STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205124	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Breakwater Commons	100 Commons Drive Rockland, ME 04841

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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. **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 on 3 of 3 units (East, [NAME] and South Units) and the laundry room for 3 of 3 facility tours/observations. (4/6/26, 4/7/26 and 4/9/26)Findings:1. East UnitOn 4/6/26 at 9:10 a.m., a surveyor observed a sit-to-stand patient lift by the central sitting area and a sit-to-stand patient lift by the nurse's station near resident room [ROOM NUMBER], that had food particles and debris in the foot base areas. Additionally, resident room [ROOM NUMBER] had a commode bucket on the floor in the bathroom.On 4/6/226 at 9:15 a.m., in an interview with a surveyor, a Certified Nursing Assistant/Medication Technician (CNA/M) confirmed the finding. 2. On 4/9/26 from 8:05 a.m. to 8:45 a.m., a surveyor conducted an Environmental tour the Maintenance Director and the Housekeeping Director in which the following findings were discussed and/or observed. South Unit- Resident room [ROOM NUMBER]- The floor mat by the right side of the bed was ripped/torn creating an uncleanable surface. The bathroom shower threshold strip was ripped/torn.- Resident room [ROOM NUMBER] - There was a wash basin and a commode bucket on the floor in the bathroom. - Resident room [ROOM NUMBER] - The baseboard heater was broken apart and in disrepair. There was a commode bucket on the floor under the sink in the bathroom. - Resident room [ROOM NUMBER] - The wall across from the foot of the bed was marked/marred and had chipped/missing paint creating an uncleanable surface. - Resident room [ROOM NUMBER] - The bathroom walls had chipped/missing paint creating uncleanable surfaces.- Resident room [ROOM NUMBER] - The toilet, the toilet seat and the seat riser had dried feces and urine on and under them. - Resident room [ROOM NUMBER] - There was a commode bucket on the floor under the sink in the bathroom. - Resident room [ROOM NUMBER]- The bathroom shower threshold strip was ripped/torn.- Resident room [ROOM NUMBER]- The bathroom shower threshold strip was ripped/torn.- Resident room [ROOM NUMBER] - The were multiple layers of white tape, approximately 10 inches wide and approximately 2 feet wide, on a shower wall covering holes in the wall. [NAME] Unit- Resident room [ROOM NUMBER] - The bathroom shower threshold strip was ripped/torn.On 4/9/26 at 8:45 a.m., in an interview with a surveyor, the Maintenance Director and the Housekeeping Director confirmed the discussed and observed findings.3. LaundryOn 4/7/26 at 8:00 a.m., two surveyors observed 4 wooden pallets under supplies in the clean section of the laundry room that were untreated, creating uncleanable surfaces. On 4/7/26 at 8:05 a.m., in an interview with two surveyors present, the Administrator confirmed the finding. On 4/9/26 at 8:45 a.m., in an interview with a surveyor, the Maintenance Director and the Housekeeping Director confirmed the discussed and observed 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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to report, allegations of Abuse to the Division of Licensing and Certification (DLC) (State Survey Agency) 5 incidents of resident-to-resident abuse, 4 incidents of resident-to-staff abuse, 3 incidents of resident-to-staff abuse and 1 incident of resident-to-visitor abuse for 1 of 21 residents reviewed during an annual recertification survey.Findings:Resident #61 was admitted 3/26 and has diagnoses to include Alzheimer's and Dementia.Review of Resident #61's clinical record revealed progress notes stating the following:3/11/26: 22:09 Resident was aggressive towards resident in room [ROOM NUMBER]B as [he/she] went up to [him/her] and slapped [him/her] in [his/her] face.3/11/26:26 14:07 Resident was aggressive with CNA's this afternoon, slapping one of them in the ribcage area .3/27/26: Resident was walking around in the common area and became very agitated with another resident that was yelling out loudly. [Resident #61] swung [his/her] arm and smacked the other resident in the upper arm with [his/her] hand flat.3/28/26: . it was reported to writer that this resident had first slapped one of the aides, across the face after grabbing her breast. [He/she] then made [his/her] way down the hallway to another resident's room, where [he /she] then verbally attacked that resident calling [him/her] a shit face and then verbally attacking the daughter who was visiting that resident .3/31/26: [Resident #61] was pacing around unit with 1:1 staff member due to [his/her] increased agitation. Per CNA, they were walking past a resident, [Resident #61] jerked [his/her] hand free from [his/hers], turned and slapped the resident on the left shoulder. While walking through the dining area [he/she] grabbed a staff members arm and would not let go. [His/her] agitation continued to increase after incident. [He/she] was yelling out and going towards other residents. [He/she] continues to walk around unit with 1:1 staff member.4/3/26: Alerted by CNA Resident was holding a chair and trying to swing the chair at others.4/4/26: Resident at nurses' station, along with this writer, a CNA and a visitor. resident took hold of the visitor's arm and was pulling her. visitor started to yell stop, I will fall. This writer and CNA went to the resident and had to peel residents' finger back to get [him/her] to release the visitor.While walking with [him/her] [he/she] would not let go of my hand, and started to push this writer into another resident's room.4/5/26: Reported by CNA that resident hit her fairly hard x2 on her hand and is fixated on certain residents. Trying to walk with them and pushing on them.Review of the DLC incident reporting portal lacked evidence that the above incidents were reported to the state agency.During an interview on 4/9/26 at 4:50 p.m., the Administrator confirmed these incidents were not reported to DLC.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to provide written notice of transfer/discharge to resident/representatives, in addition the facility failed to provide written notice of bed hold to include cost of care and appeal rights to resident/representatives for 8 of 8 residents reviewed for hospitalization (Residents #1, #3, #7, #11, #54, #64, & #78).Findings: 1. Documentation in Resident 1's clinical record indicated that he/she was transferred to an acute hospital on 1/7/26 and 1/24/26. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. 2. Documentation in Resident #3's clinical record indicated that he/she was transferred to an acute hospital on 3/9/26. Further review of the clinical record revealed a Transfer and Discharge Notice dated 3/9/26. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman.Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. 3. Documentation in Resident 7's clinical record indicated that he/she was transferred to an acute hospital on 8/13/25. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. 4. Documentation in Resident 11's clinical record indicated that he/she was transferred to an acute hospital on 7/21/25 and 7/24/25. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Documentation in Resident 54's clinical record indicated that he/she was transferred to an acute hospital on 3/31/26. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. 6. Documentation in Resident 65's clinical record indicated that he/she was transferred to an acute hospital on [DATE]. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. 7.Documentation in Resident 's 64's clinical record indicated that he/she was transferred to an acute hospital on [DATE]. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. 8. Documentation in Resident 's #78's clinical record indicated that he/she was transferred to an acute hospital on 2/24/26. Further review of the clinical record revealed an incomplete Transfer and Discharge Notice. The notice lacked the name, address (mailing and email), and telephone number of the entity which receives appeal requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request. The notice also lacked the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Additionally, the notice indicated verbal consent obtained but lacked evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative. On 4/8/26 at 9:34 a.m., in an interview with Social Service Assistant and Social Service Director stated that Transfer/Discharge notice and bed hold notice are not sent to the resident representative and the bed hold notice does not contain appeal process/rights and numbers to call if wanted.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours that included the instructions needed to provide minimum healthcare information necessary to properly care for 1 of 10 residents reviewed for new admissions (Resident #61).Findings:Review of Resident #61's clinical record revealed progress notes stating the following:3/4/26: CNA reported that resident took off the toilet tank cover and attempted to hit CNA with it. Resident then tore off towel bar .: 3/7/26: 23:35 Resident got upset when spoken to and defecated on the nurses chair and at the nurses station.3/7/26: 21:48 Resident slapped another resident from room [ROOM NUMBER] on [his/her] arms thinking that it was [his/her] wife .3/11/26: Resident was aggressive towards resident in room [ROOM NUMBER]B as [he/she] went up to [him/her] and slapped [him/her] in [his/her] face.3/11/26: 26 14:07 Resident was aggressive with CNA's this afternoon, slapping one of them in the ribcage area .3/13/26: 322 was noted by this writer guiding Resident #61 out of his room and appeared to be becoming agitated with Resident #61. Resident #61 turned around and was attempting to go back into 322 which was making 322 more agitated. This writer was able to intervene in the situation and to redirect Resident #61 back down the hall to breakfast. 