STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kennebunk Center for Health & Rehabilitation, LLC	158 Ross Rd Kennebunk, ME 04043

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment for the medication storage room and the laundry room for 2 of 4 days of survey. Findings: 1.On 4/13/26 from 11:15 a.m. to 11:30 a.m., a tour of the laundry room too place with the Director of Operations and Director of housekeeping where the following was observed and confirmed: - Chipped wood on the door of the folding table, making it an uncleanable surface. -2 broken floor tiles by the door that goes from the clean side to the dirty side along with a rusted door frame and missing sheet rock. -Chipped paint on the windowsill of the dirty side making it an uncleanable surface. -Dirt and debris noted behind all 3 washers, along with broken floor tiles exposing untreated cement. -Wall by the sink on the dirty laundry side stained with an unknown substance, wall is noted to be lifting up, and the rubber floor trim is lifting up. 2.On 4/13/26 at 1:45 p.m. while observing the medication storage room a surveyor noticed the floor on the ride side of the back of room, under the counter had dust/debris and a dried, pink substance on the floor. On 4/13/26 at 1:49 p.m. in an interview with a surveyor the Director of Nursing confirmed the unclean floor and stated she would have housekeeping clean the floor. On 4/14/26 at 7:50 a.m. a surveyor observed the medication room floor again and the pink substance had been cleaned, but the floor still appeared to have dust/debris in the corner as well as other areas of the floor, and the wall between the frig and cabinet had chipped/missing paint, and stains creating an uncleanable surface. On 4/14/26 at 7:55 a.m. during an interview with a surveyor Register Nurse #1 confirmed this finding.

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on record reviews and interviews, the facility failed to ensure that a care plan was developed in the area of dementia care for 1 of 2 residents reviewed for dementia (Resident #55), and in the area of accidents for 1 of 4 residents reviewed for falls (Resident #9).Findings: 1.Review of Resident #55's medical record stated he/she was admitted to the facility in July of 2025 with a diagnosis of dementia. The most recent care plan dated 2/9/26 lacked evidence that a comprehensive care plan was developed in the area of dementia care. On 4/15/26 at 1:29 p.m. in an interview with a surveyor, the Regional Director of Clinical Operations confirmed this finding. 2. On 10/22/25 the Division of Licensing and Certification (DLC) received a facility-reported incident that indicated that Resident #9 had sustained an unwitnessed fall on 10/21/25 and was subsequently transferred to an acute care hospital and diagnosed with multiple fractures. The facility's 5-day follow-up report, submitted to the DLC on 10/28/25 stated, .A toileting schedule has been added to care plan to attempt to decrease risk of falls while trying to get to the bathroom. A review of Resident #9's clinical record indicated that Resident #9 has diagnoses to include, but not limited to repeated falls and abnormalities of gait and mobility. Resident #9's most recent quarterly Minimum Data Set (MDS) Assessment completed 2/9/26 under Section GG indicates Resident #9 requires setup assistance for toilet transfers and toileting. A review of Resident #9's care plan revealed, Resident has a Deficit in Self Care Function.TOILETING: Independent (No help or staff oversight at any time) and lacked evidence of an intervention for a toileting schedule. Additionally, the care plan lacked evidence that goals and interventions were developed and implemented for falls. On 4/14/26 at 2:49 p.m., the surveyor discussed the above concern during an interview with the Director of Nursing (DNS). At this time, the DNS reviewed Resident #9's entire care plan and confirmed that it does not contain goals and interventions for falls. The DNS then stated that for some reason, Resident #9's fall care plan was resolved on 2/26/26.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 record reviews and interviews, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessment, for 7 of 21 residents whose care plans were reviewed (Resident #2, #7, #8, #23, #35, #40, & #79). Findings: 1. On 4/15/26 a review of Resident #2's medical record contained a quarterly Minimum Data Set (MDS) version 3.0 dated 1/16/26 and 10/16/25. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Quarterly MDS assessment. 2. On 4/15/26 a review of Resident #35's medical record contained a quarterly Minimum Data Set (MDS) version 3.0 dated 3/4/26, 1/13/26, 10/2/25, and 7/3/25. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Quarterly MDS assessment. 3. On 4/15/26 a review of Resident #79's medical record contained an annual Minimum Data Set (MDS) version 3.0 dated 2/25/26. