STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195310	A. Building B. Wing	05/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Many Healthcare and Rehabilitation Center	120 Natchitoches Hwy 6 East Many, LA 71449

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record view, the facility failed to ensure residents received treatment and care in accordance with professional standards of practice for 1 (R3) resident of 6 sampled residents reviewed for quality of care. The facility failed to transport R3 to a nephrologist appointment in a timely manner as ordered. Findings:Review of R3's medical record revealed an admission date of 02/07/2025 with diagnoses which included in part . Chronic Embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity, Bilateral, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified, Peripheral Vascular Disease, and Benign Prostatic Hyperplasia without Lower Urinary Tract Symptoms. Review of R3's current physician orders revealed in part . - Nephrology follow up appointment with Nurse Practitioner _____ at _____ on 06/11/2026 @ 9:00 a.m. one time only. (This is the rescheduled appointment- for reference.)Review of R3's 05/2026 monthly physician appointment calendar revealed in part .On 05/22/2026, R3 had an appointment at 8:20 a.m. with the Nephrologist. Further review of this date, revealed the appointment was marked through and a note written, No Gas.Review of R3's Quarterly MDS with ARD of 04/15/2026 revealed a BIMS score of 14, which indicated intact cognition and the resident used a wheelchair for mobility. In an interview on 05/26/2026 at 2:56 p.m., R3 revealed he had an appointment scheduled on 05/22/2026 to go to a Nephrologist out of town. R3 stated he was scheduled to leave early about 6:00 a.m. on this day. R3 waited to leave for his appointment by the facility front door; but time passed by and it was after his leave time. R3 revealed he went to the nurse's station and asked when he was leaving for his appointment. R3 revealed the 2 nurses at the front desk stated his appointment was rescheduled due to the facility van having no gas. R3 stated he was very upset and this was unacceptable and not my fault .that was not right. R3 stated he told his daughter and she was upset too . now he had to wait another 3-4 weeks until he had his appointment rescheduled. R3 stated this was not the first time the van did not have gas for appointments, that another resident missed an appointment for the same reasons. In an interview on 05/26/2026 at 3:20 p.m., S6 Driver revealed she was the driver scheduled to bring R3 to his appointment on 05/22/2026 and planned to leave the facility 6:00 a.m. S6 Driver stated when she got to the facility, the van did not have enough gas to bring R3 to the appointment. S6 Driver stated the gas card was locked in S1 Administrator's office and it was too late to get gas. S6 Driver stated she did not know why the last driver did not put gas in the van. S6 Driver revealed all drivers have the ability to put gas in the vans and should do so when needed. In an interview on 05/26/2026 at 4:08 p.m., S4 Maintenance revealed last week (didn't know what day) a resident's appointment was rescheduled due to not having gas in the van. S4 Maintenance stated that all the drivers had the ability to put gas in the vans . they just needed to use the facility gas card before the day ended and fill up on gas. S4 Maintenance confirmed this should not have happened and the driver should have put gas in the van for the next day.In an interview on 05/27/2026 at 10:49 a.m., S5 LPN revealed she worked on 05/22/2026 when R3's appointment was rescheduled. S5 LPN revealed R3 had a scheduled appointment to go to the Nephrologist early, about 6:00 a.m. S5 LPN stated the resident came to the nurses' station and asked what time he was leaving for his appointment. S5 LPN received report from the night nurse that the van had no gas in it and R3's appointment had to be rescheduled. S5 LPN stated the driver called S1 Administrator and to notify her; but the gas card was (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	locked in the office. When S1 Administrator arrived to work, it was too late and the appointment still needed to be rescheduled. S5 LPN confirmed that, running out of gas was an unacceptable excuse for a resident to miss an appointment and it should have never happened. S5 LPN revealed the residents need their appointments and it is already hard enough to get a specialist appointment scheduled. S5 LPN confirmed R3's rescheduled appointment will be another 4 weeks wait for the resident. S5 LPN revealed