STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185332	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Nursing and Rehabilitation Center	105 Rodgers Park Cynthiana, KY 41031

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview, record review, review of the facility's policy, and review of the facility's Plan of Correction (PoC) for the survey completed on 03/08/2025, with a compliance date of 03/28/2025, the facility failed to have an effective system to address systemic failures through the Quality Assurance Performance Improvement (QAPI) process.The facility failed to sustain compliance and implement effective corrective actions following a deficiency cited on the previous standard survey under 42 CFR S483.80 Infection Prevention and Control; 42 CFR S483.80 Influenza and Pneumococcal Immunizations; and 42 CFR S483.80 COVID-19 Immunization. This systemic failure placed residents at increased risk for preventable infectious diseases, including influenza, pneumococcal infections, and COVID-19. This deficient practice had the potential to affect all residents residing in the facility.The findings include:Review of the facility's policy titled, QAPI Plan Standard of Practice, revised 04/2025, revealed the facility was to conduct ongoing quality reviews and monitor action plans monthly to evaluate effectiveness and identify the need for revision. Further review revealed that the QAPI committee, at a minimum, consisted of the Medical Director or designee, Director of Nursing (DON), Infection Preventionist (IP), and at least three additional staff members, including the Administrator.Review of the facility's policy titled, Infection Control Policy (General), dated 10/2020, revealed the facility was expected to develop and implement an infection control program to prevent, detect, investigate, and control infections. The policy stated it required monitoring and oversight by the QAPI committee.Review of the facility's PoC related to 42 CFR S483.80 Infection Prevention and Control, for the 03/08/2025 survey, with a compliance date of 03/28/2025, revealed interventions for deficient practice in infection control included conducting QAPI team meetings monthly instead of quarterly for 12 months. Additionally, the PoC stated audits on QAPI performance would be conducted monthly for 12 months and reviewed monthly by the QAPI committee. According to the PoC, audits would be conducted by either the Administrator or the DON, including logs of audits of any active Performance Improvement Plan (PIP). Review of the facility's PoC related to 42 CFR S483.80 Influenza and Pneumococcal Immunizations, for the 03/08/2025 survey, with a compliance date of 03/28/2025, revealed the facility would offer the vaccines and would document each vaccine offering, including provision of education and whether the resident consented or declined. Additional review of the PoC revealed audit findings were reviewed by the QAPI committee, with identified issues addressed, staff reeducation provided, and determinations made regarding ongoing monitoring or additional interventions. The documentation further revealed audit results were to be presented to the QAPI committee, with disciplinary action taken against staff who failed to comply with facility policies.Review of the facility's PoC related to 42 CFR S483.80 COVID-19 Immunization, for the 03/08/2025 survey, with a compliance date of 03/28/2025, revealed the facility would offer the vaccine and would document each vaccine offering, including provision of education and whether the resident consented or declined. Additional review of the PoC revealed audit findings were reviewed by the QAPI committee, with identified issues addressed, staff reeducation provided, and determinations made regarding ongoing monitoring or additional interventions. The documentation further revealed audit results were to be presented to the QAPI committee, with disciplinary action taken against staff (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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	who failed to comply with facility policies.Review of the facility's QAPI meeting minutes, dated 05/15/2025, revealed the Medical Director or designee was not in attendance. Review of documentation provided by the facility revealed no evidence that the QAPI committee identified or implemented actions to address ongoing deficiencies related to infection prevention and control, influenza and pneumococcal immunizations, or COVID-19.Review of QAPI documentation provided by the facility revealed another QAPI meeting was not conducted until 12/24/2025, a lapse of six months and nine days. Further review revealed no evidence the QAPI committee identified or implemented actions to address ongoing deficient practices related to infection prevention and control, influenza and pneumococcal immunizations, or COVID-19.Review of the facility's QAPI meeting minutes, dated 12/24/2025, revealed the Medical Director and the IP were not in attendance. Further review revealed no evidence the QAPI committee identified or implemented actions to address ongoing deficiencies related to infection prevention and control, influenza and pneumococcal immunizations, or COVID-19.During an interview with the IP on 04/01/2026 at 3:25 PM, she stated multiple system breakdowns, including a lack of dedicated time to complete infection prevention responsibilities, a lack of proactive monitoring, unclear roles and responsibilities, and gaps in implementation and oversight of infection control practices, were responsible for the continued and repeated deficient practices related to infection control. She further stated changes in ownership and turnover in administrative staff, including the Administrator and DON, contributed to repeated deficient practice.In continued interview with the IP on 04/02/2026 at 11:57 AM, she stated her attendance at the QAPI meeting was affected when she was scheduled to work the floor the night prior to a meeting. She stated she could not say if she was provided with meeting minutes to review.During an interview with the DON on 04/02/2026 at 4:21 PM, she stated she began employment at the facility on 01/20/2026. When asked about her attendance at QAPI meetings, she stated if she did not sign the QAPI meeting attendance sheet, she did not attend. The DON further stated she could not speak as to why there were repeated deficiencies in infection control. During an interview with the Medical Director on 04/02/2026 at 4:10 PM, he acknowledged involvement in prior QAPI activities related to the facility's PoC; however, he was unable to provide detailed information regarding current monitoring or follow up processes. The Medical Director stated he could not speak as to why there were repeated deficiencies in infection control. During an interview with the Administrator on 04/01/2026 at 3:09 PM, she stated she had been employed at the facility for two weeks. She revealed, prior to identification by the State Survey Agency (SSA) surveyors, she was unaware of any current issues with the facility regarding infection control. The Administrator further stated she had not yet reviewed QAPI meeting minutes or scheduled a QAPI meeting. She stated it was her responsibility to ensure all processes established in the facility were maintained, including the QAPI program. She further stated she could not speak as to why there were repeated deficiencies in infection control.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview, record review, and review of the facility's policy, the facility failed to meet at least quarterly and have the required attendees present. The findings include: Review of the facility's policy titled, QAPI [Quality Assurance Performance Improvement] Plan Standard of Practice, revised 04/2025, revealed the facility was to conduct ongoing quality reviews and monitor action plans monthly to evaluate effectiveness and identify the need for revision. Further review revealed that the QAPI committee, at a minimum, consisted of the Medical Director or designee, Director of Nursing (DON), Infection Preventionist (IP), and at least three additional staff members, including the Administrator.Review of the facility's QAPI meeting minutes, dated 05/15/2025, revealed the Medical Director or designee was not in attendance. Review of the facility's QAPI meeting minutes, dated 12/24/2025, revealed the Medical Director and the IP were not in attendance. Further review revealed there was a lapse of six months and nine days between meetings.During an interview with the IP on 04/02/2026 at 11:57 AM, she stated in the last year she may have missed one or two of the QAPI meetings if she had to work the floor the night before. During an interview with the DON on 04/02/2026 at 4:21 PM, she stated she had been at the facility since January. She further stated that if the QAPI meeting sheet was not signed by her, she did not attend.During an interview with the Medical Director on 04/02/2026 at 4:10 PM, he acknowledged involvement in prior QAPI meetings, but he was unable to provide further information regarding the lack of meetings occurring. During an interview with the Administrator on 04/01/2026 at 3:09 PM, she stated she had been at the facility for two weeks but had yet to review the QAPI minutes or set up a QAPI meeting.

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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, review of a guideline from the Centers for Disease Control and Prevention (CDC), and review of the facility's policies, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent and control the development and transmission of communicable diseases. The facility failed to identify and correct problems relating to infection prevention practices such as improper hand hygiene and glove use, storage of contaminated and clean supplies together, lack of a hand-washing sink in a shower room, identifying a resident with a multi-drug resident organism (MDRO) as requiring Enhanced Barrier Precautions (EBP), storage of medical supplies and clean laundry that exposed them to contamination, and lack of nonpermeable aprons or disposable gloves available for staff use when handling contaminated laundry. This deficient practice had the potential to affect all 50 current residents. The findings include: Review of the CDC's guideline's Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 04/02/2024, revealed the CDC targeted epidemiologically important MDROs including extended-spectrum beta-lactamase (ESBL), as requiring EBP to reduce transmission in nursing home settings.Review of the facility's policy titled, Infection Control Policy (General), dated 10/2020, revealed the facility was expected to develop and implement an infection control program to prevent, detect, investigate, and control infections. The policy revealed infection control practices applied to all staff, residents, and visitors, included implementation of standard and transmission based precautions, and required staff training, monitoring, and oversight by the quality assurance and performance improvement committee.Review of the facility's policy titled, Enhanced Barrier Precautions Standard of Practice, revised 3/2026, revealed EBPs were implemented during high contact care activities for residents with chronic wounds, indwelling devices, or identified multidrug resistant organisms when contact precautions did not otherwise apply. The policy revealed the facility was responsible for identifying residents requiring enhanced precautions and ensuring staff implemented appropriate measures, including use of gowns and gloves.Review of the facility's policy titled, Hand Hygiene Protocol, undated, revealed staff was expected to perform hand hygiene using soap and water or alcohol-based hand rubs at key times, including before and after resident contact, after exposure to contaminated surfaces, after glove use, and before and after personal protective equipment (PPE) removal. The policy further revealed gloves were not a substitute for hand hygiene and required hand hygiene after removal.Review of the facility's policy titled, Linen Storage, dated 4/2025, revealed clean linens were required to be stored separately from contaminated linens and maintained in a manner to prevent contamination. The policy revealed linens were to be stored in covered carts or designated areas, linen carts were to remain closed when not in use, and access to clean linens was limited to authorized staff.Review of the facility's policy titled, Housekeeping (General), dated 10/2020, revealed housekeeping and maintenance services were expected to maintain a sanitary, orderly, and comfortable environment through routine cleaning of resident rooms, care areas, and common areas. The policy revealed the environment should not pose a safety risk and infection control practices were to be utilized during daily housekeeping activities.1. Observation on 03/31/2026 at 9:25 AM revealed Hospitality Aide (HA) 1 and HA2 were passing ice on the 200 Hall. Both aides were wearing gloves in the hallway. The aides failed to remove gloves or perform hand hygiene or change gloves between resident rooms. Further observation revealed the hospitality aides wore the same pair of gloves while obtaining ice from multiple residents. HA1 and HA2 picked up the ice scoop with gloved hands, held resident water pitchers over the ice bin, placed the ice scoop into its holder, and covered the pitcher, delivering it to the resident's room and returning to repeat the process. Further observation inside room [ROOM NUMBER], revealed HA2 handled the resident's water pitcher, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	of clean clothing and personal items were also stored beneath the folding counter directly on the floor. A door within the laundry room provided direct access to the exterior of the building. Staff was observed to frequently pass through the laundry room during the observation period to access an outdoor medical supply storage shed. The area was used multiple times daily by multiple staff as a pathway to the shed.Further observation revealed a secondary door within the laundry room led to a narrow L-shaped walkway. This area was used for storage of clean linen and for hanging mechanical lift slings and resident clothing. It was full, making it difficult to pass through without brushing up against the hanging clothing. Further observation of the laundry storage closet revealed two boxes of supplies were stored directly on the floor. There were no nonpermeable aprons or disposable gloves available for staff use when handling contaminated laundry. Additionally, there was no disinfectant available in the laundry area to clean the nonpermeable aprons used by staff when handling contaminated laundry.During an interview with the Environmental Services (EVS) Director on 04/02/2026 10:11 AM, she stated she had not been informed that the folding area should be separate from the washing machine area. She further stated the facility layout did not allow for separation. She stated staff usually had disinfectant spray to clean the nonpermeable aprons, but there were none available in the area for staff to use. She further stated supplies should not be stored on the floor, and staff drinks or food should not be on the folding table. Additionally, she stated residents' clothing and laundry should be handled in a safe and sanitary manner to prevent cross contamination.C. Observation of the Dirty Utility Room on 04/02/2026 at 10:40 AM revealed five linen receptacles were overfilled with bagged and unbagged soiled linen and clothing piled above the rim of the linen barrels. There were no lids in place covering the receptacles.During an interview with the EVS Director on 04/02/2026 10:40 AM, she stated linen receptacles should not be overfilled, and soiled linen and clothing should be placed in bags prior to disposal in the receptacles. The EVS Director stated the receptacles should be maintained with lids in place to ensure they remain covered. When asked by the SSA Surveyor why they were not covered, she stated she did not have any lids for the receptacles. She further stated a staff member had called in the night before and they were trying to catch up on laundry, and the facility had only one washer and one dryer. The EVS Director stated implementing infection control practices was important to prevent the spread of disease and control cross-contamination by contaminated items. 