STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205138	A. Building B. Wing	12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood A Continuing Care Center	220 Kennedy Memorial Dr Waterville, ME 04901

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews, the facility failed to ensure the Food Service Director (FSD) met the qualifications of a Certified Food Service Director. This had the potential to affect all the residents. Finding:On 12/9/25 at 9:16 a.m., during an interview with a surveyor, the FSD stated that she has been in this role for about ten months. She stated that she does not have the qualifications for the job and that she is currently not enrolled in any qualifying course or a Managerial Serve Safe course. She then stated the facility's dietician is on a consultant basis and comes in monthly. On 12/11/25 at 9:30 a.m., during an interview with a surveyor, the Administrator confirmed that the facility has failed to have a qualified Food Service Supervisor and uses a consultant dietician who is not employed by the facility in a full-time position.

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 on 3 of 3 units (Skilled, Moonlight Bay and Long-Term Care) and a common area for 1 of 1 facility tour. Findings:On 12/10/2025 from 10:10 a.m. to 10:40 a.m., an Environmental Tour was conducted with a Maintenance worker and the Administrator in which the following findings were observed: Common area - The main lobby area, near the lobby desk and door to the outdoors, had cracked and lifted linoleum creating an uncleanable surface. - The activity/dayroom next to the lobby area had had cracked and lifted linoleum at first entrance threshold to the right after entering building creating an uncleanable surface. - The entrance, going toward the Skilled Unit and the entrance going toward the Moonlight Bay Unit, had linoleum that was lifted creating uncleanable surfaces. Skilled Unit- Resident room [ROOM NUMBER] - Both privacy curtains were missing hooks, hanging down and in disrepair.- The dirty utility room wooden door, across from resident room [ROOM NUMBER], had chipped/gouged wood creating an uncleanable surface. Moonlight Bay- There were numerous vinyl planking floor edges coming up throughout the unit creating an uncleanable surfaces. - There was a chair, in the large sitting area, that had ripped material on the front of the seat and on the back rest creating uncleanable surfaces. Long Term Care Unit- The exit door, across from resident room [ROOM NUMBER], had chipped/missing paint and rusty areas on the bottom of the door. - The patient sit-to-stand lift, by resident room [ROOM NUMBER], had chipped/missing paint on the legs creating an uncleanable surface. - The exit door, by resident room [ROOM NUMBER], had chipped/missing paint and rusty areas on the bottom of the door. - Resident room [ROOM NUMBER] - The corner of the wall by the bathroom had chipped/missing paint exposing metal and sheetrock creating an uncleanable surface. The ceiling by the bathroom vent had chipped/missing paint.- Resident room [ROOM NUMBER] - The bathroom walls and the room wall outside the bathroom door had chipped/missing paint creating uncleanable surfaces. - The exit door, across from resident room [ROOM NUMBER], had chipped/missing paint and rusty areas on the bottom of the door. - The sitting room wooden bookshelf, by resident room [ROOM NUMBER], had chipped/gouged areas exposing untreated wood creating uncleanable surfaces.- Resident room [ROOM NUMBER] - The wall had chipped/missing paint around the vent near the ceiling. The bathroom floor heating unit had a corner section that was dislodged from heater and in disrepair.- The exit door, in the long-term care dining room, had rusty areas at the bottom of door. - The exit door, by resident room [ROOM NUMBER], had rusty areas at the bottom of the door. - The sit-to-stand lift, by resident room [ROOM NUMBER], had chipped/missing paint on the legs. - Resident room [ROOM NUMBER] - The bathroom had one ceiling tile with brownish stains on it.- Resident room [ROOM NUMBER]- The bathroom walls had chipped/missing paint.- The patient lift, by resident room [ROOM NUMBER], had chipped/missing paint on the legs. - The patient lift, by resident room [ROOM NUMBER], had chipped/missing paint on the legs. On 12/10/2025 at 10:40 a.m., in an interview with a surveyor, a Maintenance worker and the Administrator confirmed the findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record reviews, and interviews, the facility failed to develop a Comprehensive Care Plan that addressed the physical needs of 4 of 22 sampled residents (Resident #9 [R9], R2, R60 and R7).1. R9 was admitted in June 2024 with diagnoses to include chronic pain and bilateral hand and knee contractures. A review of R9's care plan, most recently revised on 10/22/25 states, The resident is (SPECIFY High, Moderate, Low) risk for falls r/t [related to] Gait/balance problems. and lacked evidence that the care plan was accurately revised to reflect R9's current fall risk status. Further review of the care plan indicated a focus of .acute on chronic pain as it relates to my fibromyalgia, contractures, and functional deficits. and interventions included, .Identify, record, and treat the resident's existing conditions which may increase pain.