STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185244	A. Building B. Wing	12/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stanford Crossing	105 Harmon Heights Stanford, KY 40484

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 observation, interview, record review, and review of the facility's policies, the facility failed to immediately inform the resident's physician and the resident's representative when there was a significant change in the resident's physical and mental status for one (1) of 51 total sampled residents, Resident (R) 19. The facility assessed R19 to have decreased meal and fluid intake on [DATE] through [DATE]. Per interview, R19 also had a change in level of consciousness on [DATE] and [DATE]. However, there was no documented evidence the staff notified the resident's physician or representative from [DATE] through [DATE] of the resident's changes. R19 expired on [DATE]. The facility's failure to have an effective system to ensure each resident's physician and resident's representative were notified of significant changes in the resident's physical and mental status is likely to cause harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on [DATE] and was determined to exist on [DATE] in the areas of 42 CFR S483.25 Quality of Care, F684, and 42 CFR S483.10 Resident Rights, F580, at the highest scope and severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR S483.10 Resident Rights. On [DATE], the Administrator was provided a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template and notified of the failure to ensure each resident's physician and representative were notified of acute changes in the resident's condition is likely to cause serious injury, harm, impairment, or death to a resident. This failure constituted IJ at 42 CFR S483.10 Resident Rights, F580. The IJ at F580 also constituted Substandard Quality of Care (SQC) at 42 CFR S483.10. The IJ was determined to exist on [DATE] when R19 had a decline in meal and fluid intake and level of consciousness. The facility provided an acceptable IJ removal plan on [DATE]. This plan alleged the IJ was removed on [DATE]. An Extended Survey and IJ Removal validation were conducted on [DATE]-[DATE]. The State Survey Agency (SSA) validated the IJ's Removal Plan on [DATE]. The SSA validated the immediacy of the IJ had been removed on [DATE] as alleged.The findings include: Review of the facility's policy, Notification of Changes, revised [DATE], revealed the facility was to promptly inform the resident's physician and representative when there was a change requiring notification. The policy defined circumstances requiring notification included a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status, which might include life-threatening conditions or clinical complications. Review of R19's admission Sheet, located in the medical record, revealed the facility admitted the resident on [DATE]. R19's diagnoses included diabetes and atherosclerotic heart disease. Review of R19's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed R19's Brief Interview for Mental Status (BIMS) score to be 14. This score indicated R19 was cognitively intact. Review of R19's Comprehensive Care Plan, revised [DATE], revealed the facility assessed R19 to have a full code status. Interventions included to keep the family informed of changes in condition. Record review revealed the facility assessed R19 to have decreased meal and fluid intakes from [DATE] - [DATE]. R19 refused breakfast and lunch on [DATE], consumed 0-25% of dinner on [DATE] and [DATE], refused all meals on [DATE], consumed 0-25% of breakfast and lunch (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on [DATE], and refused dinner on [DATE]. Further review revealed the facility assessed R19 to have consumed total fluid intake of 700 ml (milliliters) on [DATE], 120 ml on [DATE], and 420 ml on [DATE]. However, there was no documented evidence the facility notified the R19's physician or representative of the resident's decline in intake. During an interview, on [DATE] at 6:00 PM, Certified Nursing Assistant (CNA) 10 stated she notified nursing staff on the night shift of [DATE] that R19 would not open her eyes but did clamp her mouth closed during oral care. CNA 10 stated the nurse obtained vital signs and told her they were normal. However, there was no evidence the nurse notified R19's physician or representative. CNA 10 stated she had received in report on [DATE] night shift that R19 had not eaten or drank anything on the [DATE] day shift. During an interview, on [DATE] at 12:20 PM, Licensed Practical Nurse (LPN) 4 stated she was R19's nurse on [DATE] day shift. LPN 4 stated R19 did not eat or drink and was sleeping a lot during her shift, but she did not notify the physician or R19's representative. LPN 4 stated, during report, she was informed that R19 did not eat or drink anything on the [DATE] night shift. During an interview, on [DATE] at 12:40 PM, RN 6 stated R19 slept quite a bit on day shift on [DATE] which was not normal for R19. RN 6 stated the Certified Nursing Assistants (CNAs) reported that R19 was sleepy during the shift. However, there was no documented evidence RN 6 notified R19's physician or representative of the changes. During an interview, on [DATE] at 6:30 PM, RN5 stated she was the nurse responsible for 50 residents on [DATE] night shift. RN5 stated her shift started at 6:30 PM and she did not visualize or assess R19 until she was notified by another staff member (Kentucky Medication Aide/KMA or a CNA as she could not remember) of R19's change in level of consciousness just prior to calling 911. RN5 stated she notified Advanced Practice Registered Nurse (APRN) 1 after her assessment and was told to call Emergency Medical Services (EMS) to transfer R19 to the hospital. Review of the hospital record revealed R19 was seen in the Emergency Department on [DATE] at 1:29 AM. The hospital diagnosed R19 with intracerebral hemorrhage, sepsis, and pneumonia. Further review revealed R19 was intubated and transferred