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Quarterly MDS assessment. On 4/15/26 at 12:20 p.m. in an interview with a surveyor, the Director of Social Services confirmed the above findings stating they are working on this. She stated they are having the care plans first then the MDS assessment and need to swap so the MDS assessment comes first. She also stated that they always ask the residents if they want anything added to the care plan and the nurses can add items anytime as they come up. 4. On 4/15/26 a review of Resident #8's medical record contained a Significant Change Minimum Data Set (MDS) version 3.0 completed 1/21/26. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Significant Change MDS assessment. On 4/15/26 at 1:40 p.m., in an interview with the Director of Social Services, the above information was discussed and confirmed. 5. A review of Resident #7's clinical record revealed an MDS Quarterly Assessment was completed on 3/27/26. Further review of Resident #7's clinical record revealed that an IDT meeting was scheduled for 4/15/26 (19 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. 6. A review of Resident #23's clinical record revealed an MDS Quarterly Assessment was completed on 2/5/26. Further review of Resident #23's clinical record revealed that an IDT meeting was held 2/16/26 (11 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. 7. A review of Resident #40's clinical record revealed an MDS Quarterly Assessment was completed on 3/26/26. Further review of Resident #40's clinical record revealed that an IDT meeting was held 4/13/26 (17 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/15/26 at 9:44 a.m., during an interview with the Social Services Director, 2 surveyors discussed the above findings. At this time, the Social Services Director confirmed that Resident #7's IDT meeting is scheduled to be held today, and that the facility schedules IDT meetings within 2 weeks following the care plan review date and not within 7 days following the MDS assessments.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on policy reviews, record reviews, and interviews, the facility failed to adequately follow physician orders for blood sugar checks before meals for 2 of 3 residents reviewed and failed to adequately follow the facility's policy for administering long-acting insulin for 1 of 2 residents reviewed (Resident #15, #43 & #69). Findings:The facility's Medication Pass Policy, last revised 9/24 states, it is the policy of the facility that medications are administered safely and timely per the physician's orders, and for facilities that support a ?liberalized' med pass, the following times may also be added: - Liberalized Med Pass Morning 7 AM - 11 AM - Liberalized Med Pass Lunch/Midday 11 AM - 2 PM - Liberalized Med Pass Evening 3 PM - 7 PM - Liberalized Med Pass Bedtime/HS 7 PM - 10 PM - Liberalized Med Pass Sunrise 4 AM - 6 AMThe facility's Diabetes Management Protocol, last revised 2/25 states, Insulin: Basal Insulin (Long acting): Glargine (Lantus), Detemir (Levemir), or Degludec (Tresiba) provides 24-hour glucose control.1. On 4/14/26 at 9:11 a.m. a surveyor observed several late blood sugar orders during the medication administration observation that were highlighted in red in the electronic medical record. On 4/14/26 at 12:00 p.m., surveyor reviewed the Medication Admin Audit Report for R#43 that states they have an order for Fingerstick Blood Sugar (FSBS) before meals and at bedtime for diabetic management, notify HCP (Health Care Provider) for FSBS 70 or greater than 350 unless otherwise indicated. The record showed that on 4/14/26 R#43's blood sugar was checked at 9:29 a.m. after breakfast. 2. On 4/14/26 at 12:00 p.m. surveyor reviewed the Medication Admin Audit Report for R#69 that states they have an order for Fingerstick Blood Sugar before meals and at bedtime for diabetic management, notify HCP for FSBS 70 or greater than 350 unless otherwise indicated. The record showed that on 4/14/26 R#69's blood sugar was checked at 9:47 a.m. after breakfast. 3. On 4/14/26 at 11:54 a.m. during observation of R#5's medication administration, a surveyor observed the Medication Administration Record (MAR) which showed that the resident had not been given their Insulin. The order states, Glargine subcutaneous solution 100 unit/ml (units per milliliter), inject 15 units subcutaneously one time a day in the morning with a start date of 4/6/26. MedTech #1 stated that they do not do injections, the nurse does them.On 4/14/26 at 12:28 p.m. during an interview with a surveyor the Director of Nursing (DON) pulled the MAR up for R#15, and confirmed it had been given at 11:47 p.m. The surveyor questioned the timing of the administration of the medication and the DON stated that R15 is under the liberalized medication administration times. When the surveyor stated that it was past the liberalized time frame the DON stated, well an hour before and an hour after and all we can do is follow provider orders. On 4/14/26 at 12:30 p.m. in an interview with a surveyor, the DON confirmed the above findings.

