STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	195564	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acadia St Landry Nursing & Rehabilitation Center	830 S. Broadway Church Point, LA 70525

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 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Properly hold, secure, and manage each resident's personal money which is deposited with the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to provide quarterly statements to 3 (#83, #88, #89) residents of 4 (#64, #83, #88, #89) residents investigated for personal funds. Findings: Review of the facility's policy and procedure titled Resident Trust Fund Policy and Procedure, with a review date of 11/3/2025, read in part; 4. Resident Rights Regarding Personal Funds, Resident have the right to: Receive quarterly statements of their account. Review of Resident #83's EHR (Electronic Health Record) revealed an admission date of 12/02/2024 and diagnoses that included, but were not limited to, hypertensive heart disease with heart failure peripheral vascular disease, and chronic kidney disease. A review of the Resident #83's comprehensive MDS (Minimum Data Set) assessment dated [DATE] revealed a BIMS (Brief Interview for Mental Status) score of 11, which indicated her cognition was moderately intact. On 03/09/2026 at 10:18 a.m., an interview was conducted with Resident #83. Resident #83 stated that she had not received any quarterly statements for her money that was kept at the facility. She stated that she had never received any statements in regards to her money. On 03/11/2026 at 1:38 p.m., an interview was conducted with S7RT. S7RT stated she was responsible for providing written quarterly statements to residents in the facility. S7RT stated she had no evidence that quarterly statements were provided to residents or responsible parties. Resident #89 Review of Resident #89's admission Record revealed the resident was admitted to the facility on [DATE] with diagnoses that included, in part, type 2 diabetes mellitus with diabetic chronic kidney disease, unspecified atrial fibrillation, and cerebral ischemia. Review of Resident #89's MDS (Minimum Data Set) assessment dated [DATE] revealed the resident had a Brief Interview for Mental Status (BIMS) score of 11 which indicated moderate cognitive impairment. On 03/09/2026 at 12:47 p.m., an interview was conducted with Resident #89. Resident #89 stated she had a personal funds account at the facility and she has not been receiving quarterly statements for her personal funds account. On 03/11/2026 at 9:33 a.m., an interview was conducted with S7RT. S7RT stated she was (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0568 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible for the personal funds accounts for the residents at the facility. S7RT stated that if a resident's BIMS score is 11 or higher she would hand the statement to the resident. S7RT stated she could not provide evidence that Resident #89 received a quarterly statement or that a quarterly statement was mailed to Resident #89's Responsible Party. Resident #88 Review of Resident #88's electronic medical record revealed she was admitted to the facility on [DATE] with diagnoses that included, but were not limited to, occlusion and stenosis of unspecified carotid artery, unsteadiness on feet, hypertension, and unilateral primary osteoarthritis, left knee. Review of Resident #88's quarterly MDS (Minimum Data Set) assessment with an ARD (assessment reference date) of 12/31/2025 revealed in section C, Cognitive Patterns, she had BIMS (Brief Interview for Mental Status) score of 15, indicating she was cognitively intact. On 03/09/2026 at 10:00 a.m., an interview was conducted with Resident #88. She stated that she did not receive any statements in regards to the money she had in her account at the facility and would like to receive these statements. She further stated that she had received only one statement since her admission. On 03/11/2026 at 9:56 a.m., an interview was conducted with S7RT. She stated that she was responsible for the residents' trust funds at facility. She stated that she tried to provide residents with quarterly statements and handed those out to residents with a BIMS scores of 11-15. She confirmed that she did not have any evidence that personal funds quarterly statements were handed to Resident #88. She also confirmed that she did not have any evidence that quarterly statements were mailed to Resident #88's responsible party.