322 then calmed down and went down to breakfast as well.3/18/26: . resident was visualized in dining room rolling table on it side .3/20/26: Resident became very agitated and wander into other residents' rooms. and CNA found [him/her] trying to throw the TV out the window. Window was opened and TV was on floor when this writer came in the room. [He/she] then went to the living room and was tearing the chairs apart and throwing the chair .3/23/26:Pt found in room incontinent of Bm all over self, linens and room. Pt assisted to shower. Halfway thru shower pt became agitated and combative.3/27/26: Resident was walking around in the common area and became very agitated with another resident that was yelling out loudly. [Resident #61] swung [his/her] arm and smacked the other resident in the upper arm with [his/her] hand flat.3/28/26: . it was reported to writer that this resident had first slapped one of the aides, across the face after grabbing her breast. [He/she] then made [his/her] way down the hallway to another resident's room, where [he /she] then verbally attacked that resident calling [him/her] a shit face and then verbally attacking the daughter who was visiting that resident . 3/31/26: [Resident #61] was pacing around unit with 1:1 staff member due to [his/her] increased agitation. Per CNA, they were walking past a resident, [Resident #61] jerked [his/her] hand free from [his/hers], turned and slapped the resident on the left shoulder. While walking through the dining area [he/she] grabbed a staff members arm and would not let go. [His/her] agitation continued to increase after incident. [He/she] was yelling out and going towards other residents. [He/she] continues to walk around unit with 1:1 staff member.4/3/26: Alerted by CNA Resident was holding a chair and trying to swing the chair at others.4/4/26: Resident at nurses' station, along with this writer, a CNA and a visitor. resident took hold of the visitor's arm and was pulling her. visitor started to yell stop, I will fall. This writer and CNA went to the resident and had to peel residents' finger back to get [him/her] to release the visitor.While walking with [him/her] [he/she] would not let go of my hand, and started to push this writer into another resident's room.4/5/26: reported by CNA that resident hit her fairly hard x2 on her hand and is fixated on certain residents. Trying to walk with them and pushing on them.Review of Resident #61's care plan created 3/4/26 lacked evidence that goals and interventions were put into place for the above behaviors.During an interview on 4/9/26 at 1:45 p.m., the Director of Nursing reviewed Resident #61's care plan and confirmed goals and interventions were not put into place for the above concerns.

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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), that included, to the extent possible, participation of the resident and/or his/her representative after each Minimum Data Set (MDS) assessment for 14 of 21 residents reviewed for care planning (Residents #1, #3, #7, #9, #11, #15, #54, #64, #65, #68, #74, #78, #105, #108). Findings: 1.Review of Resident #1's clinical record revealed a MDS Quarterly Assessment was completed on 11/4/25. Further review of Resident #1's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. Review of Resident #1's clinical record revealed a MDS Quarterly Assessment was completed on 1/22/26. Further review of Resident #1's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 2. Review of Resident #3's clinical record revealed an MDS Annual Assessment was completed on 1/28/26. Further review of Resident #3's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 3. Review of Resident #7's clinical record revealed a MDS Quarterly Assessment was completed on 2/3/26. Further review of Resident #7's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 4. Review of Resident #9's clinical record revealed an MDS Quarterly Assessment was completed on 1/22/26. Further review of Resident #9's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 5. Review of Resident #11's clinical record revealed a MDS Quarterly Assessment was completed on 2/13/26. Further review of Resident #11's clinical record revealed that an IDT meeting was held on 2/12/26, one day prior to the assessment. 