

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Hartland Park Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 1500 Trent Boulevard Lexington, KY 40515	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of a manufacturer's recommendations, and review of the facility's documents, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety, which had the potential to affect all 138 current residents.1. Observations of the kitchen on 06/29/2026 and 06/30/2026 revealed poor lighting throughout the kitchen production area and grease on the floor near the door of the dry storage room. Further, review of the facility's documents revealed issues with cleanliness in the kitchen from 04/29/2026 to 06/08/2026.2. Observation of two of three nourishment rooms on 06/30/2026 revealed the Combs Unit nourishment refrigerator contained a Med-Plus supplement, which was opened but not dated. Also, the [NAME] Unit nourishment refrigerator contained a Med-Plus supplement, which was opened and dated 05/12/2026.The findings include:The State Survey Agency (SSA) Surveyor requested from the Dietary Director, on 07/02/2026 at 4:00 PM, a policy addressing the labeling and dating of food products related to the nourishment refrigerators. The Dietary Director stated she had to request the policy, but the facility did not provide the policy as of exit on 07/02/2026 at 7:30 PM.Review of the facility's documents Daily/Weekly/Cleaning Schedule, dated 05/31/2026 to 06/06/2026, 06/07/2026 to 06/13/2026, 06/21/2026 to 06/27/2026, and 06/28/2026 to 07/04/2026, revealed beverage carts were not documented as being cleaned.Review of the Pest Control Customer Service Report, dated 04/29/2026, revealed the finding of the kitchen with debris, and the action needed was to clear the debris and sanitize the kitchen.Review of the Pest Control Customer Service Report, dated 05/07/2026, revealed the finding of the kitchen with grease build up by and under the dish area, and the action needed was to clean the area.Review of the Pest Control Customer Service Report, dated 05/18/2026, revealed the finding of the kitchen areas need to be addressed, and the action needed was to address the sanitation issue. Review of the Pest Control Customer Service Report, dated 06/08/2026, revealed the finding of the action needed was for the kitchen to be cleaned again under the dishwasher, under the cook steam line, and under the carts.Review of the manufacturer's recommendations for storage of Med-Plus supplement, revealed they included after opening, consume the product within four days if properly refrigerated. 1. a. Observation during the initial kitchen tour on 06/29/2026 at 1:42 PM revealed poor lightening in the production area of the kitchen and grease on the floor near the dry storage, beside the ingredient bin.b. Observation of the supper tray line in the kitchen on 06/29/2026 at 5:15 PM revealed poor lightning in the production area and grease remained on the floor.c. Observation of the kitchen on 06/30/2026 at 8:52 AM revealed the kitchen lighting was still low, and grease remained on the floor near the dry storage.d. Observation of the kitchen on 06/30/2026 at 3:21 PM revealed the lighting was still low, and grease was still on the floor near the dry storage. Continued observation revealed three of five beverage (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	carts, by the tray line, with full clear beverage pitchers placed onto a wet puddled surface.2. a. Observation on 06/30/2026 at 3:35 PM of the nourishment refrigerator on the Combs Unit revealed a Med-Plus supplement opened and undated.b. Observation on 06/30/2026 at 3:58 PM of the [NAME] Unit nourishment refrigerator revealed a Med-Plus supplement opened, one-half full, and dated 05/12/2026.During an interview with the Dietary Director on 06/30/2026 at 3:21 PM, she stated the light needed a new ballast and maintenance needed to replace it.During an interview with the Maintenance Director on 07/01/2026 at 8:05 AM, he stated the Dietary Director just texted him about a light being out. He stated the kitchen needed to be brighter for safety and to clean the kitchen.During an additional interview with the Dietary Director on 07/02/2026 at 4:00 PM, she stated she could not do anything about the lighting in the kitchen. She stated the area near the dry storage was the water leaking from the freezer, and she mopped the area daily. Observation with the Dietary Director of the area of the water leak revealed it was behind the area identified with grease. She demonstrated the area she mopped for the water and the location of the water behind the dry storage door and the ingredient bin was not the same location as the grease in front of the ingredient bin and dry storage door. She stated the Dietitian took the medication administration supplements to the unit nourishment refrigerators. She stated the supplement had a label and date when stocked in the nourishment refrigerator. She stated she did not know the beverage carts were wet, and the beverage carts should be dry. She stated she knew the staff cleaned the kitchen even though it was not documented.During an interview with the Director of Nursing (DON) on 07/02/2026 at 6:05 PM, she stated Dietary provided the medication administration supplement with the date delivered to the unit nourishment refrigerators. She stated the supplement should be marked with the opened date and used within three days, and if any was remaining, it should be thrown away. She stated if any supplement was opened and undated it should be thrown away. She stated the utility carts needed a dry surface to prevent any potential concerns with the food being served. She stated the grease remaining on the kitchen floor was a hazard for the staff. During an interview with the Administrator on 07/02/2026 at 6:15 PM, she stated Dietary delivered the medication administration supplement to the unit nourishment refrigerators with a date, and it could only be used for three days after it was opened. She stated she expected the kitchen to be clean and well lit, and the utility carts should be dry to prevent gnats.