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record reviews, and policy review, the facility failed to ensure call systems in resident bathrooms were functional and accessible to residents at all times for 7 residents (#4, #23, #75, #112, #130, #132, and #133) out of a final sample of 48 residents. Findings: A review of the facility's policy titled Call Bell Policy with a last reviewed date of 11/03/2025 read in part, Policy Statement: The facility will maintain an effective call-light system that allows residents to summon staff assistance at any time. Resident #4Review of Resident #4's electronic health record revealed an admission date of 07/13/2023 with diagnoses that included but were not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, acute kidney failure, and diabetes mellitus due to underlying condition with diabetic neuropathy. Review of Resident #4's 5 day MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had a BIMS (Basic Interview for Mental Status) score of 11, indicating her cognition was moderately impaired. The MDS assessment Section GG also revealed Resident #4 required partial/moderate assistance with toilet transfer. On 03/09/2026 at 9:22 a.m., an observation was made of Resident #4's bathroom. The call bell pull cord was disconnected from the wall unit, near the resident's toilet, wrapped around the metal grab bar next to the toilet. On 03/10/2026 at 3:31 p.m., an interview was conducted with Resident #4. She stated that she had to constantly place the pull cord back into the call bell system's unit on the wall near her toilet. She stated that every time she pulled the cord, it disconnected from the wall unit. Resident #23 Review of Resident #23's electronic health record revealed an admission date of 02/10/2022 with diagnoses that included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, chronic kidney disease, stage 3B, and unspecified dementia. On 03/09/2026 at 10:27 a.m., and observation was made of Resident #23's bathroom. The resident's bathroom call bell pull cord was disconnected from the call bell system's wall unit and in a box on the sink counter. On 03/10/2026 at 2:51 p.m., an interview and observation was made of S13CNA assisting resident #23 to the toilet. She stated that Resident #23 was able to use the call bell pull chord located next to the resident's toilet for assistance. Resident # 75 Review of Resident #75's electronic health record revealed an admission date of 02/23/2026 with diagnoses that included but were not limited to, unspecified fracture of right femur, subsequent encounter for closed fracture with routine healing and type 2 diabetes mellitus without complications. Review of Resident #75's day MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had a BIMS (Basic Interview for Mental Status) score of 10, indicating her cognition was moderately impaired. The MDS assessment's Section GG also revealed Resident #75 required substantial/maximal assistance with toilet transfer. On 03/09/2026 9:27 a.m., an observation was made of Resident #75's bathroom. The resident's call bell pull cord was disconnected from the call bell's wall unit. The pull cord was located on the floor near the toilet. Resident #112 Review of Resident #112's electronic health record revealed an admission date of 12/18/2025 with diagnoses that included but were not limited to, heart failure and cerebral palsy. Review of Resident #112's 5 day MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had a BIMS (Basic Interview for Mental Status) score of 12, indicating her cognition was moderately impaired. The MDS assessment's Section GG revealed Resident #112 required supervision or touching assistance with toilet transfer. On 03/09/2026 9:29 a.m., an observation was made of Resident #112's bathroom. The resident's call bell pull cord was disconnected from the wall unit, near the resident's toilet, wrapped around the metal grab bar next to the toilet. On 03/09/2026 12:56 p.m., an interview was conducted with Resident #112. She stated that she had not placed the pull chord's string around the metal grab bar. She stated it had been wrapped up like that since she returned from her last hospital stay. On 03/11/2026 at 5:30 p.m. a record review and interview was conducted with S2ADON. She confirmed that Resident #112 last returned from the hospital to the facility on [DATE]. Resident # 130 Review (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of Resident #130's electronic health record revealed an admission date of 02/28/2026 with diagnoses that included but were not limited to, displaced fracture of lateral condyle of right tibia, subsequent encounter for closed fracture with routine