STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205101	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pinnacle Health & Rehab Canton	26 Pleasant St Canton, ME 04221

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews, the facility failed to ensure the confidentiality of protected health information for 1 of 41 residents during 1 of 3 days of survey (Resident #3).Findings:On 9/24/25 at 3:15 p.m., two surveyors observed an unattended medication cart outside room [ROOM NUMBER] with a fully open computer monitor with Resident #3's electronic Medication Administration Record (eMAR) displayed, visible and easily accessible to residents, visitors or other unauthorized persons. There were no staff observed in the area, and 1 resident was observed in the hall. Approximately 1 minute later the Certified Nursing Assistant/Medication Technician (CNA7) was observed coming from behind the nurses' station and walked up to the medication cart, acknowledged the unsecured medication cart and closed the eMAR stating, I was only over there at the nurses station.During an interview on 9/24/25 at 3:17 p.m., the above was discussed with Director of Nursing.

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 3 of 3 days of survey (9/22/25, 9/23/25 and 9/24/25) for resident rooms, hallways and the laundry room for 3 of 3 facility tours.Findings:1. On 9/22/25 at 8:00 a.m., a surveyor toured and observed the facility to smell of stale urine and feces throughout the facility.2. On 9/23/25 at 7:55 a.m., a picture was handing on the wall by room [ROOM NUMBER]. The frame was observed to be broken in the bottom left corner and was held together with scotch tape. There was also picture hanging directly across the hall on the wall with the bottom right edge of the frame coming apart. On 9/23/25 at 8:03 a.m. Licensed Practical Nurse (LPN #1) confirmed the finding.3. On 9/23/25 at 9:23 a.m., two surveyors noted a very strong urine order at door of room [ROOM NUMBER]. wet floor sign noted on entrance.4. On 9/24/25 at 8:00 a.m., surveyor again toured and observed the facility to smell of urine and feces throughout the facility. 5. On 9/24/2025 from 8:30 a.m. to 9:05 a.m., a surveyor did an Environmental Tour with the Maintenance Director in which the following findings were discussed and observed:- Resident room [ROOM NUMBER] - Resident #26's wheelchair had rips in both arm rests material. There was clean briefs and clothing on closet floor. The bathroom door trim had chipped/missing paint.- The shower room across from resident room [ROOM NUMBER] had a toilet with a seat that was stained yellowish in color. There were numerous commode buckets, soiled gloves and briefs on the floor. The shower non-skid transition strip was chipped and missing pieces creating an uncleanable surface. - Resident room [ROOM NUMBER]- The inside the toilet bowl was dirty/stained. - Hallway base board heater, outside resident room [ROOM NUMBER], had chipped/missing paint. - The Hallway wall light, across from resident room [ROOM NUMBER], had a broken cover which was dislodged from the lighting unit.- The bathroom across from dining room kitchenette had chipped/missing paint on the doorframe. - The walls in the dining room were marred with black marks and had chipped/missing paint. Laundry:- There were 2 wooden folding tables and 5 wooden laundry carts that had chipped/missing paint and were uncleanable. - The wooden frame, under the small dryer, had chipped missing paint creating an uncleanable surface. - The laundry room floor has chipped/missing paint creating an uncleanable surface. - The wooden drying rack had worn surfaces exposing untreated wood.- The wall exhaust fan was dusty/dirty. On 9/24/25 at 8:15 a.m., in an interview with 2 surveyors present, the laundry aide confirmed the laundry room findings.On 9/24/2025 at 9:05 a.m., in an interview with a surveyor, the Maintenance Director confirmed the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop/implement goals and interventions for psychotropic use for 3 of 16 care plans reviewed (Resident's #2, #6 and #7).Findings: 1.Resident #3 was admitted on 5/25 and has diagnoses to include major depressive disorder. Review of Resident 's active orders revealed he/she is taking antidepressant medications Remeron and Lexapro, and antianxiety medication Lorazepam. Review of Resident #3's care plan updated 5/13/25 states [Resident #3] uses antidepressant