, revealed a documented intervention of physician to evaluate.b. Review of R28's Fall Incident Report, dated 02/25/2026, revealed R28 sustained a fall with resulting discoloration to the right hand.Review of R28's CCP, dated 02/26/2026, revealed a documented intervention of physician to evaluate. c. Review of R28's Fall Incident Report, dated 03/25/2026, revealed R28 sustained a fall with resulting redness to the right face/cheek.Review of R28's CCP, dated 03/26/2026, revealed a documented intervention of physician to evaluate. d. Review of R28's Fall Incident Report, dated 04/07/2026, revealed R28 sustained a non-injury fall.Review of R28's CCP, dated 04/09/2026, revealed a documented intervention of physician to evaluate.Review of R28's CNA Kardex, dated 04/16/2026, revealed documented interventions as: make sure shoes were comfortable and not slippery, noting R28 preferred to wear tennis shoes, encourage R28 to use call bell for assistance, ensure R28 had an unobstructed path to the bathroom, and ensure and provide a safe environment, call light in reach, adequate low glare light, bed in lowest position with wheels locked, and avoid isolation.During an interview on 04/15/2026 at 8:40 AM with Certified Nursing Assistant (CNA) 8, she stated she had worked at the facility for about a year, and she used the CNA Kardex for each resident that outlined their care, which was located on the computer and at the nurse's station in a care plan book. CNA8 also stated the CNA Kardex included safety needs for the resident to prevent falls, toileting assistance, diet, assistance needed with meals, and resident personal preferences for care or refusals of care.During an interview on 04/15/2026 at 8:48 AM with Licensed Practical Nurse (LPN) 1 and LPN2, they both stated the floor nurses did not update the care plans. They stated the floor supervisors, the MDS nurse, the Infection Preventionist (IP), and other department heads that attended clinical meetings in the morning did that. LPN1 stated the CNAs had a Kardex available on the computer that outlined the residents' plans of care and would include things like diet, activity, special needs or assistance, and fall interventions.During an interview on 04/15/2026 at 8:43 AM with Registered Nurse (RN) 3, she stated the CNA Kardex that outlined resident care was online but denied there was CNA Kardex book at the nurse's station. RN3 further stated the resident's CCP and the CNA Kardex with resident specific interventions and preferences for care were updated in the morning clinical meeting with new orders and interventions by the clinical team. RN3 stated it was important for fall interventions to be up to date on a resident's care plan as well as the CNA Kardex so all staff would know how to safely care for that resident and attempt to prevent falls.During an interview on 04/15/2026 at 9:13 AM with the Infection Preventionist (IP), she stated all care interventions for a resident should appear on their CCP. The IP further stated she did not update the resident's CCP, and the MDS nurse did that during the morning clinical meeting. She stated she was not sure if all nurses could update the resident's CCP. During an interview on 04/15/2026 at 10:42 AM with the MDS nurse, she stated resident orders were reviewed and added to the resident care plan every morning in clinical meeting, and every clinical team member played a role. She further stated everyone on the clinical team could update the resident's CCP, but she was not sure if there were any audits completed to ensure orders or interventions had been accurately added. The MDS nurse also stated the CNAs followed the CNA Kardex, which contained information from the resident's CCP. She stated the CNA Kardex outlined each resident's special needs or preferences for their care like toileting, meal assistance, infection control precautions, elopement risk, and falls prevention which transferred to the CNA Kardex from the interventions added to the resident's CCP. The MDS nurse then stated a resident's CCP was initiated on admission by the admitting nurse, completed with the resident's admission MDS by the MDS nurse, and updated with each quarterly, annual, or significant change of condition MDS by the MDS nurse. She stated due to a change in the facility's electronic documentation system, resident care plans were in the process of being transitioned to the new system which was not yet complete. The MDS nurse also stated the facility wanted the physician to evaluate a resident after each fall. However, she stated there should also be a resident specific intervention placed on the resident's CCP after the root cause for the fall had been identified.During (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an interview on 04/16/2026 at 10:00 AM with the Director of Nursing (DON), she stated the purpose of a resident's CCP was to outline the needs, care, and preferences each resident required while at the facility. The DON stated the resident's CCP provided the information on the CNA Kardex that each CNA used to provide resident specific care to each resident. The DON also stated it was the responsibility of the MDS nurse to update the resident's CCP with each resident's MDS. She stated since she was the supervisor for the MDS nurse, it was her responsibility to provide oversight and ensure all necessary care plans had been developed and updated as new interventions were added. The DON stated the intervention of physician to evaluate could be a part of the response to a resident fall, but a specific intervention addressing the root cause of the fall should also be implemented.During an interview on 04/16/2026 at 5:30 PM with the Administrator, he stated he relied on nursing staff to accurately develop and update the resident's CCP, and it was his expectation that all resident falls be completely investigated and the resident's care plan be accurate, current, and reflect the specific needs and wants of each resident.