6. Review of Resident #15's clinical record revealed quarterly MDS completed 1/26/26. Review of Resident #15's clinical record lacked evidence that an IDT was held for this MDS. 7. Review of Resident #54's clinical record revealed a MDS Quarterly Assessment was completed on 8/21/25. Further review of Resident #54's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. Review of Resident #54's clinical record revealed a MDS Annual Assessment was completed on 12/5/25. Further review of Resident #54's clinical record revealed that an IDT meeting was held on 12/4/25, one day prior to the assessment. 8. Review of Resident #64's clinical record revealed the following: -Quarterly MDS with completion date 3/5/26. Review of Resident #64's clinical record revealed IDT (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	meeting was held on 2/25/26. 9 days before completion of MDS. -Quarterly MDS completed 12/5/25. IDT meeting held 11/25/25. 11 days before MDS completion. -Quarterly MDS with completion date of 8/13/25. IDT meeting held 8/12/25. 1 day prior to MDS completion). 9. Review of Resident #65's clinical record revealed a MDS Quarterly Assessment was completed on 11/13/25. Further review of Resident #65's clinical record revealed that an IDT meeting was held on 11/11/25, two days prior to the assessment. Review of Resident #65's clinical record revealed a MDS Annual Assessment was completed on 12/22/25. Further review of Resident #65's clinical record revealed that an IDT meeting was held on 1/22/26 which was not within 7 days following the assessment. 10. Review of Resident #68's clinical record revealed a Significant Change MDS Assessment was completed on 1/12/26. Further review of Resident #68's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. 11. Review of Resident #74's clinical record revealed that a Quarterly MDS Assessment was completed on 4/8/26. Further review of Resident #74's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. On 4/08/2026 at 4:17 p.m., during an interview, the social worker stated that he is unable to provide evidence that an IDT meeting occurred for the above MDS assessment. 12. Review of Resident #78's clinical record revealed MDS with completion date of 1/13/26. Review of Resident 78's clinical record revealed IDT Meeting dated 2/5/26 stating Current copy of care plan and IDT note emailed to POA. Further review of clinical record lacked evidence that an IDT meeting was held within 7 days of this MDS. 13. Review of Resident #105's clinical record revealed an MDS admission Assessment was completed on 12/29/25. Further review of Resident #105's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. On 4/08/2026 at 2:00 p.m., in an interview with the DON, she confirms that an IDT meeting had not taken place during his/her admission. 14. Review of Resident #108's clinical record revealed an MDS Quarterly Assessment was completed on 8/14/25. Further review of Resident #108's clinical record lacked evidence that an IDT meeting was held within 7 days following the assessment. On 4/8/26 at 11:00 a.m., in an interview with a surveyor, the LSW/Social Service Director stated that some of the IDT meetings were completed before the MDS assessments were completed while others were not completed within 7 days following the assessments. During an interview on 4/9/26 at approximately 2:40 p.m., the above concerns were discussed with the Administrator.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review, observations, and interviews, the facility failed to establish a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation and ensure that two people who are authorized to administer medications signed the Shift Count page of the Controlled Substances Book [a logbook used to record controlled medications], indicating that they counted all controlled substances at the change of shift for multiple shifts, for 3 of 3 units observed (West Unit, South Unit, and East Unit).Findings:1. On 4/8/26 at 9:40 a.m., during a medication storage observation on the [NAME] Unit, a surveyor reviewed the Controlled Substances Book and Shift Counts located on the [NAME] Unit medication (med) cart, which indicated the facility counts at the change of each shift, approximately 3 times per day, and observed the following:- The person authorized to administer medications coming on duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on 9/21/25 at 2:30 p.m.- The person authorized to administer medications going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 7/23/25 at 2:30 p.m., 9/21/25 at 9:00 p.m., and 10/1/25 at 6:59 p.m.