STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185160	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lexington Country Place	700 Mason Headley Road Lexington, KY 40504

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and review of the facility's policy, the facility failed to promptly notify the physician of a fall for 1 of 8 residents sampled for falls, Resident (R) 13. Record review and interviews revealed R13 sustained a fall on 03/08/2026 at approximately 8:00 PM. R13 was observed to have a significant change in condition related to her physical functioning, mobility, and pain level. Record review revealed, however, the resident's physician was not notified promptly of these changes until the resident's family requested staff to contact the physician. On 03/10/2026, approximately two days after the resident fell, Resident 13 was diagnosed to have a fracture of the distal femoral shaft (portion of the femur just above the knee) with malalignment and soft tissue swelling.Immediate Jeopardy (IJ) was identified on 04/30/2026 in the area of 483.10 Resident Rights and was determined to exist on 03/08/2026. The facility submitted an acceptable IJ Removal Plan on 05/01/2026. The immediacy was determined to be removed on 05/01/2026, prior to exit.Refer to F689The findings include:Review of the facility's policy titled, Change in Condition, dated 08/01/2024, revealed the policy required staff to recognize and report physical, cognitive, or emotional changes, including use of tools to ensure timely communication. Additionally, the policy directed staff to complete a thorough assessment, document findings, and notify the physician promptly.Review of the facility's policy titled, Falls and Injuries, dated 08/01/2024, revealed the policy required staff to notify the resident's physician following a fall to ensure timely evaluation, treatment, and direction for ongoing care. According to the policy, the physician was expected to respond timely, and staff was directed to escalate concerns to the Medical Director if an appropriate or timely response was not received.Review of R13's admission Record revealed the facility admitted the resident on 02/03/2024 with diagnoses to include Parkinson's disease with dyskinesia, repeated falls, and cognitive communication deficit.Review of R13's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/02/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 out of 15, indicating moderate cognitive impairment. Review of a Health Status Note, dated 03/08/2026 at 10:12 PM, found in R13's electronic medical record (EMR) under the Progress Notes tab, indicated staff found the resident on the floor attempting to find personal items. The resident was assessed as alert and oriented x 3/4. Furthermore, the resident had pain in her right knee, rated at five out of 10 on a numerical pain scale with 10 being the worst pain. According to the note, the Director of Nursing (DON) and R13's family member (F) 13 were notified. Documentation revealed the nurse called the resident's primary care physician and documented the physician was called to her office and was unable to talk to anybody.Review of a Fall Report, dated 03/08/2026 at 8:45 PM, revealed the resident was found on the floor of her room at 8:00 PM after attempting to reach for personal items. The resident was assessed as alert with pain rated as a 5 out of 10. Documentation revealed no injuries were observed. The report revealed predisposing environmental and situational factors were identified as other without further explanation. Psychological factors were documented as confusion. Per the Fall Report, Licensed Practical Nurse (LPN) 2 documented he notified R13's physician on 03/08/2026 at 9:00 PM.Review of a eINTERACT (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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Change in Condition Evaluation, dated 03/08/2026 at 10:20 PM, revealed the Provider Notification Feedback section regarding change in condition and notification to physician indicated yes for physician notification on 03/08/2026 at 8:00 PM. However, under recommendation of the physician, the documentation stated, Nobody answered the call and was unable to leave message.Review of nursing Progress Notes, dated 03/08/2026 to 03/09/2026, found in R13's EMR under the Progress Notes tab, and requests for further documentation from the facility, revealed no documentation indicating the facility made additional attempts to notify the physician or continued follow-up communications regarding the resident's fall or change in condition until LPN2 sent a text on 03/09/2026 at 3:04 PM.Review of a text message communication regarding R13's fall, dated 03/09/2026 at 3:04 PM, revealed LPN2 wrote to the physician, [R13] fell in her room last night. I already talked to the office number before. Her daughter wants x-ray rt. Knee for pain. Let me know please if she needs it.Review of physical therapy's (PT) Interdisciplinary Resident Screen, dated 03/09/2026, revealed the Speech Therapist assessed R13 to have multiple significant changes in physical functioning, mobility, and pain level. The screen revealed the resident had been bed bound since the previous night, refused morning and afternoon meals, and experienced increased pain rated eight out of 10 on a numerical pain scale with 10 being the worst pain. Documentation revealed R13's right knee was swollen. The assessment further documented that the resident could not bear weight on the right knee and hip. There was no documentation indicating the physician was notified.Review of a nursing Health Status Note, dated 03/10/2026 at 11:09 AM, revealed LPN15 noted, CNA alerted me patient [resident] is crying in pain. Patient [resident] noted to be in bed, tears streaming down face. She said her leg hurts so bad she can not [sic] stand it. There was not document, however, the resident's physician was notified.Review of a Radiology Report, of R13's right knee, captured at the facility, dated 03/10/2026 at 1:06 PM, revealed a fracture of the distal femoral shaft with malalignment and soft tissue swelling.Observation of R13 on 04/27/2026 at 10:15 AM revealed the resident in bed with the covers removed, wearing only briefs. A bed alarm was present but not alarming. The resident was positioned sideways in bed in a partially upright, partially reclined position, with both legs hanging off the side of the bed. The room environment was unkempt and cluttered. R13's bedside table was positioned away from the resident's and out of the resident's reach. R13 stated she was trying to reach items on the bedside table and needed to get out of bed. The State Survey Agency (SSA) Surveyor notified staff.During a telephone interview with R13's family member (F) 13 on 04/29/2026 at 11:16 AM, she stated R13 had advanced dementia with associated Parkinson's disease psychosis and experienced frequent falls. F13 stated the resident did not recognize safety risks and could not consistently understand or follow instructions, which is why she admitted R13 to the facility to provide 24/7 supervision and staff assistance to ensure her safety. F13 stated despite sustaining a major injury requiring surgical intervention and subsequent return to the facility, R13 continued to experience falls. She stated R13 fell again within a short period of time after returning to the facility following surgical repair of a fractured femur. Further, she stated on 03/09/2026, sometime during the morning, R13 called her and stated she believed she had broken her leg and was in severe pain. Additionally, F13 stated the resident continued to complain of significant pain, difficulty with moving her right lower extremity, and demonstrated verbal behaviors indicating something was wrong. She stated although the resident could not always clearly verbalize her needs, staff could recognize changes in conditions through the resident's behavior and complaints of pain. F13 stated she spoke with LPN2 and requested an X-ray. She stated she did not receive any follow-up communication from the facility until the following afternoon, after the x-ray was completed, and staff notified her R13 sustained a femur fracture, which required transfer to the local emergency department (ED). During an interview with LPN2 on 04/27/2025 at 11:45 AM, he stated that when R13 fell on [DATE], he completed an assessment of the resident following the incident. He stated at the time of the assessment there was no visible bruising, redness, swelling, shortening, or external injury noted. LPN2 stated the resident complained of some pain but did not exhibit significant (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	distress and remained in bed. Furthermore, LPN2 stated the facility's policy required notification of the physician, DON, and family following a fall. He stated communication with R13's physician typically occurred through an on-call service rather than direct physician contact. LPN2 stated he attempted to notify R13's physician on 03/08/2026 by calling the physician's medical practice on-call service but was unable to reach anyone and was unable to leave a voicemail. He reported he did not have direct contact information for the physician at that time. He stated he notified the DON of the fall but could not recall whether he informed her he was unable to reach the physician. He reported that on the morning of 03/09/2026, at approximately 9:00 AM, he spoke with the DON, who provided him with a contact number for the physician. He stated he subsequently contacted the physician later that day, though documentation reflected contact occurred at approximately 3:18 PM. He stated once the physician was contacted, an order for an x-ray was obtained per family request. When asked by the State Survey Agency (SSA) Surveyor why he did not notify the physician immediately after obtaining his cell phone number, the LPN stated he was busy with medication administration. The LPN further stated he did not contact the physician until after R13's family member (F) 13 contacted staff and requested an x-ray. LPN2 stated the x-ray was not completed until the following day and reported that timing of diagnostic services was dependent on availability. He stated he did not believe the situation required a stat (immediate) order at the time, as the resident had a history of pain.Interview with SRNA12 on 03/27/2026 at 2:15 PM revealed she cared for R13 on 03/10/2026 and observed R13 making complaints of pain throughout the shift. SRNA12 stated R13 said her whole leg hurt and the pain moved between the knee and hip. SRNA12 stated she cried in pain. SRNA12 stated she observed swelling in the knee and bluish discoloration of the leg, which she stated was not the resident's normal skin color.During a telephone interview with R13's physician on 04/30/2026 at 2:55 PM, he stated the facility did not notify him of R13's fall on 03/08/2026. The physician stated he first became aware of the fall through text message received on 03/09/2026 at approximately 3:00 PM indicating the resident's family requested an x-ray. He stated the text message did not include concerns regarding R13's pain level, swelling, injury, or decreased range of motion. The physician further stated staff did not contact him through his cell phone on 03/10/2026 and instead left a message with his office. He stated staff did not inform him R13 experienced increased pain or cried with complaints of pain rated eight out of 10. The physician stated if staff had informed him of R13's knee swelling, pain, and decreased range of motion, he would have sent R13 to the emergency department for evaluation rather than ordering an x-ray. He further stated nursing staff did not communicate the severity of R13's pain or injury when requesting the x-ray. The physician stated his preferred method of notification was direct contact through his personal cell phone. He stated the DON had his personal cell phone number, and his number was posted at the nurses' stations for staff use. The physician further stated he and facility staff previously discussed avoiding use of the on-call service, especially on weekends, because the on-call provider might not have been familiar with