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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 record review, interview and Payroll Based Journal Report (PBJ), the facility failed to ensure it was sufficiently staffed on weekends for 1 of 1 quarters reviewed (10/1/25 through 12/31/25).Findings: Review of Center for Medicare & Medicaid (CMS) PBJ Report revealed the facility triggered for low weekend staffing during the first quarter (10/1/24 through 12/31/24). On 4/15/25 at 12:00 p.m., during a review of first quarter weekend staffing with a surveyor, the Administrator confirmed the facility was not adequately staffed for 5 of 39 days reviewed (day shifts).

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure expired lab supplies were removed from supply, available for use for 4 of 4 units, and the facility failed to ensure treatment carts were locked when unattended for1 of 1 carts, for 1 of 4 days of survey.Findings: 1.On [DATE] at 7:50 a.m. two surveyors identified lab supplies (blood collection tubes) that had expired: * 95 blue top blood collection tubes with expiration date [DATE] * 3 yellow top blood collection tubes with expiration date [DATE] * 29 red blood collection tubes with expiration of [DATE] On [DATE] at 7:59 a.m. the Assistant Director of Nursing confirmed the expired blood collection tubes with two surveyors and removed them from use. On [DATE] at 10:23 a.m. in an interview the Regional Director of Operations confirmed that the facility does sometimes do their own blood draws. 2. On [DATE] at 9:37 a.m. 2 surveyors observed an unlocked and unattended treatment cart located on the Windmere Unit. The third and fourth drawers on the left side of the cart contained various resident medications/treatments, including but not limited to Compound W, Nystatin, Diclofenac, Asperflex, hydrocortisone cream, ammonium lactate, as well as individually packaged SaniCloth disinfecting wipes. Throughout the observation, several staff members walked past the surveyors going through the cart. Throughout the survey, the survey team observed multiple residents foot propelling in their wheelchairs in the halls. On [DATE] at 9:40 a.m., the Administrator walked past the surveyors going through the cart. At this time, the surveyors stopped the Administrator and discussed the observation. During an interview at this time, the Administrator stated that the nurse assigned to the treatment cart is doing wound rounds on the unit and proceeded to lock the cart.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner related to floors, walls, food preparation surfaces, the walk-in freezer, and the dish room for 1 of 1 initial kitchen tour. Additionally, the facility failed to ensure foods were sealed, labeled, and dated in a food preparation area, a dry storage room, a reach-in refrigerator, a walk-in refrigerator, and a walk-in freezer for 2 of 2 kitchen tours. Furthermore, the facility failed to maintain an emergency food supply for 2 of 4 days of survey (4/12/26, 4/13/26).Findings:Review of facility policy, Storage of Food & Supplies, revised 2/2022 states, .Labeling and rotating food supply .Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates .Food removed from its original container must be labeled with the common name of the food .Review of facility policy, Dishwashing- Dish machine, revised 1/2022 states, .Check that the machine is clean. Check wash arms, scrap trays, and final rinse jets . Clean dish machine throughout the day and during use as necessary to prevent recontamination of equipment and utensils .After Dishwashing is Complete .Clean dish room tables and dish machine. Use a de-[NAME] whenever necessary to remove mineral deposits caused by hard water .1. On 4/12/26 from 9:05 a.m.-9:45 a.m., a surveyor conducted an initial kitchen tour with [NAME] #1, during which the following was observed: In the main Kitchen/Food Preparation (prep) area:The wash sink's sanitizer solution hose was immersed below the water in the sink.There were cracks on the wall behind the sink, creating an uncleanable surface. A dedicated handwashing sink, with signage posted above the sink indicating the same, was located on a wall between the Dish Room and the food prep area. During an interview, [NAME] #1 stated that he sometimes uses the handwashing sink to rinse vegetables as a last resort. The surveyor observed that there was no air gap separation under the handwashing sink.Kitchen staff's personal water bottles, a can of RedBull energy drink, an ID badge, and a personal charger were stored on a food prep surface.There were crumbs and food debris on the stainless-steel countertop (food prep area) where the mixer is stored. A heavily soiled yellow radio was stored on the food prep countertop behind the mixer.A 48 ounce (oz) undated box of coarse flake kosher salt was observed on the bottom shelf of the food prep station next to the sink. The flip top was open, exposing the contents to air. When the surveyor discussed the finding, [NAME] #1 stated the salt was opened 3/17/26 but with repeated use, the marker