to a Level 1 Trauma Center for further treatment on [DATE]. During an interview, on [DATE] at 4:59 PM, APRN 1 stated she had worked in the facility for approximately three (3) weeks and had not met R19. The APRN stated she was in the facility on [DATE], [DATE], and [DATE]. APRN 1stated she had not been notified of R19's condition until she was called by RN5 during night shift on [DATE], at which time she was notified R19 had a change in her level of consciousness, was not responsive to sternal rubs, and had fixed and pinpoint pupils. APRN 1 stated she instructed RN5 to transfer R19 to the hospital at that point. Additionally, APRN 1 stated she expected to be notified of a patient's (resident's) decline in appetite and refusal of medications for two (2) days because it sometimes means other things are going on. APRN 1 stated she expected to be notified of a resident's change in level of consciousness or mental status change because it could be indicative of an infection. and she would order labs and X-rays to determine if a resident had an infection. During an interview, on [DATE] at 9:28 AM, the Medical Director (MD) stated he had not been informed of R19's condition at any point and it was his expectation the APRN be notified of a resident's change in condition and the APRN would contact him if needed. The Medical Director stated he would expect the APRN or MD to be notified if a patient (resident) with a Full Code Status did not eat or drink for 24 hours. During an interview, on [DATE] at 4:05 PM, R19's Family Member 1 stated she visited R19 on a regular basis and had been to visit R19 on [DATE] or [DATE], at which time R19 seemed fine and was sitting up watching television, eating pie, and joking. Family Member 1 stated she did not get any phone calls from the facility regarding a change in R19's condition until the night of [DATE], sometime around 11:00 PM or 12:00 AM, at which time she was informed by facility staff that R19 had trouble breathing and had not been eating. Family Member 1 stated facility staff asked her if she wanted R19 sent to the hospital, and she stated yes. Additionally, Family Member 1 stated she drove immediately to the hospital and was told by hospital staff that R19 was unresponsive and had not eaten in three (3) days according to the report they received from the facility. Family Member 1 stated the Emergency Department (ED) physician said there was no choice but to put R19 on a (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	ventilator because her oxygen level was at 70%, she had pneumonia really bad, and a brain computer tomography (CT) revealed a brain bleed. Family Member 1 stated R19 was intubated and transferred to a Level 1 Trauma Center. Resident 19 expired on [DATE].

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 observation, interview, record review, and review of the facility's policies, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan and failed to implement care plan interventions. Additionally, the facility failed to identify, assess, and intervene for an acute change in the resident's condition related to decreased appetite and level of consciousness for one (1) of 51 sampled residents, Resident (R) 19. The facility assessed R19 to have decreased meal and fluid intake on 11/24/2025 through 11/27/2025. Per interview, R19 also had a change in level of consciousness on 11/26/2025 and 11/27/2025. However, there was no evidence the staff completed a thorough nursing assessment from 11/24/2025 through 11/27/2025. The facility's failure to have an effective system to ensure each resident received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan was likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) was identified on 12/06/2025 and was determined to exist on 11/24/2025 in the areas of 42 CFR S483.25 Quality of Care, F684, and 42 CFR S483.10 Resident Rights, F580, at the highest scope and severity (S/S) of a J. Substandard Quality of Care (SQC) was also identified at 42 CFR S483.25 Quality of Care, F684. On 12/07/2025, the Administrator was provided a copy of the Centers for Medicare and Medicaid Services (CMS) Immediate Jeopardy (IJ) Template and notified of the facility's failure to ensure residents received treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan, failure to implement care plan interventions, and failure to identify, assess, and intervene for an acute change in the resident's condition. The Administrator was notified that IJ at F684 also constituted Substandard Quality of Care (SQC) at 42 CFR S483.25. The facility provided an acceptable IJ removal plan on 12/08/2025. This plan alleged the IJ was removed on 12/07/2025. An Extended Survey and IJ Removal validation was conducted 12/07/2025-12/08/2025. The State Survey Agency (SSA) validated the IJ Removal Plan and determined the immediacy of the IJ had been removed on 12/07/2025 as alleged. The findings include: Review of the facility's policy, Notification of Changes, revised 03/20/2025, revealed the facility was to promptly inform the resident's physician and representative when there was a change requiring notification. The policy defined circumstances requiring notification included a significant change in the resident's physical, mental, or psychosocial condition such as deterioration in health, mental, or psychosocial status. Review of the facility's policy, Activities of Daily Living (ADLs), revised 03/20/2025, revealed care and services would be provided for eating to include meals and snacks. Further review of the policy revealed a resident who was unable to carry out the activities of daily living would receive the necessary services to maintain good nutrition and oral hygiene. The facility had no nutrition policy. However, during interviews with the dietician, she stated that everyone was supposed to have at least 1500 milliliters (ml) fluid per day, or it should be reported. Advance Practice Registered Nurse (APRN) 1 stated she wanted to be notified if a resident had less than 500 ml per 12-hour shift. Review of R19's admission