(SPECIFY: arthritis, neuropathies, cancer, osteoporosis, fractures, shingles, peripheral vascular disease, ulcers, contractures, parathesia [paresthesia] r/t stroke). Review of R9's clinical record lacked evidence that R9 has or has had the diagnoses, other than contractures, indicated in the intervention on the care plan. On 12/10/25 at 1:43 p.m. a surveyor discussed the above finding during an interview with the Director of Nursing (DON) and the MDS Coordinator. At this time, the DON and MDS Coordinator reviewed R9's care plan and clinical record and confirmed the care plan was not revised to reflect R9's current needs. 2. R2 was admitted in February 2025 and has diagnoses to include recent left femur fracture, retention of urine, and indwelling urinary catheter. On 12/8/25 at 11:02 a.m., a surveyor observed R2 lying in his/her recliner, with indwelling urinary catheter tubing extending to a urinary drainage bag hanging on R2's bed frame. A review of R2's clinical record revealed that he/she was hospitalized in September 2025 and underwent surgical repair of a left hip fracture. Further record review indicated R2 was again hospitalized in October 2025 and returned to the facility with the indwelling urinary catheter. Further review of R2's clinical record revealed an active physician order for May perform voiding trial once resident is ambulatory. A review of R2's December 2025 Treatment Administration (TAR) record indicated the voiding trial had not been performed because R2 is not ambulatory. R2's care plan, most recently revised 10/29/25 includes the following: - - .resident has an ADL [activities of daily living] self-care deficit.recent fall with fx [fracture], recent UTI/Infection.TOILET USE: The resident is able to independently toilet self as desired and requires assistance as requested. - - .resident has had an actual fall with major injury.and functional decline. - - .resident has bladder incontinence r/t Dementia.Ensure the resident has unobstructed path to the bathroom. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- - .resident has Indwelling Catheter. On 12/10/25 at 1:50 p.m. a surveyor discussed the above finding with the DON and the MDS Coordinator. At this time, the DON and the MDS Coordinator confirmed that R2's care plan was not accurately revised to reflect his/her current ADL and toileting needs. 3. On 12/9/25, review of R60's clinical record indicated R60 had a fall on 11/20/25 which resulted in a hip fracture and a compression fracture in his/her back. Upon returning from the hospital on [DATE] after having hip surgery the Care Plan identified the focus area as, Impaired physical mobility, The listed interventions were determine level of needed assistance based on Activities of daily living (ADLs) evaluation Educate Resident/Representative on exercise and safe transfer techniques to evaluate post operative ADLs On 12/9/25 at 2:14 p.m., during an interview with the Director of Nursing (DON), R60's clinical record and Care Plan were reviewed. At this time the surveyor confirmed with the DON that R60's care plan was not complete by not addressing recent hip fracture and compression fracture in his/her back and that the care plan was not person centered to address R60's needs. 4. On 12/9/25, review of R7's clinical record indicated R7 needed physical and occupational therapy for a left femur fracture. The Care Plan identified the focus, The resident has limited physical mobility [related to (r/t)] left femur fracture. The associated interventions stated, AMBULATION: The resident requires (SPECIFY: assistance) by (X) staff to walk (SPECIFY FREQ) and as necessary. LOCOMOTION: The resident requires (SPECIFY assistance) by (X) staff for locomotion using (SPECIFY). On 12/9/25 at 3:40 p.m., during an interview with a surveyor and the Unit Manager, R7's clinical record and Care Plan was reviewed. The Unit Manager was unable to determined what requirements should have been specified for assistance, number of staff, and/or frequency needed. At this time the surveyor confirmed the Care Plan was not updated and/or resident centered to address the resident's physical needs related to a femur fracture.