STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue 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 0558 Level of Harm - 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 the facility's policies, the facility failed to provide 2 (Resident (R) 54 and R10) of 21 sampled residents the right to reside and receive services with reasonable accommodation of the resident's needs and preferences except when to do so would endanger the health or safety of the resident or others. The facility moved or removed personal items, furnishings, and/or equipment without consideration of resident preferences and accommodation of each resident's individual needs. This failure caused R54 emotional distress over a sustained period of time and the resident was tearful as she related that the facility moved and mounted her television on the wall in a place where she had difficulty seeing it due to her physical limitations, as well as removed shelving that housed her personal collectibles. The findings include: Review of the facility's Homelike Environment Policy, revised 07/08/2023, revealed that it was the policy of the facility to provide a homelike environment for the residents. Further review of the policy revealed that it was the procedure of the facility to encourage residents to decorate their space using their personal belongings to reflect their identity and preferences.Review of the facility's policy titled, Resident Rights, revised 04/12/2024, revealed that it was the policy of the facility to promote the rights of the residents residing in the facility. Review of this policy stated that it was the procedure of the facility to provide the resident with a dignified existence, self-determination, and communication with and access to persons and services both in and outside of the facility. Further review of the policy revealed that the facility would make every effort possible to assist the resident in exercising his/her rights and to assure that he/she was always treated with respect, kindness, and dignity. The facility would ensure that the resident could exercise his/her rights without interference, coercion, discrimination, or reprisal from the facility.Review of the facility's policy titled, Notice of Resident Rights and Responsibilities, revised 03/27/2024, revealed that it was the policy of the facility to promote and protect the rights of all residents residing in the facility. Further review of the policy revealed that residents have the right to keep and use their own personal belongings and property if it did not interfere with the rights, safety, or health of others.1. Review of Resident (R)54's Face Sheet revealed that she was admitted to the facility on [DATE], with diagnoses of [NAME] Disease (a rare, chronic, progressive cerebrovascular disorder), multiple sclerosis, muscle contractures (where joints become permanently fixed in a bent or shortened position, limiting movement), stiffness of unspecified joint, and cerebrovascular disease. Review of R54's current Physician Orders revealed an order dated 09/08/2021 that stated, May have convoluted foam mattress [also known as an egg crate mattress] on bed.Review of R54's quarterly Minimum Data Set (MDS), dated [DATE], revealed that she was assessed as participating in assessments and goal setting. Review of R54's Assessments tab revealed a Brief Interview for Mental Status Evaluation (BIMS) score of 15/15, dated 07/02/2025, indicating that the resident was cognitively intact. Review of R54's Comprehensive Care Plan, with the initiation date of 10/28/2024 and a target date of 10/08/2025, revealed that R54 was care planned for being at risk for little or no participation at times in activities per her wishes. The goal for this focus was that R54 would be encouraged to attend or participate in activities of her choice and would socialize with staff and others to improve the quality of her life. One intervention for this focus (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 0558 Level of Harm - Actual harm Residents Affected - Few	was that during leisure times in her room, she liked to watch television (TV). Observation on 07/22/2025 at 2:50 PM of R54's room revealed R54 was sitting to the left of the TV, partially in the doorway so that she could view the TV by rolling her eyes to the left to view the TV out of the corner of her eyes. Further observation revealed that the resident had two shelves hanging over her bed. Both of these shelves were greater than 18 inches from the height of any sprinkler heads in the room. The shelves contained stuffed animals and a few Coca-Cola items, messily and tightly stuffed on them. R54's TV was mounted on the wall beside the door. R54's bed was unmade at the time of the observation and there was no foam mattress/mattress topper upon the bed.In an interview with R54 on 07/22/2025 at 2:50 PM, she said that the TV once sat on her bedside table, which was observed to be approximately 2 - 3 feet below where the TV was currently mounted on the wall. R54 tearfully stated that the Administrator told her that her television had to be mounted on the wall and that it was to be placed where the Administrator chose. R54 stated that she was not allowed to have the television placed where she (R54) could see it easily, explaining that due to her neck contracture, she had to sit beside the television and look out of the corner of her eyes to watch the TV. R54 also noted that the facility also took down one of her shelves and was planning on removing her other shelves. R54 stated she had no other place to display her Coca-Cola memorabilia and was told that she would have to box up her things and place them in her closet or send them home with her daughter because the facility would be removing her remaining shelves. R54 stated she was never told why the TV had to be mounted in that specific location or why the facility was removing her shelves. R54 stated she told the Administrator that she did not want her TV moved, or her shelves removed from the wall; however, the Administrator responded that the room belonged to her (the Administrator and the facility) and not to the resident. R54 stated that the Administrator also took away her mattress topper pad, making her bed uncomfortable to sleep upon. R54 asked repeatedly for a new one, but did not receive one, and her requests for moving her television and replacing her shelves and mattress pad were also denied. R54 stated she felt like this treatment was an infringement of her rights and negatively impacted her dignity by making her feel that her needs or opinions did not matter. R54 was unable to give the exact date when her shelf was removed, and her television mounted in a place which did not accommodate the resident's physical needs or preferences, but said it happened at the end of 06/2025. In an interview with State Registered Nursing Aide (SRNA) 2 on 07/23/2025 at 8:33 AM, SRNA2 stated R54 was very upset and screamed and cried when they removed her shelf from her wall and moved her TV to where she could not see it. SRNA2 stated the incident with the shelf being removed and the television being mounted on the wall in R54's room occurred at the same time. SRNA2 was unable to pinpoint an exact date that the incident occurred but knew that it was less than a month ago. In an interview with Registered Nurse (RN) 3 on 07/23/2025 at 9:05 AM, RN3 stated that R54 cried the first day they moved her television and screamed and cried for two days after the TV was mounted on the wall and the shelf removed from her room. R54 told the Administrator that she could not see the TV where it was mounted on the wall and was told by the Administrator that it had to be there. Per RN3, the Administrator told R54 that having shelves on the walls in residents' rooms was a code violation. In an interview with Ombudsman1 on 07/23/2025 at 9:32 AM, Ombudsman1 stated R54 could not understand why her television had to be mounted on the wall and why the facility removed her shelf that had her belongings on it. Ombudsman1 stated she was told the shelves needed to come down because the residents had too much stuff on their shelves, and it was a hazard. Ombudsman1 stated R54 was very upset about this. She stated that they never asked R54 where or if they could move her TV. Ombudsman1 stated R54 did not cry when telling her about the incident, but was very frustrated about it, instead.In an interview with Contract Staff (CS) 2 on 07/23/2025 at 10:49 AM, CS2 stated that R54 was distraught about her TV being placed on the wall where she did not want it and her shelf being taken down. CS2 stated residents' televisions were being mounted on the wall because they looked better there, per the Administrator. CS2 stated she felt the way R54 was treated infringed on her resident rights and diminished her dignity. Although multiple interviews (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	with staff revealed they were aware of the resident screaming, crying, upset, and being distraught, review of R54's clinical record revealed no notes or evidence documenting this distress.2. Review of R10's Face Sheet, revealed that she was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder, bipolar type, and anxiety. Review of R10's quarterly MDS, dated [DATE], revealed that R10 was assessed as having a BIMS score of 15/15, indicating that the resident was cognitively intact.Review of R10's Physician Orders, revealed an order dated 09/11/2023 that stated, May have convoluted foam mattress on bed.Observation of R10's room on 07/23/2025 at 1:08 PM revealed that she had two shelves on her wall. The resident's TV was sitting unmounted on a bedside chest. No mattress topper was apparent on R10's bed, which felt hard.In an interview with R10 on 07/23/2025 at 1:08 PM, R10 stated she was told the facility was going to mount her TV to the wall and were going to remove all her shelves. The resident stated no reason was given why this was occurring. She stated that she would like to keep her shelves. R10 added that it was OK if they mounted her TV to the wall; however, she wanted to be the one to decide where it was put. Further interview with R10 revealed that in the past, she had a personal mattress topper like R54; however, the facility came and took it away, stating that she was no longer able to have a mattress topper.In an interview with the Director of Maintenance (DM) on 07/23/2025 at 3:16 PM, the DM stated that the Administrator decided where to mount residents' televisions and he just did what the Administrator told him. He stated that residents do not have a choice in the matter. The DM stated that the Administrator instructed him to mount the televisions on the wall where residents could see the television while lying in bed. He stated he was not sure if the Administrator had asked any resident where to put their televisions or not. He added that shelves were also being taken down because of the televisions being mounted on the walls. The DM stated he did not try and move the shelves to another location in the resident rooms because it was difficult to do so because of the limited space and the shelves had to be eighteen inches from the sprinklers. He noted that the Administrator did not want the shelves moved, only taken down. The DM stated he did not remember when he mounted R54's TV on the wall or took her shelf down. He stated that he did what the Administrator instructed him to and did not receive written work orders or keep logs of maintenance items he performed at the facility,In an interview with the Director of Nursing (DON) on 07/24/2025 at 7:58AM, she stated R54's TV was initially placed in a manner that R54 could not see it; however, it was moved a few days later and R54 was happy with where the TV was now mounted. (However, interview and observation on 07/22/2025 at 2:50 PM with the cognitively intact resident revealed that R54 displayed tearful distress/unhappiness and physical limitation in viewing her TV in the location where it was currently mounted.) Further interview revealed the DON was unaware of the removal of a shelf in R54's room and did not think the other shelves were going to be removed. The DON stated that the mattress toppers were removed prior to her becoming the DON on 04/12/2025, indicating a belief that this was done for infection control, as well as the physician-ordered mattress toppers being a fire hazard. In an interview with the Administrator on 07/24/2025 at 9:24 AM, she stated that she wanted the TVs mounted to the wall, so they were not knocked off and broken. The Administrator stated that R54 wanted her television mounted on the wall where the divider curtain was halfway over the TV. Instead, it was placed on the same location on the wall above where it previously sat on R54's bedside table. The Administrator went on to explain that because some residents in the facility had shelves that were too close to the sprinklers, all resident shelves were being removed, adding that if there were items on the shelves touching the sprinklers, this was against regulations. Further interview with the Administrator revealed the mattress toppers were uncovered egg crate/foam mattress toppers which she considered an infection control issue for incontinent residents. She stated that the mattress toppers also interfered with the mattresses on the beds in preventing pressure ulcers or shearing injuries, adding that nothing else can go on top of the mattress or it does not work correctly. In the interview, the Administrator contradicted herself by first stating that she had told residents they could not have mattress toppers, and then later in the interview, stated that if (continued on next page)

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F 0558 Level of Harm - Actual harm Residents Affected - Few	their family provided a mattress topper, she would allow a resident to have one. When interviewed about honoring the residents' personal preferences/accommodating individual needs (such as TV placement for R54, whose contractures, MS, and muscle stiffness affected her ability to move her head to watch television), the Administrator repeatedly stated, We know what's best for them, indicating that the facility was making decisions for its cognitively intact residents, regardless of their input. Although the Administrator stated that the TVs had to be on the wall to keep the resident safe from injury, and then indicated that mattress toppers could not be used due to risk of fire, the Administrator provided no evidence to indicate that either R54 or R10 had sustained these type of consequences and therefore, could not have input into accommodations to their physical environment, based on safety concerns.