Sheet revealed the facility admitted R19 on 01/13/2016. R19's diagnoses included diabetes and atherosclerotic heart disease. Review of R19's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed R19's Brief Interview for Mental Status (BIMS) score to be 14. This score indicated the resident was cognitively intact. Review of R19's care plan, revised 09/17/2025, revealed the facility assessed R19 to be at nutrition and hydration risk related to diabetes, dementia, and protein-calorie malnutrition with a goal to be at reduced risk for dehydration. Further review revealed interventions which included to assess for signs and symptoms of dehydration such as elevated temperature and change in mental status, encourage additional 240 milliliters (ml) fluid four times a day (QID), medication as ordered, monitor by mouth (po) intakes, and monitor/document/report as needed (prn) any signs and symptoms of dysphagia such as refusing to (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	eat. Continued review revealed a care plan, revised 08/10/2021, for Long Term Care with a goal that R19 would be provided with quality care which met physical and mental needs with interventions which included monitor for physical/mental improvement or decline and provide care as needed to maintain or improve R19's current functional level. Additionally, the facility would keep R19's family informed of a change in condition. Review of R19's care plan, revised 09/10/2025, revealed the facility care planned R19 for diabetes with a goal that R19 would have no complications related to diabetes. Further review revealed interventions which included to monitor/document/report PRN (as needed) any signs or symptoms of hyperglycemia (high blood sugar) which included Kussmaul breathing (rapid, deep breaths), stupor (a state of near-unconsciousness or insensibility), or coma. However, there was no evidence the facility implemented these interventions. Record review revealed the facility assessed R19 to have decreased meal and fluid intakes from 11/24/2025 - 11/27/2025. R19 refused breakfast and lunch on 11/24/2025, consumed 0-25% of dinner on 11/24/2025 and 11/25/2025, refused all meals on 11/26/2025, consumed 0-25% of breakfast and lunch on 11/27/2025, and refused dinner on 11/27/2025. Further review revealed the facility assessed R19 to have consumed a total fluid intake of 700 ml on 11/24/2025, 120 ml on 11/26/2025, and 420 ml on 11/27/2025. However, there was no documented evidence the facility conducted a thorough assessment related to R19's decline in food/fluid intake. In addition, there no documented evidence that staff notified the physician of R19's decreased appetite or fluid intake. During an interview, on 12/05/2025 at 6:00 PM, Certified Nursing Assistant (CNA) 10 stated she notified nursing staff on the night shift of 11/26/2025 that R19 would not open her eyes but did clamp her mouth closed during oral care. CNA 10 stated the nurse obtained vital signs and told her they were normal. However, there was no documented evidence the nurse completed a thorough assessment or documented R19's vital signs in the medical record. During further interview, on 12/05/2025 at 6:00 PM, CNA10 stated that she notified Registered Nurse (RN) 5 on 11/27/2025, around 12:30 AM, just prior to RN5 assessing R19's vital signs and notifying the physician, that R19 was not responsive, and her breathing was abnormal with heavy, fast breathing. CNA 10 stated RN5 obtained vital signs and obtained an oxygen level of 65% for R19. CNA 10 stated she had received in report from the prior shift that R19 had not eaten or drank anything on the prior shift. However, there was no documented evidence that RN5 assessed R19 fast abnormal breathing and responsiveness from 11/27/2025 at 6:30 PM until 11/28/2025 at 12:30 AM when she was notified by CNA10. During an interview, on 12/05/2025 at 12:20 PM, Licensed Practical Nurse (LPN) 4 stated she was R19's nurse on 11/27/2025 day shift. LPN 4 stated R19 did not eat or drink and was sleeping a lot during her shift, but she did not notify the physician. LPN 4 stated during report, she was informed that R19 did not eat or drink anything during the 11/26/2025 night shift. However, there was no documented evidence LPN 4 completed an assessment on R19. During an interview, on 12/04/2025 at 11:14 AM, Kentucky Medication Aide (KMA) 1 stated she told the nurse on 11/27/2025 night shift that R19 was not responding like she normally does because she always notifies the nurse of any changes. During an interview, on 12/05/2025 at 12:40 PM, RN 6 stated R19 slept quite a bit on day shift on 11/27/2025 which was not normal for R19. RN 6 stated the Certified Nursing Assistants (CNA) reported that R19 was sleepy during the shift. However, there was no documented evidence RN 6 completed a thorough assessment on R19 or notified the physician of the resident's change in level of consciousness. Review of the schedule revealed both LPN4 and RN 6 were scheduled on R19's unit 11/27/2025 day shift and were both notified by CNAs of R19's change in condition. However, there was no documented evidence that RN19 and LPN4 assessed R19's change in condition during the 11/27/2025 day shift. During an interview, on 12/05/2025 at 6:30 PM, RN5 stated she was the nurse responsible for 50 residents on 11/27/2025 night shift. RN5 stated her shift started at 6:30 PM. However, RN5 stated she had not visualized or assessed R19 until she was notified by another staff member of R19's change in level of conscious just prior to the 911 call. RN5 notified Emergency Medical Services (EMS) to transfer R19 to hospital but could not recall what time the call was made. Review of the EMS (Emergency Medical (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Services) run sheet and 911 recording, dated 11/28/2025, revealed Registered Nurse (RN)5 called 911 on 11/28/2025 at 12:46 AM and asked for EMS to transfer R19 to the hospital. During the 911 call, RN5 reported that the resident had decreased intake since 11/24/2025, and had agonal (gasping, abnormal) breathing, and staff could not arouse the resident with painful stimuli. Further review of the EMS run sheet revealed R19 was hot to touch. During an interview, on 12/05/2025 at 2:45 PM, Paramedic 1 stated he responded to the 911 call for R19 on 11/28/2025 at 12:56 AM. Paramedic 1 stated he could hear R19's labored breathing from the hallway before he entered R19's room. Review of the hospital record revealed R19 was seen in the Emergency Department on 11/28/2025 at 1:29 AM. The hospital diagnosed R19 with intracerebral hemorrhage, sepsis, and pneumonia. Further review revealed R19 was intubated and transferred to a Level 1 Trauma Center for further treatment on 11/28/2025. R19 expired on 12/04/2025. During an interview, on 12/06/2025 at 11:55 AM, the DON stated the facility used machines that connected to their charting system for any behaviors, medications, meals, and vital signs. He further stated this system sends alerts daily to the Unit Managers. He stated no alerts were triggered on R19 even though she had documentation of multiple missed meals and low intake. Additionally, he stated their Tapestry system was installed above residents' beds and monitored residents' breaths, heart rates, and movements. He stated the Tapestry system has been in use since March or April 2025. However, he stated it did not send any alerts on R19 during 11/24/2025 - 11/27/2025. During an interview, on 12/05/2025 at 9:48 AM, the Director of Nursing (DON) stated it was his expectation nurses did bedside rounding at the beginning of each shift. The DON stated every nurse should lay eyes on their residents before they accept assignments to make sure each resident was alive and had no immediate needs. During an interview, on 12/05/2025 at 12:18 PM, the DON stated residents' needs were identified through the charting system and daily meetings. The DON stated that not checking on a resident for four to five (4-5) hours was not acceptable, and every resident should be checked on every two (2) hours. The DON stated nurses should report if a resident was not eating and document this in the follow up report. Additionally, the DON stated if a resident could not be aroused, an assessment should be done and the provider notified. During an interview, on 12/06/2025 at 2:17 PM, the Administrator stated it was her expectation nurses documented refusal of meals and would inform the next shift in report if a resident was not eating or drinking. She further stated she expected assessments to be completed per policies.

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F 0842 Level of Harm - Actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and policy review, it was determined the facility failed to maintain medical records on each resident that were complete and accurately documented in accordance with accepted professional standards and practices for one (1) of 51 total sampled residents, Resident (R) 19. The facility failed to document assessments for R19 from 11/24/2025 to 11/27/2025 when R19 had a decline in intake and level of consciousness. R19 was transferred to the hospital on [DATE]. R19 expired on 12/04/2025.The findings include:The facility did not provide a policy for nursing documentation. Review of the facility's position description, Licensed Practical Nurse (LPN), dated 02/2025, revealed the LPN's essential functions included observing, recording, and reporting changes in residents' condition to the supervisor and attending physician and maintaining residents' medical record by way of documentation. Review of the facility's position description, RN (Registered Nurse), dated 02/01/2024, revealed the RN's major duties and responsibilities included assessing for changes in residents' status, notifying the physician and resident's family or representative, and documenting accordingly. Review of R19's admission Sheet revealed the facility admitted R19 on 01/13/2016. R19's diagnoses included diabetes and atherosclerotic heart disease. Review of R19's Quarterly Minimum Data Set (MDS), dated [DATE], revealed the facility assessed R19's Brief Interview for Mental Status (BIMS) score to be 14. This score indicated R19 was cognitively intact. Review of R19's care plan, revised 09/17/2025, revealed the facility assessed R19 to be at nutritional and hydration risk related to diabetes, dementia, and protein-calorie malnutrition with a goal to reduce the risk for dehydration. Further review revealed interventions which included to assess for signs and symptoms of dehydration such as elevated temperature and change in mental status, encourage additional 240 milliliters (ml) fluid four times a day (QID), administer medication as ordered, monitor by mouth (po) intakes, and monitor/document/report as needed (prn) any signs and symptoms of dysphagia such as refusing to eat. Continued record review revealed the facility care planned that R19 would be provided with quality care which met physical and mental needs with interventions which included monitor for physical/mental improvement or decline and provide care as needed to maintain or improve R19's current functional level. Additionally, the facility assessed R19, on 10/02/2019 to have a full code status with a goal that R19's wishes would be honored and an intervention to keep family informed of any change in condition. Review of R19's care plan, revised 09/10/2025, revealed the facility assessed R19 had diabetes with a goal that R19 would have no complications related to diabetes and an intervention which included to monitor/document/report any signs or symptoms of hyperglycemia (high blood sugar) which included Kussmaul breathing (rapid, deep breaths), stupor (a state of near-unconsciousness or insensibility), or coma. However, there was no evidence the facility implemented these interventions. Record review revealed the facility assessed R19 to have decreased meal and fluid intakes from 11/24/2025 - 11/27/2025. R19 refused breakfast and lunch on 11/24/2025, consumed 0-25% of dinner on 11/24/2025 and 11/25/2025, refused all meals on 11/26/2025, consumed 0-25% of breakfast and lunch on 11/27/2025, and refused dinner on 11/27/2025. Further review revealed the facility assessed R19 to have consumed a total fluid intake of 700 ml (milliliters) on 11/24/2025, 120 ml on 11/26/2025, and 420 ml on 11/27/2025. However, there was no documented evidence the facility assessed R19 due to the declines in food/fluid intake. Additionally, there was no documentation of nursing assessments or notes from 11/24/2025 through 11/27/2025. During an interview, on 12/05/2025 at 6:00 PM, Certified Nursing Assistant (CNA) 10 stated she notified nursing staff on the night shift of 11/26/2025 that R19 would not open her eyes but did clamp her mouth closed during oral care. CNA 10 stated the nurse obtained vital signs and told her they were normal. However, there was no documented evidence the nurse completed an (continued on next page)