the resident.During an interview with the Director of Nursing (DON) on 04/28/2026 at 11:55 AM, she stated there was no defined process when initial attempts to notify the physician were unsuccessful. She stated nursing staff had the option to contact the facility's medical director if the physician was unreachable. The DON stated LPN2 notified her on 03/08/2026 at approximately 8:30 PM regarding R13's fall. She stated LPN2 informed her on 03/09/2026 at approximately 9:00 AM he had not notified the physician. The DON stated she provided LPN2 with the physician's personal cell phone number. The DON stated staff should have continued attempts to notify the physician rather than delaying notification until the following day. She stated she was unclear why LPN2 did not immediately notify the physician and instead waited until approximately 3:00 PM on 03/09/2026 to communicate by text message. When asked by the State Survey Agency (SSA) Surveyor regarding her expectations for physician notification, the DON stated LPN2 should have continued attempts to notify the physician, including use of the physician's personal cell phone number, and should have ensured contact occurred the same night.During an additional interview with the DON on 05/01/2026 at 6:00 PM, she (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	stated it would have been reasonable for the nurse on duty to contact her if the resident required more urgent care or the physician did not respond promptly. The DON stated she could have intervened by contacting the physician directly regarding concerns about the lack of a timely response. She further stated nursing staff was expected to advocate for the resident's needs.During an interview with the Administrator on 04/29/2026 at 7:54 AM, she stated she had a concern regarding R13's fall on 03/08/2026. She stated the nurse reported attempting to contact the physician's office on the evening of the fall; however, there were no additional attempts made that evening. The Administrator stated the nurse's documentation indicated he called and did not get anybody. She stated the physician was not contacted until approximately 3:00 PM on 03/09/2026. The Administrator stated LPN2 escalated concerns to the DON at 9:00 AM and was provided the physician's personal cell phone number. However, she stated documentation of a text message revealed LPN2 waited until 3:00 PM to contact the physician through a text message. Additionally, the Administrator stated staff was expected to notify physicians in a timely manner regarding changes in condition, including falls. She stated she expected nursing staff to continue attempts to contact the physician or the DON when initial notification attempts were unsuccessful. The facility submitted an acceptable IJ Removal Plan on 05/01/2026 at 3:38 PM verbatim:Resident (R)13 sustained a fall on 03/08/26 at 8:45 p.m. An attempt was made to reach the physician immediately but there was no answer nor the ability to leave a message. On 3/09/2026 at 1:00 p.m. nurse called Physician office and spoke to office staff asking Dr. [NAME] to return call re: resident fall. However, at 3:04 p.m. on this date (03/9/2026) nurse called physician's cell phone to report right knee pain and request was made for Xray. Physician responded on 3/09/2026 at 3:18 p.m. and X-ray requested. On 3/10/2026 Portable X-Ray obtained resulting in R Femur Fracture. Physician notified us of the results on 3/10/2026 and order was obtained to transfer the resident to hospital for further evaluation and treatment.-The QAPI tool for the monitoring of MD notification for fall changes in status and for fall Root Cause analysis and intervention implementation is being utilized underthe [sic] supervision of the Administrator/Executive Director with all falls weekly X 2 weeks, then monthly X 2 months and then quarterly thereafter.An Ad hoc QAPI meeting was conducted on 04/30/26 with the QAPI committee members, including the Medical Director, Attending Physicians, Administrator, Director of Nursing, MOS Coordinator, Staff Development coordinator, Human Resource Coordinator and the Social Service Director to review the findings cited in the IJ Templates and the facility Removal Plan.Resident(s) affected by the IJ:Resident (R) 13 was identified to be affected by the deficiency. The resident had a fall on 03/08/2026 at 8:45 p.m. No external injuries are noted at this time. Resident complained of right knee pain but displayed normal ROM. M.D. office called no message left on 3/08/2026 at 9:00 p.m. MD office called again on 3/09/2026 at 1:06 p.m. then nurse messaged MD directly at 3:04 p.m. New order for X-Ray obtained. X-Ray resulted in a femur fracture on 3/10/2026 and MD notified with new orders to send to the hospital with the diagnosis of a fracture of right femur fracture.--Root cause analysis was completed on 03/13/2026 in which we rearranged resident's room and added intervention to the care plan. On 4/30/2026 another root cause analysis was completed re: this fall with the indicated intervention of Wheelchair caddy bag on inside of wheelchair for easy access of personal items. [NAME] added to the plan of care and SRNA Kardex.-Activity Staff have been educated by the Executive Director/Administrator to assist resident (R) 13 to activities daily (5 to 6 per day) to add supervision. Licensed Nurses have been educated to have resident out of the room as much as she allows, for meals, day area, etc. and this has been added to care plan and SRNA task. Education was started on 4/30/2026 by Staff Development Coordinator and no Licensed Nurse will work prior to education being completed. Resident started on 15-minute checks x 1 week beginning 05/01/2026 and Fall management team will reevaluate.-Director of Nursing, Unit Manager and MOS Nurse completed a new fall risk assessment for all residents, and they will correct any findings at the time. Audit completed 05/01/2026 and results will be discussed and reviewed in QAPI for input.Resident(s) the facility identified at risk for IJ:All residents with falls in the last 30 days (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	were at risk of being affected by F580 and F689.Training:-All licensed nurses have received in-service education on the updated Change of Condition Policy and Procedure to include the facility protocol for MD notification by the Staff Development Coordinator beginning on 04/30/2026 and no Licensed Nursing Staff member will work prior to education. The licensed staff will contact the Medical Director if the attending physician does not respond within 30 minutes for an emergency or 3 hours for non-emergencies. The licensed nurses that have not completed the in-service training on 4/30/2026 will be educated prior to the next shift worked or they will not be allowed to clock in until fall training has been completed. The training will be included in the facility orientation program for all new hire licensed nurses from 5/1/26 going forward and any agency staff will receive education prior to working shift by the Staff Development Coordinator, Director of Nursing or Unit Manager. As of 05/01/2026 13 of the 17 full-time Nurses have been educated. There is 7 prn Nurses that will also receive education prior to the next day worked. All education was provided 1:1 with staff, the LPN #2 received all education on 5/01/2026 prior to beginning his shift. All Licensed Nurses demonstrated comprehension by repeating education back to Staff Development Coordinator.-The Fall Management Team consisting of but not limited to the Administrator and or Director of Nursing, Rehabilitation Director or other therapist if unavailable, MDS Nurse, Staff Development Nurse and the Social Worker (Admissions Coordinator if unavailable) have received in-service education on Fall Management Audit Tool (see attached) and the importance of verifying all information on the displayed on the tool with follow education and reviewed in QAPI. Falls will be reviewed daily Monday-Friday and the next business day for the weekend. The Fall Audit Tool will also be completed at weekly fall meeting. Education provided by Administrator/ Executive Director and completed on 04/30/26 which includes but are not limited to: Director of Nursing, Staff Development, MDS Nurse, Therapist, and Social Worker.-The need to complete Root Cause Analysis for all resident falls to determine the indicated intervention to address the fall causative/contributing factor(s).-The need to address the determined intervention on the resident care plan and Kardex. A list of interventions attached to the fall packet for brainstorming to make interventions person centered.-The need to implement the determined intervention timely and to monitor for effectiveness.Systems implemented to ensure all staff are trained prior to providing direct care to residents& determined competent on the materials trained:-Audit of all resident falls for the last 30 days from 4/30/26 for residents that are still in house was completed by Director of Nursing, Staff Development Coordinator, and Administrator/Executive Director to identify that all MD notification of changes had been completed. The physicians were notified of all resident fall changes in condition for the last 30 days.-An audit of all resident falls for the last 30 days from 4/30/26 for residents that are still in house was completed by Director of Nursing, Staff Development Coordinator, and Administrator/Executive Director to determine that Root Cause Analysis with determination and implementation of indicated interventions had been completed. Interventions indicated by Root Cause analysis were determined to be on the care plans and in place for all residents with falls in the last 30 days.- The QAPI tool for the monitoring of MD notification for fall changes in status and for fall Root Cause analysis and intervention implementation is being utilized under the supervision of the Administrator/Executive Director with all falls weekly X 2 weeks, then monthly X 2 months and then quarterly thereafterMonitoring:-Results of Fall Risk Assessment will be discussed in Quarterly QAPI meeting including but not limited to the Medical Director, Pharmacist Consultant, Administrator, Director of Nursing, MOS Nurse, Staff Development Coordinator and Compliance/QAPI Coordinator findings will be added to PIP as indicated.-Completed QAPI tools will be reviewed in the ongoing QAPI meetings to determine ongoing compliance.Alleged removal date:5/1/26