used to date food items rubs off. A gallon container of Lea & [NAME] Worcestershire sauce was undated. A label on the side of container is dated 11/26/25. [NAME] #1 stated the label indicates the delivered date and that he opened the item the day it was delivered. An unlabeled, undated white bin with a clear lid was in the food prep area, containing what appeared to be oats.Food debris and crumbs were noted on the floor in multiple areas throughout the kitchen. Buildup was noted on floors, especially in corners and on baseboard trim throughout kitchen.The pink tray on top of the microwave was covered with crumbs and food debris and dried liquid. Additionally, a bottle of Smart Water was being stored on the pink tray. [NAME] #1 confirmed it is a staff member's water bottle. In the Dry Storage Area:1 pound (lb) box of baking soda, unlabeled, undated, and available for use. The flip top was open and exposing the contents to air.The reach-in (cook's) refrigerator contained the following available for use:- a square stainless steel container covered with foil, labeled [Cook #1's] Fat undated. [NAME] #1 stated this is bacon grease saved for him to use for food prep.- an undated 16 oz bag of whipped topping. The package indicated, Perishable .Best if used by. 14 days refrigerated. The Walk-In refrigerator contained the following available for use:- an unlabeled and undated open bag of spinach, located on the top right shelf.- 6 heads of green cabbage and1 head of purple cabbage, located on a silver tray on the right lower shelf. The tray was uncovered, unlabeled, and undated. - An unlabeled, open bag of shaved cheese, marked (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with an open date of 3/9/26 but no discard date, located on the top left shelf.The Walk-In freezer contained the following available for use:- an undated, open box of ground beef patties with the inner bag open and sticking out of the box, exposing the patties to air, located on the top left shelf. The surveyor noted freezer burn/discoloration on the edges of the exposed patties.- 2 unlabeled, a pork tenderloin, and a roll of ground beef (package imprint indicated 4/17/26 expiration date), located on the second left shelf. All were unlabeled and undated. - Additionally, the floor at back center of the freezer was covered in debris, trash, and residue buildup. The Dish Room contained the following:- The grate under the dish machine contained significant food debris.- The walls had multiple spackled areas that were unpainted, creating an uncleanable surface. -there were two wall- mounted oscillating fans, and the fan blades were covered in dust. One of the fans was blowing in the direction of the clean dishes. On 4/12/26 at 1:55 p.m., the surveyor conducted a repeat tour of the kitchen with the Administrator and discussed the above findings. At this time, the Administrator removed the visibly freezer-burnt beef patties from the walk-in freezer.On 4/13/26 at 12:48 p.m., the surveyor discussed the above findings with the Food Services Director (FSD). During an interview at this time, the FSD stated that foods should be labeled with the date received, the date opened, and a discard date.2. On 4/13/26 at 12:48 p.m., during a repeat kitchen tour with the FSD, the surveyor requested to see the facility's emergency food supply. During an interview at this time, the FSD stated that the emergency water supply is stored in the shed, but that when he started working for the facility four months ago, the emergency food supply was expired. The FSD then stated that he knows a delivery is coming tomorrow.On 4/14/26 at 9:37 a.m. during an interview, the interim Food Service Director stated that the facility's replacement emergency food supply is going to be delivered this afternoon and stated as far as she knows, the facility has always had an emergency food supply, but that she can't speak to what happened. At this time, the interim FSD stated that the facility does not have an emergency food supply list, but that she will create one today. On 4/14/26 at 9:38 a.m., during an interview in the presence of 2 surveyors, the Administrator stated the facility was utilizing its emergency food supply for routine meal prep because the supply was nearing expiration, but that there was a miscommunication, and the FSD was not replenishing the emergency supply as he used it. The Administrator then stated that the facility's emergency food supply will be delivered this afternoon. On 4/14/26 at 11:13 a.m., the surveyor observed that the emergency food supply had been delivered and was being stored in the back room of the kitchen's dry storage area.