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to ensure physician orders were followed for a physical therapy evaluation for 1 of 3 residents reviewed for positioning and mobility, for diet orders for 1 of 4 residents reviewed and for medication orders for 1 of 4 sampled residents reviewed (Resident #9 [R9] R60, R56 and R10).Findings: 1.R9 has diagnoses to include hemiplegia, muscle spasticity, and bilateral hand and knee contractures. A review of R9's provider progress note dated 9/26/25 states, .consult for spasticity.the patient is seated in [his/her] wheelchair leaning to the right. A review of R9's SBAR communication form (a form used by nurses to communicate resident needs with a physician) dated 10/29/25 states, May we have an order for resident to use seatbelt while in w/c [wheelchair]. with a written physician order at the bottom of the form for .PT/OT [physical therapy/occupational therapy] eval [evaluation] trunk stability. Further review of the form indicates sent to therapy. A review of R9's electronic medical record revealed an active physician order with a start date of 10/30/25 for PT/OT eval one time a day for Trunk stability. On 12/10/25 at 11:29 a.m. during an interview, the Physical Therapy Assistant confirmed R9 received PT from 3/23/17 through 10/10/24 but has not had any further therapy since then. On 12/10/25 at 1:00 p.m. during an interview, Registered Nurse #1 (RN1) stated that after physician orders for PT are received from a telephone order or an SBAR communication form, the nurse enters the order, and a copy of the order is placed in the therapy folder at the nurses' station, then PT evaluates the resident. RN1 then stated that he does not know if PT has evaluated R9 as ordered. On 12/10/25 at 1:08 p.m. during an interview, the above finding was discussed with the Director of Nursing (DON). 2. On 12/9/25 during a record review it was noted that R60 had a diet order for mechanical soft foods with nectar/mildly thick consistency for liquids and to cut meat small with extra gravy/butter, extra soft fruits and vegetables with full supervision and assistance as needed. On 12/9/25 at 8:30 a.m. R60 was observed in his/her room with their breakfast tray, it was observed that on his/her tray was a glass of milk that was not nectar thick, a cup/mug of water that was not nectar thick and he/she was not being fully supervised as ordered. On 12/9/25 at 9:00 a.m. during an interview with a Cna; the surveyor asked what it means when a resident is on full supervision for meals. she stated it means that you have to sit with them and help them if needed. She was not aware that R60 had an order for full supervision, and that she only sets R60 up with his/her meal and they eat independently. On 12/9/25 at 9:30 a.m. during an interview with the Unit Manager the surveyor confirmed this observation and the drinks were exchanged for nectar thick liquids. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/10/25 at 10:18 a.m. R60 was observed with his/her meal tray in his/her room, the cup/mug of water was not nectar thick as ordered. The surveyor confirmed this finding with the unit manager at the time of the observation. In addition, R60 was not supervised with his/her meal as ordered 3. On 12/9/25 at 1:00 p.m. during a record review it was noted that R56 went to the emergency room on [DATE]. On 12/9/25 at 2:07 a.m. R56 received a dose of antibiotic while at the hospital. R56 was returned to the facility with an order for cefuroxime 250 milligrams (mg) two times a day for 7 days for treatment of a urinary tract infection. Review of R56's Medication Administration Record (MAR) showed that R56 was due for a dose of cefuroxime 250 mg at 8:00 p.m. on 12/9/25. Review of the MAR shows that a 9 was entered and the progress note for that time documents that the med was not given as the med had not arrived. On 12/10/25 at 1:40 p.m. during an interview with nurse LPN1 charge nurse for Moonlight Bay unit. She stated that they do have an emergency stock of medications in the skilled unit med room, there is a box with multiple drawers and on the side of the box are lists with medications available. At this time the emergency med box was observed and the list on the side of the box showed that Cefuroxime (Ceftin) 250 mg was in drawer 5D with a par (amount) of 5 tablets available. At this time the surveyor confirmed that the facility failed to provide a prescribed antibiotic as ordered. 4. On 12/9/25 during a record review for R10 it was noted that he/she had an order dated 11/18/25 to wean (decrease) midodrine to 2.5 mg by mouth twice a day, and to decrease the frequency of blood pressure to twice a day prior to administration midodrine, if systolic blood pressure is above 140 notify the provider. Review of the MAR shows that R10 was receiving the midodrine twice a day but there is no evidence that his/her blood pressure was being monitored as ordered. On 12/9/25 at 1:42 p.m. during a review of R10's MAR with the Director of Nursing (DON) we observed that the MAR reflects that her BP is not monitored prior to the medication and the provider has not been made aware of any increased BP. The DON thought they were documented in the vital signs section of the point click care system. Upon review, with the DON R10's blood pressures were not taken twice a day as ordered. This finding was confirmed at this time.