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, 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 identify and correct problems related to infection prevention practices that had the potential to affect all residents in three of the three sampled shower rooms. Observations on 07/02/2026 of the [NAME], [NAME], and Combs Units Spa revealed the shower areas were used to store clean linens, which were uncovered, and shared resident use equipment. Also observed were dirty linens in the area and residents' personal items stored on the linen storage shelf. The findings include: Review of the facility's policy titled, Infection Control, reviewed 01/21/2026, revealed infection control policies and practices were intended to facilitate maintaining a safe, sanitary, and comfortable environment. According to the policy, the facility would establish and monitor environmental infection prevention and control practices in accordance with the Centers for Disease Control and Prevention (CDC) guidelines and state requirements. 1. Observation of the [NAME] Unit Spa on 07/02/2026 at 2:30 PM revealed the shower area was being used as storage for shared resident equipment, resident items, and linens. Two mechanical lifts, a powered wheelchair, a shower stretcher, a bedside chair, and other resident care equipment were stored in the shower area near the shower stalls. A powered wheelchair was positioned adjacent to an electrical outlet with the charging unit and power cord on the floor. The unit was plugged in. There was a hair dryer, plugged into an electrical outlet, resting on the powered wheelchair. On the floor, used tissues and a washcloth were observed near the wheelchair. Continued observation of the [NAME] Unit Spa on 07/02/2026 at 2:30 PM revealed clean towels, sheets, and other linens were stored on an open wire shelving unit without a protective cover. Linens were stacked above and around the resident care equipment and supplies. Additional resident care items, including basins, incontinence supplies, storage bins, and equipment accessories, were stored beneath the shelving on the floor. Residents' personal belongings, including clothing, shoes, and other items, were stored in a crate and a storage bin, hanging from wall hooks, and on the shower floor. A separate storage area contained numerous residents' personal belongings, including clothing, jackets, shoes, and other items, stored on open shelving, hanging from wall hooks, and in plastic crates. Clothing items were stored with several hanging and touching the floor. 2. Observation of the [NAME] Unit Spa on 07/02/2026 at 2:45 PM revealed two mechanical lifts, a shower stretcher, multiple wheelchairs, a shower chair/commode, and a bedside chair were stored in the shower area. A black bag containing soiled towels was hanging from the shower stretcher. The equipment occupied a significant portion of the available space. Continued observation of the [NAME] Unit Spa on 07/02/2026 at 2:45 PM revealed clean towels, sheets, and other linens were stored uncovered on open wire shelving. Multiple lift slings hung from the shelving. A laundry basket containing linens, storage bins, basins, incontinence supplies, and other resident care supplies were stored on and beneath the shelving. A baby doll was observed on a lower shelf among the stored linens and supplies. A Wet Floor caution sign was stored behind a mechanical lift. The lift was obstructing access to the linen shelf. Residents' personal belongings, including clothing hanging on a towel bar, clothing on the floor, and personal belongings stored with resident equipment were in the shower area. A wheelchair had towels draped over the back and seat. Additional resident equipment and supplies were stored throughout the room, contributing to a congested environment. 3. Observation of (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the Combs Unit Spa on 07/02/2026 at 3:20 PM revealed a shower chair, shower stretcher, mechanical lift, portable vital signs machine, and resident care supplies stored throughout the room. A mechanical lift was positioned in front of the shower stretcher, reducing the available space within the shower area. A linen storage rack contained clean towels, sheets, and other linens. The protective blue cover over the linen rack was open, leaving clean linens exposed. A bedside commode was used to store multiple transfer slings, with an inflatable shampoo basin placed on top of them. Multiple transfer slings were draped over a shower chair and touched the floor. Additional slings were hanging from a wall-mounted rack. Additionally, a multi-drawer plastic storage unit was used to store the resident's clothing. Various items, including supplies and slings, were stacked on top