4. Observation of Licensed Practical Nurse (LPN) 3 perform a blood glucose fingerstick on 03/31/2026 at 4:00 PM revealed, after the procedure, LPN3 removed contaminated gloves multiple times without performing hand hygiene between glove removal and reapplication. Additionally, LPN3 brought in an entire bottle of test strips into the room and placed the bottle on the barrier along with a contaminated glucometer.During an interview with LPN3 on 04/01/2026 at 8:30 AM, she stated hand hygiene was important after removal of PPE to prevent the spread of contamination and reduce the risk of infection transmission. She stated, after contaminating gloves, they should be removed and hand hygiene should be completed prior to putting on a new pair of gloves to maintain infection control and protect the resident's safety. She further stated taking medical supplies into a resident's room created the potential for contamination. She stated only the supplies needed for the procedure should be taken into a resident's room, or any items brought into the room should be cleaned and disinfected in accordance with the facility's policy prior to reuse.5. Observation on 04/02/2026 at 8:34 AM revealed Resident (R) 2, who was colonized with ESBL in the urine, had no EBP signage in place on or near her room's door.Review of the admission Face Sheet, found in R2's electronic medical record (EMR), revealed the facility admitted the resident on 01/20/2026, with diagnoses which included urinary tract infection with ESBL, chronic kidney disease, and adult failure to thrive. Review of R2's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/04/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 15 out of 15, which indicated the resident was cognitively intact. Review of R2s Comprehensive Care Plan [CCP], dated 02/09/2026, revealed a focus for infection related to urinary tract infection with ESBL. An intervention initiated on (continued on next page)

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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on interview, record review, and review of the facility's policy, the facility failed to ensure that residents were informed of and able to exercise their rights regarding advance directives. Specifically, there was no documented evidence that the facility educated the residents and/or their representative on advance directives. This failure had the potential to result in residents making uninformed decisions regarding their care and treatment preferences for 7 of 41 sampled residents reviewed, Resident (R) 12, R16, R22, R33, R35, R37 and R41.The findings include:Review of the facility's policy titled, Advance Directive Standard of Practice, reviewed 3/2026, revealed it is the resident's right to formulate an advance directive. Further review revealed the facility will inquire about the existence of any advance directives, and should the resident indicate they issued advance directives about their care and treatment, documentation must be recorded in the medical record of such directive, and a copy of such directive should be included in the resident's medical record. Additional review revealed the facility will periodically assess the resident's decision-making abilities and approach their health care proxy or legal representative if the resident is determined to not have decision making capacities regarding advance directives and/or treatment provision. Further review revealed during the care planning process, the facility will identify, clarify, and review with the residents or legal representatives whether they have the desire to make any changes to the advance directives. Review of the facility's sample Resident admission Packet revealed that the document titled, Advance Directive Policy and Record, undated, referenced the facility's policy. Further review revealed the document permits the facility to note the status of the resident's advance directive along with a place for a date and initials. 1. Review of R12's Face Sheet revealed the facility admitted the resident on 10/27/2025 with diagnoses to include congestive heart failure (CHF), diabetes mellitus, and depression. Review of R12's admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 02/12/2026, revealed the resident had a Brief Interview for Mental Status [BIMS] score of eight out of 15, indicating the resident was moderately cognitively impaired.In an interview with R12 on 04/01/2026 at 2:15 PM, she stated she had an advance directive in place and was not certain if she had provided the paperwork to the facility. She further stated she did not remember being asked about it in her care plan meeting. Review of R12's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated the .documents were not yet received, but center was informed. The only information filled in on the form was the resident's name, the representative name, and their relationship to the resident. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner she understood, only the date 10/27 with no year was included along with the initials of a staff member. 2. Review of R16's Face Sheet revealed the facility admitted the resident on 07/09/2025 with diagnoses to include depression, coronary artery disease, and bipolar disorder. Review of R16's admission MDS, with an ARD of 01/16/2026, revealed the resident had a BIMS score of 13 out of 15, indicating the resident was cognitively intact.Review of R16's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated Resident or representatives states that the resident has no written AD [advance directive]. The only information filled in on the form was the resident's name and the date, 7/9/25, along with the initials of a staff member. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner she understood.3. Review of R22's Face Sheet revealed the facility admitted the resident on 12/10/2024 with diagnoses to include heart failure, diabetes mellitus, and chronic obstructive pulmonary disease (COPD).Review of R22's admission MDS, with an ARD of 02/12/2026, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact.Review of R22's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated the Resident or representatives states that the resident has no (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	written AD. The only information filled in on the form was the resident's name and the date, 3/31/26, along with the initials of a staff member. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner she understood.4. Review of R33's Face Sheet revealed the facility admitted the resident on 02/11/2026 with diagnoses to include benign prostatic hyperplasia, renal insufficiency, and diabetes mellitus. Review of R33's admission MDS, with an ARD of 02/25/2026, revealed the resident had a BIMS score of 11 out of 15, indicating the resident was cognitively intact.Review of R33's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated the .documents were not yet received, but center was informed. The form included the resident's name; however, the representative name/relationship was blank, and it was not indicated if R33 had a legal representative, and if R33 did not have a legal representative, it was not applicable. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner she understood, only the date, 2/11 with no year, was included along with the initials of a staff member. 5. Review of R35's Face Sheet revealed the facility admitted the resident on 01/25/2024 with diagnoses to include coronary artery disease (CAD), thyroid disorder, and arthritis. Review of R35's admission MDS, with an ARD of 02/04/2026, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact.Review of R35's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated the .resident or representative states the resident has no written AD. The form included the resident's name; however, the representative name/relationship was blank, and it was not indicated if R35 had a legal representative, and if R35 did not have a legal representative, it was not applicable. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner she understood, only the date, 1/16/26, with the initials of a staff member. 6. Review of R37's Face Sheet revealed the facility admitted the resident on 10/02/2014 with diagnoses to include stroke, hemiplegia, and malnutrition. Review of R37's admission MDS, with an ARD of 01/26/2026, revealed the resident had a BIMS score of five out of 15, indicating the resident was significantly impaired cognitively.Review of R37's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated the .resident or representative states the resident has no written AD. The form included the resident's name; however, the representative name/relationship was blank, and it was not indicated if R37 had a legal representative, and if R37 did not have a legal representative, it was not applicable. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner he understood, only the date, 3/31/26, with the initials of a staff member. 7. Review of R41's Face Sheet revealed the facility admitted the resident on 10/15/2024 with diagnoses to include malnutrition (protein or calorie), depression, and scoliosis. Review of R41's admission MDS, with an ARD of 03/16/2026, revealed the resident had a BIMS score of 15 out of 15, indicating the resident was cognitively intact.Review of R41's Advance Directive Policy and Record, undated, revealed an incomplete record that indicated the .resident or representative states the resident has no written AD. The form included the resident's name; however, the representative name/relationship was blank, and it was not indicated if R41 had a legal representative, and if R41 did not have a legal representative, it was not applicable. Further review revealed no documented evidence the opportunity to formulate or decline an advance directive was explained to the resident in a manner she understood, only the date, 3/31/26, with the initials of a staff member. During an interview with the Admissions Director on 04/02/2026 at 11:57 AM, she stated she got the verbal report of whether a resident has an advance directive during admission, but Social Services obtained all the hard copies for the electronic medical record (EMR). She stated that the residents' wishes could be carried out in a way that did not align with their preferences if an accurate advance directive was not in place. During an interview with Social Services Director on 04/02/2026 at 11:57 AM, she stated she collected documents related to current advance directives upon admission and she (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assisted with completing the form from the admissions packet. She stated the interdisciplinary team (IDT) did not consistently review the advance directive status during care plan meetings. During an interview with the Director of Nursing (DON) on 04/02/2026 at 4:22 PM, she stated it was important for the residents to have an opportunity to select advanced directives, so that their wishes would be respected. During an interview with the Administrator on 03/31/2026 at 3:21 PM, she stated she expected staff to follow all facility policies and procedures related to advance directives.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, record review, review of the controlled substance log titled Controlled Medication Shift Change Log, and review of the facility's policies, the facility failed to ensure proper documentation of the narcotic card count at each change of shift in accordance with professional standards of practice for 3 of 4 medication carts.1) Review of the 100 Hall back medication cart on 04/01/2026 at 8:30 AM, revealed the oncoming nurse failed to sign the Controlled Medication Shift Change Log on the following dates 04/01/2026, 03/24/2026, and 03/10/2026.2) Review of the 100 Hall split medication cart on 04/01/2026 at 9:45 AM, revealed the oncoming nurse failed to sign the Controlled Medication Shift Change Log on 03/24/2026 and 03/10/2026.3) Review of the 200 Hall split medication cart on 04/01/2026 at 10:00 AM, revealed on 03/16/2026, the oncoming nurse failed to sign the log. On 02/26/2026 and 01/27/2026, the outgoing nurse failed to sign the Controlled Medication Shift Change Log. The findings include:Review of the facility's policy titled Inventory Control of Drugs, no date, revealed controlled drugs are inventoried and documented under proper conditions with regard to security and state and federal regulations. Scheduled II (controlled medications that have high abuse potential but are legally prescribed for medical use) medications are countered by the oncoming nurse and outgoing nurse at least once a day at the change of shift and documented on a controlled drug count verification sheet.1) Observation and review of the 100 Hall back medication cart on 04/01/2026 at 8:30 AM, revealed the oncoming nurse failed to sign the Controlled Medication Shift Change Log on the following dates 04/01/2026, 03/24/2026, and 03/10/2026.During an interview with Licensed Practical Nurse (LPN) 3 on 04/01/2026 at 8:45 AM, she stated it was the facility's policy and procedure to count controlled medications. She stated the outgoing and oncoming nurses performed the count of the controlled drug cards at each shift change to ensure the count was accurate and reconciled. LPN3 stated she had not signed the Controlled Medication Shift Change Log on 04/01/2026 at change of shift because she wanted to wait to sign the log after the pharmacy delivered new inventory. LPN3 stated it was important to sign the log at the time of shift change to prevent potential diversion.2) Review of the 100 Hall split medication cart on 04/01/2026 at 9:45 AM, revealed the oncoming nurse failed to sign the Controlled Medication Shift Change Log on 03/24/2026 and 03/10/2026.During an interview with the Assistant Director of Nurses (ADON) 2 on 04/02/2026 at 1:30 PM, she stated that her assigned responsibilities included management and oversight of the 100 Hall. She stated controlled medications were expected to be counted at each shift change by both ongoing and oncoming nurses, with both nurses signing the Controlled Medication Shift Change Log when the count was completed. Additionally, she stated she was not aware of the reason the shift change count documentation had not been completed. ADON2 stated she did not conduct routine audits of the medication carts or the shift change logs to verify the accuracy or completeness of the documentation. She stated following policy and procedures related to controlled medications was important to help prevent drug diversion and to ensure accurate accountability of all controlled substances. 