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policies, the facility failed to ensure residents received adequate supervision and failed to keep residents free from falls for 1 of 8 sampled residents reviewed for falls, Resident (R) 13.Record review revealed R13 sustained a total of 10 falls from 12/29/2025 to 04/25/2026, including some with a documented injury. For one fall, on 03/08/2026, R13 suffered a non-displaced fracture of the right femur, extending to the resident's right knee. R13 was subsequently transferred to the emergency department and later returned to the facility on [DATE] and sustained a fall after transfer. Subsequent falls continued following hospitalization and surgical intervention. The falls occurred in the resident's room while attempting toileting, self-ambulating, or attempting to retrieve personal items. Additionally, interview and record review revealed the resident exhibited acute distress following the fall on 03/08/2026, including crying and reporting severe pain. Immediate Jeopardy (IJ) was identified on 04/30/2026 in the area of 42 CFR 483.25 Quality of Care and was determined to exist on 03/08/2026. Substandard Quality of Care (SQC) was also determined to exist. The facility submitted an acceptable IJ Removal Plan on 05/01/2026. The immediacy was determined to be removed on 05/01/2026, prior to exit.The findings include:Review of the facility's policy titled, Falls and Injuries, dated 08/01/2024, revealed the policy required staff to notify the resident's physician following a fall to ensure timely evaluation, treatment, and direction for ongoing care. The policy stated the Interdisciplinary Team (IDT) was responsible for identifying and implementing individualized fall prevention interventions based on assessment to reduce the risk of falls. Continued review of the policy revealed staff were responsible for communicating interventions during shift report and rounds and ensure the residents' environment was free from potential hazards.Additional review of the Falls and Injuries policy, dated 08/01/2024, revealed the physician was expected to respond timely, and staff were directed to escalate concerns to the medical director if an appropriate or timely response was not received.Review of R13's admission Record revealed the facility admitted the resident on 02/03/2024 with diagnoses to include Parkinson's disease with dyskinesia, repeated falls, and cognitive communication deficit.Review of R13's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/02/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS], score of nine out of 15, indicating moderate cognitive impairment. Continued review revealed R13 was assessed as dependent (helper did all of the effort) with toileting, lower body dressing, and putting on/taking off footwear; and substantial/maximal assistance (helper did more than half the effort) with bathing and upper body dressing.Review of R13's Care Plan Report, dated 08/28/2025 and revised on 01/08/2026 and 04/16/2026, found in the resident's electronic medical record (EMR) under the Care Plan tab, revealed a focus for potential injury from falls related to decreased mobility, Parkinson's disease, weakness, psychotropic medication use, and opioid medication use. Goals included minimizing falls and preventing injury through the review period. Interventions included: staff were to encourage the resident to eat dinner in the common area (initiated on 08/28/2025); to encourage the resident to remain in the day area for supervision until bedtime (initiated 01/08/2026); to encourage resident to stay up in day area for supervision until bedtime, anticipate and meet the resident's needs, encourage the resident to request assistance, maintain personal safety alarms to bed and wheelchair, offer toileting before bedtime, and monitor during rounds.1. (a) Review of the Health Status Note, dated 12/29/2025 at 4:00 PM, in R13's EMR under the Progress Notes tab, revealed a State Registered Nurse Aide (SRNA) found R13 on the floor in her room after attempting to change her clothes independently. She was assessed as having no injury. (b) Review of the Alert Note, dated 02/13/2026 at 8:02 AM, found in R13's EMR under the Progress Notes tab, revealed R13 slipped out of her wheelchair and complained of right arm soreness. No redness was noted.(c) Review (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	of the Health Status Note, dated 02/22/2026 at 2:08 PM, in R13's EMR under the Progress Notes tab, revealed staff found R13 sitting on the floor next to the bedroom doorway after attempting to get ice. Staff documented the fall with injury; documenting only redness was observed to the right hip. (d) Review of the Health Status Note, dated 02/28/2026 at 6:20 AM, found in R13's EMR under the Progress Notes tab, revealed an alarm sounded and an SRNA responded as R13 ambulated toward the bathroom with a staggering gait and fell before staff could secure her. R13 struck the side of her head on the bed grab bar. No marks, bleeding, or complaints of headache were noted. The nurse noted the resident had old, scattered bruising to the body.(e) Review of the Health Status Note, dated 03/08/2026 at 8:45 PM, found in R13's EMR under the Progress Notes tab, revealed R13 sustained a fall and staff later helped the resident from the floor to the bed with a two-person assist.Review of R13's Fall Report, dated 03/08/2026 at 8:45 PM, revealed staff found the resident on the floor of her room at 8:00 PM after she attempted to reach for personal items. Nursing staff assessed R13 as alert with pain rated as a five out of 10 on a numerical scale, with 10 being the worst pain. Further review of the Fall Report revealed the nurse documented no injuries were observed for this fall.Review of a Health Status Note, dated 03/08/2026 at 10:12 PM, found in R13's electronic medical record (EMR) under the Progress Notes tab, indicated staff found the resident on the floor attempting to find personal items. Nursing staff assessed the resident as alert and oriented x 3/4. Furthermore, the resident had pain in her right knee, rated at five out of 10 on a numerical pain scale with 10 being the worst pain. Review of the eINTERACT SBAR Summary for Providers, dated 03/08/2026 at 10:20 PM, found in R13's EMR under the Progress Notes tab, indicated a change in condition (CIC) after a fall. The assessment documented vital signs, including a blood pressure of 150/85, pulse 89, and respirations 20. Review of R13's Neurological Record, dated 03/08/2026 through 03/10/2026, revealed on 03/08/2026 at 8:45 PM the section for motor response of the upper and lower extremities contained a line drawn through the boxes with no motor response documented on 03/08/2026 and 03/09/2026. Further review revealed the nurse did not assess or document motor function or external stimuli of the right lower extremity. Review of a text message communication regarding R13's fall, dated 03/09/2026 at 3:04 PM, revealed Licensed Practical Nurse (LPN) 2 wrote to the physician, [R13] fell in her room last night. I already talked to the office number before. Her daughter wants x-ray rt. Knee for pain. Let me know please if she needs it.Review of a Health Status Note, dated 03/09/2026 at 3:18 PM and documented by the Director of Nursing (DON) as a late entry note on 04/28/2026 at 5:23 PM, found in Resident 13's EMR under the Progress Notes tab, revealed R13 fell in her room. According to the note, Resident's family requested an x-ray for knee pain, and an order was obtained for an x-ray of the right knee.Review of Physical Therapy's (PT) Interdisciplinary Resident Screen, dated 03/09/2026, revealed multiple significant changes in R13's physical functioning, mobility, and pain level. The screen revealed the resident had been bed bound since the previous night, refused morning and afternoon meals, and experienced increased pain rated eight out of 10 on a numerical pain scale with 10 being the worst pain. Documentation revealed R13's right knee was swollen. The assessment further documented that the resident could not bear weight on the right knee and hip.Review of an IDT Note, dated 03/09/2026 at 10:14 AM revealed the interdisciplinary team (IDT) met to review R13's 03/08/2026 fall. Further review revealed the team updated the resident's care plan to keep the resident's Reacher close and to follow up on a requested PT screening.Review of a Health Status Note, dated 03/10/2026 at 11:09 AM, found in R13's EMR under the Progress Notes tab, indicated an SRNA found R13 in bed, with tears streaming down her face. According to the note, She [R13] said her leg hurts so bad she can not [sic] stand it.Review of a Radiology Report, of the right knee and hip, dated 03/10/2026 at 1:06 PM, revealed a fracture of the right distal femoral shaft with malalignment and non-displaceable fracture of the right greater trochanter. Review of eINTERACT Transfer Form V5, dated 03/10/2026 at 6:20 PM, revealed R13 was transferred by ambulance to the local emergency department at 4:56 PM.Review of the ED to Hosp-admission Note, dated 03/10/2026, revealed R13 was admitted to the local hospital with a (continued on next page)

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	185160	A. Building B. Wing	05/01/2026

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	closed fracture of the right femur and an injury of her head. According to the report, R13 presented to the local hospital after a mechanical fall that occurred prior to arrival. The fall resulted in her hitting the back of her head and landing on her right leg. A computed tomography (CT) scan of the head showed no intracranial abnormality. Physical exam revealed the right lower extremity with positive shortening, positive external rotation, and attempted movements of the hip were painful and restricted. The resident had moderate tenderness overlying her distal femur and was given intravenous morphine (an opioid analgesic) for pain. Radiography of the right femur revealed a nondisplaced spiral type fracture involving the distal metadiaphysis of the right femur. The fracture extends to the anterior margin of the femoral component of the patient's right knee arthroplasty. Per the note, R13 underwent surgery for placement of an intramedullary rod stabilizing the distal femoral fracture. Observation of R13 on 04/27/2026 at 10:15 AM revealed the resident in bed with the covers removed, wearing only briefs. A bed alarm was present but not alarming. The resident was positioned sideways in bed in a partially upright, partially reclined position, with both legs hanging off the side of the bed. The room environment was unkempt and cluttered. R13's bedside table was positioned away from the resident's and out of the resident's reach. R13 stated she was trying to reach items on the bedside table and needed to get out of bed. The State Survey Agency (SSA) Surveyor notified staff.During a telephone interview with R13's family member (F) 13 on 04/29/2026 at 11:16 AM, she stated R13 had advanced dementia with associated Parkinson's disease psychosis and experienced frequent falls. F13 stated the resident did not recognize safety risks and could not consistently understand or follow instructions, which is why she admitted R13 to the facility to provide 24/7 supervision and staff assistance to ensure her safety. F13 stated despite sustaining a major injury requiring surgical intervention and subsequent return to the facility, R13 continued to experience falls. She stated R13 fell again within a short period of time after returning to the facility following surgical repair of a fractured femur. Further, she stated on 03/09/2026, sometime during the morning, R13 called her and stated she believed she had broken her leg and was in severe pain. Additionally, F13 stated the resident continued to complain of significant pain, difficulty with moving her right lower extremity, and demonstrated verbal behaviors indicating something was wrong. She stated although the resident could not always clearly verbalize her needs, staff could recognize changes in conditions through the resident's behavior and complaints of pain. F13 stated she spoke with LPN2 and requested an X-ray. She stated she did not receive any follow-up communication from the facility until the following afternoon, after the x-ray was completed, and staff notified her R13 sustained a femur fracture, which required transfer to the local emergency department (ED). During an interview with LPN2 on 04/29/2026 at 11:45 AM, he stated on 03/08/2026, he completed an assessment of the resident following the incident. He stated that at the time of the assessment, no visible bruising, redness, swelling, or external injury was noted. He stated the resident complained of some pain but did not exhibit significant distress and remained in bed. He stated he attempted to notify the physician on 03/08/2026 by calling the on-call service through a medical associate line but was unable to reach anyone and left no voicemail. He reported he did not have the physician's direct contact information at that time. He stated he notified the DON of the fall but could not recall whether he informed her he was unable to reach the physician.During continued interview with LPN2 on 04/29/2026 at 11:45 AM, LPN2 stated on the morning of 03/09/2026, at approximately 9:00 AM, he spoke with the DON, who provided him with a contact number for the physician. He stated he subsequently contacted the physician later that day, though documentation reflected contact occurred at approximately 3:18 PM. He stated, later in the day, F13 called him to say she wanted an X-ray ordered for R13. LPN2 stated he did not know why F13 wanted the X-ray, but he contacted the physician. He stated he did not know why he did not document the telephone conversation with F13, but stated, She just wanted an X-ray. LPN2 stated the X-ray at the facility was not completed until the following