healing. Review of a Skilled Evaluation nursing note dated 03/09/2026 at 11:23 p.m., read in part, Mental Status: Alert and Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. Resident is alert and oriented x3. Oriented to place. Oriented to person. Oriented to time. Genitourinary: Resident is continent of urine. Resident voids via toilet. On 03/09/2026 at 9:40 a.m., an observation was made of Resident #130's bathroom. The resident's call bell pull cord was connected to the call bell wall unit near the toilet, but wrapped around the bar next to the toilet. Resident #132Review of Resident #132's electronic health record revealed an admission date of 08/22/2024 with diagnoses that included but was not limited to heart failure. Review of a Skilled Evaluation nursing note dated 03/09/2026 at 11:00 p.m., read in part, Gastrointestinal: Continent of bowel: Yes, Genitourinary: Resident is continent of urine. Resident voids via toilet. On 03/09/2026 9:52 a.m., an observation was made of Resident #132's bathroom. The resident's call bell pull cord was disconnected from the wall unit near the toilet, wrapped around the metal grab bar next to the toilet. Resident #133 Review of Resident #133's electronic health record revealed an admission date of 02/27/2026. Review of a Skilled Evaluation nursing note dated 03/05/2026 at 11:45 p.m., read in part, Mental Status: Alert and Oriented x3, communicated verbally, speech is clear, is able to understand and be understood when speaking. Resident is alert and oriented x3. Oriented to person. Oriented to place. Oriented to time. Gastrointestinal, continent of bowel- yes; Genitourinary: Resident is continent of urine. Resident voids via toilet.On 03/09/2026 at 10:02 a.m., an observation was made of Resident #133's bathroom. The resident's call bell pull cord was disconnected from the call bell wall unit and located on the floor near the toilet. On 03/09/2026 at 12:35 p.m., a tour was conducted with S6MD of the referenced residents' bathrooms. S6MD confirmed the observations made of the call bell pull cords near the residents' toilets in their respective bathrooms. He confirmed that the residents' call bell pull cords were not accessible if the residents were positioned on the floor, disconnected or when wrapped around the metal grab bar next to the toilet. S6MD demonstrated how the residents' bathroom pull cords easily detached from the wall unit. On 03/10/2026 9:36 a.m., an interview was conducted with S14CNA. She stated that she cared for Resident #4, Resident #75, Resident #112, Resident #130, Resident #132, and Resident #133. She confirmed these residents used the toilet in their bathrooms and have been left unassisted during times when doing so. She further confirmed that these residents utilized the call bell system with pull cords next to their toilets. On 03/10/2026 at 3:27 p.m., an interview was conducted with S15LPN. She stated that she cared for Resident #4, Resident #75, Resident #112, Resident #130, Resident #132, and Resident #133. She confirmed these residents used the toilet in their bathrooms and have been left unassisted at times when doing so. She further confirmed that these residents utilized their bathrooms' call bell pull cord next to their toilets. On 03/10/2026 at 3:58 p.m., an interview was conducted with S1DON. She confirmed that residents' bathroom call bell pull cords should be accessible to residents. S1DON further confirmed the residents' bathroom pull cords were not functional when the pull cords were located on the floor in the bathroom, were disconnected from the call bell system's wall unit or when wrapped around the metal grab bar near the toilet.

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F 0920 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide at least one room set aside to use as a resident dining room and for activities, that is a good size, with good lighting, air flow and furniture. Based on observations and interview, the facility failed to ensure there was sufficient space in the dining room to accommodate residents who required assistance with feeding. This deficient practice had the potential to affect 14 residents who required assistance with feeding. Findings: On 03/09/2026 at 11:25 a.m., Resident #3 and Resident #35 were observed sitting in the adjoining T.V. (television) activity section of the dining room. Other residents were eating lunch in the dining room at this time. S10TN told a CNA (Certified Nursing Assistant) that Residents #3 and #35 were waiting to eat at the table for residents who were required to be fed. On 03/09/2026 at 11:45 