3) Review of the 200 Hall split medication cart on 04/01/2026 at 10:00 AM, revealed on 03/16/2026, the oncoming nurse failed to sign the log. On 01/27/2026 and 02/26/2026, the outgoing nurse failed to sign the Controlled Medication Shift Change Log.During an interview with ADON1 on 04/01/2026 at 3:25 PM, she stated her assigned responsibility included management and oversight of the 200 Hall. She stated controlled medications should be counted at each shift change by both the outgoing and oncoming nurses, and that the count should be documented with two signatures on the Controlled Medication Shift Change Log. Additionally, she stated she was not aware of any routine audits being done to check the shift change logs. ADON1 stated without regular review, missing signatures or errors might not be caught. She stated further it was important to follow facility policy to prevent the potential for drug diversion and to ensure the accuracy of the controlled medication count.During an interview with the Director of (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurses (DON) on 04/02/2026 at 11:30 AM, she stated nursing staff was expected to sign the Controlled Medication Shift Change Log at the time they assumed responsibility for the medication cart and again when relinquishing responsibility. She stated that documentation should occur at the time of the count to ensure accountability and to clearly identify responsible staff in the event a discrepancy related to controlled drugs was identified.During an interview with the Administrator on 04/02/2026 at 5:02 PM, she stated it was her expectation that all nursing staff followed the facility policy regarding the counting and documentation of controlled drugs. The Administrator stated that completing controlled medication counts at the start of each shift was necessary to maintain accurate accountability and reduce the risk of drug diversion.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of the Centers for Disease Control and Prevention's (CDC) document, review of vaccine package inserts, and review of the facility's policy, the facility failed to ensure medications and biologicals were stored in accordance with CDC guidelines, manufacturers' recommendations, and professional standards of practice, and failed to ensure appropriate environmental controls were used to preserve their integrity. 1) Observation on [DATE] at 3:55 PM of the medication storage refrigerator revealed the temperature was at 48 F, exceeding the recommended upper limit. Review of the medication refrigerator temperature logs revealed multiple instances of temperatures falling below the minimum required range for proper medication storage (36 F to 46 F). During the month of [DATE], temperatures were documented below 36 on 13 out of 31 days. 2) Observation on [DATE] at 3: 55 PM revealed that the medication storage refrigerator revealed 58 single-dose Afluria influenza vaccines were stored tightly packed together inside a refrigerator drawer with no space between the vaccines to allow for proper circulation. At the time of the observation. The temperature was at 48 F.3) Resident 30's insulin was labeled as opened on [DATE] and expired on [DATE] according to the manufacturer's recommendations but was still being used for the resident. The findings include:Review of the CDC's Vaccine Storage and Handling Toolkit, dated [DATE], revealed vaccines must be stored to maintain potency and effectiveness through strict adherence to cold chain requirements. The guidance revealed vaccines requiring refrigeration must be maintained at temperatures between 36 and 46 degrees (F). It must not be exposed to temperatures outside of this range, including freezing or elevated temperatures, as such exposure may result in reduced potency and loss of effectiveness. The CDC further revealed vaccines must be stored in a refrigerator, which allows for proper air circulation and maintains consistent temperature control to ensure stability.Review of the manufacturer's package insert for Afluria (an inactivated influenza vaccine), no date, revealed the pre-filled syringes must be stored refrigerated at temperatures between 36 and 46 degrees (F), must not be frozen, and must not be exposed to high temperatures. The package insert further revealed any vaccine exposed to freezing temperatures should be discarded and the vaccine must be maintained under proper storage conditions to preserve potency and effectiveness until administration. Manufacturer recommendations further support storing vaccines with adequate spacing and air circulation to maintain consistent temperatures and prevent temperature fluctuations that may compromise vaccine integrity.Review of the facility's policy titled Medication Storage, no date, revealed medications must be stored to maintain integrity, resident safety, and comply with regulatory guidelines. Further review of the policy revealed medications must be stored according to the manufacturer's guidelines. Medications requiring refrigeration will be maintained between 36 and 46 degrees (F). Additionally, temperatures will be checked daily to ensure they are within the specified range, and the refrigerator should be defrosted regularly.1) Observation on [DATE] at 3:55 PM of the medication refrigerator revealed it was a small dormitory-style Unit equipped with two shelves, a bottom door, and an open freezer compartment. The thermometer reading inside the refrigerator was observed at 48 degrees (F), which exceeded the acceptable range for refrigeration medication storage. The freezer compartment revealed approximately two inches of accumulated ice and non-defrosted buildup.2) Observation of the medication refrigerator's storage drawer on [DATE] at 3:55 PM, revealed 58 single doses of Afluria influenza vaccines in boxes were stored tightly packed, on top of each other, inside the drawer at the bottom of the refrigerator with no space between the boxed vaccines to allow for proper circulation.3) Observation and review of the Refrigeration Checklist, dated 03/2026, revealed according to the documented instructions, temperatures must be maintained at or below 41degrees (F). The (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Refrigeration Checklist included a section to document corrective actions when temperatures were at or above 41 degrees (F). Documentation revealed multiple instances in which the medication refrigerator temperature fell below the minimum acceptable range of 36 to 46 degrees (F) for proper vaccine and medication storage. In [DATE], temperatures were recorded below 36 degrees (F) on 13 of 31 days. Review of the medication refrigerator temperature logs revealed temperatures falling below the required range of 36 to 46 degrees (F) during [DATE]. Specifically, temperatures were documented as follows: [DATE] at 34 degrees (F); [DATE] at 34 degrees (F); [DATE] at 34 degrees (F); [DATE] at 32 degrees (F); [DATE] at 30 degrees (F); [DATE] at 34 degrees (F); [DATE] at 32 degrees (F); [DATE] at 34 degrees (F); [DATE] at 34 degrees (F); [DATE] at 35 degrees (F); [DATE] at 31 degrees (F); [DATE] at 31 degrees (F); and [DATE] at 34 degrees (F). Further review revealed corrective action was documented on [DATE], [DATE], and [DATE], including an increase in the refrigerator temperature, but no follow-up temperature readings were documented. For all other identified dates, no documented corrective action was taken to ensure the refrigerator temperature remained within the required range.During an interview with Licensed Practical Nurse (LPN) 3 on [DATE] at 4:45 PM, she stated she wasn't sure of the proper temperature range for refrigerated medications per facility policy guidelines. She stated she believed the temperature log indicated medication and vaccines should be stored at approximately 41 degrees (F). LPN 3 stated that if she found the temperature to be at or below 41 degrees (F), it would be acceptable. She was unable to state what temperature was too low for proper storage. Furthermore, she stated if the temperature exceeded 41 degrees (F), she would take corrective action, which would include increasing the temperature of the refrigerator. She was unsure what follow-up action to take when the temperature was out of range. LPN3 stated proper storage ensures medications and vaccines remain stable, maintain their potency, and were suitable for safe administration.During an interview with the Infection Preventionist/Assistant Director of Nursing (IP/ADON1) on [DATE] at 4:15PM, she stated the night shift was responsible for taking and documenting refrigerator temperatures daily. She further stated the freezer should be defrosted and the refrigerator maintained within the correct temperature range. She stated the facility followed CDC guidelines for medication and infection control policies. When asked by the State Survey Agency (SSA) surveyor about appropriate refrigerator storage temperatures for medications and biologicals, she was unable to identify the recommended temperature range. She was also unable to describe current CDC recommendations for proper vaccine storage and handling, including temperature-monitoring requirements and the need to maintain appropriate spacing to allow adequate air circulation. The IP/ADON1 stated it was important to store medications and vaccines the right way because if they get too hot or too cold, they can stop working the way they should. She stated improperly stored medications may not treat medical conditions properly, and vaccines may not protect residents from disease. The IP/ADON1 stated proper storage helped ensure medications and vaccines were safe, effective, and were able to do what they were intended to do.During an interview with the Assistant Director of Nurses (ADON) 2 on [DATE] at 1:30 PM, she stated the refrigerator should be checked once daily to ensure appropriate temperatures were maintained. She stated the acceptable temperature range was between 36 and 46 degrees (F), and staff should routinely monitor and adjust the unit as needed to maintain consistent temperatures. She further stated the refrigerator should be maintained in good working order and defrosted routinely to prevent ice buildup. She stated she was unaware of certain CDC recommendations for vaccine storage. ADON 2 stated it was important to ensure medications and vaccines were stored properly to maintain their potency and to protect residents' safety by reducing the risk of preventable disease.During an interview with the Regional Quality Nurse (RQN) on [DATE] at 5:10 PM, she stated it was her expectation staff follow national guidelines for the refrigeration of medications and vaccinations. She stated vaccines should not be stored with other refrigerated medications to maintain their efficacy and stability. She further stated the temperature log should include the acceptable temperature range so staff could readily determine when the refrigerator was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	out of range. She stated it was important all medications were stored at appropriate refrigeration temperatures and in accordance with manufacturers' guidelines to preserve their potency and intended therapeutic effects.During an interview with the Director of Nurses (DON) on [DATE] at 11:30 AM, she stated refrigerated vaccines and medications should be stored according to guidelines. The DON stated nursing staff were expected to monitor and document refrigerator temperatures daily and take corrective action when the temperatures fell outside acceptable ranges. She stated it was important medications and vaccines were stored properly to maintain their safety and effectiveness for resident use. During an interview with the Administrator on [DATE] at 5:02 PM, she stated it was her expectation all nursing staff followed the facility policy regarding medication and vaccine storage. She stated it was important for the residents' health and safety.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, facility policy review, and review of the Facility Assessment, the facility failed to provide staffing numbers in the facility assessment based on the resident population and their needs for care and support to ensure there was sufficient staff to meet the needs of the residents at any time. There was also no plan in the facility assessment for recruitment and retention. Additionally, the lack of staffing minimums in the facility assessment contributed to complaints of slow call light response time for 7 of 41 sampled residents, Resident (R) 2, R16, R19, R30, R34, R45, and R52.The findings include:Review of the document titled, Facility Assessment Tool Record, [NAME] Nursing and Rehabilitation Center, dated 03/18/2026, revealed no documented evidence the Facility Assessment contained staffing numbers indicating the number of licensed nurse providing care, nurse aides providing care, and other nursing personnel needed to meet the needs of the residents. Additionally, the Facility Assessment did not contain information related to maintaining a plan to maximize recruitment and retention of direct care staff.Review of the document titled, Resident Rights, A Guide for Kentucky's Nursing Facility Residents, no date, revealed residents have the right to dignity, respect and freedom to be treated with consideration, respect, and dignity. All residents have the right to be addressed how they want to be addressed and the right to be clothed and groomed consistent with their gender identity. Additionally, residents have the right to be free from mental and physical abuse, corporal punishment, involuntary seclusion, and physical and chemical restraints. Facility staff cannot refuse to provide care due to resident's sexual orientation nor can staff harass a resident due to his/her gender identity.1.Review of R2's Face Sheet revealed the facility admitted R2 on 01/20/2026 with admitting diagnoses including chronic kidney disease, stage 2 (mild), difficulty in walking, not elsewhere classified, and adult failure to thrive. The admission Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/25/2026, revealed the facility assessed R2 with a Brief Interview for Mental Status [BIMS] score of 15 of 15, indicating R2 was cognitively intact.Review of R2's Care Plan titled, At Risk for Falls, dated 02/16/2026, revealed R2 was care planned for impulsive behavior, poor safety awareness, and unsteady gate. Interventions for R2 included assess for falls and place call light and frequently used items within reach.During an interview on 03/30/2026 at 1:41 PM with R2 she stated she had to wait over an hour and a half for staff to come and change her at night. R2 stated, I get upset having to wait that long when I am dirty. I am not able to get up and use the bathroom by myself. R2 also stated she was not changed from 7: 00 AM to 11:00 AM one day when staff was busy.2. Review of R 16's Face Sheet revealed the facility admitted R16 on 02/21/2026 with admitting diagnoses including chronic obstructive pulmonary disease (COPD), unspecified, acute and chronic respiratory failure with hypercapnia, and acute respiratory failure with hypoxia. The admitting MDS assessment was incomplete, and the BIMS was not available at time of survey.Review on 04/01/2026 at 10:52 AM of R16's Care Plan titled, ADLI Rehab (self-care), dated 03/09/2026 revealed R16 had problems described as self care deficit, need for assistance with activities of daily living (ADLs), goals including R16 will be clean, dressed and out of bed (OOB) daily as R16 will allow through next review date, and interventions including incontinent care as needed (PRN); adult briefs as indicated. Interview on 03/31/2026 at 10:06 AM with R16 she stated she often has to sit in a wet brief. She stated she had been wet since 7:00 AM, and staff did not change her until State Surveyor (SSA) came down the hall and staff rushed to get her changed. R16 stated Certified Nursing Assistant (CNA)2 was rude because she had to ask for ice three times before she got some ice.3. Review of R19's Face Sheet revealed the facility admitted R19 on 03/23/2026 with admitting diagnoses including type II diabetes mellitus with diabetic neuropathy, unspecified, chronic kidney disease, stage 3 unspecified, and dependence on wheelchair. The (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harrison Nursing and Rehabilitation Center	105 Rodgers Park Cynthiana, KY 41031