medication r/t Depression. Monitor/document side effects and effectiveness Q-SHIFT. Monitor/document/report PRN adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. Further review of Resident #3's clinical record lacked evidence he/she was being monitored for side effects from antidepressant medication use. [Resident #3] uses psychotropic medications. [Resident #3] will be/remain free of psychotropic drug related complications, including movement disorder, discomfort, hypotension, gait disturbance, constipation/impaction or cognitive/behavioral impairment through review date. Monitor for side effects and effectiveness. Monitor/document/report any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Further review of Resident #3's clinical record lacked evidence he/she was being monitored for side effects from psychotropic medication use. 2. Resident #7 was admitted 6/25 and has diagnoses to include Parkinsons, depression and delusional disorder. Review of Resident's active orders revealed he/she is taking antipsychotic medication Risperdal, and antidepressant medication Duloxetine. Review of care plan initiated 6/24/25 states [Resident #7] uses antidepressant medication. will be free from discomfort or adverse reactions related to antidepressant therapy through the review date. Monitor/document side effects and effectiveness Q-SHIFT. Monitor/document/report adverse reactions to antidepressant therapy: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes. Further review of Resident #7's clinical record lacked evidence he/she was being monitored for side effects from antidepressant use. [Resident #7] uses anti-anxiety medications. [Resident #7] will be free from discomfort or adverse reactions related to anti-anxiety therapy through the review. Monitor for side effects and effectiveness Q-SHIFT. Monitor [Resident #7] for safety. She is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	impairment that looks like dementia and increases risk of falls, broken hips and [NAME] gs. Monitor/document/report PRN any adverse reactions to ANTI-ANXIETY therapy: Drowsiness, lack of energy, clumsiness, slow reflexes, slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. UNEXPECTED SIDE EFFECTS: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. Further review of Resident #7's clinical record lacked evidence he/she was being monitored for side effects for anti-anxiety medication use. Further review of Resident #7's clinical record revealed he/she is taking antipsychotic medication Risperdal. The facility failed to develop/implement goals and interventions for antipsychotic use. 3. Resident #6 was admitted on 5/24 and has diagnoses to include anxiety disorder, dementia with psychotic disturbance, delusional disorders, and major depressive disorder. Review of Resident 's active orders revealed he/she is taking antipsychotic medication Risperdal and antianxiety medication Buspirone. Review of Resident #6's care plan updated 8/22/25 states [Resident #6] uses anti-anxiety medications. Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/record occurrence of for target behavior symptoms pacing, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff/others and document per facility protocol. He sometimes will get verbal with roommate. Monitor him for safety. The resident is taking ANTI-ANXIETY meds which are associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment that looks like dementia and increases risk of falls, broken hips and legs. Resident #6's clinical record lacked evidence he/she was being monitored for side effects from ANTI-ANXIETY medication use. Review of Resident #6's care plan updated 5/3/24 states [Resident #6] uses psychotropic medications r/t[related to] dementia with psychotic features. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Monitor/document/report PRN any adverse reactions of PSYCHOTROPIC medications: unsteady gait, tardive dyskinesia, EPS (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideations, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps nausea, vomiting, behavior symptoms not usual to the person. Further review of Resident #6's clinical record lacked evidence he/she was being monitored for side effects from psychotropic medication use. During an interview in presence of 4 surveyors on 9/23/25 at 12:34 p.m., The Director of Nursing (DON) stated the facility has never monitored anyone for side effects of the above medications.