day, and the timing of diagnostic services was dependent on availability. He stated he did not believe the situation required a STAT (immediate) order at the time, as the resident had a (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	history of pain, was receiving pain medication, including tramadol (narcotic analgesic) and acetaminophen (analgesic) for chronic pain, and was not expressing significant complaints beyond baseline.During a telephone interview with R13's Primary Care Physician (PCP) on 04/30/2026 at 2:55 PM, he stated R13 was admitted to the facility with a diagnosis of frequent falls. The PCP stated the facility did not notify him of R13's fall on 03/08/2026. The physician stated he first became aware of the fall through a text message received on 03/09/2026 at approximately 3:00 PM indicating resident's family requested an x-ray. He stated the text message did not include concerns regarding R13's pain level, swelling, injury, or decreased range of motion. He stated supervision with activities and anticipating the resident's needs were required to prevent falling and injury. He stated he expected staff to provide adequate supervision and interventions to prevent falls and accidents.During an interview with the Director of Nursing (DON) on 04/28/2026 at 3:45 PM, she stated the facility did not have a defined process for notifying physicians when initial attempts were unsuccessful. The DON stated staff should have continued attempts to notify the physician, including use of the physician's personal cell phone number if the on-call service did not answer, and should have made contact the same night rather than allowing a delay in care. The DON stated she was notified the night of R13's fall; however, she did not know until the following morning LPN2 had not notified the resident's physician. She further stated she did not know why LPN2 delayed contacting the physician until approximately six hours after receiving the physician's personal cell phone number on 03/09/2026. Furthermore, the DON stated LPN2 communicated with the physician by text message on 03/09/2026 regarding R13's pain and received an order for an x-ray; however, the facility did not obtain the x-ray until the following day and did not receive results until late that afternoon, delaying identification and treatment of R13's fracture. Additionally, when asked by the State Survey Agency (SSA) Surveyor why facility staff delayed R13's care for two days following her fall, the DON stated nursing notes and assessments did not identify an injury and documented the resident's pain as at zeroes, threes, and [NAME], which she stated was the resident's baseline. The DON further stated LPN2's nursing assessment did not indicate a need for a STAT (immediate) x-ray following the fall. She stated due to availability; it was not unusual if a non-STAT X-ray was delayed a day. (f) Review of a Health Status Note, dated 03/14/2026 at 4:36 PM, found in R13's EMR under the Progress Notes tab, revealed staff responded within a few minutes to R13's personal alarm sounding. Staff found R13 on the floor on the right side of the bed and documented she slid out of the bed. According to the note, R13 denied pain, no injuries were noted, and surgical dressing to the right knee and hip remained intact. Staff assisted R13 back to bed using a mechanical lift with the aid of three staff. The facility readmitted R13 following discharge from the local hospital after surgery and failed to ensure the resident was supervised to prevent falls.(g) Review of a Health Status Note, dated 03/28/2026 at 4:33 PM, found in R13's EMR under the Progress Notes tab, revealed according to the note, R13 got up from the bed and turned off the bed alarm by herself. Staff found the resident on the floor while attempting to retrieve an item from the bedside table. Documentation revealed no injuries or pain were noted.(h) Review of a Health Status Note, dated 04/04/2026 at 8:35 PM, found in R13's EMR under the Progress Notes tab, revealed staff found R13 sitting on the floor near the dresser. According to the note, staff stated the resident attempted to self-toilet. R13 denied pain, and no injury was noted. Record review of the resident's CCP revealed staff failed to implement the resident's care plan to assist the resident with toileting.(i) Review of the Fall Report, dated 04/07/2026 at 8:00 PM, found in R13's EMR under the Progress Notes tab and provided by the facility, revealed staff found R13 sitting on the floor near the bed. No injury was noted, and R13 denied pain. Staff assisted R13 back to bed and activated the bed alarm.Review of an IDT Note, dated 04/07/2026 at 11:37 AM, revealed the IDT met to review R13's 03/08/2026 fall. Further review revealed the team updated the resident's care plan to offer more blankets to keep warm.(j) Review of a Health Status Note, dated 04/15/2026 at 7:45 PM, found in R13's EMR under the Progress Notes tab, revealed R13 fell while looking for books. Staff assisted R13 back to bed with the aid of a two-person assist. No injuries were noted.Review of (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	an IDT Note, dated 04/16/2026 at 9:00 AM revealed the IDT met to review R13's 04/15/2026 fall. Further review revealed the team updated the resident's care plan to place an alarming mat at the bedside to alert staff when the resident got up.Review of a Health Status Note, dated 04/16/2026 at 12:50 PM, found in R13's EMR under the Progress Notes tab, revealed R13 got up from the wheelchair to turn off the bed alarm and lowered herself to the floor on the right side of the bed. Occupational Therapy (OT) observed the fall but did not intervene. No injuries were noted. Staff assisted R13 back to the wheelchair.(k) Observation of R13 on 04/28/2026 at 11:35 AM revealed she was sitting on the side of the bed. The bed alarm was not sounding. The bedside table had been pushed away and was not within reach of the resident. One large, insulated beverage container with lid and straw had been knocked over and water spilled onto the bedside table and onto the floor beside the bed. Additionally, another large, insulated beverage container was observed open and emptied approximately 1.5 feet away from the resident's bed. There was a large amount of water present on the floor, extending from R13's bed across the room and under her roommate's bed. R13 was attempting to get out of bed to clean up the spill. According to R13's roommate, R13 had tried to get her water off her bedside table, but when she pulled it, the cups fell off. The roommate stated the incident had happened about an hour ago. The SSA Surveyor notified the Unit Manager. Per the observation, the resident's care plan was not implemented.During an interview with State Registered Nurse Aide (SRNA) 1 on 04/28/2026 at 10:56 AM, she stated there was no specific timing or defined frequency for supervision of R13 other than staff checked on the resident A lot. SRNA1 stated R13's care plan was posted on the back of the bathroom door for nursing assistants to review, and new care plan updates were communicated during the shift report.During an interview with SRNA 12 on 04/29/2026 at 10:00 AM, she stated nursing aides monitor R13 during care and during rounds to ensure her safety. She stated R13 had a bed alarm and a wheelchair alarm. She stated there was no specific frequency defined for R13's supervision.During an interview with LPN2 on 05/01/2026 at 4:45 PM, he stated nurses communicated care plan updates and revisions during shift report. LPN 2 stated residents were rounded on frequently and nurses rounded on residents during medication pass. Continued interview with LPN2 revealed staff rounded on residences during check and change. He stated it was important to ensure residents' safety.During an interview with the MDS Nurse on 04/30/2026 at 1:30 PM, she stated care plan updates depended on IDT team communication, weekly review processes, and initiation through orders. She further stated, with inconsistent real-time updates from nursing staff, there was a potential for delays in incorporating new interventions, particularly on weekends. The MDS Nurse stated she was a member of the IDT team and attended clinical meetings. She stated she did not recall if the team discussed adding increased supervision to R13's care plan. The MDS nurse stated increased supervision was not defined beyond the existing care planned intervention to encourage the resident to remain in the day area for supervision. She stated the staff communicate changes in the care plan during shift report and rounding.During an interview with the Director of Nursing (DON) on 04/28/2026 at 3:45 PM, she stated IDT meetings were conducted daily after clinicals, with additional weekly meetings, which included falls review and at-risk residents. The DON stated the IDT notes were completed when residents were discussed, and any recommended interventions were expected to be initiated in the care plan by the Minimum Data Set (MDS) Nurse. She stated nurses could initiate interventions but typically did not because nursing staff were hesitant and instead communicated changes through her or the MDS Nurse, who would then notify the physician. Additionally, the DON stated staff monitored R13 frequently, describing checks as constant. However, when asked by the State Survey Agency (SSA) Surveyor to define what constant meant, including whether checks occurred every 15 minutes, every 30 minutes, or at another interval, the DON could not define the frequency of supervision or monitoring checks. She stated the resident's care plan did not define monitoring intervals.During an interview with the Medical Director on 04/30/2026 at 3:50 PM, he stated he was responsible for medical oversight of resident care, including review of clinical practices, care outcomes, and participation in Quality and Performance Improvement (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to ensure a resident received necessary care and services following a fall when staff failed to perform a thorough assessment, failed to accurately evaluate and document pain, and failed to obtain timely diagnostic services, resulting in a delay in identification of a femur fracture, for 1 of 8 sampled residents, Resident (R) 13. Refer to F580 and F689The findings include:Review of the facility's policy titled, Quality of Care, revised 08/01/2024, revealed the residents received treatment and care by qualified persons in accordance with professional standards of practice. The policy further stated each resident received care and services to maintain their highest practicable physical, mental, and psychosocial well-being.Review of the facility's policy titled, Change in Condition, dated 08/01/2024, revealed the facility outlined processes for early identification, assessment, reporting, and management of a change in resident condition. The policy required staff to recognize and report physical, cognitive, or emotional changes, including the use of tools to ensure timely communication. Additionally, the policy directed staff to complete a thorough assessment, document the findings, and notify the physician promptly. Review of the facility's policy titled, Falls and Injuries, dated 08/01/2024, revealed the policy required staff to notify the resident's physician following a fall to ensure timely evaluation, treatment, and direction for ongoing care. According to the policy, the physician was expected to respond timely, and staff was directed to escalate concerns to the medical director if an appropriate or timely response was not received.Review of R13's admission Record revealed the facility admitted the resident on 02/03/2024 with diagnoses to include Parkinson's disease with dyskinesia, repeated falls, and cognitive communication deficit.Review of R13's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/02/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of nine out of 15, indicating moderate cognitive impairment. Continued review revealed R13 was assessed as dependent (helper did all of the effort) with toileting, lower body dressing and putting on/taking off footwear, and substantial/maximal assistance (helper did more than half the