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitting MDS assessment, with an ARD of 03/20/2026, revealed the facility assess R19 to have a BIMS score of 15 of 15, indicating R19 was cognitively intact. Review on 04/01/2026 at 12:56 PM of R19's Care plan titled, Impaired Bowel/Bladder Elimination, dated 10/23/2025 revealed R19 was at risk for complications related to bowel/bladder incontinence and impaired renal function related to chronic kidney disease stage 3, interventions included incontinence care PRN; adult briefs and barrier cream as indicated. Additional Care Plan titled, Skin Integrity revealed R19 was at risk for altered skin integrity/pressure ulcer development related to immobility, incontinence, obesity, and skin to skin contact in groin area, interventions included monitor skin integrity every one weeks and moisture barrier cream to buttocks and peri area as needed with incontinence care. During an interview on 03/31/2026 at 10:42 AM with R19 she stated staff generally assisted with her needs; however, response times to her call light could be prolonged. She reported that it sometimes takes up to one to two hours for staff to respond, noting that delays were more common during the second shift. She further stated that she has experienced extended wait times for assistance with changing a soiled brief. The resident expressed feelings of neglect during these instances, stating she feels abandoned when help is delayed.4. Review of R30's Face Sheet revealed the facility admitted R30 on 02/20/2026 with admitting diagnoses including heart failure, unspecified, cellulitis of right lower limb, morbid (severe) obesity due to excess calories, and unsteadiness on feet. The MDS assessment, with an ARD of 02/25/2026, revealed the facility assessed R30 to have a BIMS score of 15 of 15, indicating R30 was cognitively intact.Review of R30's Care Plan titled, Skin Integrity, revealed R30 had unspecified open wound to scrotum and testes, evidenced by presence of skin breakdown or at high risk for skin breakdown related to moisture associated skin damage (MASD) with monitor skin integrity one time a week. Additional Care Plan titled, Impaired Bowel/Bladder Elimination, dated 01/20/2026 revealed R30 had alteration in elimination as evidenced by incontinence of bowel and bladder with interventions including incontinence care PRN; and adult briefs and barrier cream as indicated.During an interview on 03/31/2026 at 1:45 PM with R30's Power of Attorney (POA) she stated she telephoned R30 the day before, 03/30/2026 at 4:25 PM and he was waiting for assistance in changing his brief. The POA stated she spoke with R30 again on 03/31/2026 at 7:13 PM and R30 was still waiting for assistance with his soiled brief.5. Review of R34's Face Sheet, revealed the facility admitted R34 on 04/26/2023 with admitting diagnoses including chronic obstructive pulmonary disease, unspecified, dependence on wheelchair, and atherosclerosis of renal artery. The quarterly MDS, with an ARD of 01/05/2026, revealed the facility assessed the resident to have a BIMS score of 15 of 15, indicating R34 was cognitively intact.Review of R34's Care Plan titled, ADL rehab (self-care) dated 03/02/2026 revealed R34 had muscle weakness, generalized and dependence on wheelchair, related to self-care deficit, with interventions including incontinent care PRN; adult briefs as indicated. Review of the Care Plan titled, Skin Integrity dated 03/02/2026 revealed R34 was at risk for skin breakdown and interventions including monitoring skin integrity one time a week, moisture barrier cream to buttocks and peri area as needed with incontinence care. Review of the Care Plan titled, Bowel/Bladder Incontinence, revealed R34 had bladder incontinence related to impaired mobility, generalized weakness and chronic pain. Interventions for R34 including apply incontinence briefs/pads, provide emotional support when incontinent, provide privacy and maintain dignity during incontinence care and toileting, and toilet resident upon request.During an interview on 03/31/2026 at 9:50 AM with R34, she stated, A lot of people are scheduled but they don't come, especially the aides. R34 stated sometimes the call light is not answered in a timely manner. R34 reported it took an hour for staff to come one time. She stated she would time it with her watch but was unable to determine if it happened at night or on the weekends.6. Review on 03/31/2026 at 3:37 PM of R45's Face Sheet revealed the facility admitted R45 on 12/23/2025 with admitting diagnoses including acute and chronic respiratory failure unspecified whether with hypoxia or hypercapnia, morbid (severe) obesity due to excess calories, and muscle weakness, generalized. Review of the quarterly MDS, with an ARD of 01/09/2026, revealed the facility assessed the resident to have a (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	BIMS score of 15 of 15, indicating R45 was cognitively intact.Review of R45's Care Plan titled, Urinary Incontinence and Indwelling Catheter, dated 12/30/3035 revealed R45 was at risk for alteration in bladder elimination related to use of Foley Catheter, with interventions including change catheter and drainage bag as needed, indwelling catheter care, inspect skin for any sign of skin breakdown, and ask R45 weekly if staff can replace catheter.During an interview on 03/30/2026 at 1:53 AM, R45 stated night shift staff were slow about providing care after a bowel movement. R45 stated it took staff from 30 to 45 minutes to answer call lights at night and early in the morning. R45 stated it was awful to sit and wait for staff to come and change them.7. Review of R52's Face Sheet, revealed the facility admitted R52 on12/31/2025 with admitting diagnoses including pressure ulcer of sacral region, stage 3, age related physical debility, and muscle weakness, generalized. Review of the admission MDS, with an ARD of 01/05/2026, revealed the facility assessed the resident with a BIMS score of 14 of 14, indicating R52 was cognitively intact. Review of R52's Care Plan titled, Urinary Incontinence and Indwelling Cather, dated 01/10/2026 revealed R52 had benign prostatic hyperplasia (BPH), neuromuscular dysfunction of bladder and required the following interventions including indwelling catheter care, inspect skin for any sign of skin breakdown, keep skin and dry, and provide appropriate assistance with toileting needs. During an interview on 03/31/2026 at 9:21 AM with R52's son he stated it would take staff 35 to 40 minutes to answer call lights especially at night. R52's son also stated R52 had a catheter but required help getting to the bathroom to use the commode. R52 told his son he would have to wait a long time for help to get off the commode.During an interview on 04/01/2026 at 2:29 PM with CNA4 she stated she worked every other weekend and two to three nights a week. CNA4 stated out of the four nights she worked there was only one out of the four where there were three CNA's for the facility, the other nights there were two for 46 residents. CNA4 stated she does not have time to get her job done and she feels rushed every shift. CNA4 stated residents have to wait a ridiculous amount of time for us to help them when they use their call lights.During an interview on 04/01/2026 at 2:57 PM with CNA5 she stated she worked night shift and there were two CNA's for the entire building. CNA5 stated she feels exhausted at the end of her shift. CNA5 stated residents have to wait an average of 20 to 30 minutes for one of the CNA's to answer the call light at night. CNA5 stated the rounds overlap and we are physically not able to get to each resident.During an interview on 04/02/2026 at 3:10 PM with the Assistant Director of Nursing (ADON) and Staff Development Coordinator she stated she attended Quality Assurance Project Improvement (QAPI) meetings, and her role was to assist with audits and gathering information together for the meeting. ADON/SDC stated she had not been involved with the Facility Assessment.During an interview on 04/02/2026 at 3:53 PM with the Director of Nursing (DON) she stated it was her expectations that residents received care when their call light was turned on. The DON stated she was not familiar with the Facility Assessment. She stated the staffing numbers were based on the hours per patient day (HPPD) for the building. The DON stated if there were no staffing numbers in the facility assessment, she would go to the Administrator and the scheduler. The DON stated she would participate in QAPI at the next meeting.During an interview on 04/02/2026 at 5:21 PM with Administrator she stated she had worked with the regional person in developing the Facility Assessment. State Surveyor (SSA) asked the Administrator if she was aware the staffing numbers were absent from the Facility Assessment and the retention and recruitment plan for the facility. The Administrator stated she had been at the facility for two and a half weeks and had not had time to look over the Facility Assessment. The Administrator stated it was her expectation the facility would be appropriately staffed to meet the residents' needs. She stated the facility ran at 3.50 HPPD [Hours Per Patient Day]. The SSA informed Administrator on 03/30/2026, the HPPD was calculated at 2.97 HPPD according to the posted staffing; on 03/31/2026, the HPPD was calculated at 3.15 HPPD according to the posted staffing; and on 04/01/2026 the HPPD was calculated at 3.25 HPPD according to the posted schedule. The Administrator stated she would get with the scheduler to make sure the staffing numbers meet the residents' needs and would need to adjust the Facility Assessment.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, the Centers for Disease Control and Prevention (CDC) guidance, and review of the facility's policy, the facility failed to ensure each resident was offered influenza and pneumococcal immunizations, and each resident or resident representative received education on the benefits, potential risks, and side effects associated with influenza and pneumococcal immunizations. Additionally, the facility failed to ensure the resident's medical record included documentation, at a minimum, the resident or resident representative was provided education regarding the benefits and potential risks of the influenza and pneumococcal immunizations, each dose of the influenza and pneumococcal immunizations vaccine administered to the resident, or the resident did not receive the immunizations due to medical contraindications or refusals for 5 of 5 sampled residents, Resident (R) 16, R22, R35, R37, and R41.The findings include:Review of CDC guidance Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices (ACIP), dated 09/05/2024, revealed the CDC recommended routine annual influenza vaccination for all individuals aged six months and older, unless contraindicated, as immunity declined over time and vaccine formulations were updated each season.Review of CDC guidance ACIP Recommendations: Pneumococcal Vaccine, dated 01/08/2025, revealed pneumococcal vaccination was based on age and risk factors, with vaccination recommended for adults age [AGE] and older and those with certain high-risk conditions, utilizing a one-time dose or series depending on prior vaccination status.Review of the facility's policy titled, Pneumonia Vaccine Policy and Procedure, revised 03/21/2023, revealed the facility's policy was to offer and encourage pneumonia vaccination to all residents, when indicated, to prevent the spread of pneumonia. The policy revealed residents were assessed upon admission for pneumonia vaccination history. According to the policy, the immunization was documented in the individual's medical record. Furthermore, the policy stated residents or their representatives had the right to decline vaccination.1. Review of the admission Face Sheet, found in R16's electronic medical record (EMR), revealed the facility admitted the resident on 07/09/2025 with diagnoses which included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and congestive heart failure.Review of R16's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/14/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, which indicated the resident had moderate cognitive impairment.Review of R16's Immunization Report, with the current report ending on 01/04/2026, revealed the resident refused the influenza and pneumococcal vaccinations.Review of R16's electronic medical record (EMR) revealed no documentation of influenza or pneumococcal vaccine consent or declination, and no documentation of education provided on the benefits and potential risks of the vaccinations.During an interview with R16 on 03/31/2026 at 9:25 AM, she stated she did not remember being offered the vaccines or signing consent forms. She stated she did not receive a vaccine information sheet providing education about the influenza and pneumococcal vaccinations.2. Review of the admission Face Sheet, found in R22's EMR, revealed the facility admitted the resident on 12/10/2024, with diagnoses which included acute and chronic respiratory failure with hypoxia, acute kidney failure, and congestive heart failure.Review of R22's quarterly MDS, with an ARD of 01/28/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R22's Immunization Report, dated 04/01/2026, revealed no documented evidence of pneumococcal immunization, and no documented evidence of a current influenza immunization.Additionally, review of a second Immunization Report, provided by the facility, revealed the report reflected a date range of 01/01/2000 through 01/01/2999 and indicated it was printed on 01/04/2026 at 2:52 PM. The report documented administration of the Prevnar 20 (pneumococcal vaccination) on 11/26/2025; however, there was no recorded note documenting the