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F 0656 Level of Harm - Actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, record review, and facility policy review, the facility failed to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and/or mental and psychosocial needs identified in the comprehensive assessment for three (Resident (R)4, R46, and R36) of 21 sampled residents. The findings include:Review of the facility policy, Comprehensive Care Plans, dated 04/26/2017, revealed the facility was to develop and implement a comprehensive person-centered care plan for each resident consistent with the resident rights. Further review revealed the care plan was to include measurable objectives and timeframes to meet the resident's medical, nursing, mental, and psychosocial needs.1.a. Review of Resident (R)4's admission Record revealed the facility admitted the resident on 05/18/2019. At this time, the resident had no pressure ulcers. Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/15/2024 revealed the resident was still free from pressure ulcers. The facility identified that the resident was, however, at risk for pressure ulcers. Per the MDS, the resident required moderate to maximal assistance with mobility but was not on a turning and repositioning program. Review of R4's Comprehensive Care Plan (CCP), dated 04/18/2024, revealed the facility assessed the resident as being at risk for pressure ulcer development and included the intervention for staff to assist R4 to reposition according to facility protocol. These protocols were requested; however, the facility failed to provide any such protocols prior to exit on 07/25/2025. Review of the care plan revealed that it did not include resident-specific interventions related to turning and repositioning prior to the resident developing a facility-acquired Stage III pressure ulcer on 01/14/2025. (Refer to F686.)Review of the facility document Initial Wound Evaluation and Management Summary, dated 01/14/2025, revealed the wound doctor assessed R4 to have a new Stage III pressure ulcer on her right buttock. Review of R4's Comprehensive Care Plan, dated 04/18/2024 revealed no evidence that it reflected the new facility-acquired pressure ulcer until 06/17/2025, 155 days after the Stage III pressure ulcer was first identified. At this time, R4s CCP, dated 06/17/2025, documented that R4 had a Stage III pressure ulcer on her right buttock. The care plan continued to list the intervention to follow facility protocols for the prevention and treatment of skin breakdown although the facility was unable to provide any such protocols prior to exit on 07/25/2025. The care plan continued to not include resident-specific interventions related to turning and repositioning for this resident who required moderate-maximal assistance with mobility.Review of the facility document, Wound Evaluation and Management Summary, dated 07/07/2025, revealed R4's wound measured 2cm by 0.5 cm, and the depth was not measurable due to nonviable tissue. Further review revealed the wound doctor documented the wound had worsened due to prolonged sitting. Continued review revealed the wound doctor listed close monitoring and offloading as recommended approaches to wound healing. Review of R4's care plan revealed no evidence that the facility responded to the wound doctor's recommendations, developed a care plan to reflect the recommended approaches, or re-enforced with staff the importance of the previous care plan approaches to promote healing of the facility-acquired pressure ulcer which the wound doctor documented had now been present for greater than 175 days.Continuous observation on 07/23/2025 from 8:56 AM to 11:28 AM revealed R4 was seated in her wheelchair and no staff members came to encourage or assist the resident to change positions for pressure offloading. Interviews on 07/23/2025 at 1:16 PM with Contract Staff (CS)1, on 07/24/2025 at 4:16 PM, R46 (R4's roommate), 07/24/2025 at 3:46 PM, with SRNA5, 07/24/2025 at 2:20 PM with SRNA4, and 07/24/2025 at 4:29 PM with Registered Nurse (RN)3 revealed that R4 routinely was not repositioned as needed to relieve pressure and promote healing of her facility-acquired pressure ulcer. (Refer to F686.)In an interview on 07/24/2025 at 2:20 PM, SRNA4 stated aides could not access the full care plans with resident specific interventions. She further stated the binder with resident information sheets in it showed some resident problem areas, but not (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	resident specific interventions. SRNA4 continued to state she did not know what was in R4's care plan, so she relied on her previous experience with the resident, what she was told in report, and what the nurse told her the resident needed.In an interview on 07/24/2025 at 3:46 PM, SRNA5 stated she did not have access to resident care plans. She further stated the only way she had to tell what resident specific interventions were in place was to check the tablets on the walls where the aides would chart tasks. If a repositioning task did not populate, she would not know what resident-specific repositioning needs the resident had. She demonstrated R4's task list did not include repositioning. b. Additional review of R4's CCP revealed the facility failed to include specific interventions related to care and maintenance of R4's indwelling urinary catheter. Review of the CCP revealed the intervention listed was for staff to follow the facility policy. A request was made for this policy; however, the facility was unable to produce the policy referred to in the care plan prior to exit on 07/25/2025. 2. Review of R46's admission Record revealed the facility admitted the resident on 09/24/2024 with diagnoses including spastic hemiplegia (muscle stiffness and spasms) of the left dominant side, need for assistance with personal care, and anxiety disorder.Review of R46's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/2025 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for toileting hygiene.Review of R46's Comprehensive Care Plan (CCP) dated 10/25/2024 revealed the facility assessed R46 as dependent with toileting hygiene and included the intervention of assisting the resident as needed.Observation on 07/23/2025 at 3:23 PM revealed R46 sitting in her wheelchair in the doorway to her room, angrily talking with her neighbor. In an immediate interview, R46 stated she was incontinent, and her brief was wet. She further stated she asked SRNA5 to change her brief less than five minutes prior to the interview, but the SRNA had said I just changed you. In further interview, the R46 stated she was mad, and she did not believe it should matter how long ago staff changed her brief, if she was wet, she wanted to be changed.Observation on 07/23/2025 at 3:25 PM revealed R46 told SRNA 5 that she needed to be changed. Further observation revealed SRNA5 told the resident she had just changed her and went on to talk to the resident about getting her a drink. SRNA5 walked away without providing incontinence care. Continued observation revealed SRNA5 came back and told the resident she would check to see if she was wet later. SRNA5 then walked away from the resident. Additional observation revealed R46 again asked to be changed at 3:58 PM, SRNA nodded, but walked past the resident. At 4:04 PM, SRNA5 looked at the state surveyor standing in the hall, then told the resident she would change her. Per observation of incontinence care at this time, R46's brief was significantly wet with urine.In an immediate interview, SRNA5 stated she had just changed R46 prior to her asking and she had other residents who also needed to be changed. She stated it was the facility expectation to change residents if they ask and she should have changed R46 when she asked. In an additional interview on 07/24/2025 at 3:46 PM, SRNA5 stated she did not have access to resident care plans.3. Review of R36's admission Record revealed the facility admitted the resident on 05/21/2018. Further review revealed her diagnoses included Huntington's disease (a severe neurological disorder), Alzheimer's disease, restless leg syndrome, and dysphagia (difficulty swallowing).Review of R36's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/2025 revealed the facility completed the staff assessment of daily and activity preferences due to the resident's inability to complete the interview. Further review revealed the staff assessed that R36 liked listening to music.Review of R36's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2025 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 0/15, indicating the resident was severely cognitively impaired, and non-interviewable.Review of R36's Comprehensive Care Plan (CCP) dated 01/07/2025 revealed the facility assessed the resident as dependent on staff to meet emotional, intellectual, and social needs due to her major neurocognitive disorder. Further review revealed the facility listed R36's known (continued on next page)

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F 0656 Level of Harm - Actual harm Residents Affected - Few	favorite activities to include listening to music and watching TV.Observations on 07/23/2025 at 2:23 PM, on 07/24/2025 at 10:41 AM, and 07/25/2025 at 3:34 PM revealed R36 was awake in her room with no music or television, and no one providing social interaction. Observations throughout survey revealed no occasion where R36 was provided with or participated in an activity appropriate for her level of cognitive function. Observation on 07/23/2025 at 10:26 AM revealed R36 was not in the dining room for coffee social.In an interview on 07/24/2025 at 1:54 PM, the Activities Director stated R36 enjoyed Elvis and gospel music, but did not have anything in her room staff could use to play music for her. Per interview, the Activity Director stated she played music for R36 once or twice per month. In continued interview, the Activity Director stated it was important for each resident to have their favorite activities for their emotional health and quality of life, and R36 would benefit from increased stimulation.In an interview on 07/23/2025 at 1:58 PM, SRNA 9 stated she was an agency aide, and she did not know where to find a facility document of any kind that she could use to know what resident-specific interventions each resident required. She further stated she could not access a care plan, had not been shown any facility policies, and the only information facility staff had shared with her was to tell her which residents were dependent diners.In an interview on 07/22/2025 at 11:41 AM, Registered Nurse (RN)3 stated care plans were kept in a binder at the nurse's station. She proceeded to pull the binder off the shelf and show it to the state surveyor. In further interview, RN3 was unable to demonstrate how the information in the binder, which contained the residents' information sheets, but not care plans with the residents' specific interventions, communicated each resident's plan of care. In continued interview, RN3 stated the facility used to keep another binder at the nurse's station with MDS information, but she was unsure if that included a care plan. Additionally, RN3 stated staff usually just know what residents need because they were familiar with them. Per interview, RN3 stated the many agency staff working at the facility could ask other staff what interventions were appropriate for a resident rather than reference a care plan.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated the facility process for ensuring each resident's plan of care was implemented was for staff to do walking rounds to get information about each resident at the start of shift. She further stated the binders at the nurse's stations contained further information, including facility policies. In continued interview, the DON stated no one verified with new agency staff that they read the policies and reviewed resident information sheets at the start of their shifts.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated she expected staff to follow the care plan 100%. She further stated the care plan interventions should have been listed on the patient [resident] information sheets in the binders at the nurse's station. In continued interview, the Administrator accompanied the state surveyor to the nurse's station, looked at R4's information sheet as an example, and was unable to indicate where resident-specific interventions, particularly for wound care, were located. In additional interview, the Administrator stated staff could look at the 24-hour report sheets and discuss resident issues in report, but she acknowledged that those two methods were not likely to cover areas, such as individual resident preferences, that had not been of immediate concern beyond the past week.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, record review, and review of facility policy, the facility failed to provide treatment and services to prevent development of pressure ulcers for one (Resident (R) 4) of four residents reviewed for pressure ulcers. R4, who required staff assistance with turning and repositioning, was not care-planned with specific intervention for these services. The resident then developed a facility-acquired Stage III pressure ulcer in 01/2025. The Stage III pressure ulcer failed to heal as expected, and was present for 175+ days, as R4 failed to receive pressure relief as needed. The findings include:Review of R4's admission Record revealed the facility admitted the resident on 05/18/2019. Further review revealed her diagnoses at the time of the 07/25/2025 survey included unspecified dementia, neuromuscular dysfunction of the bladder, and a Stage III pressure ulcer of the right buttock. Per this face sheet, the pressure ulcer diagnosis was classified as occurring During Stay and was added to this face sheet on 06/10/2025,Review of R4's quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 10/15/2024, revealed the facility assessed the resident as being free from pressure ulcers. The facility identified that the resident was at risk for developing pressure ulcers, and documented R4 had a pressure relieving devices for her bed and wheelchair. Per the MDS, the resident was not on a turning and repositioning program although she required moderate to maximal assistance with mobility. Review of R4's Comprehensive Care Plan (CCP), dated 04/18/2024, revealed the facility assessed the resident as being at risk for pressure ulcer development and included the intervention for staff to assist R4 to reposition according to facility protocol. These protocols were requested; however, the facility failed to provide any such protocols prior to exit on 07/25/2025. Review of the care plan revealed that it did not include resident-specific interventions related to turning and repositioning prior to the resident developing a facility-acquired Stage III pressure ulcer on 01/14/2025. (Refer to F656.)Review of the facility document Initial Wound Evaluation and Management Summary, dated 01/14/2025, revealed the wound doctor assessed R4 to have a new Stage III pressure ulcer on her right buttock. Further review revealed this wound measured 1.5 centimeters (cm) by 1.5 cm by 0.1 cm with a surface area of 1.65 cm squared. The wound doctor removed dead tissue from the wound and recommended application of a barrier cream on the wound. Per the wound doctor's note, the estimated time for the wound to heal with proper intervention was 27 days. Review of R4's CCP, dated 04/18/2024 revealed no evidence that the facility developed new interventions at the time of the development of the facility-acquired Stage III pressure ulcer with no specific interventions for repositioning to relieve the resident's pressure.Review of the facility document Wound Evaluation and Management Summary, dated 03/11/2025, revealed the wound doctor documented that R4's Stage III pressure ulcer was exacerbated due to multi-factorial, discussed orders with nursing staff, incontinence. Further review revealed that, rather than healing in the 27 days estimated by the physician on 01/14/2025, the wound now measured 3.1cm by 5.5cm by 0.2 cm that day, with a surface area of 17.05 cm squared. Continued review revealed the wound had been present for greater than 57 days. Although the wound had not healed as anticipated, the care plan did not mention the facility-acquired pressure ulcer until 06/17/2025, over five months since it was first identified. Even when the presence of the facility-acquired pressure ulcer was documented on the care plan on 06/17/2025, the care plan did not include resident-specific interventions for repositioning. Review of R4's Comprehensive Care Plan (CCP) dated 06/17/2025 revealed that in response to R4's Stage III pressure ulcer on her right buttock, interventions were for staff to follow facility protocols for the prevention and treatment of skin breakdown and to administer treatment as ordered. The facility protocol referenced in the care plan was requested for review; however, none was provided prior to exit on 07/25/2025Review of the facility document, Wound Evaluation and Management Summary, dated 07/07/2025, revealed R4's wound measured 2cm by 0.5 cm, and the depth was not measurable due to nonviable tissue. Further review revealed the wound doctor documented the wound had worsened due to prolonged sitting. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Continued review revealed the wound doctor listed close monitoring and offloading as recommended approaches to wound healing. Review of R4's care plan revealed no evidence that the facility responded to the wound doctor's recommendations, developed a care plan to reflect the recommended approaches, or re-enforced with staff the importance of the previous care plan approaches to promote healing of the facility-acquired pressure ulcer which the wound doctor document had now been present for greater than 175 days.Review of R4's quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 07/08/2025, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 0/15, indicating the resident was severely cognitively impaired. Per the MDS, the resident had a Stage III pressure ulcer that was not present on admission or re-entry, no refusals of care, and required maximal assistance (helper does more than half of the effort) for bed mobility, sit to lying, lying to sitting, and chair to bed transfers and moderate assistance (helper does less than half the effort) to go from sitting to standing. Further review of this MDS revealed the resident continued to not be on a turning/repositioning schedule.Review of the facility policy Wound Care Policies and Procedures Patient Care Meetings, dated 01/14/2007, revealed the policy did not address turning/repositioning or pressure relief for resident who were at risk for, or who had developed a pressure ulcer. The policy did state that facility staff, as led by the Director of Nursing, would meet weekly to discuss residents with extraordinary care needs. Further review revealed the facility included residents with pressure wounds in that group. Continued review revealed the facility was to keep minutes for the meeting to review in subsequent weeks to determine the effectiveness of care. Additional review revealed the policy provided no information on repositioning, assessment of risk factors, pressure relief devices, or any other guidance on preventing or treating wounds. The State Survey Agency (SSA) requested notes from the facility interdisciplinary team meetings described in this policy; however, per the Administrator's response to the request on 07/25/2025 at 3:09 PM, the facility did not have any such documentation.Observation on 07/23/2025 at 8:53 AM revealed the Therapy Director removed R4's standard wheelchair cushion and replaced it with a thick specialty cushion. Further observation revealed the old cushion was worn and thinning in places. In an immediate interview, the Therapy Director stated the wound doctor had recommended R4 receive the specialty cushion because the resident's wound was not healing as expected, so she needed additional pressure relief while in her wheelchair.Observation on 07/23/2025 from 8:56 AM to 11:28 AM revealed R4 was seated in her wheelchair. During this 2.5 hour observation, the resident did not reposition herself in the chair, and no staff assisted or encouraged the resident to change positions for pressure offloading.Observation on 07/25/2025 at 9:32 AM revealed R4 had an open area of skin approximately 1cm by 1cm with negligible depth on her right buttock. In further observation, R4 stated it hurt when Registered Nurse (RN) 3 touched the area to apply barrier cream per physician orders.In an interview on 07/24/2025 at 4:16 PM, R46 (R4's roommate), stated she never saw staff reposition R4 in her wheelchair. She further stated staff got R4 up first thing in the morning and left her in her chair until evening, except for an occasional afternoon nap. Review of R46's quarterly MDS, with an ARD of 04/23/2025, revealed the facility assessed R46 with a BIMS score of 15/15, indicating she was cognitively intact.In an interview on 07/24/2025 at 3:46 PM, State Registered Nurse Aide (SRNA) 5 stated the facility had not trained her on a policy for repositioning, and there was no way for the staff to know what the resident required beyond word of mouth and their own professional judgement. SRNA5 stated she knew from her previous experience as an aide, residents who could not reposition themselves should be repositioned every two hours. She further stated the common practice for offloading pressure for residents in a wheelchair was to encourage them to lay down after meals, but staff did not regularly reposition residents in their wheelchairs. In continued interview, SRNA5 stated if a resident did not want to lay back down, they were not getting pressure relief from their wheelchair.In an interview on 07/24/2025 at 2:20 PM, SRNA4 stated she was frequently the aide who was responsible for R4, and she would encourage her to stand up as often as she had the chance, during her shift. She further stated that the resident was not repositioned as (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	often as other residents because her indwelling urinary catheter meant her briefs did not need to be changed as often. In continued interview, SRNA4 stated the standard expectation for turning and repositioning when a resident was in bed was every two hours. SRNA4 added that repositioning needed to occur more often when the resident was in the wheelchair, because all their weight was on their buttocks. SRNA4 stated she liked to encourage R4 to stand up and grip the hand rails a couple times during the shift to offload pressure and to maintain the resident's mobility. Per interview, SRNA4 had never seen anyone else assist the resident to stand for offloading. In further interview, SRNA4 stated it was not feasible for staff to be able to encourage R4 to reposition as often as needed when the resident was up in her wheelchair because the facility was frequently short staffed. (Refer to F725.)During the interview on 07/24/2025 at 2:20 PM with SRNA4, she stated she did not know what was in R4's care plan, so she relied on her previous experience with the resident, what she was told in report, and what the nurse told her the resident needed. During the interview on 07/24/2025 at 3:46 PM, SRNA5 also stated she did not have access to resident care plans. She stated the only way she had to tell what resident-specific interventions were in place was to check the tablets on the walls where the aides would chart tasks. If a repositioning task did not populate, she would not know what resident-specific repositioning needs the resident had. At this time, she demonstrated R4's task list did not include repositioning. (Refer to F656.)In an interview on 07/23/2025 at 1:16 PM, Contract Staff (CS)1 stated she was frequently working in the halls of the facility while R4 was up in her wheelchair. She stated she never saw staff encourage R4 to stand or to offload pressure in any way.In an interview on 07/24/2025 at 4:29 PM, Registered Nurse (RN) 3 stated R4 should have been repositioned at least every two hours when up in her wheelchair to prevent skin breakdown. She stated she tried to pitch in to help the aides and make sure residents were repositioned with incontinence care and other duties; however, with so many agency aides who did not always do what they were supposed to, she did not believe residents were always repositioned as often as they should be.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated it was her expectation that R4 be repositioned by assisting the resident to lay in her bed and take a break from her wheelchair. She further stated R4 often did not want to go back to her room, but staff could assist the resident to stand up at a grab bar for pressure relief while still honoring the resident's preference not to go back to her room during the day. In continued interview, the DON stated the facility's interdisciplinary team process was to follow the wound care doctor's recommendations, but she was unable to describe any additional action taken by the facility to audit facility practices to determine why R4's wound developed and why it took many times longer to heal than was expected per the wound doctor.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated it was her expectation that staff implement pressure reduction interventions so no residents in the facility would develop an unavoidable pressure wound. She further stated she expected residents to be repositioned every two hours if they were laying in the bed. The Administrator added that that residents like R4, who were up in their wheelchairs for extended periods of time, needed to be repositioned more often than every two hours because the resident's weight was distributed across a smaller area than if they were lying down. She stated it was unacceptable for an aide to say they did not reposition R4 due to a lack of time. In continued interview, the Administrator stated she did not recall the facility's interdisciplinary team conducting a root cause analysis on R4's facility-acquired pressure ulcer to see why it developed. However, the Administrator added, the facility did identify process problems with turning and repositioning not being followed. Further interview revealed the Administrator was unable to describe what actions the facility had taken in response to the problem. The Administrator further stated she was not out on the floor constantly but looked to her DON to ensure staff implemented care planned interventions and followed facility processes. The Administrator stated she expected staff to follow the care plan 100%. She further stated the care plan interventions should have been listed on the patient [resident's] information sheets in the binders at the nurse's station. After this statement, the Administrator accompanied the state survey team to the nurse's station, looked at (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R4's information sheet, and was unable to indicate where resident-specific interventions for wound care were located.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to post notice of the availability of the most recent survey results and failed to post those results in a place that was readily accessible to residents. The deficient practice had the potential to affect all residents' rights to be fully informed by being able to review that information upon request. The findings Include:Review of the facility's policy titled, Resident Rights, revised 04/12/2024, revealed residents have the right to receive all forms of communication while residing within the facility, and the facility would assist residents in exercising his/her rights.Observation during a tour of the facility on 07/22/2025 at 10:00 AM revealed there was no notice that indicated the location of the most recent state survey results and there was no visible physical account of the previous survey results.During an interview with the resident council on 07/22/2025 at 10:30 AM, they stated a majority of residents in attendance had never seen the facility's survey results. They stated they were not aware of the location to find the survey results. During interview with Residents (R) 1, R9, R37, and R64 on 07/22/2025 at 10:30AM, they stated the residents were unaware that survey results were available to view or where they were located in the facility.During an interview with the facility's Ombudsman on 07/22/2025 at 11:00 AM, she stated the survey results were not in a proper place. She stated the residents had inquired about survey results during previous conversations. During an interview with the Administrator on 07/25/2025 at 1:00 PM, she stated all residents had the right to review previous survey results. She stated it was the responsibility of the facility to ensure residents were educated on the survey findings and had access to the location where the findings were kept.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of National Weather Service records, the facility failed to ensure each resident had a right to a safe, clean, comfortable, and homelike environment. This deficient practice had the potential to affect all residents. The facility failed to promptly respond to problems with its cooling system and ensure that the facility was maintained at a safe, comfortable temperature, with temperatures in resident areas noted as high as 90 degrees Fahrenheit (F). The failure to provide safe, comfortable temperatures had the potential to affect all residents of the facility and constituted Substandard Quality of Care (SQC). In addition, multiple resident rooms (Rooms 209, 302, 317, and 320), a common resident gathering area, and the main dining hall needed repair and/or or cleaning. The findings include: In an interview with Ombudsman1 on 07/23/2025 at 9:32 AM, she stated she was first made aware that the facility's air conditioning (AC) was broken on 06/19/2025, which was also when the first family complaint about the AC being broken was called in to her office. She stated that she went to the facility at 8:30 PM at night and it was “like a sauna” in the facility. Ombudsman1 stated she was told by the Administrator that the AC repair person would be coming the next day. Continued interview revealed she called Ombudsman2 who came to the facility that evening and offered four large industrial fans for use in the interim. However, the Administrator declined this offer. Per interview, the following morning Ombudsman1 went back to the facility, and using her personal thermometer, found that the temperature was 83 degrees F (Fahrenheit) at 9:00 AM. By 5:30 PM when she went again it was even higher: 86-87 degrees F in the common area where the residents were eating. She stated the cook came out of the kitchen which was even hotter and almost passed out. She stated Ombudsman2 came to the facility again and the residents began saying that it was very hot. When they visited on Saturday at 2:00 PM, the facility had a large industrial fan in the hallway and had residents sitting in the hallway because the rooms had no air flow. She stated the vents were closed in many of the rooms, and one resident's room was extremely hot, at 88-89 degrees F. As part of the investigation of this concern, the survey team requested all documentation related to