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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 observation, record reviews, and interviews, the facility failed to ensure that clinical records were complete and contained accurate information for 2 of 2 sampled residents reviewed for Activities of Daily Living (Resident #49 [R49], R41) and 1 of 3 residents observed for medication administration (R52).Findings:1. A review of R49's care plan indicates he/she .has an ADL [activities of daily living] self-care performance deficit r/t [related to] Hemiplegia.often lethargic on bath days.Notify nurse and perform full bed bath instead.A review of R49's bathing task documentation in the Electronic Medical Record (EMR) indicates whirlpool or shower and document every Wednesday day shift and prn [as needed]. Further review of the task documentation states, Specify Bathing given and is documented as Not Applicable by Certified Nursing Assistant #3 (CNA3) on 12/3/25. Further review of the EMR lacks evidence of a nursing progress note or documentation indicating why R49 did not receive his/her scheduled bath/shower.On 12/11/25 at 8:38 a.m. during an interview, CNA3 stated she only uses Not Applicable to document a scheduled bath/shower if the resident is bathed the night shift prior. CNA3 then stated if a resident is too lethargic for a scheduled bath, she notifies the nurse, and the nurse documents a note in the EMR. Additional review of the EMR lacked evidence that R49 was bathed on the night shift on 12/2/25. On 12/11/25 at 8:40 a.m. during an interview, Registered Nurse #1 (RN1), stated if a CNA notifies him that a resident is sleeping or lethargic for a scheduled bath, he would have the CNA reapproach at an alternate time and that if a scheduled bath cannot be performed, the reason should document in a nursing progress note or noted on the bath schedule at the nurse's station.A review of the LTC (Long Term Care Unit) Whirlpool/shower Schedule dated 12/3/25 indicates R49 was scheduled to receive a whirlpool bath on day shift but lacked evidence that R49 was offered or refused a bath. 2. R41 has diagnoses to include hypertension and coronary artery disease.A review of R41's clinical record revealed an active physician order with a start date of 8/17/25 for Wt [weight] and vitals weekly on whirlpool day: Sunday eve [evening]. Further record review lacked evidence that R41's blood pressure was documented on 9/28/25, 11/9/25, 11/16/25, and 11/30/25 and lacked evidence that weekly vital signs were done on 9/28/25 and 11/30/25. Additionally, the clinical record lacked evidence that R41's weekly weight was done on 11/23/25, 11/30/25, and 12/7/25.A review of R41's bathing task in the Electronic Medical Record (EMR) indicates Whirlpool or shower every Sunday eve [evening] and prn. Further review of the task documentation states, Specify Bathing given and indicates Not Applicable for R41's scheduled baths on 8/31/25, 9/28/25, 11/23/25, 11/30/25, and 12/7/25.Further review of the EMR lacked evidence of a nursing progress note or documentation indicating why R41 did not receive his/her scheduled bath/shower or weights and vitals for the above dates.On 12/10/25 at 3:22 p.m. during an interview, a surveyor and the Director of Nursing (DON) reviewed R49's and R41's entire clinical record and discussed the above findings. At this time, the DON could not identify what Not Applicable indicated for each of the above scheduled baths and stated that different staff members document Not Applicable for different reasons. 3. On 12/10/25 at 8:20 a.m. during a medication observation for R52, Certified Nursing Assistant-Medication Tech #1 (CNA-M1), CNA-M1 raised R52's right pant leg to apply his/her ordered lidocaine patch to his/her knee. At this time, the surveyor and CNA-M1 observed an existing patch, dated 12/9/25, in place on R52's right knee. CNA-M1 then removed the existing patch and stated, I think that was supposed to come off last night, and proceeded to apply the new patch. After exiting R52's room, a surveyor and CNA-M1 reviewed R52's Medication Administration Record (MAR), and the MAR included an active physician order to remove R52's lidocaine patch daily at 8:00 p.m. Further review of the MAR revealed CNA-M2 documented that she removed the patch on 12/9/25 at 10:36 p.m.On 12/10/25 at 9:00 a.m., the above finding was discussed with the Long Term Care House Unit Manager. On 12/10/25 at 9:59 a.m. the finding was discussed with the Administrator.

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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 observations, interviews, record reviews, and facility policy, the facility failed to maintain an Infection Control Program designed to provide a sanitary environment to help prevent the development and transmission of disease and infection for 3 of the 4 days of survey (12/8/25, 12/9/25 and 12/11/25).1. On 12/8/25 at 1:47 p.m., during an interview with the Infection Preventionist (IP), a surveyor observed the following: Contact Precaution Signage was observed on the wall to left and right of room [ROOM NUMBER]. A Personal Protective Equipment (PPE) cart was observed to the left of the door containing masks, gowns, and gloves. A housekeeping cart was observed in the hallway outside the resident room. The IP stated that the Contact Precautions were for COVID. During the observation of the signage and PPE, the door to room [ROOM NUMBER] opened and a housekeeping staff exited the room leaving the door open. The Housekeeping staff discarded a simple mask, performed hand hygiene, donned a simple mask from the PPE cart, then left the area. The door to room [ROOM NUMBER] remained open. A Licensed Practical Nurse (LPN) stopped at the PPE cart, donned gloves, a gown, a N95 mask, and a face shield, then entered the room. The LPN closed the door on entering. The IP stated at least the LPN closed the door. The IP stated the door would normally be closed to prevent the spread of infection. At 1:50 p.m., the LPN exited the room wearing only the facial PPE. The LPN removed the N95 mask with bare hands, reached into the container of simple masks, removed a simple mask, donned the simple mask, then performed hand hygiene. At this time the surveyor confirmed with the LPN that she did not perform hand hygiene after removing her N95, and her hands were soiled when she reached into the box of simple masks. This was observed and confirmed with the Infection Preventionist at the time of the observation. 