manufacturer, lot number, or expiration date of the (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vaccine. According to the record, R22 received the influenza vaccine on 12/01/2025.During an interview with R22 on 03/31/2026 at 11:15 AM, she stated she agreed to all her vaccinations. She stated she did not remember if she signed a pneumococcal immunization consent or received education.3. Review of the admission Face Sheet, found in R35's EMR, revealed the facility admitted the resident on 01/25/2024, with diagnoses which included atherosclerotic heart disease, asthma, and chronic obstructive pulmonary disease.Review of R35's annual MDS, with an ARD of 01/22/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R35's Immunization Report, dated 04/01/2026, revealed documentation indicated only an historical record of pneumococcal and influenza vaccinations, with no specific dates provided to verify administration and no clear documentation supporting current pneumococcal or influenza vaccination. Additionally, review of a second Immunization Report, provided by the facility, revealed the report reflected a date range of 01/01/2000 through 01/01/2999 and indicated it was printed on 01/04/2026 at 2:52 PM. The report documented administration of Prevnar 20 on 01/21/2026; however, there was no note recording the manufacturer, lot number, or expiration date of the vaccine, consistent with previous vaccination documentation. The report also indicated R35 received the influenza vaccine on 01/20/2026. For both immunizations, the documented administration date was after the report print date, creating a discrepancy in the record's accuracy and reliability.Review of R35's EMR revealed there was no documentation of an influenza or pneumococcal vaccine consent or declination, and no documentation of education provided regarding the benefits and potential risks of the vaccinations.During an interview with R35 on 03/31/2026 at 10:15 AM, she stated she had received influenza and pneumococcal immunizations in the past but was unable to provide a specific date for either vaccination. She stated she did not remember signing a consent form for either vaccination. R35 further stated she was not provided with education regarding the benefits and potential risks of the vaccinations.4. Review of the admission Face Sheet, found in R37's EMR, revealed the facility admitted the resident on 10/02/2014, with diagnoses which included chronic viral hepatitis C, emphysema, and cerebral infarct with right-sided hemiplegia.Review of R37's quarterly MDS, with an ARD of 01/22/2026, revealed the facility assessed the resident to have a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired.Review of R37's EMR revealed there was no documentation of a pneumococcal vaccine consent or declination, and no documentation of education provided regarding the benefits and potential risks of the pneumonia vaccine for the resident's pneumococcal vaccination dated 03/17/2023.R37 was not interviewed due to his cognition. Attempted telephone interview with R37's representative on 04/01/2026 at 2:10 PM, provided no opportunity to leave a voicemail message.5. Review of the admission Face Sheet, found in R41's EMR, revealed the facility admitted the resident on 10/15/2024, with diagnoses which included anemia, chronic peripheral venous insufficiency, and adrenocortical insufficiency.Review of R41's quarterly MDS, with an ARD of 03/05/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R41's Immunization Report, with the current report ending on 01/04/2026, revealed the resident refused the pneumococcal vaccination. Review of R41's EMR revealed no documentation of a pneumococcal vaccine consent or declination, and no documentation of education provided on the benefits and potential risks of the vaccination.Attempted telephone interview with R41's representative on 04/01/2026 at 2:20 PM, with a voicemail left, produced no return call.R41 was unavailable for interview.During an interview with the Infection Preventionist (IP) on 04/01/2026 at 3:25 PM, she stated she had served as the facility's IP since 2020; however, she also fulfilled multiple roles, including staff nurse and Assistant Director of Nursing. She stated competing responsibilities across multiple roles impeded her ability to perform and oversee infection prevention activities effectively, including vaccinations and immunizations, as well as required documentation. She stated the facility had been cited in prior surveys for failure to ensure appropriate immunization practices. She stated the facility did not sustain compliance (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	following the plan of correction due to multiple system breakdowns. When presented with examples of residents lacking documentation of pneumococcal and influenza vaccine consent, declination, and education, the IP stated the documentation was incomplete. She stated she attributed the breakdown to staffing changes, role confusion, and lack of clear responsibility, and there had been a whole breakdown of the team. She stated responsibility for immunization oversight had not been clearly assigned during the transition to new ownership and administrative leadership. During an interview with the IP on 04/01/2026 at 3:25 PM, she stated the facility provided CDC Vaccine Information Sheets (VIS) for resident education; however, this was not documented in the residents' electronic medical records (EMR). When asked why appropriate documentation, including consent and education, was not maintained, she stated following changes in administration and ownership, she had been directed to discontinue use of the previous forms. She stated she was subsequently provided new documentation forms which she had only recently begun to implement. When asked by the State Survey Agency (SSA) Surveyor to explain the discrepancy between the immunization report printed on 01/04/2026 at 2:52 PM and the documented pneumococcal vaccine administration date on 01/21/2026, she was unable to explain how the report reflected a vaccination date occurring after the report print date and did not clarify the accuracy or reliability of the documentation. She stated R35 received the pneumococcal vaccination, and she believed the vaccination occurred on the date listed in the report. However, she stated she was unable to explain how the report reflected a vaccination date after the report's print date and could not provide additional documentation to verify the vaccine's administration. Additionally, the IP stated accurate immunization documentation was important for resident safety. She stated it ensured each resident received the appropriate vaccines and prevented missed or duplicate vaccinations. Furthermore, the IP stated pneumococcal and influenza vaccinations were important for reducing infection risk and should be administered and documented in accordance with CDC guidelines.During an interview with the Director of Nursing (DON) on 04/02/2026 at 4:29 PM, she stated the IP was responsible to ensure all residents received education regarding influenza and pneumococcal vaccinations and were offered the opportunity to consent or decline the vaccinations. She stated when a resident lacked capacity, family members or responsible parties should be informed to enable informed decision-making. The DON stated the resident's EMR should accurately reflect current and completed documentation of all vaccinations and immunizations, including administration, education provided, and any consent or declination in accordance with the facility's policy and regulatory requirements. She stated influenza and pneumococcal vaccinations were important in reducing infection risk and should be administered in accordance with CDC guidelines.During an interview with the Administrator on 04/02/2026 at 5:02 PM, she stated it was important the facility maintained appropriate documentation to demonstrate it provided the required influenza and pneumococcal vaccine education to residents to comply with CDC recommendations and adhere to the facility's infection control program. The Administrator stated the IP nurse was responsible for infection control oversight. She stated following policy and CDC guidelines was important for the safety of residents and staff.During an interview with the Medical Director on 04/01/2026 at 4:10 PM, he stated it was his expectation that staff would follow CDC guidelines for the administration of immunizations. He stated immunizations were important to reduce the risk of infection.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, record review, and review of the Centers for Medicaid and Medicare Services (CMS) recommendations, the facility failed to ensure each resident was offered the COVID-19 vaccine and that each resident or resident's representative received education regarding the benefits, potential risks, and side effects associated with the COVID-19 vaccine. Additionally, the facility failed to ensure the resident's medical record included documentation that, at a minimum, the resident or resident's representative was provided education regarding the benefits and potential risks of the COVID-19 vaccine, each dose of the COVID-19 vaccine administered to the resident, or that the resident did not receive the vaccine due to medical contradictions or refusals for 5 of 5 sampled residents, Residents (R) 16, R22, R35, R37, and R41.The findings include:Review of CMS's Center for Clinical Standards and Quality/Quality, Safety & Oversight Group's QSO-23-10-NH Memo, dated 07/25/2025, revealed Long-term Care facilities (LTC) must offer residents vaccination against COVID-19 when vaccine supplies were available to the facility. Additionally, LTC facilities must screen residents prior to offering the vaccination for prior immunization, medical precautions, and contraindications to determine whether they were appropriate candidates for vaccination.A request was made on 03/31/2026 at 9:52 AM to the Infection Preventionist (IP) by the State Survey Agency (SSA) Surveyor for all of the facility's policies and procedures regarding COVID-19 vaccination. The facility failed to provide a copy of the COVID-19 policy related to residents for review.1. Review of the admission Face Sheet, found in R16's electronic medical record (EMR), revealed the facility admitted the resident on 07/09/2025, with diagnoses which included acute and chronic respiratory failure, chronic obstructive pulmonary disease (COPD), and congestive heart failure.Review of R16's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/14/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, which indicated the resident had moderate cognitive impairment.Review of R16's Immunization Report, with the current report ending on 01/04/2026, revealed there were no documented COVID-19 vaccinations or documented declinations during the 2025-2026 vaccination period.Review of R16's facility-provided Informed Consent for COVID-19 Vaccine revealed the consent form was dated and signed on 03/31/2026, the same date the State Survey Agency (SSA) Surveyor requested the information. Review of the form revealed the resident declined the vaccination.Review of R16's EMR revealed no COVID-19 vaccination, documented declinations, and no documentation of education regarding the benefits and potential risks of the COVID-19 vaccine during the 2025 vaccination period.During an interview with R16 on 03/31/2026 at 9:25 AM, she stated she did not remember being offered the vaccine or signing a consent form. She stated she did not receive a vaccine information sheet providing education about the vaccine.2. Review of the admission Face Sheet, found in R22's EMR, revealed the facility admitted the resident on 12/10/2024, with diagnoses which included acute and chronic respiratory failure with hypoxia, acute kidney failure, and congestive heart failure.Review of R22's quarterly MDS, with an ARD of 01/28/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R22's Immunization Report, with the current report ending on 01/04/2026, revealed there was a history of refusal for the COVID-19 vaccine. However, there were no documented COVID-19 vaccinations or documented declinations during the 2025-2026 vaccination period.Review of R22's facility-provided Informed Consent for COVID-19 Vaccine revealed the consent form was dated and signed on 03/31/2026, the same date the SSA Surveyor requested the information. Review of the form revealed the resident was not administered the vaccination, even though she consented to receive the vaccine.During an interview with R22 on 03/31/2026 at 11:15 AM, she stated she agreed to receive the vaccine. However, she stated she did not receive the vaccine at the time she signed (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the consent, and she was not provided with education on the vaccine.3. Review of the admission Face Sheet, found in R35's EMR, revealed the facility admitted the resident on 01/25/2024, with diagnoses which included atherosclerotic heart disease, asthma, and COPD.Review of R35's annual MDS, with an ARD of 01/22/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R35's Immunization Report, with the current report ending on 01/04/2026, revealed there were no documented COVID-19 vaccinations or documented declinations during the 2025-2026 vaccination period.Review of R35's facility-provided Informed Consent for COVID-19 Vaccine revealed the consent form was dated and signed on 03/31/2026, the same date the SSA Surveyor requested the information. Further review revealed the resident's initials were on the signature line, and the resident did not document acknowledgement of receiving vaccine information, understanding risks and benefits, or was given the opportunity to ask questions. The form showed the resident was not administered the vaccination.Review of R35's EMR revealed no documentation of provided education regarding the benefits and potential risks of the COVID-19 vaccine.During an interview with R35 on 03/31/2026 at 10:15 AM, she stated the facility approached her previously to sign an informed consent for the COVID-19 vaccine, and she agreed to receive the vaccine. However, she stated she did not receive the vaccine at that time, and she was not provided with education on the vaccine.4. Review of the admission Face Sheet, found in R37's EMR, revealed the facility admitted the resident on 10/02/2014, with diagnoses which included chronic viral hepatitis C, emphysema, and cerebral infarct with right-sided hemiplegia.Review of R37's quarterly MDS, with an ARD of 01/22/2026, revealed the facility assessed the resident to have a BIMS score of five out of 15, which indicated the resident was severely cognitively impaired.Review of R37's Immunization Report, dated 04/01/2026, revealed there was no COVID-19 vaccination or documented consent or declination during the 2025 vaccination period.Review of R37's facility-provided Informed Consent for COVID-19 Vaccine revealed a verbal informed consent for the COVID-19 vaccination was obtained via telephone from the resident's representative (RR) on 03/31/2026, the same date the SSA Surveyor requested the information. R37's RR declined the vaccination on the resident's behalf.Review of R37's EMR revealed no documentation of provided education regarding the benefits and