of the drawer unit, while additional items were hanging from the sides of the unit. During an interview with Certified Nursing Assistant (CNA) 10 on 07/02/2026 at 3:25 PM, she stated each staff member was responsible for cleaning the shower area after providing resident care. CNA10 stated clean towels should remain covered to prevent cross-contamination. She stated staff should place used towels, washcloths, and the resident's personal items in a bag after use and should not leave them on the shower room floor. CNA10 stated maintaining a clean environment was important to prevent the spread of germs. During an interview with Licensed Practical Nurse (LPN) 9 on 07/02/2026 at 3:15 PM, she stated housekeeping performed routine cleaning of the shower room. She stated nursing staff cleaned the shower after each resident's use and maintained the area throughout the day. LPN9 stated each shift ensured the shower was clean after the shift ended. When the State Survey Agency (SSA) Surveyor asked about the condition of the shower room, LPN9 stated she did not know why various items were stored in the same room where residents bathed. She stated storing linen uncovered in the bathroom created an unsanitary condition and posed a risk for cross-contamination. LPN9 stated staff should not store personal resident items and shared resident care equipment in the shower area because moisture and splashes from resident bathing could contaminate these items. She stated the presence of stored equipment and personal items in the shower created an unclean appearance for residents receiving showers and raised infection prevention and control concerns. During an interview with the Maintenance Director on 07/02/2026 at 2:30 PM, he stated nursing staff cleaned the shower room and reported maintenance concerns through the facility's work order system. The Maintenance Director stated leaving electrical items plugged in or storing electrical equipment with charging units in the shower area posed a safety concern. He stated electrical equipment should not be left plugged in or charging in the shower room due to the presence of water and moisture in the area. He stated it was important to maintain a safe environment. During an interview with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 07/02/2026 at 4:41 PM, she stated she had identified concerns with storing shared equipment, linens, and resident-use items in the shower areas during a walk-through. She stated the shower rooms were not an appropriate location for storing those items. Additionally, the IP/SDC stated uncovered linens, wet towels, wet washcloths, mechanical lift accessories, and other equipment stored in the shower areas created infection prevention concerns. The IP/SDC stated resident care items should not be stored in a manner that would contaminate them or create an unsanitary environment. The IP/SDC stated the shower rooms should not be used as storage areas. She stated maintaining a clean, sanitary, and safe environment was important for the safety and well-being of all residents and for preventing cross-contamination and the spread of disease. During an interview with the Director of Nursing (DON) on 07/02/2026 at 6:02 PM, she stated she was concerned regarding the cleanliness and the storage of shared equipment, uncovered linens, resident items, clothing, and other supplies in the facility's shower rooms. She stated linen should be covered, and equipment should not remain in the shower room during resident care. She stated the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shower rooms were not intended for storage, although equipment could be moved temporarily to keep hallways clear. The DON stated a clean and sanitary environment promoted the health, safety, and well-being of residents. She stated keeping the room free of unnecessary items, clean, and linens covered was important to prevent the spread of infection. During an interview with the Administrator on 07/02/2026 at 6:32 PM, she stated she did not have an explanation for why equipment was being stored in the shower rooms. She stated it was important to have a clean, sanitary, and safe shower room for the safety and well-being of the residents and staff. The Administrator stated a clean environment prevented the spread of infections.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of the facility's document and policy, the facility failed to ensure a safe, functional, sanitary, and comfortable environment for resident rooms and shower rooms. The facility failed to identify and correct problems related to the residents' environment that had the potential to affect all residents that used three of the three sampled shower rooms and all residents that resided on the [NAME] Unit Hallway 1 and Hallway 2. Observation on 07/02/2026 revealed there were two holes on the right side of the [NAME] 2 Hallway, directly above the baseboard. One hole was approximately four inches long, and the other was approximately one inch long. Additional observation on 07/02/2026 revealed there was a hole approximately four inches long on the left side, above the baseboard, in the [NAME] 1 Hallway, between rooms A1 and A3. Observations on 07/02/2026 of the [NAME], [NAME], and Combs Units Spa revealed the shower areas were also used to store shared resident use equipment and supplies. Also observed were dirty linens in the area; residents' personal items stored on the linen storage shelf; and chipped, peeling, and worn non-skid coating on the shower stall tile. The findings include: Review of the facility's policy titled, Resident Rights, revised 07/18/2025, revealed the resident had the right to voice grievances. Per the policy, the facility must make prompt efforts to resolve any grievances residents might have. Review of the facility's document Resident Council Minutes, dated 03/31/2026, revealed the Maintenance Director attended the meeting. According to the Resident Council meeting minutes, residents identified Multiple Residents Need Maintenance as an issue. The documented action taken stated, Work orders. 