effort) with bathing and upper body dressing.Review of R13's Care Plan Report, revised 04/16/2026, found in the resident's electronic medical record (EMR) under the Care Plan tab, revealed a focus for potential injury from falls related to decreased mobility, Parkinson's disease, weakness, psychotropic medication use, and opioid medication use. Goals included minimizing falls and preventing injury through the review period. Interventions included supervision and redirection, staff encouragement to request assistance, maintain personal safety alarms to bed and wheelchair, offer toileting before bedtime, and monitor during rounds.Review of a Health Status Note, dated 03/08/2026 at 8:45 PM, found in Resident 13's EMR under the Progress Notes tab, revealed R13 sustained a fall, and staff later helped the resident from the floor to the bed with a two-person assist.Review of a Fall Report, dated 03/08/2026 at 8:45 PM, revealed staff found the resident on the floor of her room at 8:00 PM after she attempted to reach for personal items. Licensed Practical Nurse (LPN) 2 assessed R13 as alert, with pain rated five out of 10 on a numerical scale (10 being the worst pain). However, documentation revealed the nurse did not observe any injuries. There was no indication LPN2 assessed for bruising, swelling, shortening, rotation, or deformity of the right leg.Review of a Health Status Note, dated 03/08/2026 at 10:12 PM, found in R13's EMR under the Progress Notes tab, indicated staff found the resident on the floor attempting to locate personal items. The resident was assessed as alert and oriented x 3/4. Furthermore, staff documented the resident had pain in her right knee, rated five out of 10 on a numerical pain scale (10 being the worst pain), but there was no assessment documenting the absence of bruising, swelling, shortening, rotation, or deformity of the right leg. According to the note, the Director of Nursing (DON) and R13's family member (F) 1 were notified at the time of the fall. However, the nurse did not contact the primary care physician. LPN2 (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	documented the physician was called to her office and was unable to talk to anybody.Review of the eINTERACT SBAR [Situation Background, Assessment, Recommendation] Summary for Providers, dated 03/08/2026 at 10:20 PM, found in R13's EMR under the Progress Notes tab, indicated a change in condition (CIC) after a fall. LPN2 documented vital signs, including blood pressure of 150/85, pulse 89, and respirations 20, which were higher than R13's baseline. The SBAR did not note pain or physical assessment outcomes.Review of R13's Neurological Record, dated 03/08/2026 through 03/10/2026, revealed on 03/08/2026 at 8:45 PM, the section for motor response of the upper and lower extremities contained a line drawn through the boxes with no motor response documented on 03/08/2026 and 03/09/2026. Review further revealed LPN2 did not assess or document motor function or external stimuli of the right lower extremity. Documentation by LPN15 on 03/10/2026 at 7:00 AM revealed the resident could move all extremities appropriately.Review of an IDT Note, dated 03/09/2026 at 10:14 AM, found in R13's EMR under the Progress Notes tab, indicated the interdisciplinary team (IDT) reviewed R13's fall from over the weekend. Further review revealed the team updated the resident's care plan to keep the resident's reacher close and to follow up on a requested PT screening. Additional review revealed no indication the IDT team implemented or discussed added supervision interventions following the fall.Review of a text message communication regarding R13's fall, dated 03/09/2026 at 3:04 PM, revealed LPN2 wrote to the physician and stated, [R13] fell in her room last night. I already talked to the office number before. Her daughter wants x-ray rt. Knee for pain. Let me know please if she needs it. The physician responded yes through the same text at 3:18 PM.Review of a Health Status Note, dated 03/09/2026 at 3:18 PM and documented by the Director of Nursing (DON) as a late entry note on 04/28/2026 at 5:23 PM, found in Resident 13's EMR under the Progress Notes tab, revealed R13 fell in her room. According to the note, Resident's family requested an X-ray for knee pain, and an order was obtained for an X-ray of the right knee.Review of the Interdisciplinary Resident Screen, dated 03/09/2026 and completed by the Speech Therapist (ST), revealed multiple significant changes in R13's physical functioning, mobility, and pain level. The screen revealed the resident had been bed-bound since the previous night, refused morning and afternoon meals, and experienced increased pain rated eight out of 10 on a numerical pain scale (10 being the worst pain). Documentation revealed R13's right knee was swollen. The assessment further documented the resident could not bear weight on the right knee and hip.Review of a Health Status Note, dated 03/10/2026 at 11:09 AM, found in R13's EMR under the Progress Notes tab, indicated a State Registered Nurse Aide (SRNA) notified the nurse that R13 was crying in pain. LPN15 stated R13 had tears streaming down face and R13 stated her leg hurts so bad she can not [sic] stand it. According to the note, the nurse applied diclofenac cream (a topical non-steroidal anti-inflammatory). The note stated a call was placed to the physician about pain, they stated they will fax a new order. However, the note did not specify what information the physician's office staff provided, did not identify the new order to be faxed, and did not indicate the LPN requested a return call from the physician. Review of R13's EMR revealed on 03/10/2026 there were no new orders received from the physician related to the call at 11:09 AM.Review of a Radiology Report, of R13's right knee and hip, dated 03/10/2026 at 1:06 PM, revealed a fracture of the right distal femoral shaft with malalignment and a nondisplaced fracture of the right greater trochanter.Review of eINTERACT Transfer Form V5, dated 03/10/2025 at 6:20 PM, revealed R13 was transferred by ambulance to the local emergency department (ED) at 4:56 PM.Review of ED to Hosp-admission Note, dated 03/10/2026, revealed R13 was admitted to the local hospital with a closed fracture of the right femur and an injury to the head. According to the report, R13 presented to the local hospital after a mechanical fall that occurred prior to arrival. The fall resulted in her hitting the back of her head and landing on her right leg. A computed tomography (CT) scan of the head showed no intracranial abnormality. Physical exam revealed the right lower extremity with positive shortening and external rotation, and attempted hip movements were painful and restricted. The resident had moderate tenderness overlying her distal femur and was given intravenous morphine (an opioid analgesic) for (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	pain. Radiography of the right femur revealed a nondisplaced spiral type fracture involving the distal metadiaphysis of the right femur. The fracture extends to the anterior margin of the femoral component of the patient's right knee arthroplasty. R13 underwent surgery for the placement of an intramedullary rod stabilizing a distal femoral fracture.During a telephone interview with Family (F) 13 on 04/29/2026 at 11:16 AM, she stated R13 had advanced dementia, associated Parkinson's disease psychosis, and experienced frequent falls. She stated R13 did not recognize safety risks and could not consistently understand or follow instructions, which was why she admitted her mother to the facility to provide 24/7 supervision and staff assistance to ensure her safety. F13 stated on 03/09/2026, sometime during the morning, R13 called her and stated she believed she had broken her leg and was in severe pain. Additionally, F13 stated the resident continued to complain of significant pain, difficulty with moving her right lower extremity, and demonstrated verbal behaviors indicating something was wrong. She stated although the resident could not always clearly verbalize her needs, staff could recognize changes in conditions through the resident's behavior and complaints of pain. F13 stated her mother had a high pain tolerance but would verbalize her pain and where it hurt. F13 stated she spoke with LPN2 and requested an X-ray. She stated she did not receive any follow-up communication from the facility until the following afternoon, after the x-ray was completed, and staff notified her R13 sustained a femur fracture, which required transfer to the local emergency department (ED). She further stated she did not understand why there was a delay in follow-up care.During an additional interview with F13 on 04/29/2026 at 3:35 PM, she stated she did not come to the facility to see R13 after the 03/08/2026 fall because she was told there was no injury. She stated she first saw R13 in the ED after transfer from the facility on 03/10/2026. F13 stated when she met R13 in the ED, R13 stated her pain was the worst pain ever. She stated R13's pain was unbearable when she was touched or moved. F13 stated she was confused about how staff failed to recognize the severity of R13's injury and pain following the fall and did not seek a higher level of care sooner.During an interview with LPN2 on 04/29/2026 at 11:45 AM, he stated on 03/08/2026, he completed an assessment of the resident following the incident. He stated that at the time of the assessment, no visible bruising, redness, swelling, or external injury was noted. He stated the resident complained of some pain but did not exhibit significant distress and remained in bed. He further stated R13's cognition fluctuated, with periods of confusion and communication deficits. LPN2 said R13's continued behaviors contributed to repeated falls despite awareness of fall risks. He stated he attempted to notify the physician on 03/08/2026 by calling the on-call service through a medical associate line but was unable to reach anyone and left no voicemail. He reported he did not have the physician's direct contact information at that time. He stated he notified the DON of the fall but could not recall whether he informed her he was unable to reach the physician.During continued interview with LPN2 on 04/29/2026 at 11:45 AM, LPN2 stated on the morning of 03/09/2026, at approximately 9:00 AM, he spoke with the DON, who provided him with a contact number for the physician. He stated he subsequently contacted the physician later that day, though documentation reflected contact occurred at approximately 3:18 PM. When asked by the SSA Surveyor why he failed to contact the physician immediately after receiving the cell phone number, he stated he did not see anything wrong and was busy with medication administration. He stated, later in the day, F13 called him to say she wanted an X-ray ordered for R13. LPN2 stated he did not know why F13 wanted the X-ray, but he contacted the physician. He stated he did not know why he did not document the telephone conversation with F13, but stated, She just wanted an X-ray. LPN2 stated the X-ray at the facility was not completed until the following day, and the timing of diagnostic services was dependent on availability. He stated he did not believe the situation required a STAT (immediate) order at the time, as the resident had a history of pain, was receiving pain medication, including tramadol (narcotic analgesic) and acetaminophen (analgesic) for chronic pain, and was not expressing significant complaints beyond baseline.During an interview with the Director of Nursing (DON) on 04/28/2026 at 3:45 PM, she stated the facility did not have a defined process for notifying physicians (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	when initial attempts were unsuccessful. The DON stated staff should have continued attempts to notify the physician, including use of the physician's personal cell phone number if the on-call service did not answer, and should have made contact the same night rather than allowing a delay in care. The DON stated she was notified the night of R13's fall; however, she did not know until the following morning LPN2 had not notified the resident's physician. She