any issues with the cooling system. Although the Ombudsman stated she began receiving phone calls on 06/19/2025 and went to the facility that day to personally verify the complaints, the first “Work Order” from the Heating, Ventilation, and Air Conditioning (HVAC) repair company was not until 06/26/2025, one week later. Review of the National Weather Service Records revealed that, during the time from when the AC problem was first identified on 06/19/2025 until 06/26/2025, temperatures ranged as high as 91 degrees F on 06/23/2025, with a heat index of 104 degrees F. Review of the HVAC Work Order revealed that upon arrival on 06/26/2025, the repair person found the air temperature was 90 degrees F on the hallway where the HVAC unit the company was there to repair was located. In addition, there were two other units that were not cooling that the company was to also assess. Further review revealed that the HVAC systems were running properly but that the return drops on both systems in the attic were disconnected. It was found that the plenum (a piece of ductwork attached to the air handler) had major air leaks and the ductwork needed repair. Review of a “Work Order” from the HVAC repair company, dated 06/27/2025, revealed the facility had five units that the repair person was not able to look at and the work order stated they needed to get them cooling as best they could until they could return to finish the repair. Further (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	review revealed that the repair company cleaned the condenser coils and added refrigerant, but they could not test fully until the systems were thoroughly cleaned. Per the work order, they scheduled a return appointment for performance of all units, indicating the need for spring maintenance. Review of a “Work Order” from the HVAC repair company, dated 06/30/2025, revealed the HVAC unit for the kitchen was not cooling and it was 91 degrees F. Inspection found the condensing coils for the unit that supplied the air conditioning (AC) to the kitchen was 80% blocked. The repair company cleaned the coil and placed more refrigerant and stated they would be back to do maintenance on the other units. Review of a “Work Order” from the HVAC repair company, dated 07/07/2025, revealed the kitchen HVAC unit was still having issues with temperatures reaching 110 degrees F in the kitchen. Review of a “Work Order” from the HVAC repair company, dated 07/10/2025, revealed system maintenance and cleaning was performed, and the system was now functioning as required, 21 days after the HVAC issues were first identified . Review of Resident (R) 27’s “Face Sheet” revealed a quarterly “Minimum Data Set (MDS),” with an assessment reference date (ARD) of 05/30/2025, which documented the resident had a Brief Interview for Mental Status (BIMS) score of 15/15, indicating the resident was cognitively intact. In an interview with R27 on 07/23/2025 at 1:12 PM, she said that it had been hot during the time that the AC system was not working properly. She stated staff did not bring extra water and ice for residents that she remembered during this time. She stated that in the previous year during “hot spells” fans were purchased for residents by the facility and now she did not know where the facility put her fan. In an interview with State Registered Nurse Aide (SRNA) 2 on 07/23/2025 at 8:33 AM, she stated the facility’s AC broke down back at the end of June when there was a heat wave. She stated that the facility did not have fans on until the last two days that the AC was broken. She thought the AC was out for two weeks and noted that there was hot air coming out of the vents. SRNA2 stated the resident were complaining about the heat, and when staff mentioned how hot it was in the facility, the Administrator told staff they were complaining. In an interview with Registered Nurse (RN) 3 on 07/23/2025 at 9:05 AM, she stated that the AC was out about a month ago and the heat was “bad.” RN3 stated that only one large fan was brought in the facility, and it was placed in the East hallway. Residents were educated to leave their room door open and to sit in their doorways or in the hallway if possible. She stated that temporary AC units were never brought in to help cool the facility. In an interview with Contract Services (CS) 1 on 07/23/2025 at 10:49 AM revealed that during the time the HVAC was not functioning correctly, it would work on and off. She said that during this time, there was only one facility fan, which was blowing on the Back Hallway. She indicated that because of the heat, she educated residents to keep their doors open and sit in the hallway. She added that during morning meeting, staff were instructed to provide extra fluids and popsicles; however, she was unsure of this was effective due to the large number of agency staff who did not know the residents. In an interview with the Director of Maintenance on 07/23/2025 at 3:16 PM, he stated that the AC system never went completely out; however, six units had lower output than they should have and were not cooling the facility as well as needed during the time daily temperatures were in the high 80’s and 90’s. The facility called the repair man because the AC was not working well and because they needed it serviced and cleaned since the routine cleaning/maintenance which should have been completed in the Spring of 2025 had not occurred. Although interviews with the Ombudsman and review of work orders revealed problems with the HVAC system lasted 21 days, the Director of Maintenance stated he thought they were only having problems with the AC for a week. Further interview with the Director of Maintenance revealed he had no written evidence of verify his (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	claim that the system was only down for a week. The Director of Maintenance added that although no portable AC units were provided during this time, large fans were brought in to cool down the facility. However, the Maintenance Director also had no evidence of verify this claim or the number of fans actually provided. He stated that he checked the temperature of the facility daily, but did not keep written logs of the temperatures, and as a result, had no evidence of how hot it became during the time that the HVAC system was not fully functioning. In an interview with the Director of Nursing (DON) on 07/24/2025 at 7:58 AM, she stated that the AC never stopped working completely and that the repair people were there several times throughout the week working on the AC. She stated there were fans and that staff gave out extra water and popsicles, and residents were able to get extra fluids anytime they requested them. In an interview with the Administrator on 07/24/2025 at 9:24 AM, she stated that the AC repair people were at the facility multiple times over the week the AC was not working, starting on 06/20/2025. However, review of all HVAC work records provided by the facility no work orders until 06/26/2025, one week after the AC issues were first noted. She stated that due to electrical plug issues, there could only be one large industrial sized fan, and this was why she did not accept the fans offered by Ombudsman2. Further interview with the Administrator revealed that the Director of Maintenance was supposed to be taking temperatures and recording them. The Administrator stated that it was never over 76 degrees in the facility during the time period in question. However, the Administrator could provide no evidence that this was, in fact, accurate. The Administrator confirmed that the Director of Maintenance failed to document and maintain a log of any temperatures during the period in which the AC system was not fully functioning and temperatures as high as 90 degrees in a residential area and 110 degrees in the kitchen were documented by the facility’s own contractor. Additional interview with the Administrator revealed that the facility had no policies/procedures related to mechanical failure of the HVAC system or temperature monitoring in the event of such a failure. This interview revealed that the lack of policies related to these areas was present at the time of the HVAC problems starting 06/19/2025, and continued as of the time of the survey, with no policies developed in response to this recent incident to ensure that in the future, appropriate temperatures were maintained, temperatures were monitored and recorded, and all necessary actions were taken to ensure both the comfort and health of residents. 2. Observation on 07/24/2025 at 1:00PM of resident rooms and common areas revealed the following: a. room [ROOM NUMBER] had large water stains and peeling paint on the ceiling above the bed area. Additionally, the baseboards were heavily scuffed and covered in visible dust and debris. b. room [ROOM NUMBER] had numerous cracks in the ceiling with brownish-yellow decolorization. c. room [ROOM NUMBER] had a wall behind the headboard of the bed with a large area (½ wall panel) of brownish-yellow discoloration, indentions, and holes. d. The hallway near room [ROOM NUMBER] had a cracked ceiling with remnants of water damage and decaying infrastructure, with multiple cracks and dust collection. e. In the common area where residents gather, the wall behind the television set had no baseboard, and exposed drywall and screws. Additionally, there were pieces of drywall present along the wall base and floor. Observation on 07/25/2025 at 11:00 AM in the main dining hall revealed the areas along the baseboard (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and corner panels had dust build up, peeling/cracks in the ceiling, chipped paneling, and old discoloration stains consistent with previous water damage. During an interview with R1 on 07/24/2025 at 2:30 PM, she stated the walls had looked like that for a while and it did not feel clean. During an interview with R37 on 07/24/2025 at 3:00 PM, he stated the facility's disrepair made him feel like nobody cares. During an interview with the Director of Maintenance on 07/24/2025 at 1:30 PM, he acknowledged that some of the damaged areas had been present for several months. He stated they tried to get to the repairs when they could, but there was a backlog of repairs, and they were short-staffed. He further stated he had no autonomy to make the repairs, and a day-to-day work list was given by the Administrator. During a concurrent interview with RN1 and SRNA1 on 07/25/2025 at 1:30PM, they revealed the damages were known to the administration, as residents and family had made multiple complaints due to the conditions of the facility. However, they continued, nothing was ever done to repair them. During an interview with the DON on 07/25/2025 at 2:00PM, she confirmed repairs were needed for multiple resident rooms. She stated a plan was in place, but it was not progressing as fast as the facility had hoped. The DON stated continued deterioration could lead to safety and health hazards for all residents, staff, and visitors. During an interview with the Administrator on 07/25/2025 at 2:30PM, she stated that a lot of work was needed to be done on the older building. The Administrator confirmed that the facility was aware of the conditions in the building and indicated a plan was in place to refurbish areas. However, no specific timeline was provided to indicate when needed repairs/cleaning would occur. Further interview with the Administrator revealed that all residents had the right to a safe and clean environment that was homelike.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on observation, interview, record review, and review of the facility assessment, the facility failed to conduct and document a facility-wide assessment to determine what resources were necessary to care for its residents competently during day-to-day operations (including nights and weekends) and emergencies. The facility assessment failed to provide documented information to inform staffing decisions to ensure sufficient staffing to meet residents' needs for each shift and unit, develop and maintain a plan to maximize recruitment and retention of direct care staff, and inform contingency planning for events that did not require activation of the facility's emergency plan, but did have the potential to affect resident care, such as the availability of direct care nurse staffing or other resources for resident care. The deficient practice had the potential to affect all residents, with a census of 65.The findings include: Review of the facility assessment, dated 2025, revealed the facility failed to include information on how they determined the staffing levels needed for specific shifts, including evenings and weekends. Further review revealed the facility failed to include information about contingency planning for events that did not require activation of the emergency plan, such as a mild snowstorm, that could affect resident care due to a lack of availability of direct care staff. Review of the Payroll Based Journal (PBJ) for Fiscal Year Quarter 2, 01/2025 through 03/2025, revealed the facility triggered for one-star staffing and excessively low weekend staffing. Review of the facility's staffing agency invoices and the facility document Calculated Time by Calendar Day, dated 02/01/2025 through 02/10/2025 revealed the facility was short of the Administrator's stated target staffing for five of the 10 sampled days. Further review revealed on 02/01/2025 and 02/02/2025, a Saturday and Sunday, the facility only had four SRNAs present on day shift. Review of the facility document Daily Direct Care Nurse Staffing Information, dated 02/01/2025 revealed the facility census was 64 that day. In an interview on 07/21/2025 at 3:33 PM, Resident (R)1stated facility staffing was always worse if there was bad weather, including snow or even rain. She further stated the short staffing caused residents to have to wait longer for assistance with toileting and other needs, and they also might not get a shower. In an interview on 07/24/2025 at 11:05 AM, SRNA4 stated the facility relied heavily on agency staff because no one wanted to work for the Administrator full time because of the demeaning way she treated staff. In an interview on 07/25/2025 at 9:36 AM, RN3 stated the facility had so few regular staff, especially on night shift, because the Administrator stirred up conflict where it was not necessary. She further stated she was worried the Administrator would fire her in retaliation for speaking honestly with the State Survey Agency, but she knew speaking up was best for the residents. In an interview on 07/25/2025 at 11:02 AM, the Administrator stated the facility assessment was not as complete as it would have been if she would have used one of the tools out to develop it. She further stated she did it on her own. Per interview, the Administrator stated the current facility assessment could not be used to determine specific staffing needs on particular halls or on particular (continued on next page)