2. Review of facility policy Enhanced Barrier Precautions, revised 3/2025 states, Enhanced Barrier Precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms (MDROs) to residents.Gloves and gowns are applied prior to performing the high contact resident care activities.Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include.transferring.device care or use (central line, urinary catheter. On 12/8/25 at 11:02 a.m. a surveyor observed a sign hanging outside R2's room indicating he/she is on Enhanced Barrier Precautions. On 12/9/25 at 8:08 a.m. a surveyor observed R2's indwelling urinary catheter tubing extending below his/her clothing to a catheter drainage bag hanging from his/her bed frame. At this time R2 stated he/she wanted to get out of bed and proceeded to press his/her call light. At 8:13 a.m., Certified Nursing Assistant #1 (CNA1) answered R2's call light, left the room briefly, and returned with a sit-to-stand lift. Without putting on a gown or gloves, CNA1 picked up R2's catheter drainage bag and placed it in its cover bag, then without sanitizing her hands, proceeded to adjust her own clothing. CNA1 then placed the lift sling behind R2, attached it to the lift, and secured the leg strap around R2's legs, with the strap directly touching R2's urinary catheter tubing. CNA1 proceeded to transfer R2 to his/her recliner, then removed the sling and lift and exited R2's room. CNA1 then sanitized her hands and proceeded to wheel the lift to the end of the hall and placed it outside of room [ROOM NUMBER], with the sling draped over the lift. Without cleaning the lift or the sling, CNA1 returned to her med cart at the other end of the hall. At this time, during an interview, a surveyor discussed the above observation, and CNA1 stated she should have worn gloves to handle the urinary catheter drainage bag but that she thought she only needed to wear a gown if she was emptying R2's urinary catheter. CNA1 then stated she thinks she was supposed to clean the lift after using it to transfer R2 and proceeded to clean the sling and lift. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/9/25 at 8:35 a.m., the above finding was discussed with the Long Term Care House (LTC House) Unit Manager. On 12/9/25 at 8:43 a.m., the finding was discussed with the Administrator. 3. On 12/11/25 at 8:30 a.m. a surveyor observed the breakfast service in the LTC House dining room. CNA2 was standing by the steam table and reached behind her back with her right hand and proceeded to scratch the top of her back. CNA2 then stepped toward the counter to her left and proceeded to rub her nose repetitively with her right hand. Without sanitizing her hands, CNA2 took R9's plated meal from the staff member at the steam table, delivered it to R9, and began cutting R9's food. At this time, the surveyor intervened. CNA2 stated sometimes she sanitizes her hands if there is hand sanitizer around but that she did not see any available. The surveyor then requested CNA2 sanitize her hands before continuing to assist R9 with his/her meal set up. On 12/11/25 at 9:29 a.m., the above concern was discussed with the Director of Nursing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure residents were offered pneumococcal vaccinations in accordance with the Centers for Disease and Prevention Control (CDC) recommendations for 2 of 5 residents reviewed for immunizations (Resident #7 [R7] and R8).On 12/9/25, the Facility's Policy Pneumococcal Vaccine, revised 03/2025, was reviewed. The policy stated, 1. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility . 2. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission.On 12/10/25, from 9:20 - 10:00 a.m., during an interview with a surveyor and the Infection Preventionist (IP), the following was reviewed and confirmed:R7 was admitted on [DATE]. R7's paper chart contained a Prevnar20 Consent Form that was signed by the resident on 10/29/25, the consent form was blank and did not indicate if the resident consented or declined the vaccination. The clinical record lacked evidence that R7 had received, been offered, or refused the pneumococcal series vaccination.R8 was admitted on [DATE]. The clinical record lacked evidence that R8 had received, been offered, or refused the pneumococcal series vaccination.