potential risks of the COVID-19 vaccine.R37 was not interviewed due to his cognition. Attempted telephone interview with R37's representative on 04/01/2026 at 2:10 PM, revealed no opportunity to leave a voicemail message.5. Review of the admission Face Sheet, found in R41's EMR, revealed the facility admitted the resident on 10/15/2024, with diagnoses which included anemia, chronic peripheral venous insufficiency, and adrenocortical insufficiency.Review of R41's quarterly MDS, with an ARD of 03/05/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact.Review of R41's Immunization Report, with the current report ending on 01/04/2026, revealed there were no documented COVID-19 vaccinations or documented declinations during the 2025-2026 vaccination period.Review of R41's facility-provided Informed Consent for COVID-19 Vaccine revealed a verbal informed consent for the COVID-19 vaccination was obtained via telephone from the RR on 03/31/2026, the same date the SSA Surveyor requested the information. Further review revealed R41's representative declined the vaccination.In an attempted telephone interview with R41's representative on 04/01/2026 at 2:20 PM, a voicemail was left; however, no callback was received.Review of R41's EMR revealed no documentation of provided education regarding the benefits and potential risks of the COVID-19 vaccine.R41 was unavailable for interview.During an interview with the Infection Preventionist (IP) on 04/01/2026 at 3:25 PM, she stated she had served as the facility's IP since 2020; however, she also fulfilled multiple roles, including staff nurse and Assistant Director of Nursing. She stated competing responsibilities across multiple roles impeded her ability to perform and oversee infection prevention activities effectively. When asked why residents had not received the COVID-19 vaccination during the 2025-2026 vaccination period, she stated COVID-19 vaccines had previously been provided to the facility through the state's public (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	health program until this vaccination period. However, she stated once state-supplied vaccines were no longer available, she requested direction from the former Administrator on ordering vaccines. She stated she was informed the facility would not cover the cost, and residents would be responsible for payment. She stated she expressed concern regarding residents' ability to pay and confirmed no further action was taken. Furthermore, the IP stated she had contacted local pharmacies to establish a partnership to provide on-site COVID-19 vaccination clinics at the facility. She stated outside pharmacies could directly bill residents' insurance for vaccine administration, which the facility was unable to do. The IP stated consent documentation was initiated during the survey, and some COVID-19 consent forms were obtained on 03/31/2026 to determine the number of residents consenting to a COVID-19 vaccination for submission to a pharmacy. However, the IP stated the facility had not made a formal determination regarding when the COVID-19 clinic would be held or who would conduct the clinic.During continued interview with the IP on 04/01/2026 at 3:25 PM, she stated the facility had been cited in prior surveys for failure to ensure appropriate immunization practices, including COVID-19 vaccinations. The IP further stated the facility did not sustain compliance following the plan of correction due to multiple system breakdowns. When presented with examples of residents lacking documentation of COVID-19 vaccine consent, declination, and education, the IP stated the documentation was incomplete. She stated she attributed the breakdown to staffing changes, role confusion, and lack of clear responsibility. She stated there had been a whole breakdown of the team. She stated the responsibility for immunization oversight had not been clearly assigned during the transition to new ownership and administrative leadership. She stated the facility provided Centers for Disease Control and Prevention (CDC) Vaccine Information Sheets (VIS) for education; however, this was not documented in the residents' electronic medical records. When asked why appropriate documentation, including consent and education, was not maintained, she stated following changes in administration and ownership, she had been directed to discontinue use of the previous forms and was subsequently provided new documentation forms, which she had only recently begun to implement. Additionally, she stated accurate immunization documentation was important for resident safety. She stated it ensured each resident received the appropriate vaccines and prevented missed or duplicate vaccinations. Furthermore, the IP stated COVID-19 vaccinations were important in reducing infection risk and should be administered and documented in accordance with CDC guidelines.During an interview with the facility's Account Representative for the facility's contracted pharmacy on 04/01/2026 at 3:45 PM, he stated the pharmacy did not provide resident-specific COVID-19 vaccines billed to individual residents. He stated vaccines were supplied as house stock, and the facility would be billed directly for the vaccine. The representative stated the pharmacy did not bill individual residents' insurance, and the facility would be responsible for the cost of the vaccines.During an interview with the Director of Nursing (DON) on 04/02/2026 at 4:29 PM, she stated the IP was responsible to ensure all residents received education regarding the COVID-19 vaccination and were offered the opportunity to consent or decline the vaccination. She stated when a resident lacked capacity, family members or responsible parties should be informed to enable informed decision-making. The DON stated the resident's EMR should accurately reflect current and completed documentation of all vaccinations and immunizations, including administration, education provided, and any consent or declination in accordance with the facility's policy and regulatory requirements. She stated COVID-19 vaccinations were important in reducing infection risk and should be administered in accordance with CDC guidelines.During an interview with the Administrator on 04/02/2026 at 5:02 PM, she stated it was important that the facility maintained appropriate documentation to demonstrate it provided the required COVID-19 vaccine education to residents to comply with CDC recommendations and adhere to the facility's infection control program. The Administrator stated the IP Nurse was responsible for infection control oversight. She stated following policy and CDC guidelines was important for the safety of residents and staff.During an interview with the Medical Director on 04/01/2026 at 4:10 PM, he stated it was his expectation that (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	staff would follow CDC guidelines for the administration of immunizations, including COVID-19. He stated immunizations were important to reduce the risk of infection.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of facility's policies, the facility failed to ensure accommodation of needs and preferences for 2 of 3 sampled residents related to room accommodation and activity preferences, Resident (R) 7 and R8.The findings include: Review of the facility's policy titled, Quality of Life, dated 10/2020, revealed the facility shall provide, and each resident will receive, the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. Review of the facility's policy titled, Activities of Daily Living, dated 10/2020, revealed the facility will provide care and services to residents that are person-centered, and honor and support each resident's preferences, choices, values, and beliefs. Review of the facility's policy titled, Housekeeping Services, dated 10/2020, revealed housekeeping and maintenance services shall maintain a sanitary, orderly, and comfortable interior. 1. Observation on 03/31/2026 at 1:35 PM revealed R8 was sitting in her wheelchair midway down the 100 hall, crying, with no staff present in the hallway. The State Survey Agency (SSA) Surveyor requested for Certified Nursing Assistant (CNA) 2 to assist R8 to try and understand why R8 was upset. In an immediate interview, CNA2 stated R8 was probably upset because her television was not working, and the television was one of the only types of entertainment the resident enjoyed. Further observations on 04/01/2026 at 1:35 PM, 04/01/2026 at 3:19 PM, and 04/02/2026 at 10:09 AM, revealed R8 in her wheelchair in the hallway, by the nurses' station, or in her room by herself. No staff was observed interacting with R8. Review of R8's Face Sheet revealed the facility admitted the resident on 09/05/2025 with diagnoses to include active primary progressive multiple sclerosis, abnormal posture, and dysphasia, oropharyngeal phase. Review R8's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 12/05/2025, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 14 out of 15, indicating R8 was cognitively intact. Review of R8's Care Plan revealed the resident required staff assist and encouragement to go to activities and she liked to watch television in her room. During an interview with the Maintenance Assistant on 04/01/2026 at 1:48 PM, he stated he had been switching R8's television back and forth trying to get the cable to come back on. He stated there had been an issue at the facility over the past few months with the cable going off and the internet lagging or shutting down. He further stated the cable provider had been to the facility and could not find any issues with the cable feed from the provider. The Maintenance Assistant stated R8's cable had been going out frequently and he had tried to re-boot the cable box and that would help occasionally. Other times, he had to wait for the cable to reset and come back on. He stated R8 would become upset when it stopped working, as she had to wait until the cable came back on. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with CNA2 on 04/02/2026 at 2:55 PM, she stated the internet froze quite often. She stated it could be down from 60 seconds to two to three minutes. CNA2 stated residents complain about the cable going off, and the outage may not affect an entire section of the building, but only a few rooms. During an interview with the Activities Director on 04/01/2026 at 3:34 PM, she stated R8 liked to sit in the sun on days when it was nice out. She stated R8 liked to watch television, especially sports shows and some of the crime shows on cable. She stated R8 did become upset when the cable was not working. During an interview with the Director of Nursing (DON) on 04/02/2026 at 3:53 PM, she stated it was her expectation for staff to meet the activity needs for each resident. She stated she was familiar with R8, and she would expect staff to talk with R8 and understand what made her upset and try to correct the situation. During an interview with the Administrator on 04/02/2026 at 5:21 PM, she stated it was her expectation for staff to provide activities specifically designed to meet residents' needs. She stated the cable company had contacted her about updating the system and modem. 2. Observation on 04/01/2026 at 3:05 PM revealed the bed across from R7 had several boxes stored underneath, and on top of an empty bed, from a previous resident. The previous resident had left the faciity on [DATE] and items had been left in the room since then. R7 felt bad that previous residents' items had been left behind. During an interview with Licensed Practical Nurse (LPN) 3 on 04/01/2026 at 2:55 PM, she stated the items in R7's room had been left there for a few weeks and that social services were responsible for taking care of the previous resident's belongings. She further stated she believed the items were still in the room due to a guardianship issue. During an interview with the Social Services Director on 04/01/2026 at 3:12 PM, she stated the family of the previous resident in R7's room had told the facility they could donate the items left behind. She further stated she would contact them again to see what to do with the items. During an interview with the DON on 04/02/2026 at 3:54 PM, she stated the discharged resident's belongings should be followed up with by social services. She further stated she would give families one to two weeks to take discharged belongings. During an interview with the Administrator on 04/02/2026 at 5:22 PM, she stated she felt the discharged resident's belongings should have been placed in the social services office right away. She further stated she felt the current residents could be affected negatively by the items staying in the room.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policy, the facility failed to notify the resident of the transfer in writing and maintain a copy of the notice in the resident's medical record. The facility failed to ensure the transfer or discharge was documented in the resident's medical record. The facility failed to send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman for 1 of 1 sampled residents, Resident (R) 16.Record review and interviews revealed R16 was not notified in writing of her 07/19/2025 transfer to the hospital, to include the reason for the transfer, the duration of the bed hold, and the facility's policies regarding bed holds. There was no written transfer or bed hold documented in the resident's medical record. Furthermore, the facility did not notify the State Long-Term Care Ombudsman, either verbally or in writing, of R16's transfer to the hospital. The findings include:Review of the facility's policy titled, Admission, Transfer, and Discharge Standards of Practice, reviewed 03/2026, revealed prior to transfer or discharge of a resident, the facility was to notify the resident and/or the resident's representative of the reason for the transfer or discharge. The policy further revealed a copy of the discharge notice was to be sent to the State Ombudsman's office, and the medical record was to reflect the reason for the transfer or discharge. Additionally, the policy revealed at the time of a resident's transfer for hospitalization, written notice of the facility's bed hold policy was to be provided.Review of R16's electronic medical record (EMR) revealed no written transfer notice or a copy of the transfer notice/bed hold documented in her medical record.Review of the admission Face Sheet, found in R16's EMR, revealed the facility admitted the resident on 07/09/2025, with diagnoses which included chronic obstructive pulmonary disease (COPD), congestive heart failure, and iron deficiency anemia.Review of R16's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/14/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, which indicated the resident had moderate cognitive impairment.During an interview with R16 on 03/31/2026 at 8:30 AM, she stated at the time of her transfer to the hospital she was not informed of the facility's transfer or discharge policy or bed hold policy. She stated she did not sign any paperwork related to the transfer notice and had no knowledge of a bed hold policy.During an interview with the Social Services Director (SSD) on 04/02/2026 at 1:27 PM, she stated when a resident was transferred to the hospital, the facility sent a face sheet, vital signs, medication