further stated she did not know why LPN2 delayed contacting the physician until approximately six hours after receiving the physician's personal cell phone number on 03/09/2026. Furthermore, the DON stated LPN2 communicated with the physician by text message on 03/09/2026 regarding R13's pain and received an order for an x-ray; however, the facility did not obtain the x-ray until the following day and did not receive results until late that afternoon, delaying identification and treatment of R13's fracture. Additionally, when asked by the State Survey Agency (SSA) Surveyor why facility staff delayed R13's care for two days following her fall, the DON stated nursing notes and assessments did not identify an injury and documented the resident's pain as at zeroes, threes, and [NAME], which she stated was the resident's baseline. The DON further stated LPN2's nursing assessment did not indicate a need for a STAT (immediate) x-ray following the fall. She stated due to availability; it was not unusual if a non-STAT X-ray was delayed a day. During an interview with State Registered Nurse Aide (SRNA) 12 on 05/01/2026 at 3:30 PM, she stated she worked 7:00 AM to 7:00 PM on 03/08/2026 and was not present when the fall occurred between 7:00 PM and 8:00 PM. She stated she worked again on 03/10/2026 and cared for R13. SRNA12 stated she noticed a change from baseline, and R13 did not attempt to get out of bed, which was not typical for her. SRNA12 stated R13 complained of pain throughout the shift and reported her whole leg hurt, with the pain moving between the knee and hip. She stated R13 cried, had tears on her face, did not want to be touched, and at times refused care. She stated she observed swelling in the knee and a bluish discoloration of the leg. SRNA12 stated the leg did not appear to be the resident's normal skin color. Additionally, the SRNA stated she reported the pain, crying, swelling, and discoloration to the nurse, whom she identified as LPN15. SRNA12 stated she reported concerns more than once during the shift, including when the resident was crying. However, she stated LPN15 did not respond promptly to R13. She stated the nurse did not come in immediately to assess the resident and estimated about a 20 to 30 minute gap before she responded. SRNA12 further stated nurses did not respond immediately to SRNAs concerns. She stated they sometimes delayed care or dismissed care concerns altogether.During a telephone interview with LPN15 on 05/01/2026 at 5:01 PM, she stated she called the physician's office to report R13's pain. She stated the office informed her a fax would be sent, and she did not know what the fax would include but assumed it would contain a new order for pain management. She stated she assessed R13 for pain but could not recall if she assessed R13's right leg. LPN15 stated R13 was sent to the local ED after the x-ray revealed a fracture. She stated she never received a fax from R13's physician's office and did not call the office back until after she received the x-ray report, despite R13's continued complaint of pain. LPN15 stated X-ray results were sent electronically. She stated she checked throughout the afternoon for the results, but the report did not arrive until approximately 4:30 PM. She stated the radiologist read the X-ray at 1:08 PM, but the facility did not receive the electronic message until 4:30 PM.During an interview with Registered Nurse (RN) 1 on 04/30/2026 at 10:10 AM, she stated nonverbal indicators of pain included facial grimacing and behaviors during care. She stated residents unable to verbally communicate pain might indicate pain by nodding yes or no. RN1 stated staff used the Pain Assessment in Advanced Dementia (PAINAD) scale for residents with cognitive impairment who were unable to accurately communicate pain using a numerical pain scale. She stated the PAINAD scale differed from the numerical pain scale, which asked residents to rate pain from zero to 10, with 10 representing the most severe pain. RN1 stated residents with cognitive impairment could answer questions related to the numerical pain scale; however, in her assessment, she used the PAINAD scale because it provided a more accurate assessment of pain. Furthermore, she stated the PAINAD scale was especially important following a fall or injury in residents because it (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	allowed staff to more readily identify pain behaviors and possible injury in residents with cognitive impairment who might not accurately verbalize injury. During an interview with the Speech Therapist (ST) on 05/01/2026 at 2:12 PM, she stated she had completed a post-fall screening for R13 on the afternoon of 03/09/2026 following the resident's fall on 03/08/2026. The ST stated she did not normally complete post-fall screenings; however, due to staffing constraints, she provided the screening and remained in direct contact with the Director of Physical Therapy (DPT) regarding the resident's condition. The ST stated R13 appeared to be in significant pain. She stated she observed swelling to the resident's right knee and, through questioning and prompting, identified pain rated an eight on a PAINAD scale involving both the knee and hip, raising concern for injury beyond the knee. The ST stated, due to the resident's moderate to severe cognitive impairment, use of a PAINAD assessment rather than a standard numerical pain scale was appropriate because the resident required cueing, prompting, and simplified communication to accurately express pain symptoms. The ST stated a knee x-ray had already been ordered; however, after consultation with the DPT, concerns were raised for possible fracture and the need for imaging of the entire leg and hip. She stated the DPT had notified nursing and requested a full-leg X-ray. Furthermore, the ST stated review of nursing documentation, dated 03/09/2026, did not reflect findings such as redness, swelling, pain, or motor response documentation. She stated nursing staff should have recognized the severity of the resident's pain and completed a more comprehensive post-fall assessment based on the resident's presentation and reported pain complaints.During a telephone interview with R13's Primary Care Physician on 04/30/2026 at 2:55 PM, he stated R13 was admitted to the facility with a diagnosis of frequent falls. He stated supervision, activities, and anticipating the resident's needs were required to prevent falls and injuries. He stated he expected staff to provide adequate supervision and interventions to prevent falls and accidents. Additionally, the physician stated the text message received from the nursing staff did not indicate the severity of R13's condition but only stated the family requested an X-ray. The physician stated it would have been appropriate for nursing staff to transfer the resident immediately to a higher level of care if they felt the resident required additional evaluation, and he was not immediately reachable. He further stated the facility had access to his personal cell phone number, which he had communicated to the facility as his preferred method of contact. He stated the on-call service would only get an unfamiliar provider for the resident, and that it would take longer. He stated he was in the office during the week, and messages left with the office staff might not get a timely response.During an interview with the Medical Director on 04/30/2026 at 3:50 PM, he stated he was responsible for medical oversight of resident care, including the review of clinical practices and care outcomes, and participation in Quality and Performance Improvement (QAPI) activities. He stated he collaborated with the interdisciplinary team, provided guidance to nursing and physicians, and was available for consultation regarding changes in resident condition. The Medical Director further stated he expected staff to provide quality care in accordance with the professional standards of practice to maintain the resident's highest practicable physical, mental, and psychosocial well-being.During an additional interview with the DON on 05/01/2026 at 6:00 PM, she stated R13 was known to have a high pain tolerance per the family's report, and staff did not indicate increased pain or worsening of condition. The DON stated R13's physician was contacted on 03/10/2026. However, documentation did not clearly reflect the clinical information communicated, the urgency conveyed, or the direction provided by the physician's office. She stated on 03/10/2026, staff delayed care waiting for a faxed physician's order despite the resident's documented change in condition. The DON stated there was uncertainty about whether an order was received, and the physician might have intended to fax the orders. She stated she expected nursing staff to advocate for residents and to elevate concerns when a physician did not respond appropriately or in a timely manner. The DON stated it was a significant concern for a resident to receive delayed care. She further stated it would have been appropriate for nursing staff to escalate concerns to supervisory staff if they believed the physician was not adequately addressing the resident's condition or if the (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	physician's response was delayed.During an interview with the Administrator on 04/29/2026 at 7:54 AM, she stated staff should complete a full assessment immediately following a fall and continue to monitor the resident. She stated nursing staff was expected to document all findings and interventions in the resident's EMR. She stated R13 was admitted to the facility from home with a diagnosis of frequent falls, and the resident was care planned appropriately with interventions related to fall prevention. She further stated she expected staff to provide adequate supervision and interventions to prevent falls and ensure resident safety.During an additional interview with the Administrator on 05/01/2026 at 6:32 PM, she stated she had concern regarding R13's falls and injuries. She stated assessments and documentation related to the resident's falls were fragmented across multiple areas of the system, including risk management, post-fall packets, and progress notes, making information difficult to locate and contributing to inconsistencies in documentation and review. The Administrator stated she expected staff to complete thorough post-fall documentation, including a comprehensive assessment of the resident, a root cause analysis, and clear narrative documentation of the circumstances of the fall. She stated nursing staff should monitor residents, continue physical assessments, and implement appropriate interventions to ensure residents received quality care and maintained their safety and well-being. Additionally, she stated it would have been appropriate for nursing staff to escalate concerns to the Medical Director if they were unable to contact the primary physician.