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	shifts, including nights and weekends. In further interview, the Administrator acknowledged there was no information in the facility assessment that could inform a contingency plan if there were not enough direct care staff present in the building, such as in the case of weather-related call-ins. The Administrator continued to state the facility had not conducted a recent staff satisfaction survey to identify areas that could be improved to retain staff, though she acknowledged the facility had been having major problems retaining staff. Per interview, the Administrator was aware staff had left because they reported abusive treatment from her and other management staff, however, the Administrator's response was to say that staff either loved it at the facility, or they hated it and she could not explain why.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observation, interview, staff time punch data, and Payroll Based Journal (PBJ) data, the facility failed to have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by the resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment. The deficient practice had the potential to affect all residents in the facility with a census of 65.The findings include: Review of the Payroll Based Journal (PBJ) for Fiscal Year Quarter 2, 01/2025 through 03/2025, revealed the facility triggered for one-star staffing and excessively low weekend staffing. Review of the facility's staffing agency invoices and the facility's document Calculated Time by Calendar Day, dated 02/01/2025 through 02/10/2025 revealed the facility was short of the Administrator's stated target staffing for five of the 10 sampled days. Further review revealed on 02/01/2025 and 02/02/2025, a Saturday and Sunday, the facility only had four SRNAs (State Registered Nurse Aide) present on day shift. Review of the facility's document Daily Direct Care Nurse Staffing Information, dated 02/01/2025 revealed the facility's census was 64 that day. 1) Review of Resident (R)4's admission Record revealed the facility admitted the resident on 05/18/2019. Further review revealed R4's diagnoses, at the time of survey, included unspecified dementia, neuromuscular dysfunction of the bladder, and stage three pressure ulcer of the right buttock. Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 07/08/2025, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero out of 15. This score indicated the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as having a stage three pressure ulcer that was not present on admission or re-entry Continuous observation on 07/23/2025 from 8:56 AM to 11:28 AM revealed R4 was seated in her wheelchair and no staff members came to encourage the resident to change positions for pressure offloading. In an interview on 07/24/2025 at 4:16 PM, R4's roommate stated she never saw staff reposition R4 in her wheelchair or encouraged her to stand up while holding onto a grab bar. She stated staff got R4 up first thing in the morning and left her in her chair until evening, except for an occasional afternoon nap. In an interview on 07/24/2025 at 2:20 PM, State Registered Nurse Aide (SRNA)4 stated it was not feasible for staff to be able to encourage R4 to reposition in her wheelchair as often as needed because the facility was frequently short staffed. In an interview on 07/23/2025 at 4:32 PM, SRNA5 stated staffing was typically barely enough to do the absolute minimum for residents, which she defined as performing incontinence care and feeding dependent residents. She stated she had to rush to get tasks done. In continued interview, SRNA5 stated she typically did not have time to reposition R4 in her wheelchair as often as she needed (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	because there were too many other tasks she needed to complete. 2) Observation on 07/23/2025 at 3:23 PM revealed R46 sitting in her wheelchair in the doorway to her room, angrily talking with her neighbor. In an immediate interview, R46 stated she was incontinent, and her brief was wet. She stated she asked SRNA5 to change her brief less than five minutes prior to the interview, but the SRNA had said I just changed you. R46 stated she was mad, and she did not believe it should matter how long ago staff changed her brief, if she was wet, she wanted to be changed. Observation on 07/23/2025 at 3:25 PM revealed R46 told SRNA 5 that she needed to be changed. Further observation revealed SRNA5 told the resident she had just changed her and went on to talk to the resident about getting her a drink. SRNA5 did not provide incontinence care at that time. Continued observation revealed SRNA5 came back and told the resident she would check on later and left. Additional observation revealed R46 again asked to be changed at 3:58 PM, again the SRNA walked away, but nodded her head. At 4:04 PM, SRNA5 told the resident she would change her. Per observation of incontinence care, the R46's brief was significantly wet. In an immediate interview, SRNA5 stated she had just changed R46 prior to her asking. SRNA5 stated she had other residents who also needed to be changed. 3) In an interview on 07/21/2025 at 3:33 PM, R1 stated she asked for help to get to the bathroom around 1:00 PM, but staff did not get to her until almost 3:00 PM. She stated she had to use her brief, which made her feel angry. She stated staff told her they were too busy to get to her timely. She stated that facility staffing was always worse if there was bad weather, including snow or even rain. In continued interview, R1 stated short staffing caused residents to have to wait longer for assistance with toileting and other needs, and they also might not get a shower. R1 stated she felt frustrated when this occurred. 4) In an interview on 07/24/2025 at 10:05 AM, SRNA4 stated there were a lot of days there would be six SRNAs scheduled to work and only four would show up. She stated management would then post additional shifts for agency staff, but sometimes that did not get enough staff in the building, so they just worked short. She stated when this happened, residents were more likely to get a bed bath rather than a shower, regardless of their preferences, because that could be done more quickly. SRNA4 stated that in recent weeks, there had not been less than five SRNAs on day shift but working with five aides was still a heavy workload for staff and some things might not get done at that level. She stated the Administrator, and the Social Services Director would talk in a demeaning manner to staff and ignore their concerns, so no one wanted to leave agency and work at the facility full time. She stated agency staff would frequently work a couple shifts and then not come back because of management. In an interview on 07/24/2025 at 4:29 PM, Registered Nurse (RN)3 stated it was not unusual for the facility to work with only four SRNAs on day shift. She stated that left too little time for aides to care for each resident, especially when there were multiple dependent diners in an assignment, along with incontinent residents. Per interview, RN3 stated she believed the facility needed seven aides on day shift to meet the residents' needs. In continued interview, she stated she often helped the aides by changing incontinent residents and assisting dependent diners. RN3 stated on days when a physician was rounding, she would have to spend a significant amount of time writing their orders in multiple places in the paper chart, so on those days, she would not be available to do resident care tasks the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	aides were responsible for. She stated staffing was worse on night shift because there were fewer aides and no medication assistant, so the nurse was responsible for administering all medications. Additionally, RN3 stated staffing at the facility was inadequate. In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated the facility's goal for staffing was for six to seven SRNAs, two nurses, and one medication aide for day shift. She stated night shift should be staffed with five SRNAs, two nurses, and a medication aide. The DON stated they had not had a night shift medication aide since their last one quit. In continued interview, the DON stated the facility used several different staffing agencies to reach these numbers since they did not have enough regular staff to do so. Per interview, the DON stated she was not aware of the facility having a staffing issue in February and did not know why the PBJ would have triggered for low staffing. In an interview on 07/25/2025 at 11:02 AM, the Administrator stated her expectations for staffing levels was six to seven SRNAs on day shift. She further stated her goal for night shift was to have four aides, which would average out to a little over 15 residents per aide, but staffing should never go below each aide assignment having more than 20 residents. In continued interview, the Administrator stated she never sat down to estimate how much time it would take an SRNA to care for a dependent resident each shift, nor could she state how many dependent residents were in each SRNAs assignment. Per interview, the Administrator stated it was unlikely the SRNAs would be able to meet resident needs as care planned if there were only four or five SRNAs on day shift. The Administrator stated it was common for there to be call-ins and short staffing if the weather was bad, but she could not describe a contingency plan to cover staffing absentees for affected shifts. She stated the facility had not conducted a recent staff satisfaction survey to identify areas that could be improved to retain staff, though she acknowledged the facility had been having major problems retaining staff and relied heavily on agency. Per interview, the Administrator was aware staff had left because they reported abusive treatment from her and other management staff. However, she stated that staff either loved it at the facility, or they hated it, and she could not explain why. In additional interview, the Administrator stated she believed the data the facility submitted for PBJ was incomplete and she would have to compare the PBJ submission to the staffing agency invoices. The Administrator further stated it was important to have adequate staff to care for residents and that consistent staff provided the best care.

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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. Based on observation, interview, record review and facility policy review, the facility failed to properly label drugs and biologicals in accordance with currently accepted professional principles. They did not include the appropriate accessory and cautionary instructions, and the expiration date when applicable for 1 of 4 medication carts. The findings include: Review of the facility's policy titled, Storage of Drugs and Biologicals, not dated, revealed that it was the policy of the facility that all drugs and biologicals be properly stored in the containers in which they were received. Further review revealed the policy did not mention dating opened multi use medications upon opening them. Observation on 07/22/2025 at 7:55 AM of the medication cart from the 100/200 Hallway labeled RN revealed the medication cart had seven bottles of eye drops, two inhalers, two bottles of cough syrup, two bottles of lactulose, two bottles of polyethylene glycol, and two bottles of nasal spray. Further review revealed all of these medications were opened without dates to when they were opened documented on the bottles. In an interview with Licensed Practical Nurse (LPN)1 on 07/22/2025 at 7:55 AM she stated that if a multi-use vial of medication was not dated as to when it was opened it could be outdated and no longer effective. In an interview with the Director of Nursing (DON) on 07/24/2025 at 7:58 AM, she stated all opened multi use medications should have a date written on the bottle as to when they were opened. The DON stated if a medication was not dated when opened an expired medication could be given and this could result in an infection. During an interview with the Administrator (ADM) on 07/24/2025 at 9:24 AM, she stated she was unsure if it was the facility's practice/policy to date multi-use containers of medications with the date they were opened. She stated she thought it was a good idea to do so to prevent administering expired medications. In an interview with the Medical Director on 04/25/2025 at 10:35 AM he stated it was his expectation that staff date multi use medications when opened to prevent use of expired medications thus ensuring their efficacy.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview and review of the facility's policy, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Review of the facility's Infection Control Plan policy, not dated, revealed the purpose of the infection control plan was to provide a safe, sanitary, and comfortable environment for all residents and staff. Review of the facility's Handwashing policy, not dated, revealed all personnel shall follow the established handwashing procedure to prevent the spread of infections and disease to other personnel, residents, and visitors. Wash hands for approximately 10-15 seconds, performed under the following conditions: h) After handling items potentially contaminated with blood, body fluids, excretions, or secretions: The use of gloves does not replace handwashing. 1. Observation of wound care for Resident (R)32 on 07/23/2025 at 1:30 PM revealed Registered Nurse (RN)1 and State Registered Nurse Aide (SRNA)3 went into R32's room to position her in bed for wound care. Observation revealed an Enhanced Barrier Signage on R32's door. However, RN1 and SRNA 3 did not don (put on) a gown. Further observation of wound care for R32 on 07/23/2025 at 1:50 PM revealed that RN1 did not don a gown when performing wound care. In an interview with RN1 on 07/23/2025 at 1:50 PM she stated that the Enhanced Barrier Signage on R32's door was for residents that had pressure ulcers, wounds, catheters, etc. and that a gown and gloves should be worn during direct resident care. RN1 stated that direct resident care was when she performed wound care and that she should have donned a gown when doing wound care. She stated that pulling a resident up in bed and positioning them for wound care did not constitute direct resident care. In an interview with SRNA3 on 07/23/2025 at 2:05 PM she stated that the Enhanced Barrier Signage meant that any time direct resident care was performed she should put on gown and gloves. She stated that she questioned the nurse (RN1) about donning a gown and gloves when pulling up R32 but RN1 stated that they did not need to do so because they were not performing direct resident care. In an interview with the Director of Nursing on 07/24/2025 at 7:58 AM she stated that Enhanced Barrier Signage meant that staff needed to don a gown and gloves when providing direct resident care such as wound care or catheter care. She stated they did not need to don the gown when pulling a resident up in bed. In an interview with the Administrator (ADM) on 07/24/2025 at 9:24 AM she stated it was her expectation that staff donned a gown when performing any direct care for a resident with Enhanced Barrier Precautions. This included pulling a resident up in bed or positioning them in bed for wound care. 2. Observation of dinner service on 07/21/2025 at 5:43 PM revealed that State Registered Nurse Aide (SRNA)1 passed drinks to the entire 100/300 Hallway, without performing hand hygiene. In an interview with SRNA1 she stated that it was the facility's practice to perform hand hygiene after passing three residents' beverages. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview with the Director of Nursing on 07/24/2025 at 7:58 AM she stated that staff should perform hand hygiene after passing a tray or a drink. They should hand sanitize with alcohol-based hand rub after each tray or drink and wash their hands after every third tray or drink. In an interview with the Administrator (ADM) on 07/24/2025 at 9:24 AM she stated that her expectation was that staff perform hand hygiene after each tray. At first, she stated that they were to use alcohol-based hand rub after every third tray, then stated staff should wash their hands washing after every third tray. 3. Observation on 07/21/2025 at 4:51 PM revealed Registered Nurse (RN)2 completed glucose checks on Resident (R)21. After checking the glucose, she left the room wearing gloves. She opened the door to the nurse's station and wrote the glucometer reading on a paper. She then removed her gloves and washed her hands. During interview with RN2 at the time of the observation, she stated she has had training in infection control, she thought maybe last year. She stated she was taught about hand hygiene, and to clean her hands after removing her gloves. Observation on 07/21/2025 at 5:04 PM, revealed RN2 complete glucose check on R2. After checking the glucose, she left the room wearing gloves. She opened the door to the nurse's station and wrote the glucometer reading on a paper. She then removed her gloves and washed her hands. During interview with RN2, at the time of the observation, she stated a resident was in the bathroom, so she came to the nurse's station to remove her gloves and wash her hands. 4. Review of the facility's Respiratory Equipment Cleaning Schedule, not dated, revealed, oxygen-tubing and nasal cannulas were to be changed weekly on Thursday nights. Review of R58's Face Sheet, revealed the facility admitted R58 on 02/08/2019. R58's diagnoses included pulmonary embolism, muscle weakness, and heart disease. Review of R58's Minimum Data Set, Assessment Reference Date 06/09/2025 revealed R58 had a Brief Interview Mental Status score of 15. This score indicated R58 was able to be interviewed. Observation on 07/21/2025 at 5:13 PM revealed R58's oxygen tubing was dated as 07/04/2025. On 07/24/2025 at 8:23 PM during interview with RN2, she stated she changed the oxygen tubing every Thursday. She stated she had been off for the last two Thursdays and that was why the tubing did not get changed. She stated if the tubing was not changed it could cause the resident to get sick and the tubing may deteriorate, and the oxygen may not be effective. During an interview with the Administrator on 07/25/2025 at 2:10 PM, she stated her expectation on the oxygen tubing was for staff to change it weekly. She stated she did not know why a tubing was out of date. She stated the DON was responsible for assuring the oxygen tubing was changed in the correct time frame. On 07/25/2025 at 11:24 AM during interview with the Director of Nursing (DON)/Infectious Control Nurse, she stated new staff did not get training in infection control. She stated new staff followed another staff member and there was a check off list; staff were trained on the floor. The DON stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she expected staff to wash or sanitize their hands between providing resident care and prior to putting on gloves and after removing their gloves. She stated staff were to wash their hands for one minute. She would have to look at the Centers for Disease Control (CDC) recommendations to see what their recommendations were. On 07/25/2025 at 2:11 PM during interview with the Administrator, she stated new staff were educated on abuse and other courses. She stated there was a new hire packet that they were going to use to teach the new hires. She stated the DON was supposed to teach new hires. She stated staff sign off on the education. The Administrator stated the hand hygiene and infection disease policy were reviewed in the Quality Assurance Performance Improvement (QAPI) meeting. She stated the current policy was old and needed to be updates. She stated she did not know if the policy was addressed in QAPI.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain all mechanical, electrical, and patient care equipment in safe operating condition. The mechanical lift scale was broken, and staff reported the lift function did not always work. The facility had 4 residents who used a Hoyer lift for weights.The findings include:Review of the lift company service invoice dated 07/02/2025 revealed the Field Service Technician found the cable to the scale on the lift had been cut. Further review revealed the Field Service Technician quoted a price to replace the scale.Review of the facility's document Nurse's Report Sheet, dated 07/23/2025 revealed staff could not obtain a weight for R53 due to the lift not working.Observation on 07/24/2025 at 10:05 AM revealed State Registered Nurse Aide (SRNA)4 demonstrated the scale function on the lift scale. Observation revealed the scale did not turn on so that residents could be weighed.In an immediate interview, SRNA4 stated the battery for the lift was fully charged, so that was not the cause of the malfunction. She stated it had been that way for a long time, and the residents who required use of the lift for weights had not been weighed accurately during that time. SRNA4 stated she was particularly concerned about residents who might be retaining fluid because the clinicians would not have a warning sign of the fluid retention to be able to address it. SRNA4 stated she was unable to obtain a weight on R53 on 07/23/2025.In an interview on 07/24/2025 at 4:29 PM, Registered Nurse (RN) 3 stated the lift scale had been broken for months. She stated she and SRNA4 had told the Administrator multiple times that it was broken. However, the Administrator denied that it was broken and refused to address the issue at first. RN3 stated that when the Dietician found out about the scale not working, she was very unhappy because she did not have a key piece of information about the residents' nutritional status.In an interview 07/24/2025 at 12:56 PM, the Dietician stated she was aware the Hoyer (brand of mechanical lift) lift scale had not been functioning for at least three weeks. She stated she spoke with the Administrator, who told her the facility would have to order a new lift; however, the dietician did not know the planned time frame for the purchase. In continued interview, the Dietician stated it was important for the facility to have the equipment to accurately and consistently weigh each resident in order to catch nutritional problems that may arise so they could be addressed.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated she was aware the mechanical lift scale had not been working for approximately one month. She stated the facility had hired someone to assess it to see if it could be repaired, but she did not know the current status of that process. In continued interview, the DON stated there were four residents who were usually weighed in the lift, but she believed all but one of them could be put in the weight chair using the lift to be weighed. Per interview, the DON stated she believed the only resident who could not be safely placed in the weight chair was R58 because he could not sit upright. Additionally, the DON stated it was important to get an accurate weight on each resident to monitor their nutritional status.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated she was aware the scale on the lift was not working and she had a technician come out to look at it. She stated the technician told her fixing the scale on the existing lift would be more expensive than buying a new one, so she was looking at a new one. In continued interview, the Administrator stated she was not able to give a timeline on how soon she would order the new lift or why she had not already ordered it. Additionally, the Administrator stated she believed the facility had figured something out on how to weigh the residents who usually required a lift for weights, but she could not describe what they had done.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, record review, and facility policy review, the facility failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality for 2 of 21 sampled residents, Resident (R)4 and R36.The facility failed to ensure R36's visual privacy while she was undressed.The facility failed to ensure R4's catheter collection bag was covered.The findings include:Review of the facility's policy, Resident Rights, dated 04/12/2024, revealed the facility was to protect and promote the right of each resident to a dignified existence. Further review revealed the facility would provide an environment that enhanced the resident's quality of life and recognized the resident's individuality.1) Review of R36's admission Record revealed the facility admitted the resident on 05/21/2018. Further review revealed her diagnoses included Huntington's disease (a severe neurological disorder), Alzheimer's disease, restless leg syndrome, and dysphagia (difficulty swallowing).Review of R36's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 06/27/2025 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero out of 15, indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as dependent on staff for upper and lower body dressing.Review of R36's Comprehensive Care Plan (CCP) dated 01/07/2025 revealed the facility identified R36 as at risk for mood changes and behaviors related to lack of self-awareness and mental status changes as a result of Huntington's disease. Further review revealed the facility failed to include interventions to protect the resident's dignity.Observation on 07/21/2025 at 5:14 PM revealed R36 in her room, wearing a hospital gown. Further observation revealed the resident had her arms wrapped in the bottom part of the gown, exposing her bare legs up to the top of her thighs. Per observation, R36 repeatedly raised her arms above her head, exposing her bare breasts. In continued observation, R36's door was open, the curtain was not pulled, resulting in the resident's nude body being exposed to anyone in the hallway. Additional observation at 5:21 PM revealed State Registered Nurse Aide (SRNA)6 walked by and looked at R36 while her arm was down, but her legs were exposed, and her arms were visibly tangled in her gown. SRNA6 failed to pull the curtain or close the door to protect the resident's privacy.In an immediate interview, SRNA6 stated R36 often pulled her clothes off and staff usually kept her curtain closed for privacy or a blanket over her to protect her privacy. SRNA6 stated she did not know why the curtain was not pulled at that time. The SRNA pulled the resident's blanket up over her.In an interview on 07/24/2025 at 4:29 PM, Registered Nurse (RN)3 stated based on R36's reactions, she did not like to have pants on. RN3 stated staff typically dressed R36 in a top and covered her lower half with a blanket. In further interview, RN3 stated if R36 started trying to take her clothes off, that was her right, but staff should pull the curtain to protect her dignity.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated it was her expectation that staff pull the curtain around a resident who disrobed while in their room.In an interview on 07/25/2025 at 3:32 PM, the Administrator stated that if a resident wanted to take their clothes off, staff should either close the door or pull the curtain to protect visual privacy of the resident's body.2) Review of R4's admission Record revealed the facility admitted the resident on 05/18/2019. Further review revealed her diagnoses at the time of survey included unspecified dementia, neuromuscular dysfunction of the bladder, and stage three pressure ulcer of the right buttock.Review of R4's CCP, dated 04/18/2025 revealed the facility identified R4 as needing an indwelling urinary catheter and included the interventions related to providing catheter care per facility protocol. Further review revealed the care plan did not include interventions related to use of a dignity bag and other measures to protect the resident's dignity while using a urinary catheter.Review of R4's Quarterly MDS with an ARD of 07/08/2025, revealed the facility assessed the resident with a BIMS score of zero out of 15, indicating the resident was (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	severely cognitively impaired. Further review revealed the facility assessed the resident as requiring an indwelling urinary catheter. Observation on 07/21/2025 at 2:37 PM revealed R4 self-propelling her wheelchair throughout common areas with no dignity bag over her catheter collection bag.In an interview on 07/24/2025 at 5:01 PM, SRNA3 stated residents should have bags covering their urine collection bags to protect the resident's dignity.In an interview on 07/24/2025 at 4:29 PM, RN3 stated dignity bags should be kept in place over resident's catheter collection bags to protect their dignity and privacy. She further stated R4's bag slid off sometimes, but staff should be aware of that and replace it as soon as possible.In an interview on 07/25/2025 at 2:40 PM, the DON stated it was her expectation that all residents with a catheter should have a dignity bag over the collection bag to protect the resident's privacy.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated resident catheter collection bags should be covered according to the resident's preference for the resident's dignity.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on interview, record review, and facility policy review, the facility failed to protect the resident from misappropriation of property for 2 of 2 residents investigated for personal property. Resident (R) 24 and R10 filed grievances for missing clothing, but the facility failed to reimburse the residents for their missing items.The findings include:Review of the facility's document, Notice of Resident Rights and Responsibilities, dated 03/27/2024, revealed residents had the right to keep and use their personal belongings, and to have the facility protect their property from theft.1) Review of R24's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/30/2025 revealed the facility admitted the resident on 06/02/2021. Further review revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Continued review revealed R24 responded Very Important when asked how important it was to her to take care of her personal belongings.Review of the facility's form Grievance/Complaint Form, dated 05/19/2025 revealed R24 reported she was missing a coral t-shirt, a yellow t-shirt, a sweatshirt, and two pairs of jogging pants. Further review revealed the facility located the sweatshirt and pants in the resident's room. Continued review revealed the facility did not find the t-shirts but marked the grievance as resolved because they were going to keep looking for the shirts. Additional review revealed no documented evidence the facility found the shirts, replaced them, or reimbursed the resident.In an interview on 07/21/2025 at 2:58 PM, R24 stated the facility lost clothing of hers, including a yellow shirt and some pants in the laundry. She further stated the facility had not reimbursed her for the lost items of clothing.2) Review of R10's Quarterly MDS with an ARD of 05/13/2025 revealed the facility admitted the resident on 01/22/2018. Further review revealed the facility assessed the resident with a BIMS' score of 15 out of 15, indicating the resident was cognitively intact.Review of R10's Annual MDS with and ARD of 11/12/2024 revealed the resident responded very important when asked how important it was to her to take care of her personal belongings.Review of the facility's document Grievance/Complaint Report, dated 04/21/2025 revealed R10 reported missing a brand-new beige shirt. Further review revealed the facility marked the grievance as not resolved, stating the shirt had not been found, but they would continue to look.Review of the facility's document Grievance/Complaint Report, dated 05/19/2025, revealed R10 again reported missing the brand-new beige shirt. Further review revealed the facility could still not locate the shirt, and again marked the grievance as unresolved, stating they would continue to look for the shirt.In an interview on 07/21/2025 at 4:02 PM, R10 stated she had a shirt go missing in the laundry. She stated the facility had not replaced or reimbursed her for the shirt that was never found.In an interview on 07/24/2025 at 9:53 AM, the Administrator stated the facility's process when a resident reported an item missing was to fill out a grievance and try to locate the item. She stated the facility only replaced items that were missing if it was the fault of the facility. The Administrator stated that an example of this would be if someone in laundry spilled bleach on a resident's clothing. In an additional interview on 07/25/2025 at 11:02 AM, the Administrator stated if a resident reported an item missing and it was not found within an unspecified amount of time, the facility would replace the item or reimburse the resident for the cost of the item.