list, and pertinent nursing notes with the resident. She stated if a transfer and bed hold form was completed, copies of those documents should be maintained in the electronic medical record. She further stated the resident and resident's representative or power of attorney (POA) were provided verbal notification of the transfer. She stated R16 was her own POA. Furthermore, she stated she was not aware of whether a written notice of transfer or discharge was provided to R16, whether documentation was mailed, or whether documentation was retained to provide evidence compliance with written notification requirements.During an interview with the Admissions Coordinator on 04/02/2026 at 1:38 PM, she stated when a resident was transferred to the hospital, the process was for Admissions to document the transfer and send a notification to the Business Office Manager (BOM) via email. She stated the e-mail served as a record of the transfer and was maintained in the electronic medical record. Furthermore, she stated the transfer and bed hold notice was only provided to the resident or resident's representative if a copy was requested. The Admissions Coordinator was unable to provide documentation regarding R16's transfer to the hospital on [DATE]. She further stated she was unaware if the facility had notified the State Long-Term Care Ombudsman's office of a resident's transfer to the hospital.During an interview with the BOM on 04/02/2026 at 1:39 PM, she stated a transfer and bed hold notice was provided only to the resident or resident's representative if a copy was requested. She stated a copy of an e-mail document from the Admissions Coordinator was (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	maintained in the electronic medical record; however, she was unable to provide documentation related to R16's transfer to the hospital on [DATE]. The BOM further stated the facility did not notify the State Long-Term Care Ombudsman's office of a resident's transfer to the hospital.During an interview with the Director of Nursing (DON) on 04/02/2026 at 4:29 PM, she stated she was not aware of a process requiring completion of a transfer or discharge form, obtaining signatures from the resident or the resident's representative, or mailing a hard copy of the notice of transfer to the resident or resident's representative and the State Long-Term Care Ombudsman's office. The DON stated when a resident was transferred from the facility to the hospital, the physician was notified, and the facility notified the resident's family or the resident's representative.During an interview with the Administrator on 04/02/2026 at 5:02 PM, she stated she had been employed at the facility for approximately two weeks and was not yet familiar with the facilities transfer, discharge and bed hold process. She stated it was her expectation that the facility followed all applicable guidelines to ensure that residents and their representatives were notified in accordance with regulatory requirements, including the transfer or discharge process and bed hold provisions.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs for 2 of 13 sampled residents, Residents (R) 16 and R35.1. During an interview with R16 on 03/31/2026 at 9:45 AM, she stated she had chronic back pain. However, review of R16's care plan revealed no non-pharmacological interventions were developed or implemented to address the resident's chronic pain.2. During an interview with R35 on 03/31/2026 at 10:15 AM, she stated she had chronic bilateral lower extremity and left knee pain. However, review of R35's care plan revealed no non-pharmacological intervention was developed or implemented to address the resident's chronic pain.The findings include:A request on 04/02/2026 at 3:50 PM for the facility's policy titled Care Plan Policy was made by the State Survey Agency (SSA) Surveyor; however, the facility failed to provide the policy for review.1. Review of the admission Face Sheet, found in R16's electronic medical record (EMR), revealed the facility admitted the resident on 07/09/2025, with diagnoses which included low back pain, osteoarthritis, and chronic obstructive pulmonary disease (COPD).Review of R16's quarterly Minimum Data Set [MDS], with an Assessment Reference Date (ARD) of 01/14/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of 12 out of 15, which indicated the resident had moderate cognitive impairment. Further review revealed the resident had impairment in her bilateral upper and lower extremities. The MDS stated she required substantial/maximal assistance (helper does half of the effort) to roll left to right, sitting to lying down, and lying to sitting on the side of the bed.Review of R16's Comprehensive Care Plan [CCP], dated 03/09/2026, revealed a focus for pain, with a goal for the resident to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the next review date. An intervention initiated on 10/31/2025 indicated staff was to administer pain medications as ordered. Additionally, an intervention dated 10/31/2025 indicated staff was to notify the physician if interventions were unsuccessful or with a significant change from baseline. There were no non-pharmacological interventions developed to address R16's chronic pain.Review of the Physician's Order Form, dated 03/2026, found in R16's EMR, revealed orders for acetaminophen (analgesic) 500 milligrams (mg), two tablets by mouth four times daily as needed for pain; Aspercreme (analgesic) external lotion 10 percent, apply to both shoulders every 12 hours as needed (PRN) for pain; gabapentin (analgesic) 300 mg one capsule by mouth twice daily for insomnia; and hydrocodone-acetaminophen (narcotic analgesic) 7.5-325 mg, one tablet by mouth three times daily for unspecified displaced fracture, second cervical vertebra, subsequent encounter for fracture with routine healing.During an interview with R16 on 03/31/2026 at 9:45 AM, she stated she had chronic back pain from a motor vehicle accident, a history of fractures, and osteoarthritis. She stated she experienced constant pain and at times rated her pain between eight and 10 on a zero to 10 pain scale, with 10 being the worst pain. She stated she received both scheduled and PRN pain medications. She further stated she also received physical therapy to help with mobility and pain. She stated she was aware her pain would never go away, but it was managed with treatment. R16 stated nursing staff did not offer non-pharmacological interventions to assist with her pain management. She stated she believed her pain would be better managed if she were offered non-pharmacologic interventions. R16 stated repositioning, application of heat or cold, and use of supportive devices would help provide additional comfort.2. Review of the admission Face Sheet, found in R35's EMR, revealed the facility admitted the resident on 01/25/2024, with diagnoses which included primary osteoarthritis of left ankle and foot, chronic pain, and chronic obstructive pulmonary disease.Review of R35's annual MDS, with an ARD of 01/22/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Further review revealed she was dependent (helper does all the effort) for assistance to roll left to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	right, sitting to lying down, and lying to sitting on the side of the bed.Review of R35's CCP, dated 01/27/2026, revealed a focus for pain, with a goal for the resident to verbalize adequate relief of pain through the next review date. An intervention initiated on 01/16/2026 indicated staff was to monitor pain every 12 hours. Additionally, an intervention initiated on 03/16/2026 directed staff to administer pain medications as ordered. There were no non-pharmacological interventions developed to address R35's chronic pain.Review of the Physician's Order Form, dated 03/2026, found in R35s EMR, revealed orders for acetaminophen 500 mg by mouth every six hours PRN for pain; pregabalin (analgesic) 150 mg by mouth twice daily for chronic pain; and acetaminophen (analgesic) 500 milligrams (mg) by mouth three times daily for pain.During an interview with R35 on 03/31/2026 at 10:15 AM, she stated she had chronic pain in her bilateral lower extremities and left knee. She stated she took scheduled pain medications. R35 stated nursing staff did not offer non-pharmacological interventions to assist with pain management. She stated she believed adding non-pharmacological interventions, especially frequent repositioning and the application of heat or cold, would make her more comfortable and decrease her pain.During an interview with the MDS Nurse on 03/31/2026 at 3:11 PM, she stated she did not necessarily put in non-pharmacological interventions for residents with chronic pain. She stated appropriate interventions to provide comfort would include repositioning, use of supportive devices, and application of heat or cold. The MDS Nurse stated nursing staff should monitor the effectiveness of interventions and adjust care based on the resident's response. She stated adding non-pharmacological interventions to the plan of care was important for improving the resident's comfort and reducing pain.During an interview with Licensed Practical Nurse (LPN) 3 on 04/01/2026 at 8:55 AM, she stated the care plan served as a guide for staff to deliver consistent and appropriate care. LPN3 stated interventions such as repositioning and other comfort measures could help reduce pain and should be implemented in addition to pain medications as appropriate. She further stated non-pharmacological interventions were important for supporting pain management, enhancing comfort, and improving residents' overall well-being.During an interview with the Director of Nursing (DON) on 04/02/2026 at 4:29 PM, she stated it was her expectation that residents with chronic pain would have a care plan that included appropriate interventions. She stated pain medications should be administered as ordered, both scheduled and as needed. She stated if pain was not relieved by pharmacological interventions, nursing staff was expected to notify the physician and implement non-pharmacological interventions, including repositioning, use of supportive devices, application of heat or cold as appropriate, range-of-motion exercises, distraction techniques, and provision of sensory and comfort measures. Additionally, she stated staff should provide emotional support and reassurance to address anxiety or fear related to pain, assess pain routinely using a standardized scale, monitor the effectiveness of interventions, and revise the care plan as needed. The DON further stated non-pharmacological interventions were effective and should be included in the care plan to guide ongoing care. The DON stated it was important that care plans were individualized to reflect each resident's needs, including pain management to enhance their quality of life and overall well-being.During an interview with the Administrator on 04/02/2026 at 5:02 PM, she stated it was her expectation that all clinical staff followed the physician's orders as written to prevent complications and ensure the residents' safety and well-being.During a telephone interview with the Medical Director on 04/02/2026 at 4:10 PM, he stated it was his expectation that the nursing staff would follow the physician's orders. He stated including non-pharmacological interventions in the plan of care promoted safety, enhanced well-being, and helped relieve pain. The Medical Director further stated it was his expectation staff would follow the physician's orders and the resident's plan of care. The Medical Director stated adherence to it was essential to providing appropriate care in a rehabilitation setting.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, record review, review of the facility's procedure manual, Lippincott Nursing Procedures, and the staff's Skill Competency sheets, the facility failed to ensure residents had their urinary collection bags secured properly below the bladder for 1 of 2 residents assessed for urinary catheters, Resident (R) 33. The findings include:Review of the facility's procedure manual revealed the facility used Lippincott Nursing Procedures, ninth edition, copyright 2023 Wolters Kluwer, which stated, Keep the drainage bag below the level of the patient's bladder to prevent backflow of urine into the bladder, which increases the risk of catheter urinary tract infection.Review of the staff's Skill Competency sheet given to CNAs and nurses in orientation revealed there was no mention of the importance of keeping the urinary catheter collection bag below the resident's bladder.Review of the admission Face Sheet, found in R33's electronic medical record (EMR, revealed the facility admitted the resident on 02/11/2026 with diagnoses to include end stage renal disease, diabetes, and Alzheimer's dementia.Review of R33's admission Minimum Data Set [MDS], found in R33's EMR, with an Assessment Reference Date (ARD) of 02/25/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of nine of 15, which indicated R33 had moderate cognitive impairment.Review of R33's Care Plan found in the resident's EMR and dated 02/12/2026, revealed there was no intervention to educate the resident on the risks of urinary tract infection when the urinary collection bag was on the side of the wheelchair.Observation on 03/30/2026 at 1:56 PM, 04/01/2026 at 8:22 AM, 04/02/2026 at 12:16 PM and 3:07 PM revealed R33's urinary catheter bag on the side of the chair above the resident's bladder. During an interview on 03/31/2026 at 3:13 PM with Certified Nurse Aide (CNA) 2, she stated R33 liked the urinary catheter bag on the side of the wheelchair.During an interview with CNA9 on 04/02/2026 at 12:04 PM, she stated she placed the urinary collection bag below the bladder so it could drain instead of urine backing up into the bladder.During an interview with Licensed Practical Nurse (LPN) 1, she stated the importance of keeping the urinary catheter bag below the bladder was to prevent urinary tract infections. She further stated R33 liked the urinary bag on the side of the wheelchair. She also stated R33 was care planned to have the urinary collection bag on the side of the chair. She stated she did not know if he had been educated on the risks of a urinary tract infection when the urinary collection bag was on the side of the chair and below his bladder. During an interview with Registered Nurse (RN) 1 on 04/02/2026 at 11:49 AM, she stated the urinary catheter collection bag should be positioned to the resident's preference. She further stated for a resident who was in a wheelchair, the urinary collection bag should be lower than the bladder. She also stated if it was not positioned below the bladder, it would not flow correctly and could cause a urinary tract infection.During an interview with the Director of Nursing (DON) on 04/02/2026 at 4:21 PM, she stated if a catheter collection bag was above the bladder, urine could flow back into the bladder. She stated staff should be taught that the urinary collection bag should be below the bladder.During an interview with the Administrator on 04/02/2026 at 5:23 PM, she stated she would expect staff development to do education on urinary catheters. She further stated she was not sure if this was in the current education.