1. Observation on 07/02/2026 at 12:08 PM revealed there were two holes on the right side of the [NAME] 2 Hallway, directly above the baseboard. One hole was approximately four inches long, and the other was approximately one inch long. Additional observation on 07/02/2026 at 3:10 PM revealed in the [NAME] 1 Hallway between Rooms A1 and A3, there was a hole approximately four inches in length on the left side above the baseboard. 2. Observation of the [NAME] Unit Shower Room Spa on 07/02/2026 at 2:30 PM revealed staff used it as storage for shared resident equipment, resident belongings, and resident care supplies, as well as the residents' shower room. Two mechanical lifts, a powered wheelchair, a shower stretcher, a bedside chair, and other resident care equipment were stored near the shower stalls, reducing the available space within the shower room. A powered wheelchair was positioned adjacent to an electrical outlet with the charging unit and power cord on the floor. The wheelchair remained plugged in. A hair dryer rested on the powered wheelchair while plugged into a nearby electrical outlet. Tissues and a wet washcloth were thrown on the floor beside the wheelchair. The white tiled floor inside both shower stalls had multiple areas where the black non-skid coating was peeling, chipping, and worn, creating an inconsistent walking surface which could reduce slip resistance and pose a potential safety hazard for residents and staff. Shelving units contained resident supplies, storage bins, basins, incontinence supplies, and equipment accessories. The supplies and equipment appeared disorganized and were stored throughout the shower room. Residents' personal belongings, including clothing, shoes, and other items, were stored in crates and storage bins, on wall hooks, and on the shower room floor. 3. Observation of the [NAME] Unit Shower Room Spa on 07/02/2026 at 2:45 PM revealed staff stored two mechanical lifts, a shower stretcher, multiple wheelchairs, a shower chair/commode, and a bedside chair throughout the shower room. The stored equipment occupied a substantial portion of the available shower area. Shelving units contained resident supplies, storage bins, basins, incontinence supplies, equipment accessories, and (continued on next page)		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	other resident belongings. The supplies and equipment appeared disorganized throughout the room. A baby doll was placed on a lower shelf among the residents' belongings. A Wet Floor caution sign remained stored behind a mechanical lift, which obstructed access to the shelving. Residents' personal belongings, including clothing hanging from a towel bar, clothing on the floor, and personal belongings stored with resident equipment, remained throughout the shower room. The white-tiled floor in both shower stalls had multiple areas where the black non-skid coating was peeling, chipping, and worn, creating an inconsistent walking surface. 4. Observation of the Combs Unit Shower Room Spa on 07/02/2026 at 3:20 PM revealed the shower chair, the shower stretcher, a mechanical lift, a portable vital signs machine, and resident care supplies stored throughout the shower room. A mechanical lift was positioned directly in front of the shower stretcher, reducing the available space within the shower area. A bedside commode, wall-mounted rack, and a multi-drawer storage unit were used to store transfer slings, resident supplies, and residents' clothing. Supplies and equipment appeared disorganized and were stacked on, around, and hanging from the storage units throughout the shower room. The white-tiled floor in both shower stalls had multiple areas where the black non-skid coating was peeling, chipping, and worn. Additionally, mechanical lift pads were stored on the wall, on top of a storage container, and on a toilet chair, under an inflatable hair shampooing basin. During an interview with Family Member (F) 3 on 07/02/2026 at 2:45 PM, she stated she remained concerned about the overall cleanliness of the facility, the disrepair observed throughout the facility, and the condition of the shower area. F3 stated the shower room appeared dirty, and the floor appeared covered in mold. She stated portions of the floor were chipped and peeling. F3 stated the shower rooms were overcrowded with resident supplies and equipment, making it difficult to provide resident showers and creating a safety concern during bathing. She stated the condition of the shower area did not appear clean or well maintained. She stated she was concerned for the safety of the residents and staff. During an interview with the Maintenance Director on 07/02/2026 at 2:30 PM, he stated leaving electrical items plugged in or storing electrical equipment with charging units in the