that this was not the first time a resident had missed an appointment due to not having gas in the van. S5 LPN knew of this happening at least 2 other times for other residents.In an interview on 05/27/2026 at 11:22 a.m., S2 DON revealed that in regard to R3's missed appointment on 05/22/2026, That should have never happened. S2 DON stated that no resident should miss an appointment due to there being not enough gas in the van. S2 DON confirmed these were unacceptable practices and delayed R3's treatment. S2 DON confirmed that R3's Nephrologist appointment was an acute appointment, should not have been missed, and acknowledged how difficult it was to obtain these appointments, and now reschedule them. In an interview on 05/27/2026 at 12:29 p.m., S1 Administrator revealed on 05/22/2026 R3's appointment was canceled due to not having gas in the van. S1 Administrator confirmed that this was inexcusable and should have not happened .that all the drivers were capable of and responsible for putting gas in the van. S1 Administrator stated the gas card was kept locked in her office, but the drivers should have filled up the van with gas the day prior. The driver could have also asked to leave the gas card locked in the nurse's cart for the morning shift or they could have paid for the gas and gotten reimbursed. S1 Administrator stated all drivers were aware of the gas procedures. S1 Administrator agreed that R3's appointment was an important specialist appointment and was now delayed 4 more weeks due to poor transportation planning on the facility's part, but should have never happened.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to maintain accurate records in accordance with accepted professional standards and practices for 1 (Resident #1) resident of 6 sampled residents. The facility failed to ensure nursing staff accurately documented Resident #1's medication/treatment administrations.Findings: Review of facility policy on 05/27/2026 at 1:54 p.m., titled, Medication Administration with a revision date of 03/05/2026 revealed the following in part .Purpose: To ensure medications were prepared, administered, and documented safely, accurately, and in accordance with prescriber orders and accepted nursing standards of practice. Review of Resident #1's medical record revealed an admission date of 12/04/2025 with diagnosis which included in part .End Stage Renal Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Chronic Obstructive Pulmonary Disease, and Essential Primary Hypertension.Review of Resident #1's 03/2026 EMAR/ETAR (electronic medication administration record/electronic treatment administration record) revealed the following dates with no documented evidence of order administration for the following orders: -03/15/2026 at 4:30 p.m., 03/18/2026 at 6:30 a.m., 03/21/2026 at 6:30 a.m., 03/22/2026 at 6:30 a.m. 03/27/2026 at 6:30 a.m.: Sevelamer Hydrochloride oral tablet 800 milligram give 3 tablets by mouth before meals related to End Stage Renal Disease;-03/27/2026: Artificial Tears Ophthalmic Solution 1 % Instill 2 drops in both eyes one time a day related to Dry Eye Syndrome of Bilateral Lacrimal Glands;-03/27/2026: Cinacalcet Hydrochloride oral tablet 60 milligrams give 1 tablet by mouth one time a day related to End Stage Renal Disease;-03/27/2026: Cranberry oral tablet 450 milligrams give 1 tablet by mouth one time a day for Frequent Dysuria;-03/27/2026: Lantus Solo-Star Subcutaneous Solution pen injector 100 unit/milliliter (Insulin Glargine) Inject 20 units subcutaneously one time a day related to Type 2 Diabetes Mellitus with Hyperglycemia;-03/27/2026: Polyethylene Glycol 3350 oral powder 17 grams/scoop give 1 scoop by mouth one time a day every Monday, Wednesday, Friday, and Sunday related to Constipation.-03/27/2026: Spironolactone oral tablet 25 milligrams give 1 tablet by mouth one time a day related to Generalized Edema;-03/27/2026: Torsemide oral tablet 100 milligrams give 1 tablet by mouth one time a day related to Generalized Edema. If edema 3+ or greater for 3 consecutive days, notify Medical Doctor; and-03/27/2026: Novolog Injection Solution 100 unit/milliliter (Insulin Aspart) Inject as per sliding scale: if 0-150 = 0 units; if blood sugar is 400, give 12 units & recheck in 1 hour. If still >400, notify Medical Doctor subcutaneously three times a day related to Type 2 Diabetes Mellitus with Hyperglycemia.In an interview on 05/27/2026 at 10:31 a.m., S7 LPN revealed all nurses were aware to chart on the EMAR/ETAR in real-time during medication administration . that this was standard practice. S7 LPN stated if a nurse accidently