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interview, the facility failed to perform adequate screening and documentation for the updated coronavirus (Covid-19) vaccine as required for 4 out of 5 residents screened for Covid-19 immunizations (Resident #7 [R7], R8, R71, and R85).On 12/10/25, from 9:20 - 10:00 a.m., during an interview with a surveyor and the Infection Preventionist (IP), the following was reviewed and confirmed:R7 was admitted on [DATE]. The clinical record lacks evidence that R7 was offered the updated COVID-19 vaccination or signed informed consent and/or declination for the updated Covid-19 immunization.R8 was admitted on [DATE]. The clinical record lacks evidence that R8 was offered the updated COVID-19 vaccination or signed informed consent and/or declination for the updated Covid-19 immunization.R71 was admitted on [DATE]. The clinical record lacks evidence that R71 was offered the updated COVID-19 vaccination or signed informed consent and/or declination for the updated Covid-19 immunization.R85 was admitted on [DATE]. The clinical record lacks evidence that R85 was offered the updated COVID-19 vaccination or signed informed consent and/or declination for the updated Covid-19 immunization.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on Certified Nursing Assistant (CNA) employee education review and interview, the facility failed to implement and maintain an effective training program to ensure that a CNA attended the required 12 hours of annual in-service education training, and annual dementia training for 3 of 5 randomly selected CNAs reviewed on survey (CNA4. CNA-M3 and CNA-M4).Findings:1.On 12/11/25, review of CNA4's employee record indicated the date of hire to be 1/17/21. The education file lacked evidence of annual education in the areas of Dementia training, communication, behavioral health and ethics, 2.On 12/11/25, review of CNA-M3's employee record indicated the date of hire to be 1/2/1983. The education file lacked evidence of annual education in the areas of Dementia training, communication, behavioral health and ethics.3.On 12/11/25, review of CNA-M4's employee record indicated the date of hire to be 1/17/21. The education file lacked evidence of annual education in the areas of Dementia training, communication, behavioral health and ethics, On 12/11/25 at 9:37 a.m. during an interview with the staff educator RN4 the above education files were reviewed and there was no evidence that the above trainings were provided. The surveyor confirmed this finding at this time.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations and interviews the facility failed to promote care for residents in a manner that maintains each resident's dignity and respect when staff failed to serve all residents seated at the same table at the same time for 1 of 3 meals and observed staff standing while assisting residents with their lunch meal. (12/8/25)Findings:On 12/8/25 on the Moonlight Bay unit during the lunch meal observation between 12:00 p.m. and 12:36 p.m., at 12:08 p.m. the surveyor observed 2 residents sitting at the far table nearest the window cutout were being assisted with their meals while their 2 table mates sitting across from them were not being assisted. The tablemates were not served and assisted with their meals until 12:24 p.m. This observation was confirmed by the surveyor with a corporate consultant at the time of the observation.On 12/8/25 at 12:13 p.m. during the above meal observation a Certified Nursing Assistant (Cna) was observed standing while assisting two residents with their lunch meals. The charge nurse was made aware and stated she was not aware that staff could not stand while assisting a resident with their meals.The surveyor confirmed the above finding with the charge nurse at the time of the observation.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews and interviews, the facility failed to issue a written transfer/discharge notice and a bed hold notice to include cost of care to the legal representative for 2 of 3 sampled resident reviewed for transfer to an acute care hospital. (Residents #82, #2 [R82, R2]).Findings: Resident #82 was originally admitted to the facility in August 2022 with diagnoses to include Heart Failure and Chronic Kidney Disease. Review of Resident #82's complete clinical record revealed he/she was transported to an acute care hospital and subsequently admitted on [DATE]. Further review of Resident #82's clinical record lacked evidence that the resident representative received a written transfer/discharge notice and a written bed hold notice. On 12/10/25 at 9:36 a.m., in an interview with a surveyor, the Nurse Manager for the Long Term Care unit confirmed that a written transfer/discharge notice and a bed hold notice were not provided to the resident representative in writing for the above-named date. On 12/10/25 at 9:52 a.m., in an interview with 4 surveyors present, the Administrator confirmed that a written transfer/discharge notice and a bed hold notice were not provided to the resident representative in writing for the above-named date. 2. R2 was admitted to the facility in February 2025. A review of R2's clinical record indicated he/she was transported to an acute care hospital on 9/14/25 and was subsequently admitted . Further review of the clinical record revealed R2 was readmitted to the facility on [DATE] and was again transported to an acute care hospital on [DATE] and was subsequently admitted . R2's clinical record lacked evidence that his/her representative received a written transfer/discharge notice and a written bed hold notice for the above dates. On 12/10/25 at 9:59 a.m. during an interview with 4 surveyors, a surveyor discussed the above finding with the Administrator. At this time, the Administrator confirmed R2's representative did not receive a written transfer/discharge notice and a written bed hold notice for the above dates.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on record review and interview, the facility failed to ensure a resident's physician supervised and evaluated weight loss for 1 of 5 residents reviewed with potentially significant weight loss (Resident #7 [R7]). On 12/8/25, R7's clinical record was reviewed and revealed the following:-Review of documented weights indicated R7's weight on 10/29/25 was 119.8 pounds, R7's weight on 11/28/25 was 112.2 pounds, which is a -6.34% weight loss in 1 month.