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and facility policy, the facility failed to conduct regular inspection of all bed frames and mattresses as part of a regular maintenance program to ensure that the mattresses and bed frames are compatible and identify areas of possible entrapment for 4 of 4 units observed (Eagle, [NAME], Sagamore, and Windmere).Finding:Facility Policy Patient Bed Side Rails, revised 5/2/25 states, .The following areas of entrapment will be checked when the bed is in the flat position .Zone #7 between the head and foot board and the mattress end will not exceed more than 4 3/4 inches . Zones 5, 6 and 7 will be measured in accordance with the measurements for zones 1-4 until such time as new recommendations are made by the FDA [Food and Drug Administration] .All the beds in the facility will be checked annually using the Bed Assessment Tool to Prevent Entrapment, and when there is a change in side rail status. On 04/12/26 at 10:59 a.m., a surveyor observed Resident #7 asleep in his/her bed with his/her head at the foot end of the bed. During a repeat observation on 4/12/26 at 2:56 p.m., the surveyor observed a large gap between Resident #7's mattress and the footboard of the bed, creating an area of possible entrapmentOn 4/12/26 from 3:23 p.m. to 3:34 p.m., 3 surveyors observed large gaps between the mattress and the footboard on the following beds:- Windmere Unit: Rooms 100 Door (D), 106 D, 107 Window (w), 108 W, 109 W- Eagle Unit: room [ROOM NUMBER] W- Sagamore Unit: room [ROOM NUMBER]W- [NAME] Unit: Rooms 18 D, 20 DOn 4/12/26 at 3:38 p.m., during an interview with the Administrator, 3 surveyors discussed the above observations. At this time, the Administrator stated that the improperly fitting mattresses are something the facility has identified and has been auditing and actively working on replacing. The surveyors then requested evidence of the facility's audits and bed gap measurements.On 4/13/26 at 10:24 a.m. during an interview with the Regional Engineering Director and the Administrator in the presence of 4 surveyors, the Regional Engineering Director stated that the facility inspects zone 1-4 annually and provided a binder containing the facility's measurements. The Administrator was unable to provide evidence of the facility's original audit to the survey team and stated that a facility-wide audit was completed this morning. A review of the provided Bed System Measurement Device Test Results Worksheet revealed that only 10 beds were measured in 2024, only 6 beds were measured 9/25/25, and lacked evidence of annual measurements.

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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 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 and interviews, the facility failed to provide care to residents in a manner that maintains each resident's dignity by failing to serve all residents seated at the same table at the same time for 1 of 2 dining observations on 1 of 4 days of survey (4/12/26).Finding:On 4/12/26 between 12:07 p.m. and 12:18 p.m., a surveyor observed the lunch meal service in the facility's dining room. Upon surveyor entrance to the dining room at 12:07 p.m., Residents #7 and #48 were seated at a table with Resident #29. Resident #29 had received his/her meal, and Residents #7 and #48 had not yet received their meals. Staff proceeded to deliver meals to residents at other tables in the dining room. At 12:10 p.m., Resident #7 asked Certified Nursing Assistant (CNA) #1 where their meals were and told the CNA that Resident #29 was waiting to begin eating until he/she and Resident #48 received their meal. CNA #1 replied that she was waiting for the rest of the meal trays to be delivered to the dining room, and then continued delivering meals to residents at the other tables. At 12:16 p.m. Residents #7 and #48 still had not received their meal, and Resident #48 asked a staff member when they were going to receive their meals. At this time, the staff member replied, It's going to come out. They're really busy today. At 12:17 p.m., Resident #48 received his/her meal, followed by Resident #7. On 4/12/26 at 12:21 p.m. during an interview, CNA #2 stated that the facility recently started a new way of passing meals on the weekend and that there is supposed to be one meal cart specifically for residents seated in the dining room, but that some residents' meals ended up on the carts designated for delivery to the units.On 4/13/26 at 3:40 p.m. the surveyor discussed the above observation with the Administrator. During an interview at this time, the Administrator stated that until recently, all residents were eating in their rooms, except residents who require special assistance with meals, and that this is only the second day of implementing meal delivery in the dining room on the weekends.