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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 review and interviews, the facility failed to review and revise the care plan by an interdisciplinary team (IDT), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 5 of 16 residents (R) reviewed for care planning (R2, R6, R12, R36, R35).Findings: 1. A review of R35's clinical record revealed an MDS admission Assessment was completed on 8/12/25. Further review of R35's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. On 9/23/25 at 11:32 a.m. during an interview with 2 surveyors, the Social Services Director stated that an IDT meeting was not held following R35's admission Assessment. Findings: 2 Review of Resident #2's clinical record revealed the following: -Annual MDS with completion date 1/22/25. Further review of Resident #2's clinical record revealed the IDT meeting was held on 1/16/25 (6 days prior to completed MDS). Quarterly MDS with completion date 10/23/24. Further review of Resident #2's clinical record revealed the IDT meeting was held on 10/17/24 (7 days prior to completed MDS). 3.Review of Resident #12's clinical record revealed the following: -Quarterly MDS with completion date 1/22/25. Further review of Resident #12's clinical record revealed the IDT meeting was held on 1/16/25 (6 days after the completed MDS). During an interview on 9/23/25 at 10:49 a.m. Licensed Social Worker (SW) stated IDT meetings are scheduled either the week before or the week of the MDS. At this time the above was reviewed and confirmed. 4 Review of Resident #6's clinical record revealed the following: - Quarterly MDS with completion date 11/6/24. Further review of Resident #6's clinical record revealed the IDT meeting was held on 10/31/24 (6 days prior to completed MDS). - Quarterly MDS with completion date 2/5/25. Further review of Resident #6's clinical record revealed the IDT meeting was held on 1/30/25 (6 days prior to completed MDS). 5. Review of Resident #36's clinical record revealed the following: - Quarterly MDS with completion date 6/18/25. Further review of Resident #36's clinical record revealed the IDT meeting was held on 6/12/25 (6 days prior to completed MDS). On 9/24/25 at 1:10 p.m., in an interview with a surveyor, the Licensed Social Worker confirmed that R6's and R36's care plans were not reviewed and completed within 7 days of the IDT meetings.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 monitor and document targeted side effects to support the use of an antipsychotic and antianxiety medication for of 3 residents reviewed for unnecessary medications (Resident's #2, #6 &#7). Findings: 1.Resident #3 was admitted on [DATE] and has diagnoses to include major depressive disorder. Review of Resident #3's active orders revealed: -Order with start date of 5/14/25 for antidepressant Lexapro Oral tablet 10 mg (Escitalopram) Give 1 tablet by mouth one time a day. -Order with start date of 5/13/25 for antidepressant Remeron Oral Tablet 15 mg (Mirtazapine). Give 1 tablet by mouth at bedtime. -Order with start date of Lorazepam Intensol Oral Concentrate 2 MG/ML (Lorazepam) Give 0.25 ml by mouth every 3 hours as needed for anxiety or restlessness. Review of Resident #3's care plan updated 5/13/25 states: [Resident #3] uses antidepressant medication r/t Depression; Monitor/document side effects and effectiveness Q-SHIFT. [Resident #3] uses psychotropic medications. Monitor for side effects and effectiveness. Further review of Resident #3's entire clinical record lacked evidence he/she was being monitored for side effects of these medications. 2. Resident #7 was admitted with diagnoses to include Parkinson's, depression, and delusional disorders. Review of Resident #7's active medications revealed: -Order with start date of 7/2/25 for antidepressant Duloxetine HCL Capsule Delayed Release Particles 60 mg. Give 1 capsule by mouth two times a day. -Order with start date of 9/17/25 for antipsychotic Risperdal Oral Tablet (Risperidone). Give 0.75 mg by mouth two time a day for delusion, hallucination and mood stabilization. Further review of Resident 7's clinical record lacked evidence that he/she was being monitored for side effects of these medications. Review of Resident #7's care plan imitated 6/27/25 states [Resident #7] uses antidepressant medication. Monitor/document side effects and effectiveness Q-SHIFT. Monitor/document/report PRN adverse reactions: change in behavior/mood/cognition; hallucinations/delusions; social isolation, suicidal thoughts, withdrawal; decline in ADL ability, continence, no voiding; constipation, fecal impaction, diarrhea; gait changes, rigid muscles, balance probs, movement problems, tremors, muscle cramps, falls; dizziness/vertigo; fatigue, insomnia; appetite loss, wt loss, n/v, dry mouth, dry eyes . [Resident #7] uses anti-anxiety medications. Monitor for side effects and effectiveness Q-SHIFT. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Monitor/document/report .Drowsiness, lack of energy, clumsiness, slow reflexes, Slurred speech, confusion and disorientation, depression, dizziness, lightheadedness, impaired thinking and judgment, memory loss, forgetfulness, nausea, stomach upset, blurred or double vision. Unexpected side effects: Mania, hostility, rage, aggressive or impulsive behavior, hallucinations. [Resident #7] has anxiety. Monitor/document for side effects and effectiveness. Review of Resident #7's entire clinical record laced evidence he/she was monitored for side effects of the above medications. During an interview in presence of 4 surveyors. on 9/23/25 at 12:34 DON confirmed the clinical record lacked evidence of monitoring for the side effects of antipsychotic and antianxiety medications. 3. Resident #6 was admitted in 5/24 and has diagnoses to include anxiety disorder, dementia with psychotic disturbance, delusional disorders. Review of Resident 's active orders revealed he/she is taking antipsychotic medication Risperdal and antianxiety medication Buspirone. - Review of Resident #6's active orders revealed: -Order with start date of 5/7/25 for antipsychotic Risperdal Oral Tablet (Risperidone) Give 0.5 mg by mouth two times a day. -Order with start date of 2/16/25 for antianxiety Buspirone HCl Oral Tablet 10 MG (Buspirone HCl) Give 1 tablet by mouth four times a day. - Review of Resident #6's active orders revealed: [Resident #6] uses antipsychotic medications. Administer PSYCHOTROPIC medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Further review of Resident #6's entire clinical record lacked evidence he/she was being monitored for side effects of these medications. - Review of Resident #6's active orders revealed: [Resident #6] uses anti-anxiety medications. Administer ANTI-ANXIETY medications as ordered by physician. Monitor for side effects and effectiveness Q-SHIFT. Further review of Resident #6's entire clinical record lacked evidence he/she was being monitored for side effects of these medications. On 9/23/25 at 12:35 p.m., in an interview with a surveyor, the Director of Nursing [DON], confirmed the clinical record lacked evidence of monitoring for the side effects of antipsychotic and antianxiety medications.

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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. Based on observations, interviews, and review the facility's Food Storage Policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for fans, a food mixer, and floors. Additionally, the facility failed to ensure foods were properly labeled for 1 of 1 kitchen tour on 1 of 3 days of survey. (9/22/25)Findings:The facility's Food Storage Policy noted: Each item will be dated with a received date, once opened the box will be dated with an open date. Items taken out of the box and opened needs a received date and an open date (as of 9/22/25 all items taken out of a box without labeling of the contents will be labeled with the item name) receive date and open date.On 9/22/25 from 9:00 a.m. to 9:50 a.m., a surveyor conducted a kitchen tour with the Food Service Supervisor in which the following findings were observed: - The dish room had a wall fan that was dusty/dirty, had two ceiling tiles that had fallen partially out of the ceiling grid holding them in place and had a wall air vent that was heavily soiled with dust.- The food mixer had chipped/missing paint on the mix arm and base. Also, there were dried food particles and dried liquid residue on the base. - The dry storage room had ten large bags of cereal that were not labeled. - The walk-in refrigerator floor was extremely rusty. - The walk-in freezer floor was rusty. There were six large bags of breaded patties that were not labeled. On 9/22/25 at 9:50 a.m., in an interview with a surveyor, the Food Service Supervisor confirmed the findings. On 9/22/25 at 2:50 p.m., in an interview, a surveyor discussed the findings with the Food Service Director.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, record review and interviews, the facility's Quality Assurance Committee failed to ensure that the Plan of Correction (POC) for an identified deficiency from the annual Long Term Care Recertification Survey, dated 11/19/25, was effective. The Federal citation F583, F584 and F689 were cited again during the re-visit to the annual Long Term Care Recertification Survey, dated 12/30/25.Findings:During the follow-up survey on 12/30/25, it was determined that F583, F584 and F689 would be recited for the same reasons: F583 for failure to ensure the confidentiality of protected health information, F584 for failure to provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment and F689 for failure to ensure that the resident's environment was free of accident hazards. (see F583, F584 and F689)On 12/30/25 at 1:45 p.m., during an interview, the above was discussed with the Director of Nursing.