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F 0842 Level of Harm - Actual harm Residents Affected - Few	assessment or documented R19's vital signs in the medical record. During an interview, on 12/05/2025 at 12:20 PM, Licensed Practical Nurse (LPN) 4 stated she was R19's nurse on 11/27/2025 day shift. LPN 4 stated R19 did not eat or drink and was sleeping a lot during her shift and was informed during report that R19 did not eat or drink anything during the 11/26/2025 night shift. However, there was no documented evidence LPN 4 completed or documented an assessment on R19. During an interview, on 12/05/2025 at 12:40 PM, RN 6 stated R19 slept quite a bit on day shift on 11/27/2025 which was not normal for R19. RN 6 stated the Certified Nursing Assistants reported that R19 was sleepy during the shift. However, there was no documented evidence RN 6 completed or documented an assessment on R19. During an interview, on 12/05/2025 at 6:30 PM, RN5 stated she assessed R19 on 11/27/2025 night shift when she was notified by another staff member that R19 had a change in level of consciousness. RN5 stated she could not recall the time, but it was shortly before she called 911 to transport R19 to the hospital. However, there was no documented evidence RN5 had completed or documented an assessment on R19 between 11/27/2025 at 6:30 PM, at the beginning of her shift, until she entered a note on 11/28/2025 at 12:30 AM. Review of R19's Progress Notes, dated 11/28/2025 at 12:30 AM, charted by RN5, revealed R19 had a temperature of 97.5 degrees Fahrenheit. Review of the EMS (Emergency Medical Services) run sheet, dated 11/28/2025 at 1:04 AM, revealed Paramedic 1 assessed R19's temperature to be 104.2 degrees upon arrival to the facility. Further review of the EMS run sheet revealed Paramedic 1 documented the resident was noted to be hot to touch. R19 was transferred and admitted to the hospital on [DATE]. The hospital diagnosed R19 with intracerebral hemorrhage, sepsis, and pneumonia. R19 expired on 12/04/2025. However, review of R19's medical record revealed no documented evidence of the resident's change in condition. R19 expired on 12/04/2025. During an interview, on 12/05/2025 at 12:18 PM, the Director of Nursing (DON) stated residents' needs were identified through the charting system. The DON stated nurses should document if a resident was not eating. Additionally, the DON stated if a resident could not be aroused, an assessment should be completed and documented. During an interview, on 12/06/2025 at 2:17 PM, the Administrator stated it was her expectation nurses documented refusal of meals.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled:11Number of residents cited: 7 Based on observations, interviews, record review, review of facility staffing documentation, and review of the facility's Payroll Based Journal (PBJ) report, the facility failed to ensure it had an effective system to provide sufficient numbers of qualified nursing staff to meet the needs of 6 of 51 sampled residents (Resident (R) 8, 18, 30, 68, 94 and 117). The findings include: Review of the facility's policy titled, Staffing, implemented 03/20/2025, revealed the purpose was to provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Further review of the facility's staffing policy revealed the facility must ensure that nurse aides were able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments and described in the plan of care. Review of the Payroll Based Journal (PBJ) the facility has a one-star staffing rating. The one-star staffing rating means that a LTC facility has not met the minimum staffing set by the Centers of Medicare and Medicaid Services. 1.During an interview with Resident (R) 94 on 12/03/2025 at 9:50 AM, R94 stated that she takes a fluid pill and required multiple bathroom trips during the night. R94 stated she had to wait longer for assistance which was not comfortable. R94 stated, They don't have enough workers. 2.During an interview with R8 on 12/03/2025 at 5:00 PM, he stated that he sometimes received his medications later than the scheduled time. R8 stated getting his medications late was due to a lack of staff. 3. During an interview with R30 on 12/04/2025 at 8:50 AM, R30 stated that he liked living in the facility but did not believe there was enough staff. R30 stated that the staff always appeared rushed. He stated that this made him feel like staff did not have time to provide his care. R30 stated staff were not compassionate or friendly with him when care was provided. 4. During an interview with R18 on 12/04/2025 at 10:30 AM, R18 stated that he often waited a long time for his call light to be answered. R18 explained that he required assistance with the activities of daily living and became frustrated when he was left waiting for his needs to be met. He stated that staff should answer call lights regardless of what they assume he may need. R18 stated that at times he observed aides sitting in the dining area having what he described as a [NAME] party instead of answering call lights. 