- Additionally, on 7/24/25, 7/25/25, 8/6/25, 8/16/25, 11/28/25, 11/29/25, 11/30/25, 12/1/25, 3/9/26, 3/10/26, 3/11/26, and 3/26/26, there are incomplete entries that lack date, time, and/or the status of count.On 4/8/26 at 9:55 a.m., the above findings were discussed during an interview with the [NAME] Unit Manager.2. On 4/8/26 at 12:18 p.m., during a medication storage observation on the South Unit, a surveyor reviewed the South Unit Controlled Substances Book #2 and Shift Counts located on med cart #2, which indicated the facility counts at the change of each shift, approximately 3 times per day, and observed the following:- The person authorized to administer medications coming on duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: 12/28/25 at 2:00 p.m., approximately 2/9/26 (entry after 2/9/26 at 10:45 p.m. lacks date and time),- The person authorized to administer medications going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on the following dates: approximately 12/27/25 (pg. 274-entry after 12/27/25 at 11:00 p.m. lacks date and time), 1/9/26 at 11:00 p.m., 1/15/26 at 6:45 a.m., and 2/10/26 at 3:00 p.m.- Additionally, on approximately 12/27/25 (pg. 274-entry lacks date and time), 1/16/26, approximately 2/10/26 (pg. 278-entry lacks date and time), and 4/5/26, there are incomplete entries that lack date, time, and/or the status of count.3. On 4/8/26 at 3:35 p.m., during a medication storage observation on the East Unit, a surveyor reviewed the Controlled Substances Book and Shift Counts located on the East Unit med cart, which indicated the facility counts at the change of each shift, approximately 3 times per day, and observed the following:- The person authorized to administer medications going off duty failed to sign the Shift Count page of the Controlled Substances Book that indicated the controlled substances count was done on 11/18/25 at 11:00 p.m.- Additionally, on 12/18/25 and 4/3/26, there are incomplete entries that lack the time and the status of count.On 4/8/26 at 3:38 p.m., the surveyor discussed the above findings with the Director of Nursing.On 4/8/26 at 4:52 p.m., the surveyor discussed the above findings with the Administrator.

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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 and interviews, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a food slicer, a food mixer, a food disposal unit, fans, chemicals, a hood system, a stove, floors and kitchenette refrigerators/freezers; and failed to ensure foods in food bins, a reach-in freezer, a walk-in refrigerator and a walk-in freezer were dated, labeled and/or sealed; and failed to ensure that kitchen staff members with facial hair wore facial hair protection for 3 of 3 kitchen/kitchenettes tours. (4/6/26)Findings:1. On 4/6/26 from 8:05 a.m. to 8:35 a.m., a surveyor conducted an Initial Kitchen Tour in which the following findings were observed and shared with the cook:- The dry storage room had three large bags of cereal that were not dated. - A reach-in freezer had two packages of waffles that were not labeled and dated. - The walk-in refrigerator had a large bag of diced onions that was not labeled and a pan of beans that was not covered/sealed. - The walk-in freezer had a package of wraps that was not labeled and dated. - A large bin of flour, a large bin of sugar and a large bin of gluten free flour were not dated. Additionally, the gluten free flour bin had a scoop inside of it. - The food slicer had dried food particles and dried liquid residue on it. - The food mixer had dried food particles and dried liquid residue on it.- The food disposal unit had dried food particles and dried liquid residue on it. - There were two circular floor fans that were dusty/dirty. - There were chemicals stacked on the floor that were not stored in a metal cabinet. - The hood system was dusty/dirty. - There was food and debris on the floor around and under the cook stove. - The cook stove had dried food particles and dried liquid residue on the front and surface of it. - A male cook with facial hair and was not wearing facial hair protection.On 4/6/26 at 8:35 a.m., in an interview with a surveyor, the cook confirmed the findings.On 4/6/26 at 8:40 a.m., a surveyor discussed the findings with the Administrator. 2. On 4/6/26 at 9:00 a.m., a surveyor observed the East unit refrigerator/freezer shelving had dried food particles and dried liquid residue on them.On 4/6/26 at 10:00 a.m., a surveyor observed the South unit refrigerator/freezer shelving had dried food particles and dried liquid residue on them.On 4/6/26 at 12:05 p.m., a surveyor observed the [NAME] unit refrigerator/freezer shelving had dried food particles and dried liquid residue on them.On 4/6/26 at 12:10 p.m., a surveyor discussed the findings with the Administrator. 3. On 4/6/26 at 12:30 p.m., a surveyor did a follow-up visit to the kitchen and observed the male cook and another male employee with facial hair in the kitchen with no facial hair protection. At this time, the male cook and another male employee confirmed the findings.On 4/06/2026 at 12:40 p.m., a surveyor discussed the finding with the Administrator.