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's procedure resource, Lippincott Nursing Procedures, the facility failed to ensure that a resident who needed respiratory care was provided with such care, consistent with physician orders and professional standards of practice for 3 out of 3 sampled residents, Resident (R) 16, R22, and R38.The findings include: Review of the facility's procedure resource, [NAME] Nursing Procedures ninth edition manual, copyright 2023 Wolters Kluwer revealed, Hypoxemia (low oxygen) causes pulmonary vasoconstriction and subsequently pulmonary hypertension, which increases workload in the right side of the heart. For implementation, the manual stated to verify the practitioner's order for oxygen therapy. Review of the admission Face Sheet, found in R38's electronic medical record (EMR) revealed the facility admitted R38 on 10/26/2025 with diagnoses to include heart failure, obesity, and shortness of breath. Review of R38's Minimum Data Set [MDS], with an Assessment Reference Date of 03/05/2026, revealed the facility assessed the resident to have a Brief Interview for Mental Status [BIMS] score of zero (00), indicating R38 was severely cognitively impaired. Review of R38's Monthly TAR [Treatment Administration Record], for 03/2026, revealed an order ID #88/23369307 which started on 03/24/2026 for oxygen at 3 liters per minute (LPM) via nasal cannula. Observation on 03/30/2026 at 4:49 PM revealed R38 with a nasal cannula in his nose to deliver oxygen. However, the oxygen concentrator beside the bed was set at zero. The State Survey Agency (SSA) Surveyor requested Licensed Practical Nurse (LPN) 2 check the order for R38's oxygen in the computer. She opened the EMR and found the order for R38's oxygen which stated it was to be set at 3 Liters Per Minute (LPM). At this time, the Assistant Director of Nursing (ADON) 1 was at the nurse's station and stated she was going to check R38's oxygen level. The SSA Surveyor walked to R38's room with ADON1 along with Licensed Practical Nurse (LPN) 1. LPN1 stated R38's oxygen concentrator was to be set at 1.5 LPM. ADON1 checked R38's oxygen level by pulse oximetry, and it was 88 percent, a low reading. LPN1 said the concentrator was unplugged, so she plugged in the concentrator and set the level to 1.5 LPM. The resident's oxygen level increased to 94 percent. Review of R38's Progress Note, dated 03/30/2026 at 6:51 PM, written by ADON1 revealed Guardianship was notified and the Advanced Practice Registered Nurse (APRN) was aware of the incident. Review of R38's Treatment Administration Record [TAR], revealed on 03/30/2026 the resident's oxygen was set at 3 LPM via nasal cannula and acknowledged with a check mark. During an interview with LPN1 on 03/30/2026 at 4:58 PM, she stated she was the nurse on the unit caring for R38. When asked, she stated R38's oxygen was to be set at 1.5 LPM. When asked how she knew what a resident's oxygen order was, she stated she had a sheet that she wrote the oxygen setting on when she started working. The SSA Surveyor asked LPN1 to look at the sheet and let the SSA Surveyor know what R38's oxygen setting was supposed to be. She looked at the sheet and stated R38's oxygen setting was to be at 3 LPM. LPN1 then went to R38's room and increased the resident's oxygen setting on the concentrator to 3 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with ADON1 on 03/31/2026 at 7:26 AM, she stated there were orders in the computer to find the resident's oxygen setting. She further stated the facility had 12-hour shifts, and the setting was checked twice a day and documented on the treatment administration record (TAR). She further stated it was important for the resident to have the correct oxygen setting, so the oxygen saturation of the resident was adequate. She also stated if the correct setting was not provided, the resident could become short of air and become confused. She then stated Certified Nurse Aide (CNA) 1 had unplugged R38's oxygen to plug in a bed. She further stated CNA1 was educated on the spot to never unplug an oxygen concentrator without checking with the nurse. During an interview with CNA1 on 03/31/2026 at 7:36 AM, she stated R38's oxygen tubing was not in his nose, so she thought he did not need the oxygen. She stated she needed to plug in a bed, so she unplugged the oxygen concentrator. She further stated she was educated by ADON1 and now knew to check with the nurse before unplugging a resident's oxygen concentrator. During an interview with CNA2 on 03/31/2026 at 7:44 AM, she stated she knew a resident was on oxygen by looking at the care profile (computer site for CNAs). When asked to show the SSA Surveyor where R38's oxygen was documented on the CNAs care profile, CNA2 could find where R38 needed oxygen. During an interview with ADON2 on 03/31/2026 at 10:51 AM, she stated she was assigned to R38's unit. She also stated she was working on progress notes in the office during the incident. She stated from what she understood, R38's oxygen concentrator was unplugged, and as soon as staff was aware, she stated she notified the doctor and family. She also stated the CNAs knew a resident was on oxygen because it was on the resident care profile. She stated the importance of having the correct oxygen setting was to keep the resident from having shortness of breath. She further stated if the oxygen setting was too low, a resident might need to go to the hospital from a decreased oxygen saturation level. During an interview with Registered Nurse (RN) 1 on 04/02/2026 at 11:49 AM, she stated she made sure the oxygen was at the correct setting by checking the order. She stated she looked at the oxygen concentrator and verified the setting. She stated she then looked at the resident. She stated R38's oxygen was set on 2 LPM. She stated she knew that because she went into the room and looked at the machine this morning. She stated the importance of following the provider's order was to keep a resident from getting into respiratory distress. She also said if the setting was too high, the resident could get dizzy. During an interview with the Director of Nursing (DON) on 03/31/2026 at 7:38 AM, she stated she heard about the incident. She further stated the doctor and family were notified, and the resident was not harmed. The DON stated the nurse knew the resident needed oxygen because of the provider's order in the computer. She further stated the CNA knew by the care profile. She stated the residents' oxygen setting was also discussed in morning report. She stated the importance of keeping oxygen at the correct setting was to keep the resident's cells oxygenated and for the resident's comfort. During additional interview with the DON on 04/02/2026 at 4:21 PM, she stated she expected staff to follow the physician's orders for oxygen. She stated, if the resident refused oxygen, she expected staff to notify the physician. She further stated after the episode where R38's oxygen was turned off; the facility did an audit of all residents on oxygen. During an interview with the Administrator on 04/02/2026 at 5:23 PM, she stated she was not notified (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	about R38's oxygen being turned off. She further stated she would expect the staff to notify her if there was an issue with oxygen. During an interview with the Medical Director on 04/02/2026 at 4:10 PM, he stated he was not notified that R38's oxygen had been turned off. He stated another provider might have been notified. He further stated a resident could develop respiratory distress if the oxygen orders were not followed. 2. Review of the admission Face Sheet, found in R16's EMR, revealed the facility admitted the resident on 07/09/2025, with diagnoses that included chronic obstructive pulmonary disease (COPD), congestive heart failure, and iron deficiency anemia. Review of R16's quarterly MDS, with an ARD of 01/14/2026, revealed the facility assessed the resident to have a BIMS score of 12 out of 15, which indicated the resident had moderate cognitive impairment. Review of the Physician's Order Form, dated 03/2026, found in R16's EMR, revealed R16 may have oxygen at 3 LPM via nasal cannula. Review of the Treatment Administration Record (TAR), dated 03/31/2026, found in R16's EMR, revealed nursing staff had documented on the TAR at 7:00 AM that oxygen was being administered at 3 LPM via nasal cannula. Review of R16's Comprehensive Care Plan [CCP], initiated on 03/09/2026, revealed a focus for alteration in respiratory status, with a goal for the resident to remain free from signs and symptoms of respiratory distress through the next review date. An intervention dated 02/21/2026, indicated the resident was to receive oxygen at 3 LPM via nasal cannula, delivered by an oxygen concentrator. Observation on 03/31/2025 at 8:00 AM, revealed R16 was in bed with her eyes closed and appeared to be sleeping. Oxygen was in place via nasal cannula at 1.5 LPM. Continued observation on 04/04/2026 at 11:00 AM revealed R16's oxygen concentrator remained set at 1.5 LPM. 3. Review of the admission Face Sheet, found in R22's EMR, revealed the facility admitted the resident on 12/10/2024, with diagnoses which included acute and chronic respiratory failure with hypoxia, acute kidney failure, and congestive heart failure. Review of R22's quarterly MDS, with an ARD of 01/28/2026, revealed the facility assessed the resident to have a BIMS score of 15 out of 15, which indicated the resident was cognitively intact. Review of R22's Physician's Orders, dated 03/2026, revealed R22 was to receive continuous oxygen at 2 LPM via nasal cannula at the hour of sleep, and as needed, every shift. Review of the TAR, dated 03/31/2026, revealed nursing staff had documented at 7:00 AM that oxygen was being administered at 2 LPM via nasal cannula. Review of R22's CCP, initiated 10/30/2025, revealed a focus for alteration in respiratory status, with a goal for the resident to have no complication related to shortness of air through the next review date. An intervention dated 09/21/2025 indicated the resident could receive oxygen at 2 LPM via nasal cannula, delivered by an oxygen concentrator. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 03/31/2026 at 8:30 AM, revealed R22 was in bed with her eyes closed and appeared to be sleeping. Her oxygen was in place via nasal cannula at 2.5 LPM. Continued observation on 03/31/2026 at 11:52 AM revealed her oxygen remained set at 2.5 LPM. During an interview with LPN2 on 03/31/2026 at 9:00 AM, she stated she assessed each resident's respiratory status every shift and ensured oxygen was delivered at the prescribed liters per minute. According to the LPN, she checked both R16's and R22's oxygen at the correct flow rate during start of shift rounding and confirmed the flow rate was correct. LPN2 stated it was important to verify the oxygen concentrator was set to the correct flow rate, as settings could change. She further stated an incorrect flow rate for a resident with COPD or respiratory failure could result in complications, including worsening of the resident's condition. During additional interview with ADON1 on 03/31/2026 at 10:57 AM, she stated nurses were responsible to ensure oxygen flow rates were consistent with physician orders. ADON1 stated nurses were expected to assess residents during medication administration and perform respiratory assessments each shift for residents who received oxygen. During additional interview with the DON on 04/02/2026 at 4:29 PM, she stated nursing staff was expected to follow the physician's orders for oxygen administration. The DON stated staff received education regarding oxygen administration which emphasized the importance of adhering to physician orders, as an incorrect oxygen concentration could result in complications, including worsening of the residents' respiratory status. During additional interview with the Administrator on 04/02/2026 at 5:02 PM, she stated it was her expectation that all clinical staff followed the physician's orders as written to prevent complications and ensure the residents' safety and well-being. During a continued telephone interview with the Medical Director on 04/02/2026 at 4:10 PM, he stated it was his expectation that nursing staff would follow physician orders. The Medical Director further stated when a resident had an order for oxygen, and it was not administered as ordered, this could cause problems, including shortness of breath. He again stated failure to follow oxygen orders could negatively impact the resident's respiratory status.

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F 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interviews, and review of the facility's policies, the facility failed to ensure the area around the two outside dumpsters was free of trash, and the elimination of debris prevented the potential for vermin and pest attraction. This had the potential to affect all 50 residents who resided in the facility.The findings include:Review of the facility policy titled, Housekeeping Services (General), reviewed March 2026, and provided by the facility, revealed, Housekeeping and maintenance services shall maintain a sanitary, orderly, and comfortable. The facility reported that they do not have a specific policy for Food-Related Garbage and/or Refuse Disposal. Review of the facility policy titled, Pest Control, reviewed March 2026, and provided by the facility, revealed, The facility shall maintain a safe and sanitary environment to mitigate potential pest concerns. Observation made on 03/31/2026 at 8:00 AM, of the outdoor dumpster area in a corner of the facility parking lot, revealed cigarette butts, straws, soda cans, medical gloves, papers, plastics and plastic utensils on the ground near the dumpster area. Observation made on 03/31/2026 at 9:32 AM, of the outdoor dumpster area in a corner of the facility parking lot, revealed cigarette butts, straws, soda cans, medical gloves, papers, plastics and plastic utensils on the ground near the dumpster area. During an interview with Maintenance/Housekeeping Director on 03/31/2026 at 4:27 PM, he stated that Housekeeping was responsible for taking out the trash and was also responsible for keeping the dumpster area clean. He confirmed the trash around the dumpster area was unacceptable. During an interview with the Kitchen Supervisor (KS) on 03/31/2024 at 10:11 AM, she stated that garbage should be contained when being transported from the kitchen to the dumpster area and that the dietary aides are assigned that task. She further stated that Housekeeping empties trash in the rest of the building and they are responsible for maintaining the dumpster area in a sanitary condition. KS stated that if the area is not maintained rodents could be attractive for rodents. During an interview with the Director of Nursing (DON) on 04/02/2026 at 2:05 PM, she stated that she did not go to the area where the dumpsters were located but said that animals could come if there were trash or debris on the ground.During an interview with the Administrator on 03/31/2026 at 3:21 PM, she stated housekeeping staff were responsible for maintaining the trash/dumpster area and her expectation was for the dumpster's lids to be closed with no trash on the ground. She stated that an unsanitary area could attract things such as pests.