5. During an interview with R68 on 12/04/2025 at 10:35 AM, R68 stated that he became aggravated when he had to wait for assistance. He stated that the previous night he walked into the hallway seeking help for his roommate because the call light had been activated for a while without response. 6. During an interview with R117 on 12/04/2025 at 10:40 AM, she stated that she frequently received her nighttime snacks very late. R117 stated she believed this occurred due to insufficient staffing. On 12/04/2025 at 12:18 PM, an observation on the 100 Hallway revealed a resident's call light that remained illuminated for 24 minutes before Certified Nursing Assistant (CNA) 6 responded and entered the resident's room. When interviewed at 12:50 PM on 12/04/2025, CNA 6 stated that she was busy with another resident and was unable to answer the call light. On 12/05/2025 at 11:14 AM, an additional observation on the 100 Hallway revealed a call light that remained illuminated for 18 minutes before CNA 4 responded. When interviewed at 11:40 AM, CNA 4 stated that she thought that someone else had answered the call light. During an interview on 12/04/2025 at 4:05 PM, CNA 4 stated she had been employed for one month and believed the facility was short staffed. CNA 4 explained that she often was responsible for up to 25 residents per shift and had difficulty finding assistance to turn residents who required a two-person assist. She stated that some residents wait long periods to be changed. CNA 4 further stated that although she reported concerns to the Director of Nursing and Administrator, her concerns go in one ear and out the other. During an interview with CNA 5 on 12/04/2025 at 4:15 PM she stated that staffing levels did not allow her sufficient time to (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide the care to the residents without her feeling rushed. CNA 5 stated that she often could not follow the assigned shower schedule due to lack of time and stated, I do what I can. CNA 6 was interviewed on 12/04/2025 at 4:20 PM. She stated that she worked as a float across all shifts/units and believed that all units were understaffed. CNA 6 stated that she must prioritize care tasks and was often unable to complete all required care. During an interview with the Director of Nursing (DON) on 12/05/2025 at 12:00 PM, she stated that there were a lot of call ins, but the facility took an all-hands-on deck approach by having all department heads, including himself, to help provide resident care. The DON stated that there have been complaints brought to him that the facility was short staffed, and they did not have enough help on the floor to provide resident care needs. He stated that he discussed the CNA to resident ratio with the staff at the time the complaint was voiced. The DON stated there was enough staff to provide care to residents despite staff complaints. During an interview with the Administrator on 12/05/2025 at 11:35 AM, she stated the facility averaged 38 staff call-ins per month and required employees to give at least two hours' notice prior to calling in. She stated that when an employee called in, mass text messages were sent to all staff, and the scheduler began calling employees to cover the shift. The Administrator stated that department heads were required to fall in and cover shifts when necessary. She stated the facility did not mandate overtime. During the interview, the Administrator explained that staff often grumble about staffing when she passed them in the hallway, but she had not received what she considered legitimate complaints. She stated that each CNA was assigned between 6 and 12 residents depending on the acuity (level of assistance needed). The Administrator acknowledged that residents had raised concerns during the Resident Council meetings regarding call-light response times. She stated her expectation was that call lights be answered within 5 to 10 minutes or acknowledged by staff with an attempt to locate someone who could provide the needed care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and facility policy review the facility failed to provide housekeeping services to ensure a clean and sanitary environment for eight of 51 sampled residents (R) Residents ((R) 6, R7, R64, R37, R58, R70, R72, and R92). The findings include: Review of the facility's undated policy titled, Resident Rights, revealed the resident had a right to a safe, clean, comfortable and homelike environment. Review of the facility's housekeeping policy titled, Housekeeping Daily Duties, dated 12/2001, revealed a schedule of what housekeeping would do on each day of the week. The policy stated All corners and along all baseboards must be dust mopped to prevent buildup. When water pushes dust into corners, problems occur.1. On 12/04/2025 at 9:18 AM, observation of R6's room revealed a tile in the doorway that was cracked and potentially a fall hazard. Continued observation revealed that a handrail in the bathroom next to the toilet was loose and missing one of four screws. 2. On 12/04/2025 at 9:26 AM, observation of R7's room revealed five cracked tiles in the doorway of the resident's room. 3.Observation on 12/04/2025 at 9:39 AM, of R64's room revealed two cracked tiles in the doorway of the resident's room. Continued observation revealed a black substance on the base board in the resident's room next to the entrance to the bathroom.Interview with R64 on 12/04/2025 at 9:46 AM revealed the black substance had been there for a long time. R64 stated, I used to keep my house very clean. I don't like that they have not fixed this. It makes me feel dirty.4. On 12/04/2025 at 10:04 AM, observation of R37's room revealed two cracked tiles in the doorway. Further observation revealed a two-inch hole in the wall behind the resident's bed. 5. On 12/04/2025 at 10:12 AM, observation of R58's room revealed that the overbed table had the rubber missing around the top which exposed a sharp edge. 6. On 12/04/2025 at 10:28 AM, observation of R70's room revealed a broken tile in the middle of the room. In an interview with R70 on 12/04/2025 at 10:46 AM, the resident stated This tile has been broken since the first day I was here. I sit in my wheelchair a lot and sometimes the wheel of my wheelchair will get stuck in the hole in the tile and I am not strong enough to push myself out of it.7. On 12/04/2025 at 10:46 AM, observation of R72's room revealed two cracked tiles in the floor in the bathroom. Continued observation revealed a one-inch gap in the drywall around the sink in the bathroom. 