a.m., Resident #3 and Resident #35 were placed at the table for residents who were required to be fed when space became available. On 03/10/2026 at 11:25 a.m., another observation was conducted in the dining room during lunch. Resident #35 was waiting in the adjoining TV activity section of the dining room to eat. On 03/10/2026 at 11:31 a.m., an interview was conducted with S10TN who was the nurse responsible for overseeing dining activities at that time. S10TN was asked why residents were waiting in the T.V. activity section of the dining room to eat. S10TN stated that the facility did not have enough space to seat all residents who were required to be fed at the feeding table all at once, so staff rotated the residents out. She further stated that when one resident was finished eating, they were removed from the table and another resident was then placed in that spot at the table to eat. An observation was then made of the area of the dining room for residents who were required to be fed. A large round table and small square table were observed. There was no space for any additional residents or staff members to sit at the tables, and no space for any additional tables to be placed in that area. On 03/11/2026 at 11:35 a.m., Resident #121 was observed waiting in T.V. activity section of the dining room to eat. There were no available seats at the feeding table at this time. On 03/11/2026 at 11:43 a.m., an interview was conducted with S1DON. S1DON stated that because there were 16 residents who had to be fed, it was not feasible for all of them to sit at the table at one time. She stated the CNAs brought all of the residents that were required to be fed to the dining room at one time to ensure that everyone ate. Staff seat them in the T.V. activity section of the dining room while they wait for space to become available at the feeding table. S1DON agreed that the residents who had to wait in the T.V. activity section of the dining room were able to see other residents eating at the tables in the adjoining dining area, and because there was an influx of residents that were required to be fed, they could not all be seated at the table and fed at the same time.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure the plan of care/physician orders were implemented for 1 (Residents #2) out of 48 sampled residents. The facility failed to apply topical cream to a suprapubic site, irrigate a suprapubic catheter, and document suprapubic catheter output for Resident #2.Findings:Review of Resident #2's electronic health record revealed an admission date of 08/27/2024 with diagnoses that included but were not limited to, calculus in bladder and benign prostatic hyperplasia with lower urinary tract symptoms. Review of Resident #2's Annual MDS (Minimum Data Set) assessment dated [DATE], revealed the resident had a BIMS (Basic Interview for Mental Status) score of 11, indicating his cognition was moderately impaired. Review of Resident #2's current plan of care revealed in part: Focus- urinary catheter (suprapubic); Interventions- Document suprapubic cath (catheter) output q (every) shift, Irrigate suprapubic cath with 60cc (cubic centimeter) NS (normal saline) bid (twice a day), and Medications as ordered. Review of Resident #2's March 2026 physician orders revealed:1. Dated 09/06/2024 for Clotrimazole External Cream 1% (Clotrimazole Topical) Apply to suprapubic catheter site topically two times a day related to candidiasis of skin and nail,2. Dated 01/24/2025 for Irrigate suprapubic catheter with 60cc NS two times a day, and 3. Dated 10/04/2025 for Document suprapubic cath output q shift. Review of Resident #2's TARs (Treatment Administration Record) for the months of November 2025, December 2025, January 2026, February 2026 and March 2026 revealed the following ordered treatments:1. Clotrimazole External Cream 1% (Clotrimazole (Topical) Apply to suprapubic catheter site topically two times a day related to candidiasis of skin and nail,2. Irrigate suprapubic catheter with 60cc NS two times a day and3. Document suprapubic cath output q shift.Further review of Resident #2's TAR for failed to include nurses' initials or evidence that the three treatments, as mentioned above, were performed as ordered on the following dates: 1. Application of ordered topical cream to Resident #2's suprapubic catheter site failed to include documentation care was completed for: November 2025: a. 6:30 a.m. - 11/12/2025 and 11/13/2025 b. 6:30 p.m. - 11/05/2025, 11/11/2025, 11/12/2025, 11/17/2025, 11/22/2025, 11/23/2025, and 11/26/2025 December 2025: a. 6:30 a.m. - 12/03/2025, 12/05/2025, 12/09/2025, and 12/21/2025 b. 6:30 p.m.