did not chart on the EMAR/ETAR the order will show up as red/alert until the nurse addressed the order in the medical record. S7 LPN stated that if a nurse does not chart in the EMAR/ETAR or medical record then the procedure did not happen. S7 LPN confirmed that a resident's medical record should be considered inaccurate if a nurse omitted documenting in the EMAR/ETAR properly. In an interview on 05/27/2026 at 11:22 a.m., S2 DON revealed she had been the DON of the facility for about 20 years, and she expected the nurses to document on the EMAR/ETAR in real time when administering medications/treatments. S2 DON revealed all nurses were aware to do so. S2 DON stated if a medication/treatment was missed it would have flagged in red on the EMAR/ETAR, thus prompting the nurse to address the order. S2 DON stated all orders should be documented and never left blank. In a record review, at the time of interview, S2 DON confirmed the above information for Resident #1's 03/2026 EMAR/ETAR and that all mentioned orders were not documented on properly and left blank, but should not have been. S2 DON confirmed Resident #1's medical record was inaccurate due to omission of documentation on the 03/2026 EMAR/ETAR.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observations, interviews, and record reviews the facility failed to maintain a safe, functional, and comfortable environment for 4 (Resident #1, Resident #3, R1, and R2) residents of 6 sampled residents reviewed for physical environment. The facility failed to provide transportation for residents to their appointments with a fully functional air conditioning system during the warm/hot weather climates.Findings: Review of a facility policy on 05/26/2026 at 3:10 p.m. titled, State of Resident Rights with an revision date of 12/13/2023 revealed the following in part .The resident does not give up any right when you enter a nursing facility. The facility must encourage and assist you to fully exercise your rights. Any violation of these rights is against the law. The resident has a right to: 1. all care necessary for you to have the highest possible level of health; 2. Safe, decent and clean conditions. Review of a facility vehicle maintenance inspection report on 05/27/2026 at 1:54 p.m. with a date of 11/2025-05/2026 revealed in part .Inspect air conditioning front and rear units, if equipped. Review of a facility vehicle maintenance inspection report on 05/27/2026 at 2:18 p.m. with a date of 04/29/2026 revealed in part .Grey Van: Heating and air conditioning with a result of Poor.Review of the weather forecast of the city Resident #1's appointment was located, on 04/29/2026, revealed in part . the weather had a prediction of a high temperature of 87 degrees. Resident #1Review of Resident #1's medical record revealed an admission date of 12/04/2025 with diagnosis which included in part .End Stage Renal Disease, Type 2 Diabetes Mellitus with Hyperglycemia, Chronic Obstructive Pulmonary Disease, and Essential Primary Hypertension. Review of Resident #1's current physician orders revealed the following orders in part .- Ophthalmology follow up appointment at _____ on 04/29/2026 at 1:45 p.m. one time only.- Resident to receive dialysis 3 days a week on Tues, Thurs, and Sat at _____ dialysis center under the care of Nephrology; Chair Time 6:30 a.m.Review of Resident #1's Quarterly MDS with an ARD of 03/12/2026 revealed a BIMS score of 15, which indicated intact cognition. Resident #1 used a wheelchair for mobility and required dialysis services. Review of Resident #1's care plan with an initial date of 12/04/2025 revealed in part .Focus: The resident has acute renal failure elated to End Stage Renal Disease and requires dialysis x3 weekly. In an interview on 05/26/2026 at 10:32 a.m., S4 Maintenance revealed he worked as the facility maintenance man for 2 years and the facility had 2 transportation vans (1 grey van and 1 white van). S4 Maintenance confirmed the grey van's air conditioning was not working in the back/rear of the van. S4 Maintenance stated, himself, and Administration/Corporate were made aware of the air conditioning was not working for at least 2 years. S4 Maintenance revealed that Corporate obtained quotes for repairs and the quote was more than what the van was worth, so Corporate decided not to fix the broken air conditioning in the grey van. S4 Maintenance was instructed (along with the drivers) to still utilize the grey van. The facility was to use the grey van for short/local trips such as: dialysis trips, during the winter months, or in emergency situations. S4 Maintenance stated the grey van was