-Review of R7's brief interview for mental status dated 12/5/25, indicated R7 has moderate cognitive impairment. -Review of the Provider's Progress Note dated 12/5/25 indicated R7 denied weight loss. The progress note lacked evidence that the potentially significant weight loss was identified or addressed. On 12/9/25 at 3:03 p.m., during an interview with a surveyor, a Licensed Practical Nurse (LPN) and the Unit Manager (UM), R7's clinical record was reviewed. The LPN stated if a resident has weight loss, staff will tell the provider first, and they would try a nutritional supplement such as Ensure or Glucerna. Then we will do weekly weights to ensure the changes are effective. The provider may also want to order labs to see if there is an imbalance related to weight loss. Normally nursing communicates health concerns to the provider, but Dietary will also identify weight loss prior to Interdisciplinary meetings.On 12/9/25 at 3:15 p.m., during an interview with a surveyor, a Licensed Practical Nurse (LPN) and the Unit Manager (UM), the UM stated, staff notify the provider (of weight loss) by submitting an SBAR (Situation, Background, Assessment, Recommendation). At this time a surveyor confirmed with the UM that an SBAR was not created for the weight loss, and the clinical record lacked evidence that R7's potential significant weight loss was identified and/or addressed.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure that two people who are authorized to administer medications signed the Shift Count page indicating that they counted all controlled substances at the change of shift for multiple shifts, for 2 of 6 Controlled Substances Books reviewed (Long Term Care House 5/6 [LTC House 5/6] and LTC House 7/8 Medication Tech med cart books).Findings:1. On 12/9/25 at 10:27 a.m., during a medication storage observation, Controlled Substances Book and Shift Counts for the LTC House 5/6 medication tech med cart were reviewed, which indicated the facility counts at the change of each shift, approximately 2 times per day, and revealed 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: 4/14/25 at 5:30 a.m., 6/22/25 at 2:30 p.m., 6/27/25 at 11:00 p.m., and 7/15/25 at 11:00 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: 4/14/25 at 6:12 a.m., 5/3/25 at 6:30 a.m., 5/15/25 at 5:30 a.m., 5/23/25 at 6:30 a.m., and 7/14/25 at 6:00 a.m.- Additionally, on 5/23/25, 6/20/25, 6/21/25, 7/11/25 or 7/12/25, and 7/17/25, there are incomplete entries that lack date, time, and the status of count. 2. On 12/10/25 at 8:36 a.m., during a medication storage observation, Controlled Substances Book and Shift Counts for the LTC House 7/8 medication tech med cart were reviewed, which indicated the facility counts at the change of each shift, approximately 2 times per day, and revealed 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 12/3/25 or 12/4/25 (the entry is not time or dated and lacks status of the count).- 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: 1/18/25 at 5:30 a.m., 5/16/25 (entry lacks date and time), 7/1/25 at 6:00 a.m., and 9/28/25 at 2:00 p.m.- Additionally, on 12/4/25 or 12/5/25, there is an incomplete entry that lacks the date, time, and status of the count.On 12/10/25 at 9:00 a.m., the above findings were discussed with the LTC House unit manager.On 12/10/25 at 3:45 p.m. the above findings were discussed with the Director of Nursing.

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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 ensure expired medications were removed from the supply available for use for 1 of 2 medication storage rooms observed (Long Term Care [LTC] House med storage room). Finding:On 12/10/25 at 9:00 a.m. during an observation of the LTC House med storage room with the LTC Unit Manager, a bottle of Lido-Nystatin 50/50 (a medication commonly known as Magic Mouthwash) labeled for R74 with a written date of 10/8/24 and an expiration date of 10/8/25, was available for use. At this time, the surveyor confirmed the finding with the LTC House Unit Manager, and the unit manager discarded the expired medication.On 12/10/25 at 3:45 p.m., the finding was discussed with the Director of Nursing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and the facility's Food Storage, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner for a dish machine, metal shelving and the floor; and failed to ensure foods were sealed, labeled, dated and/or discarded if past use by date in a walk-in refrigerator for 1 of 1 kitchen tours. (12/8/25) Findings: The facility's Food Storage policy effective 03/2025 noted: All foods must be covered, labeled, dated and routinely monitored to assure foods are used by their use by dates or discarded. On 12/8/25 from 10:45 a.m. to 11:20 a.m., a surveyor completed a kitchen tour with the facility Food Service Director and a Food Service Director from a sister facility, in which the following findings were observed:-The dish machine had large amounts of food debris, dried liquid residue and dried chemical residue on the top and sides of it. -The metal shelf under the hot water booster was rusty. -There was a one pound box of corn starch on a kitchen shelf that was open to the air and not sealed.