shower area posed a safety concern. He stated electrical equipment should not be left plugged in or charging in the shower room due to the presence of water and moisture in the area. He stated it was important to maintain a safe environment. During an additional interview with the Maintenance Director on 07/02/2026 at 4:43 PM, he stated all maintenance concerns submitted through the facility's work order system generated service requests with an expected completion time of four to five days. He stated weekly reports generated each Monday identified outstanding work orders and flagged those exceeding 30 days. He stated the facility evaluated his performance based on the timely completion of work orders. He stated he had one maintenance assistant and had interviewed an additional applicant that day, intending to hire a second full-time maintenance assistant. During an interview with the Director of Nursing (DON) on 07/02/2026 at 4:51 PM, the DON stated she expected staff to repair holes in walls promptly. When the State Survey Agency (SSA) Surveyor asked whether 24 hours would be an appropriate timeframe, the DON stated, Yes. She stated she expected staff to repair holes in the walls within 24 hours. The DON stated she had not received any complaints from residents regarding the condition of the building. During an additional interview with the DON on 07/02/2026 at 6:02 PM, she stated staff submitted maintenance work orders when they identified environmental concerns or building damage. She stated maintaining the physical environment remained important because the facility served as the residents' home and should remain safe, clean, and as homelike as possible. The DON stated she remained concerned about the condition of the resident shower rooms, including their cleanliness and the storage of equipment within the rooms. She stated staff did not intend the shower rooms for storage, although they occasionally placed (continued on next page)		

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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, review of the facility's job description, and review of the facility's policies, the facility failed to promote and maintain resident dignity for 2 of 52 sampled residents, Resident (R) 1 and R101. 1. During an interview with R101 on 06/29/2026, he stated staff did not respond in a timely manner to his call bell for toileting assistance, resulting in a fecal incontinent episode, which embarrassed and humiliated him. 2. During observations on the Combs Unit on 06/29/2026, 06/30/2026, and 07/01/2026, R1 had a suprapubic catheter connected to a urine-meter drainage bag. The urine collection bag hung on the right side of the bed and was not covered with a dignity bag cover, leaving it visible to others. The findings include: Review of the facility's undated policy titled, Dignity, revealed each resident would be cared for in a manner that promoted and enhanced the resident's well-being, satisfaction with life, self-worth, and self-esteem. The policy further stated staff was expected to promote and maintain each resident's dignity and assist residents by promptly responding to a resident's request for toileting assistance and by ensuring urinary catheter bags remained covered. Review of the facility's policy titled, Activities of Daily Living (ADLs), reviewed 07/18/2025, stated, Residents will be provided with care, treatment, and services appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. The policy further stated appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident in accordance with the plan of care, including hygiene support and assistance with elimination (toileting). Per the policy, residents shall be assisted with toileting as needed, and residents who were incontinent of bladder or bowel would be provided care in a timely manner. Review of the facility's job description Certified Nursing Assistant, reviewed 01/2026, revealed the Personal Nursing Care Responsibilities included assisting residents with bathing, grooming, hygiene, placement of adaptive equipment, keeping residents dry, and assisting residents with bowel and bladder functions. 1. a. Review of R101's admission Record, found in the resident's electronic medical record (EMR) under the Profile tab, revealed the facility admitted the resident on 05/19/2026 with diagnoses to include ankylosing spondylitis of multiple sites in spine, chronic inflammatory demyelinating polyneuritis, and bilateral primary osteoarthritis of knee. Review of R101's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 05/29/2026, 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 15 out of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed R101 was always incontinent [no episodes of continent bowel movements]. Review of R101's Care Plan Report, dated 05/19/2026, found in the resident's EMR under the Care Plan tab, revealed a focus for requiring toileting assistance, initiated on 05/19/2026, for staff to support R101 in remaining as clean and dry as possible. During an interview with R101 on 06/29/2026 at 1:47 PM, he stated the Certified Nursing Assistants (CNA) responded to his call light in about 30 minutes to an hour last night, and he felt humiliated and embarrassed being dirty and not able to do anything about it. He stated he thought he got pretty good care, but the staff got busy and sometimes did not respond as quickly as he would prefer. He stated having a