8. On 12/04/2025 at 11:08 AM, observation of R92's room revealed numerous holes in the drywall on all four walls of the room. Continued observation revealed a trash can sitting underneath the sink. In an interview with R92 on 12/04/2025 11:18 AM, the resident stated They put that trash can underneath the sink to catch the dripping water. I don't know when they are going to fix this.The Maintenance Director stated in interview on 12/04/2025 at 11:42 AM, that they use a system called Tails, and anyone could put a work order in. He stated, Everyone knows that they can put a work order in, and we will make sure it gets done. The Maintenance Director stated there were no active work orders currently and he has not been made aware of anything that needs repaired In an interview with the Director of Nursing (DON) on 12/04/2025 at 12:13 PM, he stated that he was unaware of any black substance on the walls or baseboards of any of the residents' rooms. The DON stated that if there was something like that growing on the walls and baseboards, housekeeping should notify him, and they would have someone come in and look at it and find out what it was and how to treat it. During an interview with the Housekeeping Manager on 12/04/2025 at 1:12 PM, she stated, Every resident room gets a deep clean once a week and on the days we don't deep clean, we spot clean. The Housekeeping Manager stated that she was not aware of any black substance on the baseboards in any room. During observation of R64's room with the housekeeping manager, she observed the black fuzzy substance. She stated that there was a black fuzzy substance. The Housekeeper stated that she had never been notified of this.During the interview with the Administrator on 12/04/2025 at 1:38 PM she stated that anyone in the facility could put a work order in and it would get sent to maintenance and they would prioritize it. She stated, We have a good system in place, and everyone has the capacity to place a (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	work order. We encourage everyone to put a work order in the system if they see anything that needs fixed. When asked if she was aware of any cracked tiles or black substances on the base boards, she stated, I am not aware of anything like that. If there are cracked tiles in the floor, we need to get them fixed immediately. This could cause a resident to fall and get hurt and that is not what any of us want to happen.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, the facility failed to ensure a care plan was developed and implemented for two of 51 sampled residents (Resident (R5 and R90). The findings include: 1.Review of the facility's policy titled, Comprehensive Care Plans, dated 04/06/2015 and revised 02/09/2024, revealed the facility would develop and implement a comprehensive person-centered care plan for each resident, that included measurable objectives and time frames to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. Closed record review of R5's face sheet revealed the facility admitted the resident on 04/22/2024. R5's readmission on [DATE] included diagnoses that included subsequent encounter for closed fracture with routine healing; personal history of Transient Ischemic Attack (TIA/stroke); and cerebral infarction without residual deficits, and difficulty in walking, not elsewhere classified. Review of the admission Minimum Data Set (MDS) Assessment, dated 04/25/2024, revealed the facility assessed R5 to have a Brief Interview for Mental Status (BIMS) score of four out of 15. This score indicated the resident was not cognitively intact. Record review revealed no documented evidence the facility developed a Comprehensive Care Plan for R5 that was resident specific. R5's care plan had interventions in place such as Encourage resident to not yell at other residents and Encourage resident to voice their feelings. However, the facility had assessed R5 to be cognitively impaired. Record review reveals that R5's care plan was not updated quarterly.2. Closed record review of R90's face sheet revealed the facility admitted the resident on 10/29/2024 for short term rehabilitation following an ischemic stroke. Further review of the closed record revealed no documented evidence the facility developed and revised a comprehensive care plan for R90 that was personalized. Record review revealed the facility developed a goal for R90 to Return to home. However, R5 had been homeless before being admitted to facility. In an interview with the MDS Coordinator on 12/04/2025 at 12:34 PM, she stated R90's care plan should have a goal that was tailored to them. She stated the care plan should stated, return to community instead of return to home. In addition, the facility failed to update R90's care plan quarterly. During an interview with the Minimum Data Set (MDS) Coordinator on 12/05/2025 at 11:12 AM, she stated R5 and R90 should have had a Comprehensive Care Plan implemented when they were admitted to the facility. The MDS Coordinator stated that she was in charge of implementing and updating care plans. During an interview with the Director of Nursing (DON) on 12/04/2025 at 10:06 AM, he stated each resident should have a person-centered Comprehensive Care Plan and the MDS Coordinator was responsible for implementing the care plans. The DON stated his expectations were for each resident to have the appropriate care plan implemented. During an interview with the Administrator on 12/04/2025 at 10:41 AM, she stated she expected all residents to have a comprehensive care plan and for staff to follow the facility's policies. She stated that all care plans should be revised and reviewed quarterly, at minimum.