often used for dialysis trips weekly.In a telephone interview on 05/26/2026 at 11:14 a.m., Resident #1 revealed she resided at the facility from 12/2025-05/11/2026 and received dialysis three times weekly, (Tuesday, Thursday, and Saturday). Resident #1 stated on 04/29/2026 she had an eye appointment scheduled. Resident #1 revealed that S6 Driver drove her to her eye appointment (about 1.5-2 hours away from the facility) in the grey van. They left for the appointment at 11:45 a.m. and returned to the facility about 7:00 p.m. that evening. Resident #1 stated she used a wheelchair and sat in the back/rear of the van where the air conditioning was not working. Resident #1 stated the outside weather on her appointment day was sunny and hot, at least 80 degrees. Resident #1 stated she was hot and very uncomfortable in the van, however she did not say anything to S6 Driver because the air conditioning was broken for so long and staff always said there was nothing they could do. Resident #1 stated Corporate was not fixing the air condition, so there was no point in reporting it. Resident #1 stated she always rode in the grey van for her dialysis (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	appointments three times weekly and it was hot and uncomfortable riding in the grey van since she admitted to the facility. Resident #1 revealed that the grey van interior ceiling drapes would always fall onto her head while sitting in the back seat, which was ridiculous. Resident #1 stated the van was old, outdated and needed some maintenance. Observation of the facility grey van on 05/26/2026 at 11:48 a.m., accompanied with S4 Maintenance and S8 Driver revealed in part .the grey van had 2 front seats (driver and passenger), a middle row, and a rear area to fit 2 wheelchair residents. While the van was running and air condition ON, the rear 4 air condition vents did not blow any air. S4 Maintenance confirmed the findings stated above. S4 Maintenance and S8 Driver confirmed the grey van was currently used for dialysis appointments, during the winter months, for an emergency situation, and used on 04/2026 for an appointment to _____ (1.5- 2 hours from the facility). S8 Driver revealed S6 Driver drove Resident #1 to _____ in 04/2026 to her appointment. S8 Driver revealed she did not know why S6 Driver drove the grey van out of town on a long trip with no air conditioning. In an interview on 05/26/2026 at 12:01 p.m., S3 Transportation Scheduler revealed she was the medical records/transportation scheduler for 2.5 years and the facility had 2 vans (the white van and the grey van). S3 Transportation Scheduler stated the appointment scheduling was very difficult due to only having 1 functional van and the grey van not having proper air conditioning for the state's climate. S3 Transportation Scheduler revealed the grey van's air conditioning does not work in the back/rear of the van where the wheelchair residents were seated. S3 Transportation Scheduler stated she and everyone (Administration and Corporate) were all aware for at least 2 years of the air conditioning was not working. S3 Transportation Scheduler was instructed by Administration/Corporate to still utilize the grey van during the winter months, for emergency situations, and local trips such as: to/from dialysis .which S3 Transportation Scheduler did routinely use the grey van to bring different residents to/from dialysis three times weekly. S3 Transportation Scheduler voiced the grey van was not intended to be used for trips out of town, due to the hot weather, at this time. S3 Transportation Scheduler revealed the last time the grey van was used was on 05/18/2026, 05/20/2026 and 05/22/2026 for dialysis transports of multiple residents. S3 Transportation Scheduler revealed the last time the grey van was used to go out of town was on 04/29/2026 for Resident #1's eye appointment in _____and S6 Driver drove her. S3 Transportation Scheduler revealed she had difficulty scheduling transportation at this time, so she spoke to S2 DON to work on how Resident #1 was going to go to the appointment in _____, on 04/29/2026. S3 Transportation Scheduler stated they agreed to send Resident #1 on the grey van due to Resident #1 kept her room hot and the weather was supposed to be in the 70s-80s. S3 Transportation Scheduler revealed the driver and the resident left the facility in the grey van on 04/29/2026 at 11:45 a.m. to _____and returned in the evening (not sure of return time, due to after business hours). S3 Transportation Scheduler confirmed the drive to the appointment was about 1.5-2 hours and the drive back to the