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure residents' assessments accurately reflected the resident's status for 1 of 21 sampled residents. The findings include: Review of R30's Face Sheet revealed the facility admitted R30 on 06/14/2022 with diagnoses that included unspecified congenital malformation of limbs, anemia unspecified, and obesity unspecified. The diagnosis type II diabetes mellitus was added on 01/14/2025. R30 was ordered Lispro 100 unit/1ml (milligram) insulin pen sliding scale before meals on 01/19/2025. R30 also received orders for Lantus Solstar Pen 100 unit/1ml insulin pen 60 units twice a day on 03/15/2025. Review of R30's Annual MDS (Minimum Data Set) dated 05/23/2025 revealed R30 was coded in Section N0300, Injections, as having no injections during the seven-day look back period. Review of Section N0350, Insulin, revealed R30 as not having any documented injections in the seven-day look back period. Review of R30's MAR dated 05/2025 revealed R30 received Lispro, although the lunch (11:30 AM) and dinner (4:30 PM) doses were cancelled as of 05/15/2025. R30 continued to receive Lantus twice a day. During an interview on 07/23/2025 at 2:08 PM with the MDS Nurse, she stated she started working as the MDS Nurse in mid to late May 2025. When reviewing R30's Annual MDS, the MDS Nurse noted the person that trained her, Licensed Practical Nurse (LPN)3, had completed R30's MDS. The MDS Nurse stated it was important that the MDS be accurate both for billing purposes, and it also drives the resident's care planning. During an interview on 07/24/2025 at 8:57 AM, LPN3 stated she was the former MDS Nurse. She stated when completing MDS assessments, she went back and read the last three months of notes in addition to reviewing all pertinent documentation. When LPN3 reviewed R30's 05/23/2025 Annual MDS with the State Survey Agency Surveyor, she noted she read the order change discontinuing breakfast injections for R30 and failed to realize R30 was continuing to receive insulin injections. LPN3 stated it was important for the MDS to be accurate, as it affects billing. During an interview with the Director of Nursing (DON) on 07/24/2025 at 8:00 AM, she stated there would not have been a seven (7) day period during 05/2025 when R30 went without insulin. She stated her expectation was that MDS assessments were accurate as they guide resident care planning. During an interview on 07/24/2025 at 9:24 AM, with the Administrator, she stated her expectation regarding MDS was they should be complete and accurate. She stated the facility had gone through audits on MDSs to ensure they were up to date. She stated that she, the DON, a former Assistant Director of Nursing (ADON), and the Medication Nurse all went to MDS training. The Administrator stated it was important for MDS Assessments to be complete and accurate, as it was a profile of what was going on with the resident. She stated the care plans were developed from the MDS.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review, the facility failed to ensure the comprehensive care plan was revised following an incident for 1 of 21 sampled residents. Resident (R)2 suffered a fall on 01/24/2025 resulting in injury; however, R2's comprehensive care plan was not revised following the fall. The findings include: Review of R2's Face Sheet revealed the facility admitted R2 on 06/26/2024 with diagnoses that included encephalopathy unspecified, unspecified dementia without behavioral disturbance, and unspecified malignant neoplasm of the skin. Review of 12/23/2024 Quarterly Minimum Data Set (MDS) assessment, revealed the facility assessed R2 as 13/15 on a Brief Interview for Mental Status (BIMS), indicating intact cognition. Further review revealed the facility assessed R2 as independent with a wheelchair for mobility and required supervision with transfers. The assessment further noted R2 had not had any falls since admission. Review of a Progress Note, dated 01/24/2025 at 5:00 PM revealed a resident across the hall from R2 alerted a nurse that R2 was on the floor in her room. Further review revealed R2 was in front of her wheelchair on the left side of her back. The resident stated she hit her head very hard and her back and tail bone hurt severely. According to the note, R2's vital signs were stable, R2's responsible party and MD (medical doctor) were contacted. The MD ordered for the resident to be sent to the hospital. Continued review of R2's medical record revealed orders dated 01/24/2025 at 5:15 PM for R2 to be sent to local hospital emergency room status post a fall. R2 had complaints of head pain and severe back pain. Review of the Emergency Department (ED) notes dated 01/24/2025 revealed R2 was found to have a sacrum fracture and a urinary tract infection (UTI). Review of R2's care plan revealed R2 was care planned for falls on 07/03/2024. However, there was no evidence the facility revised R2's care plan following the 01/24/2025 fall. During an Interview with R2 on 07/22/2025 at 10:29 AM, she stated she fell near her closet and broke her tailbone. During an interview with the Director of Rehabilitation (DR), on 07/23/2025 at 9:00 AM, she stated R2 fell and break her tailbone. The DR stated R2 required therapy for at least two or three months after the fall. However, review of the care plan revealed it was not revised to include additional interventions including therapy after the 01/24/2025 fall.During an interview with the Director of Nursing (DON) on 07/24/2025 at 8:41 AM, she stated R2's fall was prior to her hire as the DON. She stated R2 was her own person, and when a resident had a fall the POA (Power of Attorney) was contacted as well as the MD. The DON stated the MD would determine whether or not the resident needed to be sent out or if other interventions needed to be placed. The DON stated the facility completed a fall investigation with a root cause analysis, with the resident's care plans updated according to the investigation's findings. The DON stated when R2 fell, the nurse was an agency nurse who did not follow the facility's procedure. The DON stated that although the nurse made note of the fall, contacted the POA and the MD, and sent the resident out to the hospital, she did not initiate the investigation paperwork. The DON stated she had looked but was unable to locate any investigation into R2's fall on 01/24/2025, and as a result of no fall investigation, there was no revision to the care plan. The DON stated R2 was picked up by therapy following the fall. She stated they placed an extra pad to R2's wheelchair for her comfort following the fall. The DON stated R2's care plan should have been revised to reflect the new interventions. During an interview on 07/24/2025 at 9:24 AM with the Administrator, she stated although R2's fall was charted, they were unable to find a fall investigation. The Administrator stated the fall investigation form initiated the investigation, which was discussed in the morning meeting where a root cause analysis was determined. She stated the nurse that was here when R2 fell, missed filling that form out and revising the care plan. The DON stated nursing was responsible for ensuring agency staff were educated on the facility's procedures.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to provide services to dependent residents to maintain good personal hygiene for 1 of 5 residents investigated for activities of daily living (ADL) care, Resident (R)46. The findings include:Review of R46's admission Record revealed the facility admitted the resident on 09/24/2024 with diagnoses that included spastic hemiplegia (muscle stiffness and spasms) of the left dominant side, need for assistance with personal care, and anxiety disorder.Review of R46's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/23/2025 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of 15 out of 15, indicating the resident was cognitively intact. Further review revealed the facility assessed the resident as dependent on staff for toileting hygiene.Review of R46's Comprehensive Care Plan (CCP) dated 10/25/2024 revealed the facility assessed R46 as dependent with toileting hygiene. Further review revealed interventions included to assist the resident as needed.Observation on 07/23/2025 at 3:23 PM revealed R46 sitting in her wheelchair in the doorway to her room, talking with her neighbor. R46 appeared to be upset.In an immediate interview, R46 stated she was incontinent, and her brief was wet. She stated she asked State Registered Nurse Aide (SRNA) 5 to change her brief less than five minutes prior to the interview, but the SRNA had said I just changed you. In further interview, R46 stated she was mad, and she did not believe it should matter how long-ago staff changed her brief, if she was wet, she wanted to be changed.Observation on 07/23/2025 at 3:25 PM revealed R46 told SRNA 5 that she needed to be changed. Further observation revealed SRNA5 told the resident she had just changed her and went on to talk to the resident about getting her a drink. SRNA5 walked away without providing incontinence care. Continued observation revealed SRNA5 came back and told the resident she would check to see if she was wet later. SRNA5 then walked away from the resident. Additional observation revealed R46 again asked to be changed at 3:58 PM, SRNA5 nodded, but walked past the resident. At 4:04 PM, SRNA5 looked at the State Survey Agency (SSA) Surveyor standing in the hall and told the resident she would change her. Per observation of incontinence care, R46's brief was significantly wet.In an immediate interview, SRNA5 stated she had just changed R46 prior to her asking and she had other residents who also needed to be changed. She stated it was the facility's expectation to change residents if they asked and she should have changed R46 when she asked.In an interview on 07/24/2025 at 4:29 PM, Registered Nurse (RN) 3 stated it was not acceptable for any staff member to tell a resident they had just had their brief changed and not provide care. She stated if a resident reported to an aide that their brief needed to be changed, the aide should change the brief.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated staff should provide incontinence care to a resident who reported being wet. She stated that was important because staff should treat residents the way they would want to be treated, and no one would want to sit there in a wet brief.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated her expectations for incontinence care were for staff to check and change briefs every two hours and more often if necessary for a particular resident. She stated it was unacceptable for a staff member to tell a resident they had just changed them and not change the resident who reported being wet.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, record review, and facility policy review, the facility failed to provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group activities and individual activities, designed to meet the interests and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community for 1 of 1 residents investigated for activities, Resident (R) 36. Observations throughout survey revealed R36 sitting alone in her room, awake, with no television, music, or other form of stimulation available to her.The findings include:Review of the facility policy, Activities and Social Events, not dated, revealed the facility expectation was for all residents to choose the types of activities in which they wished to participate. Further review revealed the facility was to develop activities schedules based on resident preferences and in conjunction with their plan of care.Review of R36's admission Record revealed the facility admitted the resident on 05/21/2018. Further review revealed her diagnoses included Huntington's disease (a severe neurological disorder), Alzheimer's disease, restless leg syndrome, and dysphagia (difficulty swallowing).Review of R36's Annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/07/2025 revealed the facility completed the staff assessment of daily and activity preferences due to the resident's inability to complete the interview. Further review revealed the staff assessed that R36 liked listening to music.Review of R36's Quarterly MDS with an ARD of 06/27/2025 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero out of 15, indicating the resident was severely cognitively impaired.Review of R36's Comprehensive Care Plan (CCP) dated 01/07/2025 revealed the facility assessed the resident as dependent on staff to meet emotional, intellectual, and social needs due to her major neurocognitive disorder. Further review revealed the facility listed R36's known favorite activities to include listening to music and watching TV.Observations on 07/23/2025 at 2:23 PM, 07/24/2025 at 10:41 AM, and 07/25/2025 at 3:34 PM revealed R36 awake in her room with no music or television, and no one providing social interaction. Observations throughout survey revealed no occasion where R36 was provided with or participated in an activity appropriate for her level of cognitive function. Observation on 07/23/2025 at 10:26 AM revealed R36 was not in the dining room for coffee social.In an interview on 07/24/2025 at 1:54 PM, the Activities Director stated staff occasionally brought R36 to morning coffee social, but they had not done so the day before. She stated that meant R36 did not get any activities for that day, or almost any day she did not come to coffee social. In further interview, the Activity Director stated R36 enjoyed Elvis and gospel music but did not have anything in her room staff could use to play music for her. Per interview, the Activity Director stated she played music for R36 once or twice per month. In continued interview, the Activity Director stated it was important for each resident to have their favorite activities for their emotional health and quality of life. Additionally, the Activity Director stated R36 would benefit from increased stimulation. Furthermore, she stated her activity aides were responsible for other tasks, such as organizing linens or going to appointments with residents, but activity aides did not provide 1:1 activity for residents who required those services.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated she did not get involved in activities. She stated she expected staff to interact with residents while providing care to promote socialization, but beyond that, she did not get involved in activities.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated her expectations were for the activity department to provide 1:1 activities at least daily to residents whose cognition, mobility, or preferences meant they did not obtain the most benefit from group activities. She further stated having a resident sit in their room with no options for stimulation or their favorite individual activities was not acceptable.