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, record review, and review of the facility's policies, the facility failed to provide a safe, clean, comfortable, and homelike environment for 5 of 25 sampled residents, Resident (R) 6, R13, R14, R26, and R93.Observations on 04/27/2026 and 04/28/2026 revealed in five resident rooms the privacy curtain was in disrepair. Further observation revealed trash on a bedside table and the floor, including used mouth swabs and a contaminated dressing and gloves; debris accumulation around the baseboards; and soiled bed linens on a bed.The findings include:Review of the facility's undated policy titled, Resident's Rights, revealed the resident had the right to be treated with consideration, respect, and recognition of their dignity and individuality.The State Survey Agency (SSA) Surveyor requested a policy on housekeeping from the Administrator on 04/29/2026 at approximately 10:00 AM. The Administrator provided the Cleaning and Disinfecting policy. Review of the facility's policy titled, Cleaning and Disinfecting, dated 08/01/2024, revealed housekeeping staff cleaned floors and tabletops regularly, when spills occurred, and when surfaces were visibly soiled1. Observation of R14's room on 04/27/2026 at 9:04 AM revealed trash and debris on the floor. There were straw wrappers and a napkin on the floor. Food crumbs were also scattered around the room.During an interview with R14 on 04/27/2026 at 9:04 AM, she stated housekeeping did not sweep and mop her room daily. She stated the floor was often covered with crumbs and trash, and the trash cans were not emptied until they overflowed. R14 stated she preferred a clean and tidy room and did not like seeing trash or debris on the floor.2. Observation of R6's and R13's room on 04/27/2026 AM at 10:13 AM revealed multiple trash items found on the floor, including a wound dressing, dated 04/26/2026, on the floor behind the trash can. The area along the wall and baseboard contained visible debris accumulation. A pair of contaminated gloves were observed under the bed, rolled up inside out. There were multiple pairs of gloves on top of the bedside table. Additionally, trash, used tissues, and debris were observed on the floor. During an interview with R6 on 04/27/2026 at 11:45 AM, she stated her room had not been cleaned over the weekend. She stated nursing staff threw discarded gloves on the floor and sometimes left extra supplies in her room, which made it cluttered and untidy. She stated the condition of the room made her feel uncomfortable.3. Observation of R26's room on 04/27/2026 at 11:35 AM revealed the resident's bed was visible from the hallway. The bed was unmade, and the bed linens were visibly soiled. [NAME] and yellow stains were present on both the top sheet and fitted sheet. The pillowcase contained a large stain on one corner. Crumbs were observed across the fitted and draw sheets, along with what appeared to be fecal smearing on the draw sheet. Used tissues were also present in the bed.During an interview with State Registered Nurse Aide (SRNA) 1 on 04/27/2026 at 11:35 AM, she stated she had gotten R26 dressed and out of bed and had not yet cleaned the room. She stated she tried to make the bed and straighten up the room after getting the residents up for the day. SRNA1 stated it was important because this is their home and it should be clean.4. Observation of R93's room on 04/28/2026 at 8:10 AM revealed the resident was in bed resting. The privacy curtain was pushed back near the head of the bed. A portion of the privacy curtain was lying on the floor. Further observation revealed multiple hooks were missing, which prevented the curtain from hanging properly on the track. Additionally, there was trash on the bedside table and the floor, including used mouth swabs.During an interview with Family (F) 15 on 04/29/2026 at 7:45 AM, she stated resident rooms were not always kept as tidy as she would like, especially during staff call-ins or on weekends. She stated the facility appeared cleaner since the State Survey Agency (SSA) Surveyors entered the building.During an interview with Housekeeper (HSK) 1 on 04/30/2026 at approximately 10:45 AM, she stated two housekeepers worked weekends compared to four during the week. She stated she believed housekeeping staff had call-ins over the weekend and arrived late for work on Monday, resulting in normal cleaning duties not being completed on time. She stated it was important to keep curtains and personal items off the floor to prevent the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spread of germs.During an interview with the Housekeeping Supervisor on 04/29/2026 at 9:10 AM, she stated the facility employed four full time housekeepers during the week and two housekeepers on weekends. She stated housekeeping staff was responsible for maintaining a clean, safe, and sanitary environment. She stated daily tasks included cleaning resident rooms, bathrooms, and common areas. She stated housekeeping staff performed dusting, sweeping, mopping, and disinfection of high touch areas such as handrails and doorknobs. Additionally, the Housekeeping Supervisor stated housekeeping staff should ensure privacy curtains were clean and in proper working order. She stated they could be taken down and replaced with new ones or repaired by adding new hooks. The Housekeeping Supervisor stated nurse aides were responsible for emptying trash and putting linen and trash in the Dirty Utility Room.During an interview with SRNA12 on 04/29/2026 at 10:00 AM, she stated SRNAs were responsible for keeping rooms tidy throughout the day and for cleaning up after themselves. She stated housekeeping was available if there were large spills or messes. She stated beds should have been made daily, and if they were soiled, the sheets should have been changed immediately. Furthermore, SRNA12 stated staff should take trash out of the room throughout the day to prevent the trash receptacle from overflowing. SRNA12 stated, This is their home, and we need to take care of our residents.During an interview with the Administrator on 04/29/2026 at 10:13 AM, she stated that four housekeeping staff worked Monday through Friday, and two worked on weekends. She stated the facility provided housekeeping services seven days per week. The Administrator stated weekend staffing was adequate because not every resident room required cleaning every day. She stated staff was expected to clean spills and remove any debris or trash observed during rounds or resident care. The Administrator stated she expected resident rooms to remain clean, tidy, and maintained in a home like environment. She stated maintaining a clean and safe facility was important because it was the residents' home.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview, record review, and review of the facility's document and policy, the facility failed to send a written notice of transfer to the resident's representative, including the reason for the transfer, the effective date of the transfer, the duration of the bed hold, and the facility's bed hold policy, for 2 of 3 residents sampled for Admission, Transfer, and Discharge, Resident (R) 13 and R96.Record review and interviews revealed the facility failed to provide responsible parties with written notification of hospitalization for R13 on 03/10/2026 and for R96 on 04/16/2026.The findings include:Review of the facility's policy titled, Transfer/Discharge Policy, dated 08/01/2024, revealed resident transfers would be conducted in accordance with resident rights, physician orders, and regulations to maintain continuity of care. Further review revealed a written notice form would be placed in the clinical record and provided to the resident or resident representative. Furthermore, the policy revealed that at the time of a resident's transfer for hospitalization, written notice of the facility's bed hold policy was to be provided to the resident or resident's representative.Review of the facility's undated document Skilled Nursing admission Agreement revealed if a resident left the facility for a hospital stay or therapeutic leave overnight, the facility could hold the resident's bed for a limited period of time. Additionally, the agreement stated, Medicare generally did not pay for bed holds, but Medicaid may pay depending on state rules. It further stated the facility would notify the resident's representative about holding a bed. The facility might also require authorization forms and payment if the leave extended beyond three days.1. Review of R13's admission Record, found in the resident's electronic medical record (EMR) under the Profile tab, revealed the facility admitted the resident on 02/03/2024. R13's diagnoses included Parkinson's disease with dyskinesia, repeated falls, and cognitive communication deficit. Review of R13's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/02/2026 and found in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 11 out of 15, indicating moderate cognitive impairment. Review of R13's electronic medical record (EMR) revealed no transfer in writing or a copy of the transfer notice/bed hold documented in her medical record. Review of an eINTERACT Transfer Form, dated 03/10/2026 at 4:59 PM, revealed the resident was transferred to a local emergency department (ED) by emergency medical services (EMS) after radiology reports revealed R13 had a fractured femur. During a telephone interview with Family (F) 13 on 04/29/2026 at 11:16 AM, she stated the facility did not inform her of the transfer/discharge paperwork or the facility's bed hold policy related to R13's 03/10/2026 hospitalization. She stated she did not receive a written copy of her mother's transfer/discharge documentation or bed hold information, in person or by mail following R13's hospitalization. 2. Review of R96's admission Record, found in the resident's eEMR under the Profile tab, revealed the facility admitted the resident on 04/15/2026 with diagnoses to include Alzheimer's disease; dementia in other diseases unspecified without behavioral disturbances, psychotic disturbances, or mood disturbances; and anxiety. Review of a Social Services Note, dated 04/23/2026, revealed the resident had a BIMS score of three out of 15, indicating severe cognitive impairment. Review of R96's EMR revealed the resident was transferred to a local ED by EMS for evaluation after a fall on 04/16/2026. No transfer information was documented in the record, nor was there a copy of the transfer notice/bed hold in her medical record.The State Survey Agency (SSA) Surveyor attempted a telephone interview with R96's Family (F) 14 on 04/30/2026 regarding R96's ED visit on 04/16/2026. However, there was no answer, and a voicemail was left. F14 did not return the call. During an interview with Licensed Practical Nurse (LPN) 15 on 05/01/2026 at 5:01 PM, she stated when the facility transferred a resident to a local hospital, staff printed a transfer form from the resident's EMR and provided the form to EMS at the time of the transfer. She stated she notified F13 of R13's transfer by telephone. However, LPN15 stated she was not aware of a written notice mailed to the (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's representative documenting the transfer and discharge paperwork or bed hold information.During an interview with the Director of Nursing (DON) on 04/29/2026 at 11:00 AM, she stated nursing staff completed a transfer form and provided the paperwork to EMS at the time of the resident's transfer to the hospital. The DON stated F13 was notified of the transfer. However, she stated she could not confirm documentation reflected R13's representative (F13) received written notification regarding the reason for the transfer, transfer and discharge information, or bed hold rights. The DON further stated she could not identify where the facility maintained notification documentation. Additionally, she stated staff sent a transfer form and other pertinent discharge paperwork with the resident to the hospital and expected hospital staff to provide the paperwork to the resident's representative.During an interview with the Admissions Director on 04/29/2026 at 11:12 AM, she provided R13's Discharge Summary, dated 03/14/2026, as documentation of the transfer and discharge paperwork related to R13's 03/10/2026 hospitalization. The admission Director stated the facility did not provide any additional written forms or notices to the residents' representatives regarding transfers. She further stated she did not mail written notices of transfer/discharge information or the facility's bed hold policy to the residents' representatives.During an interview with the Administrator on 05/01/2026 at 6:32 PM, she stated a transfer form was given to EMS to give to the resident's representative at the local hospital. She stated the facility did not mail written notifications to the residents' representatives. Additionally, she stated the facility reviewed the bed hold conditions with residents or their representatives during the admission process as part of the admission packet, which was signed upon admission. She stated admission paperwork explained how the facility could hold a resident's bed during a temporary hospitalization and outlined potential payment responsibilities when the bed was held for an extended period of time. She further stated the bed hold policy did not apply to R13 because she was covered under the Medicaid program.