facility was 1.5-2 hours. S3 Transportation Scheduler confirmed when she used the grey van to pick up dialysis in the afternoon it was hot and uncomfortable and that the dialysis residents were acute residents and should not be in the hot van with no air conditioning. S3 Transportation Scheduler stated the days when it was hot outside it was even hotter in the grey van. S3 Transportation Scheduler revealed she was instructed to still use the grey van; however, she would rather not use to the grey van due to the poor conditions and felt the facility needed a new functional van for the residents. In an interview on 05/26/2026 at 3:20 p.m., S6 Driver revealed she was the driver for Resident #1's appointment on 04/29/2026. S6 Driver stated she left with the resident on 04/29/2026, at about 12:00 p.m. and returned about 7:00 p.m. to the facility. S6 Driver revealed since 10/2025 as the van driver, she was aware the grey van did not have proper air conditioning but this van was still used for local appointments and going to/from dialysis. S6 Driver claimed she, nor the resident were not hot in the van on 04/29/2026.In an interview on 05/26/2026 at 4:08 p.m., S4 Maintenance revealed the grey van was a 2006 model van with over 242,000 miles on it. S4 Maintenance confirmed the grey van was old and unreliable. S4 Maintenance revealed he would rather (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to just park the van and not use it. S4 Maintenance revealed that the Corporate Maintenance Director was aware of the issues with the grey van and the facility was supposed to get new vans, but that was 2 years ago.Observation on 05/27/2026 at 10:31 a.m., accompanied by S4 Maintenance, revealed it was very hot in the back/rear of the van. Observed the interior ceiling of the back/rear of the van with over 50% of the interior ceiling drapes torn open, exposing the cushions, with the drapes hanging downward into the back sitting area. Observation of the ceiling drapes revealed they were hanging in a manner where, when a wheel-chaired resident was seated in the back, the drapes would fall over their head area. S4 Maintenance confirmed all the above findings during the observation. S4 Maintenance stated the interior ceiling drapes were hanging due to being so worn down, old age, and being dry rotten.In an interview on 05/27/2026 at 11:22 a.m., S2 DON revealed Resident #1 had an appointment on 04/29/2026, and S3 Transportation Scheduler voiced she needed help with transportation due to the white van being used for other appointments. S2 DON stated Resident #1 liked to have her room hot, so S2 DON reviewed the weather forecast on 04/29/2026 (she did not know which city weather she reviewed or if she reviewed the morning or afternoon weather) and it was expected to be in the 70s. S2 DON instructed S3 Transportation Scheduler to schedule the grey van for transport. S2 DON acknowledged the grey van was old, unreliable, had a non-functioning air condition but still used the van for an appointment to _____ (1.5-2 hour drive away from the facility). S2 DON confirmed the appointment was in the afternoon and the resident and driver were gone all afternoon, stating the temperatures probably did change from city to city and from morning to afternoon. S2 DON acknowledged it was hotter in a vehicle with non-working air conditioning than it was in outside weather. S2 DON stated she would have rather had the grey van parked and not in use. S2 DON confirmed that the dialysis residents were acute residents with possible blood pressure issues and sitting in a hot van without air conditioning for any amount of time was not acceptable. In reference to the ceiling interior of the grey van, S2 DON stated, The grey van is actually embarrassing and should not be used anytime. S2 DON was unaware the grey van interior ceiling was in such poor conditions.In an interview on 05/27/2026 at 12:29 p.m., S1 Administrator revealed she was notified by S2 DON that Resident #1 had an appointment in _____ on 04/29/2026 and the nursing team decided to use the grey van. S1 Administrator stated she was told S2 DON that Resident #1's son called on that day and reported that his mother was hot on the van. S1 Administrator stated she, and Corporate, were aware the grey van's air conditioning has not worked properly for about 1.5-2 years. Corporate had chosen not fix the grey van due to the repairs costing more than what the van was worth. S1 Administrator revealed the van was to be utilized for short trips, and in the winter time. S1 Administrator confirmed that Resident #1's appointment on 04/29/2026 was from 11:45 