- 12/02/2025, 12/03/2025, 12/06/2025, 12/07/2025, 12/08/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/25/2025, 12/30/2025, and 12/31/2025 January 2026: a. 6:30 a.m.- 01/01/2026, 01/12/2026, 01/14/2026, 01/16/2026, and 01/23/2026 b. 6:30 p.m.- 01/03/2026, 01/04/2026, 01/10/2026, 01/12/2026, 01/16/2026, 01/25/2026, 01/26/2026, and 01/28/2026 February 2026: a. 6:30 p.m.- 02/01/26, 02/03/2026, 02/11/2026, 02/13/2026, 02/19/2026, 02/20/2026, 02/21/2026, 02/22/2026, and 02/24/2026 March 2026: a. 6:30 p.m.- 03/03/2026, 03/04/2026, and 03/08/2026 2. Irrigation of the resident's suprapubic catheter with 60cc NS twice a day failed to include documentation care was completed for: November 2025: a. 7:30 a.m. - 11/12/2025 and 11/13/2025 b. 2:30 p.m. - 11/01/2025, 11/02/2025, 11/11/2025, 11/12/2025, 11/15/2025, 11/23/2025, 11/26/2025, and 11/29/2025 December 2025: a. 7:30 a.m. - 12/03/2025, 12/05/2025, 12/21/2025, and 12/29/2025 b. 2:30 p.m.- 12/01/2025, 12/02/2025, 12/05/2025, 12/06/2025, 12/07/2025, 12/09/2025, 12/11/2025, 12/12/2025, 12/13/2025, 12/14/2025, 12/18/2025, 12/19/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/25/2025, 12/26/2025, 12/27/2025, 12/29/2025, and 12/31/2025 January 2026: a. 7:30 a.m.- 01/01/2026, 01/12/2026, 01/14/2026, 01/16/2026, and 01/23/2026 b. 2:30 p.m.- 01/01/2026, 01/03/2026, 01/04/2026, 01/10/2026, 01/12/2026, 01/13/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/19/2026, 01/20/2026, 01/22/2026, 01/23/2026, 01/24/2026, 01/25/2026, 01/26/2026, 01/29/2026, 01/30/2026, 01/31/2026 February 2026: a. 7:30 a.m.- 02/07/26 b. 2:30 p.m.- 02/01/26, 02/03/2026, 02/04/2026, 02/05/2026, 02/06/2026, 02/07/2026, 02/08/2026, 02/12/2026, 02/13/2026, 02/14/2026, 02/18/2026, 02/21/2026, and 02/22/2026 March 2026: a. 2:30 p.m.- (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	03/07/2026, 03/08/2026, and 03/10/2026 3. Documentation of resident's suprapubic cath output ever shift failed to include documentation care was completed for: November 2025: a. 5:00 a.m. - 11/02/2025, 11/12/2025, 11/13/2025, 11/15/2025, 11/16/2025, 11/18/2025, 11/20/2025, 11/22/2025, 11/23/2025, 11/26/2025, 11/27/2025, and 11/30/2025 b. 1:00 p.m. - 11/11/2025, 11/12/2025, 11/17/2025, 11/22/2025, 11/23/2025, and 11/26/2025 c. 9:00 p.m.- 11/01/2025, 11/11/2025, 11/12/2025, 11/13/2025, 11/14/2025, 11/16/2025, 11/19/2025, 11/20/2025, 11/23/2025, 11/24/2025, 11/25/2025, 11/26/2025, 11/27/2025 December 2025: a. 5:00 a.m. - 12/03/2025, 12/05/2025, 12/06/2025, 12/07/2025, 12/08/2025, 12/09/2025, 12/11/2025, 12/12/2025, 12/17/2025, 12/18/2025, 12/19/2025, 12/21/2025, 12/22/2025, 12/23/2025, 12/24/2025, 12/26/2025, 12/29/2025, 12/30/2025, and 12/31/2025. b. 1:00 p.m.- 12/02/2025, 12/03/2025, 12/06/2025, 12/08/2025, 12/11/2025, 12/13/2025, 12/18/2025, 12/20/2025, 12/21/2025, 12/22/2025, 12/25/2025, 12/30/2025, and 12/31/2025 c. 9:00 p.m.- 12/06/2025, 12/13/2025, 12/15/2025, 12/20/2025, 12/23/2025, 12/24/2025, 12/28/2025, and 12/30/2025 January 2026: a. 5:00 a.m.- 01/01/2026, 01/02/2026, 01/04/2026, 01/05/2026, 01/06/2026, 01/07/2026, 01/08/2026, 01/09/2026, 01/12/2026, 01/14/2026, 01/15/2026, 01/16/2026, 01/23/2026 b. 1:00 p.m.- 01/04/2026, 01/10/2026, 01/12/2026, 01/13/2026, 01/15/2026, 01/16/2026, 01/17/2026, 01/20/2026, 01/21/2026, 01/23/2026, 01/24/2026, 01/25/2026, 01/26/2026, 01/28/2026, and 01/29/2026 c. 9:00 p.m.- 01/01/2026, 01/10/2026, 01/16/2026, 01/20/2026, 01/21/2026, 01/22/2026, 01/27/2026, and 01/29/2026 February 2026: a. 5:00 a.m.- 02/27/26 b. 1:00 p.m.- 02/03/26, 02/05/2026, 02/11/2026, 02/13/2026, 02/19/2026, 02/20/2026, 02/21/2026, 02/22/2026 c. 9:00 p.m.- 02/03/26, 02/09/2026, 02/11/2026, 02/17/2026, 02/18/2026, 02/20/2026, and 02/22/2026, March 2026: a. 1:00 p.m.- 03/01/2026, 03/02/2026, and 03/03/2026, 03/04/2026, and 03/08/2026 b. 9:00 p.m.- 03/01/2026 and 03/08/2026On 03/11/2026 at 12:16 p.m. an interview was conducted with Resident #2. He stated that facility staff were irrigating his suprapubic catheter and applied cream around his suprapubic site mostly once a day, rarely twice a day. On 03/11/2026 at 3:45 p.m. an interview and review of Resident #2's TARs was conducted with S1DON. S1DON confirmed that the nurses' initials on the above respective dates were missing. She further confirmed that without the signatures present on the TAR, there was no evidence that the above orders had been implemented for those dates. S1DON stated Resident #2 was a reliable source of whether catheter irrigation and application of cream around his suprapubic site had been implemented as ordered.