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record reviews, interviews, and policy review, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 2 residents reviewed for neurological assessments (Resident #78 and #105) and 1 of 1 resident reviewed for pressure ulcers (Resident #9). Findings: A review of the facilities Fall Management Policy Under Section V. subsection F states A neurological assessment tool will be for falls where there is a known head bump. A review of the facilities Neurological Assessment Policy states, Residents with suspected neurological compromise will have neurological signs monitored and recorded for a minimum of 12 hours. Further review of the policy under the procedure section states Neurological assessments following a residents head injury will be completed for all residents sustaining head trauma or suspected head trauma. In EMR (electronic medical record): Neuro checks will be conducted every 15 minutes X4, every 30 minutes X4, every 1 hour X4, every 4 hour X2, and every 8 hour X1. Frequency of neuro checks after 24 hours is determined by resident observed signs and symptoms of neurological compromise. 1. A review of Resident #105's clinical record indicated he/she sustained an unwitnessed fall on 2/15/26 at 4:00 a.m Review of the residents' neurological assessment lacked evidence of fully completed 30 minute and 1 hour neurological assessments. Further review of his/her clinical record showed he/she sustained another fall on 2/15/26 at 1:20 p.m Review of the residents' neurological assessment lacked evidence of fully completed 1 hour and 4 hour neurological assessments. On 4/7/26 at 12:23 p.m., in an interview with the Director of Nursing (DON) and 2 surveyors present, the DON confirmed the residents 30 minute neurological checks and 1 hour neurological checks were not fully complete for the fall at 4 a.m She also confirms that the 1 hour neurological checks and the 4 hour neurological checks were not fully completed for the fall occurring at 1:20 p.m 2. A review of Resident #78's clinical record indicated he/she sustained an unwitnessed fall's on 11/19/25 at 2:45 p.m., 2/24/26 at 18:22, and on 3/3/26 at 11:31 p.m Review of the residents' neurological assessments lacked evidence of fully completed 30 minute and 1 hour neurological assessments. During an interview on 4/8/26 at 3:45 p.m. the Director of Nursing confirmed neurological assessments were not completed for the above unwitnessed falls. 3. Facility Policy, Skin Management Program Policy revised 6/25 states under Procedure, section C, Daily documentation of.the site.dressing status and/or surrounding skin areas if the site is covered. weekly wound measurements by a registered nurse. care plan will be reviewed and updated based on assessed outcomes. Resident #9 has diagnoses to include but not limited to stage 4 pressure injury of the right heel. On 4/7/26 at 11:02 a.m. a surveyor observed Resident #9 seated in his/her wheelchair with a gauze (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressing and a surgical shoe on his/her right foot. During an interview at this time, Resident #9 stated that he/she has a right heel wound and that he/she goes to the wound center, but that the facility performs his/her wound treatments. Resident #9's most recent Minimum Data Set (MDS) quarterly assessment, completed 1/22/26, indicated that Resident #9 has a Stage 2 pressure ulcer. Review of Resident #9's care plan states, Wound Care and Management . Assess and monitor wound healing . Record wound measurements. A review of Resident #9's daily wound documentation completed by the Registered Nurse on 4/8/26 lacked evidence of the Pressure Injury Stage, measurements, and description of the wound. Review of Resident #9's daily wound documentation prior to the 4/8/26 assessment also lacked evidence that staging and measurements of the wound were completed. A review of Resident #9's active physician orders revealed an order with a start date of 3/24/26 for Dressing Change Three Times Weekly. PRESSURE ULCER OF RIGHT HEEL, STAGE 2. There is a round open stage 4. A review of Resident #9's physician progress notes revealed a provider progress note dated 1/21/26 that states, .Stage 2 pressure ulcer on the right heel and under Wound Assessment(s) states, Wound #1 Right Heel is a Stage 3 Pressure Injury. The progress note then states, under Plan, .Right Heel: There is a round open stage 2. Further review of Resident #9's clinical record revealed an outpatient wound clinic After Visit Summary dated 1/22/26 that indicated Resident #9 has a stage 4 pressure injury of the right heel. Subsequent wound clinic progress notes dated 