STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0850 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Hire a qualified full-time social worker in a facility with more than 120 beds. Based on the facility bed licensure, staff interviews, and a review of the facility staff roster, it was determined that there were no qualified or licensed social worker or qualified social services designee employed on a full-time basis for this 162 licensed bed facility. This was observed during the recertification/complaint survey and has the potential to affect all residents.The findings include:Facilities licensed for more than 120 bed capacity must employ a qualified social worker on a full^time basis. A qualified social worker is defined as an individual with a licensed in social work or a bachelor's degree in a related human services field and at least one year of supervised social work experience in a health care setting. A social worker contributes to the well-being and quality of life of the residents by addressing the emotional, social, and psychological needs of the residents.When conducting a state survey, if the facility is licensed for over 120 beds and does not have a full time licensed social worker, or a qualified social services designee, an extended survey must be conducted to identify areas of substandard quality of care. This involves further review of the facility policies and procedures related to the deficiencies found during the standard survey.During the review of the facility entrance documentations on 1/5/2026 at 0900, it was noted that the facility is licensed for 162 beds with a current census of 147.On 1/6/26 at 10:26 AM, when the Director of Nursing (DON) was asked about the social worker, The DON stated that staff #1 is the Social Services Director (SSD), but she/he is not licensed, and the previous licensed social worker had resigned. An interview with the Nursing Home Administrator (NHA) on 1/6/2026 at 12:38 PM revealed that the previous social worker worked at the facility for 4.5 months and the regional social worker came to the facility monthly. There was no evidence provided to show when the regional social worker came to the building.On 1/12/26 at 11:32 AM a review of the SSD employee file failed to reveal a degree of any type.The Human Resources Director (HRD), staff #32 stated on 1/12/26 at 11:39 AM that she spoke to the SSD and confirmed that she/he did not have a college degree. On 1/12/26 at 11:46 AM, in an interview with the SSD when asked if she/he had a bachelor's degree she/he stated, no, but is working towards an SSD certification. On 1/12/2026 at 12:15 PM, the DON and NHA were made aware that not having a full-time employed qualified social worker at the facility is a concern and had resulted in an extended survey. The DON and NHA acknowledged the concern and stated that there was a hiring request made for a qualified and licensed social worker.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on a review of resident council meeting minutes and interviews with residents and facility staff, it was determined the facility failed to give adequate responses to grievances that were presented by the resident council. This was evident for 6 of 6 months of the Resident Council meeting minutes reviewed during the recertification/complaint survey. The findings include: The Resident Council is a group of residents that meets regularly on the behalf of all residents in the facility to discuss concerns about facility policies and procedures affecting residents' care, treatment, and quality of life. Facility staff are required to consider resident and family group views and act upon grievances and recommendations. This may include developing or changing policies affecting resident care and life. Facility staff should discuss their decisions with the resident and/or family group and document in writing its response and rationale. The facility must be able to demonstrate their response and rationale.On 01/07/2026 at 8:45 AM, during an interview, Resident #155 voiced a concern that the facility does not respond to concerns expressed during the Resident Council meeting; therefore, the concerns keep recurring.On 01/07/2026 at approximately 11:00 AM a review of the most recent 6 months' Resident Council meeting minutes was conducted. However, the documentation lacked identified resident information pertaining to the concerns, evidence that individual residents' concerns were addressed, or proof of a resolution/action taken to resolve the concern, including notification of that resolution to the resident. A review of June 2025's Resident Council meeting minutes revealed the following concerns: missing/delayed laundry returns, slow call light response, lack of access to the eye doctor, poor staff attitude, and inadequate training for new Geriatric Nursing Assistants (GNAs).A review of July 2025's Resident Council minutes revealed three concerns: Residents had inquired about the status of the bus for summer outings. Geriatric nursing assistants reportedly refuse to assist residents not assigned to them, often turning off call lights and stating they will notify the assigned aide. A third concern was the timely ordering of medications.A review of August 2025's Resident Council meeting minutes revealed the following concerns: residents who smoke are not going out on time; a continued concern of GNAs turning off call lights without addressing resident needs; staff speak a different language; and excessive noise occurs during the 11 PM to 7 AM shift change. A review of September 2025's Resident Council meeting minutes revealed the following resident concerns: long wait times for staff assistance, poor staff attitudes, excessive noise during the 11:00 PM to 7:00 AM shift change, inability to watch football during the season, delayed smoker outings, staff speaking non-English languages, and staff using Bluetooth devices.A review of the October 2025 Resident Council meeting minutes revealed the following concerns: staff still being on their phones, call lights still not being answered timely, and persistent staff attitudes.A review of November 2025's Resident Council meeting minutes revealed the following concerns: call lights not being answered timely. On 01/07/2026 at 11:40 AM, during an interview with Staff #34 (Activity Director) stated the Resident Council grievances/concerns are documented individually on a concern form and sent to the relevant department (e.g., laundry concerns go to Laundry). The department returns the form to her, and she keeps them in a binder in her office; however, the binder is missing. The Activity Director was informed of this concern. On 01/07/2026 at 2:49 PM during an interview, the Administrator, who is also the Grievance Officer, described the grievance process: concerns are submitted on a form to him, then assigned to the relevant department for resolution. The resolution is documented on the form, communicated to the complainant, and returned to the Administrator. The Administrator was informed of the concern at this time.