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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. Based on observation, interview, record review, and review of the facility's policy, the facility failed to promote and maintain resident dignity for 1 of 2 sampled residents, Resident (R) 93.Observations on 04/27/2026, 04/28/2026, and 04/29/2026 revealed staff failed to ensure R93's urinary catheter drainage bag remained covered with a dignity cover. The urinary drainage bag remained visible to individuals passing by R93's room.The findings include:Review of the facility's undated policy titled, Resident's Rights revealed the resident had the right to be treated with consideration, respect, and recognition of their dignity and individuality.Review of R93's admission Record, found in the resident's electronic medical record (EMR) under the Profile tab, revealed the facility admitted the resident on 04/23/2026. R93's diagnoses included unspecified protein-calorie malnutrition, benign prostatic hyperplasia, and aphasia following cerebral infarction.Review of R93's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 04/23/2026, found in the resident's EMR, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, indicating moderate cognitive impairment. Continued review of the MDS revealed R93 had an indwelling urinary catheter.Review of R93's Care Plan Report, dated 04/25/2026, found in the resident's EMR under the Care Plan tab, revealed a focus for a urinary catheter, initiated on 04/25/2026. According to the Care Plan, there were no interventions related to R93's refusal of a dignity bag cover.1. Observation of R93 on 04/27/2026 at 9:53 AM revealed the resident's urinary catheter drainage bag was attached to the bed frame while the dignity cover hung beside the bag. However, staff did not place the urinary drainage bag inside the dignity cover. The drainage bag remained visible from the hallway. 2. Observation of R93 on 04/28/2026 at 8:10 AM revealed the resident's urinary catheter drainage bag was secured to the bed without a dignity cover in place. Continued observation outside R93's room revealed staff had left the urinary drainage bag visible to individuals passing by the room. 3. Observation on 04/29/2026 at 9:28 AM, outside R93's room, revealed R93's urinary catheter drainage bag was visible from outside the resident's room. The urinary drainage bag was not in the dignity bag cover.During an attempted interview with R93 on 04/27/2026 at 9:35 AM, the resident was unable to answer questions. Resident 93 had aphasia following a cerebral infarction and difficulty communicating during the interview. Due to the resident's communication impairment, the State Survey Agency (SSA) Surveyor was unable to determine whether the resident refused care or how the resident felt about the catheter collection bag being visible.During an interview with State Registered Nurse Aide (SRNA) 12 on 04/29/2026 at 10:00 AM, she stated staff placed dignity covers over urinary catheter drainage bags to maintain resident privacy and dignity unless the resident or family requested not to use a cover. SRNA12 stated staff monitored residents with catheters during care and rounds to ensure dignity covers remained in place.During an interview with Licensed Practical Nurse (LPN) 2 on 04/29/2026 at 11:45 AM, he stated SRNAs kept urinary catheter drainage bags covered with a dignity cover to protect resident privacy. LPN2 further stated he checked to ensure drainage bags remained covered during nursing rounds. He stated he was not sure why R93's catheter bag was not covered.During an interview with the Medical Director on 04/30/2026 at 3:50 PM, he stated residents should have a dignity cover placed over urinary catheter drainage bags to protect the resident's privacy and dignity.During an interview with the Director of Nursing (DON) on 05/01/2026 at 6:00 PM, she stated staff was expected to keep urinary catheter drainage bags covered with a dignity cover to maintain resident dignity and privacy.During an interview with the Administrator on 05/01/2026 at 6:32 PM, she stated the facility expected staff to ensure urinary catheter drainage bags remain covered to protect resident privacy and preserve dignity.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, record review, review of the Centers for Disease Control and Prevention (CDC) guidelines, 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 and control the development and transmission of communicable diseases. The facility failed to implement its infection prevention and control policies and procedures and identify and correct problems relating to infection prevention practices for 1 out of 10 sampled residents, R93.Observation on 04/27/2026 at 9:16 AM revealed Licensed Practical Nurse (LPN) 3 exited R93's room. The resident was on enhanced-barrier precautions (EBP) for wounds and gastrostomy tube (G-tube). The nurse failed to remove gloves upon exit. She then obtained a cup from the medication cart with the contaminated gloves and re-entered the room.Observation on 04/28/2026 at 8:10 AM revealed Unit Manager (UM) 1 performed oral care for R93 and then held the resident's G-tube. Further observation revealed there was an enteral syringe containing a pink colored liquid on the resident's overbed table. UM1 failed to don (put on) the required personal protective equipment (PPE), including a gown, when providing high-risk direct care for a resident on EBP.The findings include:Review of the CDC's guidelines titled, Core Infection Prevention and Control Practices for Safe Healthcare Delivery in All Settings, dated 04/12/2024, revealed hand hygiene should be performed immediately before providing resident care and after care was completed. According to the guidelines, staff should ensure the proper selection and use of PPE based on the nature of the patient (resident) interaction and potential for exposure to blood, body fluids, and/or infectious materials.Review of the facility's policy titled, Enhanced Barrier Precautions [EBP], revised 09/09/2025, revealed EBP were implemented to reduce the transmission of multi-drug-resistant organisms (MDRO) through the use of gowns and gloves during high-contact resident care. The policy stated high-contact resident care included device care involving feeding tubes, including gastrostomy tubes (G-tube), and required staff to use gowns and gloves during care. Additionally, the policy stated staff were expected to discard personal protective equipment (PPE) prior to exiting the resident's room.Review of the facility's policy titled, Personal Protective Equipment [PPE], dated 08/01/2024, revealed staff was expected to remove PPE in a manner that avoided contamination and remove all PPE before exiting the resident's room. Review of the policy further revealed used gloves were expected to be discarded in the waste receptacle inside the room.Review of the facility's policy titled, Hand Hygiene, dated 08/01/2024, revealed staff must adhere to hand hygiene practices to reduce transmission of pathogens. According to the policy, staff must use an alcohol-based hand rub (ABHR) before and after direct care with residents, and after removing gloves.Review of R93's admission Record, found in the resident's electronic medical record (EMR) under the Profile tab, revealed the facility admitted the resident on 04/23/2026. R93's diagnoses included unspecified protein-calorie malnutrition, benign prostatic hyperplasia, and aphasia following cerebral infarction.Review of R93's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 03/20/2026 found in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, indicating moderate cognitive impairment. Continued review of the MDS revealed R93 had an indwelling urinary catheter and a G-tube.Review of R93's Order Report, dated 04/2026, found in the resident's EMR under the Orders tab, revealed the resident was under EBP related to the presence of a wound, a G-tube, and an indwelling urinary catheter. 1. Observation on 04/27/2026 at 9:16 AM revealed LPN3 exited R93's room wearing gloves after providing care. Signage on R93's door indicated the resident was under EBP. LPN3 exited the room wearing gloves and did not remove her gloves or perform hand hygiene. She touched the top surface of the medication cart with one contaminated gloved hand, then used the other gloved hand to remove a plastic cup from the stack of cups, and returned to the resident's room. LPN3 did not remove her gloves or perform hand (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hygiene.During an interview with LPN3 on 04/27/2026 at 9:17 AM, she stated she did not remove her gloves because they were not dirty. When interviewed whether she had provided care to R93 prior to exiting the room, LPN3 did not answer. She turned around, reentered R93's room wearing the same gloves, and closed the door.2. Observation in R93's room on 04/28/2026 at 8:10 AM revealed Unit Manager (UM) 1 was leaning up against the resident's bed while she performed oral care for R93 and then handled the resident's G-tube. Further observation revealed the cap to the G-tube was open while UM1 handled the device. R93 was on EBP related to the presence of a G-tube. UM1 failed to wear the required gown while providing the high-contact direct care to the resident. Furthermore, there was an enteral syringe containing a pink colored liquid on the resident's overbed table.During an interview with UM1 during the time of the observation, she stated she was only holding R93's G-tube and was not going to administer medications or an enteral feeding or flush the tube. UM1 denied she intended to administer the pink liquid though the G-tube. The UM stated she did not believe a gown was necessary because she was not providing high-contact care.During an interview with the Infection Preventionist (IP) on 04/29/2026 at 10:36 AM, she stated all staff received infection prevention education upon hire, with ongoing reinforcement through in-services and town hall meetings. She stated education included hand hygiene before and after entering residents' rooms and use of gown and gloves for direct care to prevent cross-contamination, including EBP rooms and activities such as dressing changes, tube feedings, and resident transfers. She stated a gown, and gloves should be used when handling a G-tube. Additionally, the IP stated gloves should not be worn in the hall. She stated staff should remove all PPE before they exited a resident's room, followed by hand hygiene. The IP stated she conducted daily rounds to audit compliance and completed annual competency checkoffs and skills validations for hand hygiene and PPE use. Furthermore, the IP stated she expected nurses, unit managers, and nursing leadership to reinforce infection prevention practices. The IP stated she expected all staff to follow the CDC's guidelines and the facility's policies to prevent the spread of disease and protect the safety of residents and staff.During an interview with the Director of Nursing (DON) on 04/29/2026 at 11:00 AM, she stated she expected staff to follow the facility's infection control and enhanced barrier precaution policies to prevent the spread of infection and protect the health and safety of residents and staff.During an interview with the Medical Director on 04/30/2026 at 3:50 PM, he stated staff was expected to use proper hand hygiene before and after resident care. The Medical Director stated enhanced barrier precautions required gowns and gloves when handling a G-tube during feedings and medication administration. The Medical Director further stated staff was expected to gown and glove appropriately, especially when performing high-contact direct care to residents who met the criteria for EBP to help prevent cross-contamination and the spread of disease within the facility.During an interview with the Administrator on 05/01/2026 at 6:32 PM, she stated staff received training on infection control policies and protocols. The Administrator stated she expected staff to follow posted precaution signage before entering resident rooms and providing care. Furthermore, she stated adherence to the facility's policy and state and federal guidelines was necessary to protect residents from the spread of infection and maintain a safe environment.