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, interviews, facility policy, and U.S. Centers for Disease Control and Prevention (CDC) guidance, the facility failed to maintain an Infection Control Program designed to help prevent the development and transmission of disease and infection related to the handling of soiled linen for 3 of 3 observations on 2 of 3 days of survey (9/22/25 and 9/24/25) and Enhanced Barrier Precautions (EBP) for 1 of 1 day of survey (9/23/25). Additionally, the facility failed to ensure that a resident being treated for an open and draining wound was maintained on EBP for 1 of 2 sampled residents (R) reviewed for wounds (R35). Findings: The facility's Laundry and Bedding, Soiled policy and procedure dated 04/01/24 noted: Policy: Soiled laundry/bedding(e.g., personal clothing, uniforms, scrub suits, gowns, bedsheets, blankets, towels, etc.) shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen. Procedure: 2. Place contaminated laundry in a bag or container at the location where it is used and do not sort or rinse at the location of use. 3. Place and transport contaminated laundry in bags or containers that are labeled and color-coded in accordance with established policies governing the handling and disposal of contaminated items. 4. Anyone who handles soiled laundry must wear protective gloves and other protective equipment) e.g., gowns if soiling of clothing is likely). 1. On 9/22/25 at 9:45 a.m., a surveyor observed Certified Nursing Assistant (CNA #1) come out of Resident room [ROOM NUMBER] carrying a large armful of unbagged soiled linen against her body and she was not wearing gloves. On 9/22/25 at 9:47 a.m., the CNA #1 confirmed that she should have been wearing gloves, the soiled linen should have been bagged, and she should have not carried it next to her body. On 9/22/25 at 9:58 a.m., in an interview with two surveyors present, the Director of nursing confirmed the finding. 2. On 9/24/25 at 8:00 a.m., a surveyor observed CNA #2 carry an armful of unbagged soiled linen, against her body, to the shower room and put the linen in the soiled linen hamper. She was observed to not be wearing gloves. At this time, the CNA confirmed she carried soiled linen against her body, unbagged and ungloved to the soiled linen hamper. 3. On 9/24/25 at 8:40 a.m., a surveyor observed Registered Nurse (RN #2) carry unbagged soiled linen to the shower room and put it in a soiled linen hamper. RN #2stated that she came from resident room [ROOM NUMBER] and knows the soiled linen should have been bagged. At this time, in an interview with a surveyor, RN #2 confirmed the finding. On 9/24/2025 at 9:45 a.m., in an interview with two surveyors present, the findings were discussed with the Director of Nursing. 4The facilities' Enhanced Barrier Precaution policy and procedure, last reviewed by the facility on 9/9/25 states, Enhanced Barrier Precautions expand the use of Personal Protective Equipment (PPE) and refer to the use of gown and gloves during high-contact resident care activities that provide (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	opportunities for transfer of Muli-Drug Resistant Organisms (MDRO) to staff hands and clothing. 4. On 9/23/25 at 10:02 a.m., a surveyor observed CNA#5 remove bed linens from a resident's bed using only gloves in a room with Enhanced Barrier Precautions. On 9/23/25 at 10:17 a surveyor confirmed the finding in an interview with CNA#5. 5. The U.S. Centers for Disease Control and Prevention (CDC), under Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes, dated 6/28/24 states, Enhanced Barrier Precautions [EBP] are recommended for residents with indwelling medical devices or wounds, who do not otherwise meet the criteria for Contact Precautions, even if they have no history of MDRO [Multi-Drug Resistant Organisms] colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring a MDRO and many residents colonized with a MDRO are asymptomatic or not presently known to be colonized. Review of facility policy. Categories of Transmission-Based Precautions revised 9/9/25, states, Enhanced Barrier Precautions [EBP] .Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated .for nursing home residents with wounds . Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: Dressing . Bathing/showering . Transferring . providing hygiene .changing linens .Changing briefs or assisting with toileting .Wound care . R35 has diagnoses to include cellulitis of right lower limb and rash and nonspecific skin eruption. On 9/22/2025 at 9:28 a.m. and 9/23/25 at 9:20 a.m., observations of R35's room lacked signage for EBP or Personal Protective Equipment [PPE] cart. Throughout the survey, a surveyor observed multiple other rooms on the Long Term Care unit with EBP signs and PPE carts outside resident rooms. R35's care plan, most recently reviewed on 8/22/25 states, .has infection of the rt. [right] lower leg .Administer antibiotic as per MD [medical doctor] orders . Review of R35's August 2025 Medication Administration Record (MAR) indicates R35 received Amoxicillin (an antibiotic) for soft tissue infection from 8/5/25-8/8/25 and 8/8/25-8/11/25 and again received Amoxicillin for cellulitis from 8/19/25 - 8/26/25. Review of R35's active physician orders revealed the following: An order with a start date of 9/9/25 for Refer to wound center for treatment of right lower extremity open areas, weeping An order with a start date of 9/9/25 for cleanse areas on right lower leg with normal saline apply calcium alginate followed by foam dressing change every 3 days and prn [as needed] please soak with normal saline if dressing is adhered. every day shift every 3 day (s) for wound treatment. On 9/24/25 at 8:33 a.m., during an interview with 3 surveyors, the Infection Preventionist (IP) stated residents with surgical wounds or wounds that require care need to be on EBP. At this time, a (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	surveyor discussed the above findings, and the IP stated she knew that R35 had completed his/her antibiotic but was not aware that he/she had a wound being treated and that based on R35's current orders for treatment of an open wound, she would expect R35 to be on EBP. On 9/24/25 at 8:41a.m., during an interview, Registered Nurse (RN) #2 stated R35's wounds are still open but are drying out and that his/her wounds appear worse with the current treatment, so she wants to talk to the provider today before doing R35's wound treatment. At this time, RN #2 stated she wears gloves only for wound care and thinks only residents with infected wounds are placed on EBP. On 9/24/25 at 9:14 a.m., during an interview with 2 surveyors, the above concerns were discussed with the Director of Nursing (DON). At this time, the DON stated only residents with highly draining wounds or wounds with known infectious organisms are placed on EBP and that R35 has a closed dressing for his/her wounds and should not be on EBP.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interview, the facility failed to implement and maintain an effective training program for nursing staff contracted through the AllShifts Application (App) in the areas of dementia care, resident rights, and abuse and neglect training by failing to ensure contracted AllShifts Professionals completed training prior to independently providing services to residents for 4 of 4 contracted staff reviewed during a complaint investigation (Certified Nursing Assistant [CNA] #8, #9, and #10, and Licensed Practical Nurse [LPN] #3).Finding:Review of the AllShifts Terms of Service states, under section 2.1 ALLSHIFTS MARKETPLACE, LLC AS A MARKETPLACE, AllShifts merely makes the Site and Services available to enable Professionals and Facilities to find and transact directly with each other.Users alone are responsible for evaluating and determining the suitability of any shift, Facility, or Professional. and under section 2.2 USERS ARE INDEPENDENT FROM ALLSHIFTS states, .Facilities are solely responsible for and have complete discretion with regard to their use of and activities on AllShifts Marketplace, including.decisions they make with respect to any Professionals with whom they connect for shifts. No actions or decisions of a facility shall in any way affect the relationship of Professionals with AllShifts, which shall remain that of an independent contractor under all circumstances. and under section 3.1 SAFETY AND SUPERVISION BY FACILITIES, states, .It is the sole responsibility of Facilities to monitor and enforce all policies and procedures with Professional, both by including such information in Facilities' User Profiles on the Site and notifying Professionals of such information when they arrive and carry out their responsibilities at Facilities' Facilities.Review of Facility Assessment-Pinnacle Health & Rehab, updated 6/10/25, under Staff training/education and competencies, states, .Upon hire and annually, all employees will attend a comprehensive education program which will include .resident rights, abuse, neglect and exploitation, what constitutes abuse, neglect, exploitation .Each employee must have an orientation check off list completed .A review of the facility's staffing sheets for the dates referenced in the complaint (6/12/24-12/8/24) revealed