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	195564	A. Building B. Wing	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Acadia St Landry Nursing & Rehabilitation Center	830 S. Broadway Church Point, LA 70525

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff interviews, the facility failed to ensure that services were provided to meet professional standards of quality for 2 (#7 and #54) out of 48 sampled residents as evidenced by:1. Failing to ensure Resident #7 swallowed all medications before the nurse exited the room, and2. Failing to ensure Resident #54's tube feeding bottle was labeled with the date and time it was hung and the nurse's initials.Findings: Resident #7 Review of a facility policy titled Administration of Drugs from Medication Carts, with a last reviewed date of 11/03/2025, revealed in part, 12. Never leave the drugs at the bedside or in the patient's hand or mouth. The patient must take the medicine while the nurse is present. Review of Resident #7's medical record revealed an admit date of 08/06/2008 with diagnoses that included, in part, artherosclerotic heart disease of native coronary artery without angina pectoris, chronic pain syndrome, and hypokalemia. Review of Resident #7's MDS (Minimum Data Set) dated 01/14/2026 revealed the resident had a Brief Interview for Mental Status (BIMS) score of 9, indicating moderate cognitive impairment. On 03/11/2026 at 1:01 p.m., an observation and interview was conducted with Resident #7. An observation was made of a medicine cup containing tablets and capsules on Resident #7's bedside table. The tablets and capsules in the medicine cup were clumped together and some of the tablets had started to dissolve. No nurse was present in the resident's room. Resident #7 stated he tried to swallow his medications and the medications got wet. Resident #7 stated he choked on his medications and had to spit the medications out. Resident #7 stated that his nurse put the medications in the medication cup on his bedside table then left his room. Resident #7 stated his nurse did not watch him take his medications. On 03/11/2026 at 1:07 p.m., an interview and observation was conducted with S2ADON in Resident #7's room. S2ADON confirmed that there were medications in the medicine cup on Resident #7's bedside table. S2ADON confirmed that resident's nurse should not have left medications at the bedside and should have remained in the room and observed the resident take his medications. On 03/11/2026 at 1:22 p.m., an interview was conducted with S11LPN. S11LPN confirmed that she was Resident #7's nurse and that she administered Resident #7's morning medications to him today. S11LPN stated she put the medications in Resident #7's mouth and exited his room. S11LPN confirmed that the medications on Resident #7's MAR dated 3/11/2026 and signed with her initials were the tablets and capsules that were administered during the morning med pass and in Resident #7's medicine cup at his bedside. On 3/11/2026 at 1:25 p.m., a review of Resident #7's March 2026 MAR (Medication Administration Record) was conducted with S11LPN and the following medications were documented as administered to Resident #7 on the morning of 03/11/2026: Allopurinol oral tablet 100 mg (milligram); 2 Azo oral tablets 95 mg; Calcium Citrate + oral tablet 315-5 mg-mcg (microgram); Cholecalciferol oral tablet 5000 units; Gabapentin oral tablet 600 mg; Hydrocodone-Acetaminophen oral tablet 5-325 mg; Mirabegron ER (extended release) oral tablet 50 mg; Pantoprazole Sodium EC oral tablet 40 mg; (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Potassium Chloride oral tablet 20 meq (milliequivalent); Sotalol HCL oral tablet 80 mg; Sucralfate oral tablet 1 gram; Tamsulosin HCL oral capsule 0.4 mg; 3 Tart Cherry oral capsules; Venlafaxine HCL ER oral capsule 75 mg; Verapamil HCL ER oral tablet 180 mg; and Vitamin B Complet oral tablet. On 03/11/2026 at 4:45 p.m., an interview was conducted with S2ADON. S2DON stated the nurses use a facility document titled Med Pass Tips during orientation. A review was conducted of the facility document titled, Med Pass Tips, which revealed in part, watch resident swallow all meds. Do not leave meds at bedside unless there is an order to do so. Resident #54 Review of Resident #54's Electronic Health Record (EHR) revealed she was admitted to the facility on [DATE] with diagnoses including, but not limited to, encounter for attention to gastrostomy and dysphagia. Review of Resident #54's physician's orders revealed the following order dated 11/17/2025: Enteral Feed, every shift, Jevity 1.2 at 70(cubic centimeters) per hr (hour) continuous to provide 2016 Kcal 93 gm (gram) protein, 20ml (milliliter) H2O (water) flush q (every) hour to provide 1836 ml free H2O. On 03/09/2026 at 9:08 a.m., an observation was made of Resident #54's room tube feeding setup. There was no label on the tube feeding bottle that identified the date and time it was started or the nurse's initials. On 03/09/2026 at 11:57 a.m., an observation was made of Resident #54's tube feeding bottle. The resident's tube feeding bottle was infusing at this time. The tube feeding bottle was not labeled with the date and time that it was started, or nurse's initials. On 03/09/2026 at 12:04 p.m., an observation was made of Resident #54's tube feeding bottle with S8LPN. She stated that she did not setup the tube feeding bottle, but it should have been labeled with the date and time it was hung and nurse's initials. On 03/09/2026 at 12:06 p.m., an interview was conducted with S1DON who stated the tube feeding formula bottle should have been labeled with the date and time it was started and nurse's initials.