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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 and facility policy review, the facility failed to provide services to prevent urinary tract infections for 1 of 2 residents with an indwelling catheter, R4. Observations throughout survey revealed R4's catheter tubing and catheter bag dragging the ground under her wheelchair.The findings include:Review of the facility's policy Indwelling Catheter Use, dated 05/14/2006, revealed the policy did not address a protocol for the care of urinary catheters to include measures to prevent infections, including steps for cleaning the catheter, and instructions for maintenance of the collection system.Review of Resident (R)4's admission Record revealed the facility admitted the resident on 05/18/2019. Further review revealed R4's diagnoses included unspecified dementia, neuromuscular dysfunction of the bladder, and stage three pressure ulcer of the right buttock.Review of R4's Comprehensive Care Plan (CCP), dated 04/18/2025 revealed the facility identified R4 as needing an indwelling urinary catheter and included the interventions related to providing catheter care per facility protocol. Further review revealed the care plan stated to take care of the catheter per facility policy. However, the CCP failed to include specific interventions related to the care of the urinary catheter.Review of R4's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date of 07/08/2025, revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) score of zero out of 15, indicating the resident was severely cognitively impaired. Further review revealed the facility assessed the resident as requiring an indwelling urinary catheter. Observations on 07/21/2025 at 2:37 PM, on 07/23/2025 at 8:56 AM and 9:48 AM, and on 07/24/2025 at 3:44 PM revealed R4's catheter bag and tubing dragging on the floor under the resident's wheelchair as she self-propelled around the facility. Further observation on 07/25/2025 at 9:32 AM revealed R4's catheter bag was lying flat on the bathroom floor during wound care.In an interview on 07/24/2025 at 5:01 PM, State Registered Nurse Aide (SRNA)3 stated it was important to keep a resident's catheter collection bag and tubing off the floor because having it drag on the floor put the resident at risk for urinary tract infections.In an interview on 07/24/2025 at 4:29 PM, Registered Nurse (RN) 3 stated catheter tubing and bags should be kept from dragging the floor because they could get ripped out, which would be uncomfortable for the resident.In an interview on 07/25/2025 at 2:40 PM, the Director of Nursing (DON) stated she expected catheter tubing to be kept off the ground (floor) to decrease the chances of an urinary tract infection. She stated staff should follow the facility's policy, but she was not able to describe what the policy said.In an interview on 07/25/2025 at 11:02 AM, the Administrator stated catheter tubing should not drag the ground under a resident's wheelchair. She stated leg bags were good for residents who needed a catheter, but were up and about in the facility. However, residents did not always want to use them. She stated she did not know if R4 had been offered a leg bag. In continued interview, the Administrator stated it was important for the bag to not drag the floor for infection control reasons.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185389	A. Building B. Wing	07/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Edgemont Healthcare	323 Webster Avenue 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 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility's policies, the facility failed to ensure residents requiring dialysis received services consistent with professional standards of practice by failing to ensure ongoing communication and collaboration with the dialysis facility regarding dialysis care and services for 1 of 3 residents reviewed for dialysis, Resident (R)3. Record review and interview revealed the facility failed to obtain or document R3's post dialysis center vital signs, weight and pertinent report information following dialysis visits. Further review revealed the facility failed to provide communication to the dialysis facility for pre-dialysis vital signs, medications and pertinent changes. The findings include:Review of the facility's policy Care of Residents on Dialysis, not dated, revealed the facility shall maintain ongoing communication and collaboration with the dialysis facility regarding dialysis care and services to ensure the resident's needs were met. Further review revealed maintaining ongoing communication and collaboration included ensuring documentation requirements were met. Review of the facility's agreement with the dialysis center Nursing Home Dialysis Transfer Agreement, signed by the facility on 01/28/2015 and signed by the dialysis center on 03/09/2015, revealed the facility shall ensure at the time of transfer to the dialysis clinic the resident would be accompanied by appropriate medical information. This information would include treatment currently being provided, including medications, changes in condition (physical or mental), change of medication, diet or fluid intake as well as any information that would facilitate the adequate coordination of case.Review of the admission Record for R3 revealed the facility admitted the resident on 12/07/2020 with diagnoses of atrial fibrillation, kidney and ureter disorder, bipolar, and end stage renal disease.Review of R3's most recent Quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview of Mental Status (BIMS) score of 14 out of 15, indicative of intact mental cognition. Further review revealed R3 was dependence on hemodialysis therapy. Review of R3's ?Physician's Order' dated 07/01/2025 revealed an order for dialysis every Monday, Wednesday and Friday, a 1200 milliliters (ml) fluid restriction, monitor thrill in AV Fistula (an irregular connection between an artery and a vein) every shift, and numbing cream applied topically to right arm and wrap with saran wrap every Monday, Wednesday and Friday prior to dialysis. Review of R3's medical record revealed a copy of a faxed form received from the dialysis center, dated 11/18/2024 requesting the facility to fax the Medication Administration Record (MAR). Further review revealed the dialysis center also informed the facility that the resident's phosphorus had trended above limits for the previous two months. The clinic requested an active order for calcium acetate two tablets with meals three times a day and one tablet with snacks twice a day. Review of R3's medical record revealed a copy of a form titled ?Patient Curfew Letter' received from the dialysis center, dated 01/02/2025. Further review revealed the Letter informed the facility that the resident required dialysis and transportation to the clinic during curfew hours.Review of R3's medical record revealed a copy of a faxed form received from the dialysis center, dated 06/16/2025 informing the facility that the dialysis clinic had ordered Calcium Acetate for R3. Further review revealed instructions were attached on how to reorder the medication. Review of R3's medical record revealed a copy of a faxed form received from the dialysis center, dated 07/21/2025 requesting a medication be discontinued. Review of R3's medical record revealed a ?Nurse's Note' dated 04/28/2025 that documented the dialysis clinic had called and reported the resident was being sent back without completion of treatment due to not being able to access the port. Further review revealed information for an upcoming specialty appointment for treatment was included. Review of R3's medical record revealed a ?Nurse's Note' dated 07/21/2025 a fax from the dialysis clinic requesting an order for Ergocalciferol 50,000 units monthly.Review of R3's hard copy medical record and electronic medical record (EMR) revealed no communication or daily transfer sheets for communication/collaboration of information between the facility and the dialysis clinic.Review of R3's dialysis clinic ?Treatment Details Report' (continued on next page)

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	185389	A. Building B. Wing	07/25/2025

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided by the dialysis clinic, revealed treatments were delivered on 07/03/2025, 07/04/2025, 07/07/2025, 07/09/2025, 07/11/2025, 07/14/2025, 07/16/2025, 07/18/2025, 07/21/2025, 07/23/2025 and 07/25/2025. Further review revealed documents contained pre-treatment, intra-treatment and post-treatment vital signs and weight, nursing assessment and assessment of access site. During interview with R3 on 07/24/2025 at 4:15 PM, R3 stated the facility did not send any paperwork to accompany her to her dialysis treatments. However, the dialysis clinic did not send any paperwork back to the facility following treatments. In further interview R3 stated during the entire admission at the facility and receiving dialysis treatment at the same location no paperwork had been sent with her or brought back. She stated she could not recall ever being asked for any information. During an interview with Licensed Practical Nurse (LPN)4, on 07/24/2025 at 3:52 PM, she stated that the facility did not send any communication forms or paperwork with a resident receiving dialysis and no paperwork was returned with the resident after returning from treatment. In further interview she stated, if any changes or complications were to occur the dialysis clinic would either call the facility or send a fax.During an interview with the Dialysis Clinical Coordinator on 07/24/2025 at 3:48 PM, she stated since R3 had been coming to dialysis treatments no paperwork had been sent by the facility, including no communication forms, medication sheets or face sheets. The Dialysis Clinical Coordinator stated in the past when a medication changed or a need for specific information was required, they would send a fax request to the facility or ask R3 or get the medical information from the Nephrologist (kidney specialist). She further stated that the dialysis treatment was documented and recorded in the clinic's electronic medical records and the facility could request any of the treatment records, but to date the facility had not ever made any request for information. Interview with previous Director of Nursing (DON) 2 on 07/24/2025 at 4:02 PM, she stated that routine paperwork was not sent to each dialysis treatment with R3, but initially a face sheet and list of medical history and current medication information was sent to the dialysis clinic. DON 2 stated that R3 did not return with any post-dialysis paperwork because the clinic would give them to the resident, but the resident was keeping them and refusing to give to staff. In further interview she stated that there had never been any instance for concern regarding communication and the clinic would call or send a fax with any pertinent information. She stated she never had any concerns due to R3 being alert, oriented and able to make her own decisions. During an interview with the DON on 07/25/2025 at 11:09 AM, she stated she had taken the position on 04/12/2025 and prior to that had worked as a staff nurse at the facility. The DON stated that when a resident started dialysis, they were sent with a face sheet or medication sheet and no other paperwork was provided to the clinic unless a change in medications occurred and a new medication list would be provided. The DON stated that the clinic did not send any paperwork back to the facility following treatment. Further interview revealed she was vaguely familiar with the facility's policy and believed the requirement for documentation communication and collaboration with the clinic was met by the clinic calling or sending a fax to the facility and by the facility sending a new face sheet or medication list.During an interview with the Administrator on 07/25/2025 at 1:42 PM, she stated she was unfamiliar with the facility's dialysis policy but acknowledged that there was one and to her understanding the dialysis clinic provided the resident with paperwork that she refused to give to staff upon her return. She stated the resident was within her rights to do so. The Administrator stated she could not answer how documentation requirements were met by the facility or how communication and collaboration was ensured due to that being the responsibility of the DON.