the following:CNA #8's first shift through AllShifts was 6/17/24, and she worked a total of 16 shifts throughout the above-referenced timeframe. A review of CNA #8's employee file lacked evidence that she received education in the areas of Abuse and Neglect, Resident Rights, and dementia.CNA #9's first shift through AllShifts was 6/12/24, and she worked a total of 25 shifts throughout the above-referenced timeframe. A review of CNA #9's employee file lacked evidence that she received education in the areas of Abuse and Neglect, Resident Rights, and dementia.CNA #10's first shift through AllShifts was 6/18/24, and she worked a total of 11 shifts throughout the above-referenced timeframe. A review of CNA #10's employee file lacked evidence that she received education in the areas of Abuse and Neglect, Resident Rights, and dementia.LPN #3's first shift through AllShifts was 8/8/24, and she worked a total of 10 shifts throughout the above-referenced timeframe. A review of LPN #3's employee file lacked evidence that she received education in the areas of Abuse and Neglect, Resident Rights, and dementia.On 9/24/25 at 12:26 p.m., during an interview, the Director of Nursing (DON) stated that she relies on AllShifts' packet for each contracted Professional that is hired from the App, and that the facility does not provide education to staff contracted through the App. The DON then stated that when a surveyor requested evidence of Abuse and Neglect; Resident Rights; and Dementia training for the above contracted staff yesterday, she contacted AllShifts and requested evidence of the training but has not received it. The DON was unable to provide evidence that the above contracted staff had received the training prior to the end of the survey.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews, record review and facility policy, the facility failed to thoroughly investigate an allegation injury of unknown origin for 1 of 1 facility incident reports reviewed (Resident #12).Findings:Review of Abuse Investigation policy (undated) states All reports of resident abuse, neglect, and.shall be promptly and thoroughly investigated by facility management. The individual conducting the investigation will.Review the completed concern/complaint report; Interview the resident, Interview any witnesses to the incident; Review the resident's medical record to determine events leading up to the incident; interview staff members who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors as applicable; Interview other residents to whom the accused employee provides care or services; and review all events leading up to the alleged incident. Witness reports are required to be written with signature and date. On 12/31/24 the Department of Licensing received a facility reported incident stating: On 12/31/24; 12:35 p.m.,. Resident [12], asked to speak with the SW [Social Worker]. [He/she] reported that aide, [Certified Nursing Assistant (CNA)4], pressed [his/her] forehead and pulled [his/her] ear. During an interview on 9/23/25 at 10:49 a.m. Licensed Social Worker (SW) confirmed she was the one that conducted the investigation, but there were no findings. At this time SW was asked to provide complete investigation details. SW stated the whole investigation was in the 5 day follow up. Review of the 5 day follow up dated 12/31/24 states [1/7] Investigation closed. No findings. At this time SW again stated that the entire investigation was on the original incident report, and she had no more information. States she did not interview anyone besides [Resident 12] and [CNA4], and there was no facility education was provided, but she did tell CNA4 not to pull Resident 12's ear anymore. SW confirmed she did not and did not talk to any other residents or staff because she didn't know she needed to.During an interview on 9/24/25 at 11:11 a.m., the above was discussed with Director of Nursing. ˆ

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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 record review, interviews, and facility policy, the facility failed to ensure that residents receive treatment and care in accordance with professional standards of practice by failing to follow their own Accident and Incident and Fall policies when a Certified Nursing Assistant (CNA) failed to notify the charge nurse before moving a resident after a witnessed fall for 1 of 3 residents reviewed for accidents (Resident [R] 26). As a result, the resident's arm got caught in his/her wheelchair, and he/she sustained a right humeral head fracture.Finding:Review of facility ?s Accidents and Incidents Policy, revised 9/9/25, states Regardless of how minor an accident or incident may be .it must be reported to the charge nurse as soon as such accident/incident