2/24/26 and 3/24/26 also indicated the heel wound was a stage 4 pressure injury. On 4/9/26 at 8:49 a.m. during an Interview, Licensed Practical Nurse (LPN) #1 stated she cannot stage pressure ulcers, but that she believes Resident #9's heel wound is a stage 3. LPN #3 then stated that the wound has improved significantly and is no longer open. On 4/9/26 at 11:12 a.m. during an interview with the interim East Unit Manager and the Nurse Practitioner (NP), the NP stated that the facility defers to the wound clinic for assessment of Resident #9's wound and that treatment is consistent with the wound center's recommendations. When the surveyor discussed the conflicting pressure injury staging in Resident #9's clinical record, including in the NP's progress notes, and asked for clarification of the staging of Resident #9's pressure injury, the NP stated that she has not seen the wound in months but when she last saw the wound, it was a Stage 3 or 4, but that she does not know what stage it is now because it has improved. On 4/9/26 at 11:46 a.m. the surveyor discussed the above findings during an interview with the Director of Nursing (DON). At this time, the DON stated the facility does not reverse-stage wounds, and that it is her expectation that the daily wound evaluation documentation is completed, including the staging and description of the wound.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on facility policy review, record reviews, and interview, the facility failed to ensure that the resident and/or resident representative was provided with written information, concerning the right to accept or refuse medical or surgical treatment and/or formulate an advanced directive, or appoint a surrogate, was completed for 2 of 4 residents reviewed for advanced directives. (Resident #15 and #78).Findings:1.Resident #15 was admitted 10/2025. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive.2. Resident #78 was admitted 1/2025. A review of the entire electronic medical record lacked evidence that the facility offered or reviewed with the resident and/or resident representatives or that the resident and/or resident representatives were provided with written information concerning the right to formulate an advanced directive.During an interview with 3 surveyors on 4/8/26 at 11:48 am Director of nursing confirmed Resident's #15 and #78's records showed no evidence of the opportunity for filling out advanced directive.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility failed to complete a Minimum Data Set (MDS) upon a residents death (Resident #97).Review of Resident 97's clinical record revealed he/she died in mid January of 2026. Review of Resident 97's Minimum Data Set (MDS) lacked evidence that a MDS was completed upon his/her death.During an interview on [DATE] at 2:15 p.m., the Director of Nursing reviewed Resident #97's clinical record and confirmed an MDS was not completed after resident died.

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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 a review of Safety Data Sheets (SDS), the facility failed to ensure that the resident's environment was free of accident hazards relating to the storage chemicals being properly secured for 2 of 2 observations for 1 of 4 days of survey. (4/6/26)Findings:The Safety Data Sheet for Febreze Air Effects Gain Original noted in Section 4:Eye Contact: Rinse immediately with plenty of water, also under the eyelids, for at least 15 minutes. Get medical attention immediately if irritation persists.Skin Contact: None under Normal Use.Ingestion: Not an expected route of exposure. If swallowed, clean mouth with water and afterwards drink plenty of water.Inhalation: None under Normal Use. On 4/6/26 at 9:40 a.m., a surveyor observed in resident room [ROOM NUMBER], two 8.8 ounce spray bottles of Febreze Air Effects Gain Original sitting on a shelf at the foot of the resident's bed.On 4/6/26 at 9:46 a.m., in an observation and interview with a surveyor, a Licensed Practical Nurse (LPN) confirmed the finding and stated that there are confused residents that move around the unit and could go into the residents room and access the hazardous chemicals. On 4/6/26 at 10:20 a.m., a surveyor discussed the finding with the Administrator.