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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 observation and interview, it was determined that the facility failed to store and maintain food in accordance with professional standards for food service. This was evident during an initial tour of the kitchen during the recertification/complaint survey. The findings include:On 01/05/2026 at 7:37 AM during an initial tour of the kitchen accompanied by Staff #9 (Dietary District Manager) in a large walk-in refrigerator, the following items were found: 3 clear medium-sized containers of fruit with a use-by date of 01/04/2026, 1 large container of vegetable soup with no date, and French toast in a steel container with a date of 12/29. Staff #9 was not able to determine if the date for the French toast was an open or a use-by date. On 01/05/2026 at approximately 7:45 AM, a continued observation in the large walk-in refrigerator revealed a small steel container of fish with no date, 1 large container of sliced cheese with a prep date of 10/23/2025 and a use-by date of 12/23/2025, and one clear container of cantaloupe with a prep date of 12/23/2025 and a use-by date of 12/30/2025.On 01/05/2026 at approximately 7:50 AM, a further observation of the kitchen revealed that under the food tray line was a large bin labeled Starch with a use-by date of 12/28/2025.On 01/07/2026 at 8:35 AM, during an interview, Staff #9 (Dietary District Manager) confirmed food should be labeled with a date and discarded on the expiration date. At this time, he was notified of the concern. On 01/09/2026 at approximately 3:30 PM the Administrator and Director of Nursing was made aware of the concern.

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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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with facility staff and review of facility documentation and employee files, it was determined that the facility failed to ensure staff received mandatory communication training. This was evident for 4 (LPN #45, GNA #46, GNA #47, GNA #48) out of 6 direct care staff employees reviewed during the Extended Survey portion of the facility's recertification survey.A facility must include effective communications as mandatory training for direct care staff. Direct care staff are defined as those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Effective communication helps staff understand what a resident is trying to communicate so staff can appropriately respond. It also helps staff to effectively provide information to residents. This helps to ensure that residents are provided with information in a language and manner they can understand. On 1/8/26 at 11:32 AM in an interview with Human Resources Director (HRD #32) and the Infection Preventionist/Staff Educator (IP/SE #10), when asked if HRD #32 handles any of the staff training, HRD #32 stated, I get staff set up with a background check and orientation paperwork. I do not personally complete any trainings. IP/SE #10 acknowledged and confirmed this. On 1/8/26 at 11:34 AM in an interview with IP/SE #10 when asked the different ways trainings were provided to staff, she stated staff completed Relias training that was scheduled from corporate and that from me personally, I do handwashing, PPE (personal protective equipment), and [resident] falls in-services. When asked if there was any mandatory training all staff received, she stated, Yes, the ones in Relias. During the interview she stated on the first day employees completed onboarding paperwork and there was no training and on the second day they did their Relias, PPD (tuberculosis skin test), and flu. Then employees were scheduled to do floor orientation. When asked how long the two orientation days were, she stated 8 hours. When asked if there were any mandatory trainings all staff received upon and/or within 90 days of hire, she stated, Yes, handwashing, donning and doffing PPE, and that is more or less it. When asked how the facility kept track of staff participation in the required trainings/education/in services, she stated, We have a form that when we have an