a.m. - 6:30 p.m. and the weather probably did change and the temperature did get warmer throughout the day-that it probably was hot and uncomfortable in the van. S1 Administrator acknowledged that the state's weather changes from morning to afternoon and from city to city. S1 Administrator agreed that the inside of a vehicle, without proper air conditioning, would be hotter than the outside temperatures and uncomfortable. Resident #3Review of Resident #3's medical record revealed an admission date of 12/06/2024 with diagnoses which included in part .Fusion of the Spine, Cervical Region, Chronic Obstructive Pulmonary Disease, and Major Depressive Disorder.Review of Resident #3's Annual MDS with ARD of 03/16/2026 revealed a BIMS score of 14, which indicated intact cognition and the resident used a rolling walker for mobility. In an interview on 05/26/2026 at 2:36 p.m., Resident #3 revealed she resided at the facility for 2 years and the facility vans transported her to all her appointments. Resident #3 revealed she used a rolling walker for mobility and sat in the front seat or the middle seat when she rode in the vans. Resident #3 revealed it was common knowledge to all the staff and Administration that the air conditioning in the grey van did not work in the back/rear area. Resident #3 stated many residents also know this information and Corporate don't want to fix the air conditioning because it will cost more than what the van is worth and I don't understand why they drive residents in a hot van with no air conditioning. Resident #3 revealed residents voiced that they (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stopped complaining about the hot van because Corporate was already aware and did not do anything. Resident #3 had rode in the grey van in the past and it was very hot and uncomfortable for her in the front seat .so she knew the residents in the back/rear seat were very hot. Resident #3 told transportation she refused to ride in the grey van again and they knew better than to book her in the grey van. R1Review of R1's medical record revealed an admission date of 08/04/2021 with diagnoses which included in part .End Stage Renal Disease, Hypertensive Chronic Kidney Disease with Stage 1 through Stage 4 Chronic Kidney Disease, and/or Unspecified Chronic Kidney Disease. Review of R1's Significant Change MDS with an ARD of 04/10/2026 revealed the resident used a wheelchair and required dialysis services. In an interview on 05/26/2026 at 2:24 p.m., R1 revealed he went to dialysis Monday, Wednesday, and Friday and the facility van took him to his dialysis appointments. R1 revealed he ambulated and sat in the middle seat of the van .when he was weak he would use his wheelchair and sat in the back/rear of the van. R1 stated that one van had broken air conditioning and he has ridden on this van to/from dialysis. R1 stated he was hot, uncomfortable and tired from dialysis on these trips in this van. R1 has told the drivers in the past, but the driver's tell him, I know it's hot, there is nothing we can do. R1 stated he rode on the van with the broken air conditioning last week and it was hot and uncomfortable .he stated he was tired of complaining so he just does not complain anymore. R1 stated 2 other residents rode with him to dialysis and he knew they were hot too, especially because they sat in the back/rear seat with no air conditioning. R1 stated the facility needed to do something with the broken air conditioning on the van. R2Review of R2's medical record revealed an admission date of 10/10/2023 with diagnoses which included in part .Asperger's Syndrome, Type 2 Diabetes Mellitus without Complications, and Generalized Anxiety Disorder. Review of R2's Quarterly MDS with an ARD of 03/13/2026 revealed a BIMS score of 15, which indicated intact cognition. In an interview on 05/26/2026 at 2:48 p.m., R2 revealed he was the facility Resident Council President and the residents and staff were aware for a long time that the grey van had broken air conditioning. R2 revealed the Resident Council stopped complaining a long time ago about the air conditioning, due to corporate being aware and said they were not going to fix it. R2 stated he ambulated with no issues and sat in the middle seat when he rode in the van. R2 stated he rode in the grey van in the past, on the middle seat, and it was hot and uncomfortable. R2 stated he asked for future appointments, to not put him on the grey van because it was so hot. R2 revealed S1 Administrator was aware and thought S1 Administrator would make sure other residents did not use this van during the hot weather.