roommate to know he was waiting and dirty made it worse on him. b. Review of R33's admission Record, found in the resident's EMR under the Profile tab, revealed the facility admitted the resident on 05/21/2026 with diagnoses to include myasthenia gravis with (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(acute) exacerbation, traumatic subdural hemorrhage, and acute bronchitis. Review of R33's admission MDS, with an ARD of 05/25/2026, found in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. During an interview with R33, R101's roommate on 06/29/2026 at 1:53 PM, he stated he could confirm the time frame that R101 waited for assistance with toileting during the night shift on 06/28/2026. R33 stated R101 waited forever and I felt sorry for him. I was right here next to him while he waited. During an interview with CNA6 on 06/29/2026 at 2:30 PM, he stated staff was to answer the call lights as soon as possible. During an interview with Unit Manager (UM) 1 on 07/02/2026 at 11:55 AM, she stated she expected all staff to answer call lights. She stated she kept her office door open so she could see the staff respond to call lights. She stated responding timely to call lights was important to make certain the resident was okay and to help with whatever they needed. She stated delayed care could result in harm to the resident. During an interview with the Infection Preventionist/Staff Development Coordinator (IP/SDC) on 07/02/2026 at 4:25 PM, she stated staff was trained on dignity and activities of daily living (ADLs) upon hire, in the moment, and at least annually. During an interview with the Director of Nursing (DON) on 07/02/2026 at 5:55 PM, she stated she expected all staff to answer call lights and to support the CNAs. She stated responding to call lights timely was important to maintain the residents' dignity. She stated skin issues could develop from delaying toileting care. She stated staff was trained to answer the call lights timely. During an interview with the Administrator on 07/02/2026 at 3:22 PM, she stated she expected staff to respond within five minutes to call lights or as soon as possible. She stated anyone could answer a call light, but the light should not be turned off without getting the resident's needs met. The Administrator stated the facility expected staff to provide care to preserve dignity and promote respect. She stated staff received consistent training through the SNF Clinic platform, and they had an annual Skills Fair where return demonstrations were required for all the tasks. 2. Review of R1's admission Record, found in the resident's EMR under the Profile tab, revealed the facility admitted the resident on 01/02/2025 with diagnoses to include neuromuscular dysfunction of the bladder, hydronephrosis, and pseudarthrosis after fusion. Review of R1's admission MDS, with an ARD of 06/15/2026, found in the resident's EMR under the MDS tab, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, indicating the resident was cognitively intact. Continued review of the MDS revealed R1 had an indwelling suprapubic catheter. Review of R1'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 06/11/2025, that directed staff to maintain the catheter by using a dignity cover. a. Observation of R1 on 06/29/2026 at 1:30 PM revealed the resident's urinary 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. During an interview with R1 on 06/29/2026 at 1:30 PM, she stated the CNAs emptied the urinary catheter drainage bag throughout the day. When asked by the State Survey Agency (SSA) Surveyor about the use of a dignity cover, she stated she was not aware whether one was in place. However, the resident stated if a dignity bag cover were available, she would prefer to have one to provide privacy. b. Observation of R1 on 06/30/2026 at 9:39 AM revealed staff secured the resident's urinary drainage bag to the bed without a dignity cover in place. Continued observation outside of R1's room revealed the staff had left the urinary catheter drainage bag visible to individuals passing by the room. c. Observation outside R1's room on 07/01/2026 at 8:30 AM revealed the resident's urinary catheter drainage bag was visible to individuals outside the resident's room. The catheter drainage bag was not in the dignity bag cover. During an interview with CNA2 on 07/01/2026 at 8:30 AM, she (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. CNA2 further stated staff monitored residents with catheters during care and rounds to ensure the dignity covers remained in place. She stated she was unsure why R1 did not have a dignity bag cover. CNA2 stated it was important to replace the cover after providing catheter care to protect R1's dignity and privacy. During an interview with Licensed Practical Nurse (LPN) 4 on 07/01/2026 at 3:00 PM, she stated CNAs kept urinary catheter drainage bags covered with dignity covers to protect the resident's privacy. LPN4 further stated she checked to ensure drainage bags remained covered during nursing rounds. She stated she was not sure why R1's catheter bag was not covered. LPN4 stated urinary bag covers were important to maintain privacy and resident dignity. During an interview with the Director of Nursing (DON) on 07/02/2026 at 6:02 PM, she stated she expected to keep urinary catheter drainage bags covered with a dignity cover to maintain resident dignity and privacy. The DON stated the facility attempted to keep dignity covers in stock and replace them as soon as possible when residents returned from the hospital or were admitted without one. She stated nursing leadership rounded daily and should have noticed R1's urinary drainage bag was not covered. She stated providing a cover for the urinary drainage bag was important to maintain the resident's dignity. During an interview with the Administrator on 07/02/2026 at 6:32 PM, she stated she was concerned that uncovered catheter bags had been observed on multiple occasions. She stated that it should have been identified during nursing rounds. The Administrator stated the facility expected staff to ensure urinary catheter drainage bags remained covered to preserve dignity and protect the resident's privacy.