-There was food debris and dirt on the floor under the stove and shelving. -The walk-in refrigerator had a bag of alfredo sauce that was not labeled and dated. Additionally, there were four 32-ounce containers of heavy cream, available for use, with a used-by-date of 11/25/25. On 12/8/25 at 11:20 a.m., in an interview with a surveyor, the facility Food Service Director and a Food Service Director from a sister facility confirmed the findings.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interviews and record review, the facility failed to provide specialized rehabilitative services or obtain the required services from an outside resource that is a provider of specialized rehabilitative services for 1 of 1 residents reviewed for rehabilitative services (Resident #7 [R7]).On 12/9/25, review of R7's clinical record indicated the following:-R7 had a diagnoses included a left femur fracture with routine healing.-Review of Physician's Telephone Orders, signed on 11/5/25, indicated and order to Continue current [Physical Therapy (PT)]/[Occupational Therapy (OT)]/[Speech Therapy(ST)] [Plan of Care (POC)] under new therapy provider, Reliant Rehabilitation, effective 11/01/25.-Review of the Order Summary Report indicated an active order to Continue current PT/OT/ST POC under new therapy provider Reliant Rehab, effective 11/1/25 and an active order clarifying Physical Therapy to see R7, 5 times per week.-Review of the Care Plan was not updated to address R7's physical needs related to a femur fracture (See F657).The surveyor was unable to find therapy documentation. On 12/9/25 at 3:03 p.m., during an interview with a surveyor and the Long-Term-Care House Unit Manager (LTC UM), R7's clinical record was reviewed. LTC UM stated she does not have access to therapy notes, that Physical Therapy is not always available and believes Occupational Therapy would try to cover both services with visits as the old therapy company did not have enough availability. At this time the surveyor confirmed there is an order for Physical Therapy, Occupational Therapy, and Speech Therapy dated 11/1/25, and Physical Therapy is ordered for 5 visits per week. On 12/9/25 at 4:30 p.m., the Director of Nursing (DON) provided the surveyor, the Physical Therapy Transitional Evaluation and Plan of Treatment documentation, which indicated under the Plan of Treatment heading, Frequency: 5 time(s)/week. On 12/10/2025 at 11:07 a.m., during an interview with a surveyor and the Therapy Coordinator (TC), R7's clinical therapy records were reviewed. TC stated, we get our orders by word of mouth or an SBAR (Situation, Background, Assessment, Recommendation). TC stated, I heard [R7] had an order for speech, but I did not get the information myself. At this time the surveyor confirmed there was an order for Speech Therapy, and a Speech Therapy evaluation for treatment was not completed for R7, and that R7 did not receive PT 5 times a week per Physician's Orders and as recommended in PT evaluation. TC stated, it has been difficult with staffing and all my other duties.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observations and interview, the facility failed to post in a place accessible to all residents, family members and legal representatives, the results of the most recent surveys for 4 of 4 survey days.Findings: On 12/10/25, between 1:15 p.m. and 1:30 p.m., it was observed that there were no survey results posted on the three facility Units (Skilled Unit, Moonlight Bay Unit (secured dementia unit) and the Long Term Care Unit). The only survey result posted is pinned to a bulletin board in a hard, clear plastic cover, approximately six feet or more from the floor, in the front lobby. The only posted survey available is dated from a survey completed in 12/2021, although the State Agency has completed surveys in 8/2023, 11/2024 and complaints/facility reported incidents. Not all residents leave the Units to go to the front lobby.On 12/10/25 at 2:00 p.m., the surveyor confirmed this finding in an interview with the Administrator.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observations and interview, the facility failed to post the nurse staffing information in a predominant place, readily accessible and visible to all residents in 3 of 4 areas of the facility for 4 of 4 survey days. Finding:On 12/10/25, between 1:15 p.m. and 1:30 p.m., it was observed that on the three facility Units (Skilled Unit, Moonlight Bay Unit (secured dementia unit) and the Long Term Care Unit), the nurse staffing information was not posted. The only nurse staffing information posted is pinned to a bulletin board in the front lobby. Not all residents leave the Units to go to the front lobby.On 12/10/25 at 2:00 p.m., the surveyor confirmed this finding in an interview with the Administrator.

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on the review of annual evaluations and interviews, the facility failed to complete annual performance evaluations for Certified Nursing Assistants - Medication Aide (CNA-M) at least every 12 months, for 3 of 5 personnel files reviewed with employment greater than 1 year. (CNA#4, CNA-M3, CNA-M4)Findings:1. CNA4 was hired on 1/17/21. The employee record lacked evidence of an annual performance evaluation being completed for 2025. 2. CNA-M was hired on 1/2/1983. The employee record lacked evidence of an annual performance evaluation being completed for 2025. 3. CNA-M was hired on 6/17/12. The employee record lacked evidence of an annual performance evaluation being completed for 2025.On 12/11/25 at 10:01 a.m. during an interview with the Administrator, she was unable to provide the 2025 evaluations for the above staff. The evaluations were prepared but there was not evidence to show the evaluations were reviewed with the above-mentioned staff. The surveyor confirmed the above finding at that time.