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205095	A. Building B. Wing	04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on record review, interview and facility policy, the facility failed to ensure the physician was notified of a significant change and/or incident for 1 of 3 residents reviewed for hospitalizations. (Resident #91)Findings:Facility policy titled Change of Condition Notification states The facility will inform the resident, consult with the resident's healthcare provider, and if known, notify the resident's legal representative or family member when there is. A significant change in the resident's physical, mental, or psychosocial status. A decision to transfer the resident from the facility. Under the section titled Procedure it states Physician/family notification must be documented in the electronic health record.A review of Resident #91's clinical record shows a progress note dated 2/16/25 at 1:59 p.m., which stated Patient lethargic this afternoon. Patients unable to answer simple questions. Vitals signs reflect an infectious process. BP (blood pressure) 159/88, p (pulse) 108, temp 99.1, oxygen saturation 88% on RA (room air) . Is appearing to be off [his/her] baseline. Writer will contact on-call. Writer applied supplemental oxygen at 2 L/m (liters per minute) . Patient has a history of Urosepsis. Progress note dated 2/16/25 at 2:19 p.m., stated, Writer spoke with on-call [provider] orders from provider are as follows. CBC (complete blood count), CMP (comprehensive metabolic panel), procalcitonin, and UA (urine analysis) STAT (urgent). Start Augmentin 875 mg for 5 days. Start NS (normal Saline) at 75 ml/hr (milliliter/per hour) for 1 bag. Start neuro checks. Notify on call for any changes in condition. Further review of the clinical record showed a progress note dated 1/16/25 at 3:13 p.m. which stated, . resident unable to swallow antibiotic. writer unable to start IV (intravenous) due to lack of supplies. Writer entered labs into PCC (point click care) for lab draw on Monday morning due to lab drop off center being closed on Sunday. Another progress note on 2/16/25 at 4:34 p.m., stated Temp is up to 101.2, POA (power of attorney) wants patient send to hospital. Patient sent out to the ED (Emergency Department) for further evaluation via EMS (Emergency Medical Services) for AMS (Altered Mental Status), abnormal vitals, and increased weakness.A review of the resident's entire clinical record lacked evidence that the provider was notified regarding the residents further change in condition after he/she was initially seen by the provider along with the inability to obtain stat labs, lack of supplies needed to start an IV, and the resident's inability to swallow the antibiotics.On 4/14/26 at 9:05 a.m., in an interview with the Facility Administrator, it was confirmed that the physician was not notified of the residents further change in condition.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on record review and interview, the facility failed to issue a written transfer/discharge notice and a bed hold notice to include cost of care and a statement of the resident's appeal rights to the legal representative for 1 of 5 sampled residents reviewed for transfer to an acute care hospital (Resident #77).Finding:1. Documentation in Resident #77's clinical record indicated that he/she was transferred to an acute care hospital on 1/15/26 and on 4/12/26. Further review of Resident #77's clinical record lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative for the above dates.On 4/15/26 at 2:19 p.m. during an interview in the presence of 4 surveyors, the Business Office Manager confirmed that she does not issue a written transfer/discharge notice and bed hold notice to resident representatives.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observations, record review, and interviews, the facility failed to ensure physician orders were followed for 1 of 1 resident receiving oxygen therapy (Resident #11).Finding:On 4/12/26 at 9:09 a.m. and 11:48 a.m., a surveyor observed Resident #11 asleep in bed, wearing oxygen (O2) via a nasal cannula with the oxygen concentrator flow rate set between 3.5 and 4 liters per minute.A review of Resident #11's clinical record revealed an active physician order for Oxygen at 2 liters per minute continuous via nasal cannula.every shift for shortness of breath.On 4/13/26 at 3:59 p.m., during an interview, Resident #11 stated that staff hand him/her the oxygen tubing and that he/she puts it on and takes it off, but that staff make all adjustments to the oxygen concentrator settings.On 4/14/26 at 8:45 a.m., the surveyor observed Resident #1 asleep in bed wearing oxygen with the oxygen concentrator flow rate set to 2.5 liters per minute.On 4/15/26 at 11:45 a.m., during a repeat observation, Resident #11 was lying in bed and was not wearing oxygen, and his/her oxygen concentrator was powered off. During an interview at this time, Resident #11 stated that he/she does not need to wear his/her oxygen today.On 4/15/26 at 1:55 p.m the surveyor discussed the order for continuous oxygen at 2 liters per minute and the above observations during an interview with the Director of Nursing (DNS). At this time, the DNS stated that the providers definitely do not want Resident #11's oxygen to be worn as needed, but that it is within Resident #11's rights to remove his/her oxygen and that he/she often does. The surveyor then discussed that Resident #11's clinical record, such as nursing progress notes and/or care plan, does not reflect Resident #11's frequent removal of the oxygen. On 4/15/26 at 3:49 p.m., the surveyor discussed the finding with the Administrator and the Regional Director of Operations.