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. Based on record review, facility policy, and interview, the facility failed to identify a resident's current diagnosis of Post-Traumatic Stress Disorder (PTSD)/trauma to determine what trigger(s) might cause re-traumatization for 1 of 3 sampled resident reviewed with a current diagnosis of PTSD. (Resident #74)Findings:Review of the facilities policy titled Trauma Informed Care developed in 10/2019 under section Purpose states Trauma-specific intervention(s) will be placed on the residents' care plan, and this will be reviewed quarterly and updated as necessary. A review of Resident #74's clinical record indicated he/she was admitted to the facility in 2023 with the diagnosis post-traumatic stress disorder (PTSD). Further review of his/her clinical record revealed a quarterly Minimum Data Set (MDS) 3.0 completed on 4/8/26 which showed, Section I, Active Diagnoses, Psychiatric/Mood Disorder, I6100 was coded to indicate Resident #74 had an active diagnosis for Post Traumatic Stress Syndrome (PTSD). Review of Resident #74's Trauma Screen indicated that he/she has trauma related to combat/exposure to war. Further review of the trauma screen shows his/her triggers are loud noises or when things go missing or are misplaced in in {his/her} room. Review of Resident #74's care plan updated 3/6/2026 lacked evidence that a trauma informed care plan was established to include triggers for this resident's PTSD diagnoses. On 4/8/26 at 3:04 p.m., in an interview with the Social Worker, he confirmed that Resident #74's care plan lacked evidence of Resident #74's triggers that might cause re-traumatization.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and interviews, the facility failed to adequately store controlled substances in a permanently affixed compartment for 2 of 3 medication refrigerators observed (West Unit medication refrigerator, South Unit medication refrigerator). Additionally, the facility failed to ensure medications were stored properly in medication storage refrigerators on 3 of 3 units (East Unit, [NAME] Unit, and South Unit).Findings:1. On 4/8/26 at 10:40 a.m. during an observation of the South Unit Medication Room, Certified Nursing Assistant Medication-Medication Tech (CNA-M) #2 accessed the locked medication room with her employee badge. Inside the unlocked refrigerator was an unaffixed plastic box with a handle, containing three 30 milliliter (mL) vials of lorazepam oral concentrate (a Schedule IV controlled medication).Additionally, the refrigerator was a dormitory-type refrigerator (a compact, combination refrigerator/freezer unit outfitted with one exterior door), which is not proper for storing medications due to temperature fluctuations. There was ice buildup in the freezer compartment, and medications, including insulin, were stored in the refrigerator.2. On 4/8/26 at 12:57 p.m., during an observation of the [NAME] Unit Med Storage Room with the [NAME] Unit Manager, the unlocked refrigerator contained an unaffixed plastic tackle-type box with a handle, containing four 30mL boxes of lorazepam oral concentrate.Additionally, the dormitory-type refrigerator's freezer compartment contained significant ice buildup, and medications, including insulin, were stored in the refrigerator.At this time, the surveyor discussed the findings with the [NAME] Unit Manager.3. On 4/8/26 at 1:36 p.m., during an observation of the East Unit Medication Room with Licensed Practical Nurse (LPN) #2, the dormitory refrigerator's freezer compartment contained ice buildup, and medications, including insulin, were stored in the refrigerator.On 4/8/26 at 2:30 p.m., during an interview in the presence of 4 surveyors, the above findings were discussed with the Director of Nursing (DON). At this time, the DON stated that it is her understanding that all medication techs and all nurses employed by the facility have their badges programmed to access all medication rooms throughout the facility. The DON then stated that the South Unit Manager (UM) would have the best knowledge of how controlled medications are to be stored in the facility.On 4/8/26 at 2:57 p.m. a surveyor, CNA-M #3, LPN #3, and the South UM observed the South Unit Medication room, including the unlocked refrigerator. During an interview at this time, CNA-M #3 stated that she has no idea where the keys to the refrigerator are, and that she has never had a key for the refrigerator, and LPN #3 confirmed that staff do not keep the refrigerator locked. The South UM then confirmed that any nurse or medication tech from any of the facility's units can access this medication room and remove the unaffixed box containing lorazepam.On 4/8/26 at 3:17 p.m. a surveyor and the South UM observed the [NAME] Unit Medication Room. At this time, the South UM confirmed that the refrigerator was not locked and that the box containing the four vials of lorazepam is unaffixed. During an interview at this time, CNA-M #4 stated that she has voiced concerns about how the lorazepam is stored, but that previous leadership told her that the refrigerator does not need to be locked.On 4/8/26 at 3:25 p.m. the surveyor discussed the above findings during a follow-up interview with the DON.On 4/8/26 at 4:52 p.m. the surveyor discussed the findings with the Administrator.