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's document and policy, the facility failed to have a process to prevent expired medications from being available for resident use and failed to provide pharmaceutical services to meet the needs of each resident for 1 of 52 sampled residents, Resident (R) 78. Observation of the medication refrigerator on the [NAME] Unit on 07/02/2026 at 10:06 AM revealed R78 had one unopened vial of lorazepam 20 milligrams per 10 milliliters with an expiration date of 06/2026. Review of the pharmacy shipping manifest revealed a delivery date of 07/01/2026. The findings include: Review of the facility's policy titled, Medication Storage, revision date 07/18/2025, revealed the facility shall store drugs in a safe, secure, and orderly manner to include not using drugs that were outdated. Observation of the medication refrigerator on the [NAME] Unit on 07/02/2026 at 10:06 AM revealed R78 had one unopened vial of lorazepam 20 milligrams per 10 milliliters (used to treat active seizures) with an expiration date of 06/2026. Review of R78's admission Record, found in the resident's electronic medical record (EMR), revealed the facility admitted the resident on 01/03/2022 with diagnoses to include cerebral palsy, epilepsy, and Down syndrome. Review of R78's Comprehensive Care Plan [CCP], initiated on 01/03/2022, revealed the resident was identified for risk of adverse reactions related to requiring anticonvulsants for treatment related to epilepsy with interventions to receive medications as ordered. Further review revealed the CCP identified R78 as at risk for neurological complications to include seizures with an intervention to administer medication as ordered. Review of R78's Orders revealed an order placed on 04/14/2026 for Ativan (lorazepam) Injection Solution 2 milligrams (mg) per milliliter (ml), inject 2 mg intramuscularly (IM) every 24 hours as needed for seizure and could repeat in 2 hours if not effective. Review of R78's June and July 2026 Medication Administration Record (MAR) revealed no doses of Ativan had been administered during the month of June 2026 or the month of July 2026, through 07/02/2026. Review of the pharmacy's Shipping Manifest, dated 07/01/2026 at 11:16 PM, revealed two medications were listed with one being lorazepam 20 mg per 10 ml vial with quantity of 10 ml for R78. Licensed Practical Nurse (LPN) 8 signed the manifest for 07/01, with no year or time given. Review of the Controlled Drug Record for the expired vial of lorazepam revealed R78 had not received any doses from the vial. The State Survey Agency (SSA) Surveyor attempted to reach LPN8 by telephone on 07/02/2026 at 3:59 PM but was unsuccessful. During an interview with the Pharmacist from the providing pharmacy on 07/01/2026 at 11:20 AM, he stated he was a licensed pharmacist and the Director of the pharmacy services that provided pharmaceutical services to the facility. When asked if he was aware of R78's lorazepam being expired, he stated he was made aware by the facility earlier. When asked how that happened, he stated the pharmacy had not pulled the expired medications from the refrigerator, and they were still stored in the refrigerator at the pharmacy prior to the delivery. He stated the pharmacy's staff should have removed the expired medications to ensure no expired medications were taken to the facility. He stated all medications delivered to the facility were sealed in a plastic vinyl bag, and the accepting staff checked the manifest of medications delivered. When asked if they checked the medications for the expiration dates, he stated only the manifest was presented to them at the time of the delivery, and staff was never asked to check expiration dates since there were so many medications. He stated it was a pharmacy error. During an interview with the Director of Nursing (DON) on 07/02/2026 at 1:36 PM, she stated an administered expired medication could cause harm to the resident. She (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated when medications were delivered from the pharmacy, staff checking in the medications did not typically check all the medications for the expiration dates since there was such a large bulk of medications. The DON stated pharmacy had just delivered the medications around midnight on 07/01/2026. She stated night shift checked all the medications each night on all the carts for expiration dates. During an interview with the Administrator on 07/02/2026 at 3:35 PM, she stated her tasks included making sure the facility followed all regulations, and she depended on the DON for the clinical side of things. When asked about the expired lorazepam for R78, she stated the new vial had just literally been delivered early that morning, and no medication had been given from the vial. She stated her expectation was for each staff member giving medications to check the expiration date prior to administering. She stated night shift performed audits on all the medications in all the carts for expiration dates and would remove them if they were expired.