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and review of the facility's policy, the facility failed to provide necessary activities of daily living care to maintain 1 of 2 sampled dependent residents in a clean manner, Resident (R) 11. The facility failed to ensure R11 had clean clothing, clean bed linens, and grooming assistance. The findings include:Review of the facility's policy titled, Activities of Daily Living [ADL] dated 2025, revealed the facility would provide care and services consistent with each resident's comprehensive assessment, needs, and choices. The policy further stated residents unable to perform activities of daily living would receive necessary services for bathing, dressing, grooming, and personal hygiene.Review of R11's admission Record revealed the facility admitted R11 on 10/18/2024 with diagnoses of dementia, atrial fibrillation, and limited mobility.Review of R11's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/12/2026, revealed R11 was severely cognitively impaired, had no Brief Interview for Mental Status [BIMS] score recorded, rarely or never made decisions, and required dependent assistance with bathing, dressing, and personal hygiene.Review of R11's Care Plan Report revealed R11 required total assistance with activities of daily living due to functional and cognitive limitations. Interventions, initiated on 11/06/2025 and revised on 01/28/2026, included staff providing the resident's dressing and grooming routine. Additional interventions included total assistance with dressing, bathing, grooming, toileting, transfers, bed mobility, and eating. Observation on 04/14/2026 at 8:44 AM revealed R11 was lying in bed wearing a t-shirt with dried brown stains around the neckline and chest area that were hardened to the touch. R11's blanket and bed linens contained similar dried brown stains, and his hair was uncombed and appeared disheveled.Observation and interview on 04/15/2026 at 4:00 PM, in the presence of Family Member (FM) 6, who stated staff had just provided personal care to R11. R11 remained in bed wearing the same stained t-shirt, with the same stained blanket and bed linens. R11's hair remained uncombed and disheveled. R11 repeatedly asked FM6 and the surveyor for a clean shirt during the observation. FM6 stated she visited R11 daily, and before entering the nursing facility, R11 had been particular about his personal cleanliness and preferred to be kept clean.During an interview on 04/15/2026 at 10:05 AM, Certified Nursing Assistant (CNA) 7 stated staff was responsible for ensuring residents were clean, dressed in clean clothing, had clean linens, and received grooming assistance. CNA7 stated she did not realize R11's shirt and bed linens were stained.During an interview on 04/16/2026 at 10:20 AM, the Director of Nursing (DON) stated staff was expected to keep residents clean and well-groomed. She stated staff should clean residents after each meal, comb their hair daily and as needed, and provide personal care in a manner that maintained dignity and respect.During an interview on 04/16/2026 at 10:40 AM, the Administrator stated residents should be kept clean at all times. He stated staff was expected to provide clean clothing, clean linens, and grooming assistance as needed.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, record review, review of the Activity Director job description, and review of the facility's policy, the facility failed to provide an ongoing program to support the residents' choice of activities based on their comprehensive assessment, care plan, and preferences, specifically one-to-one interaction, as directed for 2 of 2 sampled residents, Resident (R) 12 and R13. Observations from 04/14/26 through 04/16/2026 revealed R12 and R13 were in bed, dressed in bed clothing or a shirt only. No observations were made of staff providing one-to-one interaction.The findings include:Review of the undated policy titled Activities, revealed the facility provided an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. It also stated individual activities would be designed to support their physical, mental, and psychosocial well-being and encourage interaction within the community. Review of the undated job description for the Activity Director (AD) revealed it was the responsibility of the AD to direct the development, implementation, supervision, and ongoing evaluation of the activities program designed to meet the social, psychosocial, and therapeutic needs of the resident. This included matching the skills and abilities and interest of the resident and monitoring the response, documenting outcomes, and making revisions as necessary. 1. Review of the Care Plan [CP], located in the electronic medical record (EMR), revealed the facility admitted Resident (R) 12 on 06/17/2018 with diagnoses of dementia, anxiety, psychosis, and mood disturbance disorder. It also revealed a focus initiated on 01/30/2026 related to preference for self-directed activities, such as watching television. An intervention also dated 01/30/2026 encouraged one-to-one activities.Review of R12's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/12/2026, revealed no Brief Interview of Mental Status (BIMS) score was documented, but severe cognitive impairment was listed in her assessment for Cognitive Skills for Daily Decision Making. The MDS also revealed R12 had difficulty concentrating on things such as television. In addition, R12 was documented as non-ambulatory and did not use any type of mobility device, including mechanical lift, wheelchair or walker. It also revealed that the resident was dependent on staff for partial to moderate assist with eating and oral care, substantial to max assist with dressing, showering, personal hygiene, and bed mobility.Review of documentation that was printed from the EMR POC (Point of Care) entries dated 01/01/2026 through 04/06/2026, revealed the Certified Nursing Assistant (CNA) documentation for one-to-one activities for R12 was Not Applicable for all opportunities to document activities. Review of the Activity Department's form One-To-One Activities provided to R12 listed people watching, verbalization, and watching television. Documentation included Monday through Friday activities. No activities were documented on Saturdays or Sundays. Observations on 04/14/2026 at 1:05 PM and again at 3:12 PM