occurs is discovered . The Charge nurse must be immediately informed of accidents or incidents so that medical attention can be provided .Do not move the victim until he/she has been examined for possible injuries .The Charge Nurse shall .Examine all accident/incident victims .Notify the victim's physician of the accident or incident.Review of the facility's Falls Policy, revised 9/9/25, states, All falls need assessment by a licensed nurse prior to moving the resident.On 9/22/25 at 8:41 a.m. during an interview, R26 stated recently, a CNA was pushing him/her in his/her wheelchair when he/she fell forward out of the wheelchair and onto the floor in the hall. R26 then stated his/her right arm and shoulder got broken. A review of R26's clinical record revealed the following progress notes:Nursing progress note, dated 6/24/25, states Resident was sliding from [his/her] wheelchair tonight and when CNA went to pull [him/her] up in chair, [his/her] arm was caught in wheelchair.Nursing progress note, dated 6/24/25, entered 6/25/25, states Late entry: Was told by CNA that Resident was sliding from chair and [he/she] was pulled back up into chair. When [he/she] was pulled up. arm was caught between the wheel and chair. Was not told about [him/her] being on floor at this time.Nursing progress note, dated 6/25/25 states, Seen by . NP [nurse practitioner] for follow up of shoulder pain.Resident is stating [he/she] was 'launched' out of [his/her] wheelchair. Spoke with evening charge nurse, she states she was only told that resident was sliding out of chair and aide pulled [him/her] back, catching [his/her] arm in the chair resulting in the pain.Provider note dated 6/25/25 states, . Patient reported to have been slipping out of [his/her] wheelchair last evening. Reported that [he/she] fell out.complained of right arm pain. has swelling to [his/her] right upper arm with faint bruising and tenderness. states [he/she] cannot extend it because it hurts too much .Due to pain will obtain xray [x-ray] to right shoulder and humerus . Nursing progress note dated 6/25/25 states, Radiology called.verbally reported that resident does have right humeral head fracture. Nursing progress note dated 6/26/25, Follow up investigation of incident- per CNA resident was being wheeled down through hall, aide turned chair to back resident through double doors when resident fell out of chair. She said she sat [him/her] up and then assisted [him/her] back into chair, then went and told nurse about the incident.Per charge nurse, she was not aware an actual fall had occurred, therefore did not notify on call per policy.Review of the facility's incident report dated 6/24/25 states, Resident was sliding out of [his/her] chair and CNA pulled [him/her] back into chair.right arm was caught in between wheel and chair. [He/she] complained to this nurse that [his/her] arm was caught in chair and it was hurting [him/her] at this time. Further review of the incident report and of R26's clinical record lacked evidence that the charge nurse notified the provider of the accident/incident or R26's complaint of arm pain.On 9/22/25 at 2:23p.m., during an interview, the Director of Nursing (DON) stated she is the one who notified the provider the next morning after R26 fell due to increased pain in R26's arm and stated CNA #6 did not tell the charge nurse that R26 had fallen, so the provider was not notified at the time of the accident/incident.On 9/24/25 at 9:16 a.m., during an interview with 2 surveyors, the above concerns, including CNA #6's failure to notify the charge nurse of the fall before moving R26 and the charge nurse's failure to notify the provider of the accident/incident or of R26's complaint of arm pain following the accident/incident, were discussed with the DON. At this time, the DON stated that she would not expect the charge nurse to notify the provider that R26's arm got caught in the wheelchair and that the charge nurse verbally counseled CNA #6 following the incident.

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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 observation and interview, the facility failed to ensure that the resident's environment was free of accident hazards by ensuring a base board heater cover was secure and in place covering sharp metal for 1 of 1 observation on 1 of 3 days of survey. (9/22/25)Finding:On 9/22/25 at 9:53 a.m., a surveyor observed a base board heating unit in the hallway across from resident room [ROOM NUMBER] that had the front cover partially off exposing sharp metal fins.On 9/22/25 at 9:58 a.m., in an interview with two surveyors present, the Director of Nursing confirmed the finding and stated that the facility has residents that ambulate around the facility and move around the facility in wheelchairs.