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a resident received the necessary care and treatment for a pressure ulcer consistent with professional standards of practice evidenced by the nurse failing to conduct accurate weekly skin/ body audit assessment, and complete comprehensive weekly wound assessments for 1 (Resident #9) out of 3 (#9, #10, #109) residents investigated for pressure ulcers out of a total sample of 48 residents. Findings:Review of Resident #9's electronic medical record revealed she was admitted on [DATE] with diagnoses that included, but were not limited to spina bifida, unspecified, type 2 diabetes mellitus without complications, unspecified and paraplegia, unspecified. Review of the facility's policy with a review date of 11/03/2025, titled Pressure Ulcer/Skin Breakdown Risk Assessment read in part, Steps in the Procedure, 4. a. Conduct a comprehensive weekly skin assessment/body audit. b. Once inspection of skin is completed document the findings on a facility-approved skin assessment tool. c. If a new skin alteration is noted, initiate a facility wound assessment related to the type of alteration in skin. Review of the facility's policy with a review date of 11/03/2025, titled Wound Care revealed in part, Steps in procedure: Documentation: The following information should be recorded in the resident's medical record; 4. All assessment data (wound bed color, size, drainage, etc.) obtained when inspecting the wound. Review of Resident #9's care plan revealed she was care planned for impaired skin integrity to her right foot with a goal to be free of skin breakdown through review date. Initiated on 04/15/2025 and revised on 02/17/2026. Interventions/Tasks included in part, monitor and measure wound (s) weekly. Review of the physician's progress note dated 02/02/2026 revealed in part; Reason for Visit: Evaluate and treat. Order for wound care; Right heel: apply aquacel and mepilex border 6 x 6, every other day and as needed.Review of Resident #9's weekly skin assessment audits dated February 2026 and March 2026 revealed no pressure ulcer was present to the right heel for dates; 02/04/2026, 02/11/2026, 02/18/2026, 02/25/2026 and 03/04/2026. Review of the wound rounds for February 2026 and March 2026 for Resident #9 failed to identify a wound/pressure ulcer to the right heel for Resident #9. On 03/11/2026 at 9:51 a.m., an interview and record review with S12LPN/TN was conducted. She stated that she was responsible for conducting skin assessment audits for residents. She stated that for the above dates she had assessed Resident #9 and had not identified her stage 2 pressure ulcer to the right heel. S12LPN/TN stated that a treatment was provided for this pressure ulcer and she had not placed it on the weekly skin assessments for the above dates. She also stated that she had not conducted any wound rounds for the right heel. S12LPN/TN confirmed that wound rounds should be conducted weekly for residents with pressure ulcers or wounds that require treatment and should include a picture with assessment of wound including measurements to determine healing progress. She confirmed that she had not performed any wound rounds for Resident #9's right heel pressure ulcer until 03/11/2026. On 03/11/2026 at 11:24 a.m., an interview and record review was conducted with S1DON. She confirmed that Resident #9 had a stage 2 pressure ulcer on 02/02/2026 that had not been placed on the skin assessment audits for the above dates and had also not been placed on the weekly wound rounds and should have been.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of records and policies and procedures, the facility failed to implement care plan interventions to ensure the resident's environment remained free of hazards for 1(#66) out of 9 residents investigated for accidents.Findings:Review of the facility's policy titled Smoking Policy - Residents with a last reviewed date of 11/03/2025, read in part: Policy Statement: This facility shall establish and maintain safe resident smoking practices. Policy Interpretation and Implementation .7. Any smoking-related privileges, restrictions, and concerns (for example, need for close monitoring) shall be noted on the care plan.Review of Resident #66's Electronic Health Record (EHR) revealed she was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease; cerebral infarction; muscle wasting and atrophy, not elsewhere classified, right hand; and muscle wasting and atrophy, not elsewhere classified left hand.Review of Resident #66's admission Minimum Data Set (MDS) assessment revealed a Brief Interview for Mental Status (BIMS) score of 11, indicating moderate cognitive impairment. Further review revealed the resident was a current tobacco user.Review of Resident #66's plan of care revealed a focus area initiated on 01/29/2026 which read, Resident smokes and potential for injury r/t smoking. Further review revealed an intervention initiated on 02/04/2026 Cigarettes and Lighter kept at desk.On 03/10/2026 at 3:30 p.m., an observation was made of Resident #66 smoking in the designated smoke room. There were no staff members observed in the smoke room. The resident was interviewed regarding smoking supplies. She stated she kept