revealed R12 wearing a shirt and a brief, resting with her eyes closed.Observations on 04/15/2026 at 10:25 AM, and at 1:28 PM revealed R12 was lying in bed with her eyes closed and was wearing the same shirt as on 04/14/2026 but with pajama pants. Observation on 04/16/2026 at 10:02 AM and again at 3:17 PM revealed R12 was lying in bed, with her eyes closed.No observation of active or passive activities was made during any of the observations. During an interview on 04/16/2026 at 1:22 PM with CNA10, she stated she did not think the resident got out of bed and was assisted with cleaning and meals. She stated she was not sure what types of things the resident would be interested in but noted she could review the care plan for that information. She stated residents getting out of bed or participating in some form of activity would be good for them to socialize, and might increase their quality of life. 2. Review of the CP, located in the EMR, revealed the facility admitted R13 on 03/07/2025 with diagnoses of cerebral infarction, traumatic brain injury, cognitive communication deficit, and severe dementia with agitation. The CP revealed R13 was dependent on enteral nutrition and received continuous bladder irrigation. Further review revealed the most recent update on 04/02/2026 revealed a focus of activities, noting a lack of interest related to immobility and an intervention of the resident's preference for one-to-one (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	visits from activity staff, social services, and being read to. Also updated on 04/02/2026 was a focus related to falls that listed the resident's preference to stay in bed. Review of R13's annual MDS, with an ARD of 03/16/2026, revealed a diagnosis of severe cognitive impairment and a Brief Interview of Mental Status [BIMS] score that was blank. The functional abilities assessment revealed dependence on staff for maximum assistance for all ADLs. Additionally, documentation revealed the resident was bedbound and did not utilize a wheelchair. Review of documentation that was printed from the EMR POC (Point of Care) entries dated 01/01/2026 through 04/06/2026, revealed the CNA documentation for one-to-one activities for R13 was Not Applicable for all but three opportunities to document activities. One-to-one activity was documented by Activity Assistant 2 on one occasion, 01/20/2026. On 03/27/2026 and 04/06/2026, the Activity Director documented participation in group activities. Review of the Activity Department's form One-To-One Activities, for 01/01/2026 through 04/06/2026, revealed R13 participated in reading to self, phone, watching television, and socialization. There was no indication of one-to-one activities or the resident's response. Observation on 04/14/2026 at 12:55 PM revealed R13 lying in bed with her eyes closed with each pass-by of her room. Subsequent observations revealed the same on 04/14/2026 at 3:10 PM, 04/15/2026 at 10:12 AM and at 1:20 PM, 04/16/2026 at 9:48 AM, 11:40 AM, and at 3:01 PM. No observation of active or passive activities was made. During an interview on 04/16/2026 at 3:03 PM with CNA11, she stated R13 slept all day because she was awake most of the night and could not recall the last time she had been up in a Geri-chair. She stated that sometimes she turned on the television for the residents, but there were no activities at night. CNA11 stated that occasionally, R13 was given coloring pages. During an interview on 04/16/2026 at 10:49 AM, the Activity Director stated her schedule was Monday through Friday, 8:00 AM until 4:30 PM. She stated she also had an assistant scheduled to start working every other weekend beginning the next weekend, and another assistant who worked on Sundays. She stated the documentation of one-to-one activities was done by the Activity person who provided the care. After reviewing the recorded activities for R12 and R13, she stated the residents scheduled for one-to-one activities were provided with activities in their rooms. She stated the use of a telephone and receiving mail were more of a resident's right and that people watching was not a legitimate activity, much less a result of one-to-one interaction. She stated she could not explain how a resident with a severe cognitive deficit could read to herself or work word puzzles as listed on their activity log. She stated more appropriate activities for these residents might benefit their psychosocial welfare. She stated residents who were more active at different times of the day/week might benefit from the additional opportunities that the new schedule would present.During an interview on 04/16/2026 at 3:04 PM, Activity Assistant (AA) 1 stated one-to-one activities were provided for those unable to participate otherwise. She stated most of the time, this included residents with severe dementia. She stated she tried to find things that those types of residents would want to do. She stated some of the activities listed were things that residents had been observed doing, such as people watching. AA1 stated that it was not an activity that qualified as a one-to-one activity and that receiving mail or using the phone were not activities but more of a resident's right. AA1 stated there were areas where one-to-one activities could be more engaging. She stated not providing that type of activity could create resident isolation.During an interview on 04/16/2026 at 6:08 PM with the Director of Nursing (DON) and the Interim Administrator, the DON stated activities were an important part of resident care. She stated it provided them with ways to stay engaged with others, and it was especially important for those who could not get out, as most others could. Both the DON and the Administrator were made aware of observations and concerns regarding R12 and R13. The DON and Administrator stated their desire for staff to provide more meaningful interaction with residents who had severe cognitive deficits. The DON stated she expected staff would not only identify and meet the needs of residents but also document the results of those efforts with more clarity. The Interim-Administrator stated she agreed with the DON's statement.