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure drugs and biologicals used in the facility were labeled in accordance with currently accepted professional principles for 2 of 52 sampled residents, Resident (R) 98 and R130. 1. Observation of the [NAME] Hall Insulin Cart on 07/02/2026 at 10:00 AM revealed R98's insulin lispro KwikPen and Lantus 100 units/milliliter insulin pen did not have the original pharmacy label. 2. Observation of the [NAME] Hall Insulin Cart on 07/02/2026 at 10:00 AM revealed R130's insulin degludec U-100 pen and insulin lispro KwikPen did not have the original pharmacy label. The findings include: Review of the facility's policy titled Medication Storage, revised 07/18/2025, revealed medications were stored in their original pharmacy issue packaging and containers. According to the policy, medications with missing, incomplete, improper, or incorrect pharmacy labels must be returned to the pharmacy for proper labeling before being stored or used. 1. During an observation on 07/02/2026 at 10:00 AM of the [NAME] Hall Insulin Cart revealed R98's insulin lispro KwikPen and Lantus 100 units/milliliter insulin pen were without the original pharmacy label. Both pens had a handwritten pink label with designated spaces for the resident's name and the date the pen was opened. Further observation revealed staff had handwritten R98's name on the label with a marker; however, the resident's name was not easily legible due to the limited space provided on the label. No other resident-specific identifying information from the original pharmacy label was present on the handwritten label. 2. During an observation on 07/02/2026 at 10:00 AM of the [NAME] Hall Insulin Cart revealed R130's insulin degludec U-100 pen and insulin lispro KwikPen were missing the original pharmacy label. Both pens had a handwritten pink label with designated spaces for the resident's name and the date the pen was opened. Further observation revealed staff had handwritten R130's name on the label with a marker; however, the resident's name was not easily legible due to the limited space provided on the label. No other resident-specific identifying information from the original pharmacy label was present on the handwritten label. During an interview with Licensed Practical Nurse (LPN) 3 on 07/02/2026 at 10:00 AM, she stated the pharmacy dispensed medication pens with the original pharmacy label attached to each pen. She stated the label included the resident's name. LPN3 further stated if the original pharmacy label fell off, clinical staff replaced it with a handwritten label containing designated spaces for the resident's name and the date the pen was opened. She stated maintaining the original pharmacy label ensured staff could accurately identify the medication for safe administration. During an interview with the Pharmacy Director on 07/02/2026 at 11:20 AM, he stated the pharmacy dispensed insulin pens in a labeled plastic bag. He stated when an order included three insulin pens, the pharmacy placed all three pens in the bag with a large pharmacy label on the outside. He further stated the pharmacy also affixed a smaller label containing the resident's identifying information to each insulin pen. The Pharmacy Director stated if an individual's insulin pen's original pharmacy label was missing, staff should return the medication to the issuing pharmacy for proper labeling and storage before use. According to the Pharmacy Director, each individual's insulin pen label might include the resident's name, other resident-specific identifying information, the medication name, the medication dosage and strength, and the medication expiration date. When the State Survey Agency (SSA) Surveyor asked whether an individual insulin pen would ever lack a resident-specific label, the Pharmacy Director stated that it should not occur, except in the limited circumstance in which staff (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	removed a pen from an emergency kit for single-dose use. He stated staff should not return an emergency kit pen to stock and should discard it after use. He further stated individual labeling enabled staff to identify the resident to whom the insulin pen belonged during storage and use and helped to prevent medication errors. During an interview with the Director of Nursing (DON) on 07/02/2026 at 6:02 PM, she stated insulin pens should have pharmacy labels identifying the correct resident, medication, and dose. She stated if a label was missing, staff should address it and ensure the pen was properly labeled or returned, as appropriate. She further stated individual labeling of medications helped to prevent medication errors. During an interview with the Administrator on 07/02/2026 at 6:32 PM, she stated original pharmacy labels ensured clinical staff identified the correct resident and medication and followed medication administration rights. She stated if a pharmacy label came off an insulin pen, staff should return the pen or otherwise address it in accordance with facility policy.		