her cigarettes and lighter in her room. On 03/11/2026 at 8:17 a.m., a second observation was made of Resident #66, now in her room eating breakfast. An open pack of cigarettes was observed on the right side of the resident's bed, and a lighter observed on her night stand. On 03/11/2026 at 8:27 a.m., an interview and review of the resident's care plan was conducted with S9MDS who stated she was responsible for updating care plans. She confirmed the resident was care planned for her cigarettes and lighters to be kept at the nurse's desk. S9MDS stated Resident #66's cigarettes and lighter should not have been in the resident's room. On 03/11/2026 at 8:29 a.m., an interview was conducted with S8LPN. She confirmed Resident #66 should not have cigarettes and lighter in her room. She stated the CNAs (Certified Nursing Assistants) and nurses were responsible for checking the resident's room for cigarettes and lighters. On 03/11/2026 at 8:30 a.m., an observation of Resident #66's room was conducted with S3CN/IC, who stated she was the charge nurse. She entered the resident's room and returned with a pack of cigarettes and two lighters. S3CN/IC stated the resident was new at the facility and required staff to monitor her behaviors through her next assessment period in April of 2026 to determine if she was a safe smoker. She stated at this time Resident #66 should not have cigarettes and/or lighters in her room.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility failed to ensure each resident's drug regimen must be free from unnecessary drugs as evidenced by failing to adequately monitor for anticoagulant side effects for 1 (#5) out of 5 residents investigated for unnecessary medications.Findings:Review of the facility's policy titled, Anticoagulation-Clinical Protocol, with a last reviewed date of 11/03/2025, revealed in part, 5. The staff.will monitor for possible complications in individuals who are being anticoagulated, and will manage related problems. a. If an individual on anticoagulation therapy shows signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.Review of Resident #5's medical record revealed resident was admitted to the facility on [DATE] with the following diagnoses including, but not limited to: atherosclerotic heart disease of native coronary artery without angina pectoris, type 2 diabetes mellitus without complications, and hyperlipidemia.Review of Resident #5's MDS (Minimum Data Set) dated 01/14/2026 revealed, Section N-Medications, High-Risk Drug Classes: Use and Indication, E. Anticoagulant-is taking.Review of Resident #5's Care Plan revealed, At risk for bleeding r/t anticoagulant/blood thinner use. Goal: free of bleeding or bruising. Interventions: .Observe for bruising or signs of bleeding and notify MD.Review of Resident #5's Order Summary Report revealed an order dated 08/14/2024 that read, Rivaroxaban (anticoagulant) Tab 2.5 mg, give 1 tablet by mouth two times a day related to Athscl (artherosclerotic) heart disease of native coronary artery w/o (without) [NAME] pctrs (angina pectoris). Further review revealed no order for anticoagulant monitoring.Review of Resident #5's Medication Administration Record (MAR) from January 2026 to March 10, 2026 revealed documentation that Resident #5 had received Rivaroxaban 2.5 mg, 1 tablet by mouth two times a day. Further review of Resident #5's MAR from January 2026 to March 10, 2026 failed to reveal evidence of anticoagulant monitoring for Resident #5.On 03/11/2026 at 4:30 p.m., an interview was conducted with S16LPN. A review was conducted with S16LPN of Resident #5' MAR. S16LPN confirmed that Resident #5 was receiving an anticoagulant medication. S16LPN confirmed that there was no evidence of anticoagulant monitoring on Resident #5's MAR and there was no order for anticoagulant monitoring in Resident #5's physician's orders. On 03/11/2026 at 5:18 p.m., an interview was conducted with S1DON. S1DON confirmed that there was no evidence that Resident #5 had been adequately monitored for side effects of anticoagulants.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, interview and review of the facility's policy and procedures, the facility failed to maintain sanitary conditions in the kitchen by failing to ensure all staff wore a hair covering when entering the kitchen.127 residents consumed foods from the kitchen.Findings:On 03/09/2026, a review of the facility's policy titled, Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices with a reviewed date of 11/03/2025, read in part: Policy Statement: Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Policy Interpretation and Implementation .12. Hair nets or caps and/or bead restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens.On 03/09/2026 at 10:43 a.m., an observation was made of S6MD entering the kitchen and walking to the stove where there was an uncovered pot with bite-sized meat simmering. S6MD stood at the stove near the pot. S6MD had a full head of hair. He was not wearing any hair covering. S6MD was asked if he knew not to enter the kitchen without hair covering and he stated he usually wore a hat, but today he did not. On 03/09/2026 at 11:00 a.m., an interview was conducted with S5DM who was responsible for the kitchen and kitchen staff. She stated that everyone, including maintenance, was aware they are not supposed to enter the kitchen without hair covering. She stated that S6MD should not have entered the kitchen without hair covering.