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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, and review of the facility's policies, the facility failed to maintain an effective infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for four (4) of 51 sampled residents (Resident (R)7, R28, R42 and R50).The findings include:Review of the facility's policy, titled Enhanced Barrier Precautions (EBP), dated 03/08/2024, revealed the EBP policy was implemented to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility. The policy stated EBP would be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities. The policy stated high contact care activities included assisting with and providing hands on care.Review of the facility's policy titled Infection Control dated 03/10/2024, revealed that all nebulizer tubing should be in a sealed bag when not in use. The policy stated that it was okay to take the tubing out of the bag to be used, but it should be in a bag when not in use. 1. Observation on 12/24/2025 at 3:12 PM, revealed Certified Nursing Assistant (CNA)2 failed to don (put on) Personal Protective Equipment (PPE) prior to providing care for R7 who was on Enhanced Barrier Precautions (EBP). Additionally, CNA2 failed to wash or sanitize his/her hands upon exiting R7's room after providing care.Observation of R7 on 12/04/2025 at 11:12 AM revealed a nebulizer machine with tubing laying on the overbed table. The tubing was not in use and not in a bag.Review of R7's Physician's Orders dated 10/10/2024, revealed orders for Enhanced Barrier Precautions (EBP-infection control intervention designed to reduce transmission of multidrug-resistant organisms) related to a history of Methicillin-resistant Staphylococcus aureus (MRSA) found in the wound.Observation on 12/04/2025 at 3:42 PM, revealed a sign on the door to R7'a room that stated, enhanced barrier precautions. Further observation revealed there was a cart at the door of R7's room that contained boxes of gloves and disposable gowns.2. Observation of R28's room on 12/04/2025 at 11:36 AM revealed a nebulizer machine with tubing touching the floor. The machine was not in use, and the nebulizer kit was laying on the floor. The tubing was not in use and was not stored in a bag.3. Observation of R42's room on 12/04/2025 at 11:58 AM revealed a nebulizer kit laying on the overbed table, not in use. The nebulizer kit was not stored in a bag.4. Observation of R50's room on 12/04/2025 at 12:14 PM revealed a nebulizer kit sitting on the nightstand. The nebulizer was not in use, and the nebulizer kit was not stored in a bag. During an interview with CNA2, on 12/04/2025 at 9:22 AM, she stated if PPE was not donned appropriately for Enhanced Barrier Precautions (EBP), it placed the resident, other residents and staff at risk for spread of infection. CNA 2 stated all residents on EBP should not be touched by staff unless staff was wearing gloves and a disposable gown.During continued interview with CNA2, she stated, she always tried to don appropriate PPE prior to entering R7's room. She stated she knew she should wash or sanitize her hands upon exiting the room. CNA2 stated, I must have been in a hurry. I would never put any of my residents at risk for getting an infection or bacteria.During interview with Registered Nurse (RN) 1, on 12/04/2025 at 3:12 PM, she stated all staff had been educated on infection control policies and a sign on the door indicated the resident was on EBP. RN1 stated all staff should be aware they were to don the appropriate PPE before providing any type of care for residents on EBP. The RN stated she monitored as she was going down the halls and if staff were identified as not wearing appropriate PPE, she would immediately educate them. RN1 stated the Infection Preventionist (IP) completed daily rounds to monitor for infection control measures as well.During an interview with the IP on 12/05/2025 at 1:46 PM, she stated she expected nursing staff to follow the facility's policies regarding PPE and EBP. The IP stated if she ever saw any staff not following proper infection control procedures, she would immediately provide them education on what they did wrong, and the corrective actions needed. The IP stated following infection control policies and procedures for a resident on EBP was important to prevent other residents or staff from being exposed. Further, the IP stated it was (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	important to use good hand hygiene after providing care, and upon exiting a resident's room. She stated she tried to make daily rounds and educate staff regarding infection control procedures as needed. The IP stated that per their policy, all nebulizer tubing should be stored in a bag at the resident's bedside when not in use. During an interview, on 12/04/2025 at 2:32 PM, the Administrator, stated general hand washing was number one, and donning PPE as indicated was expected of all staff. The Administrator stated she left it to the clinical management staff to make rounds to ensure there were no infection control concerns. She stated that the facility's policy was that all nebulizer tubing should be stored in a bag, and this was her expectation. The Administrator stated she expected all staff to follow the facility's infection control policies.