in-service, they have to sign for it, an attendance sheet. When asked where those attendance sheets are stored, she stated, I have a binder when I have in-services and it's stored in my office. The surveyor requested all in-services and any other training/education related documentation for staff for 2024 and 2025. The surveyor and IP/SE #10 walked to her office and she provided a white, 3-ring binder titled 2025 In Service that had monthly dividers from January through December and five manilla folders with attendance sheets. When asked if there was any further documentation to provide as evidence of facility staff trainings, education, in-services, et cetera, she stated no. When asked if there was any competency documentation for GNAs she stated, I told you it's in Relias. When asked if there was any competency documentation for nurses, she pulled one manila folder from the pile provided, titled Med Pass Completed. When asked if this was for nurses, she stated yes. When asked if every nurse needed to complete this she stated yes. When asked if all nurses had completed it, she said, I want to say 80% did because I have not seen them all. When asked how she could verify all nurses or GNAs competed a training, in-service, education, et cetera, she stated I have a staff roster, and I check it off. When asked if she could share one example, IP/SE #10 flipped through the manilla folder. The surveyor asked if she saw the staff roster she had mentioned and she stated no. In a dual observation, the surveyor and IP/SE #10 looked through the remaining manilla folders and she verified there was no staff roster check off completed to ensure all staff received the offered education, training, and/or in services. On 1/8/26 at 12:32 PM review of Licensed Practical Nurse (LPN #45's) employee files revealed she was hired on 8/19/25; however, failed to reveal communication training.On 1/8/26 at 1:12 PM review of Geriatric Nursing (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assistant (GNA #46's) employee files revealed he was hired on 6/26/24; however, failed to reveal communication training.On 1/8/26 at 1:22 PM review of GNA #47's employee files revealed he was hired on 6/5/24; however, failed to reveal communication training.On 1/8/26 1:42 PM review of GNA #48's employee files revealed she was hired on 6/5/24; however, failed to reveal communication training.On 1/12/26 at 10:36 AM review of all training, education, in-services from the white, 3-ring binder (2025 In Service) revealed the following required trainings:12/6/24 Effective Communication Training12/19/24 Abuse/Neglect/Mistreatment/MisappropriatingFrom 8/25 through 12/25 there were no attendance sheets in the binder for any of those monthsOn 1/12/26 at 11:44 AM review of the four manilla folders revealed attendance sheets for the following training and dates:Folder #1 Med pass observations completed in 10/2025 and 12/2025Folder #2 G-tube observations completed in 10/2025Folder #3 Perineal Care 8/2025, Pain meds 10/2025, Identifying Substance Abuse 10/2025, Nurses documenting order after orders are written 11/2025, Identifying residents with a history of overdose or overdosing 11/2025 Folder #4 Abuse 9/2025, Discard sharps in room [ROOM NUMBER]/5/26, Hand hygiene 7/2025, 9/2025, 10/2025, 11/2025 and 1/2026, Perineal Care 6/2025, Dating Nebulizer Treatment 9/2025, E. coli in urine 6/2025, IDT Fall Assessment after a fall 12/2025, Infection Prevention- Ice Scoop 10/2025, Fill out inventory sheet properly 11/2025, No medical documents placed in shower book 12/2025, Nurses Not to do Sternal rub on residents complaining of chest pain 11/2025, Nurses to administer meds timely 11/2025, Narcotic signing and hand off 12/2025, Alert Charting 12/2025, Bed locked 12/2025, Dignity to residents 11/2025, Get resident out of bed every day 12/2025, HIPPA 12/2025, and Dialysis Assessment Pre and Post Dialysis 10/2025. Folder #5 PPE 10/2025, Timely call bell response times 10/2025, Staff Introduction at beginning of shift 10/2025, Town Hall Meeting 9/2025, Hot Beverages 9/2025, Disaster Plan 9/2025, Label Resident Urinal 10/2025, No Gloves in Hallway 10/2025, Room Cohorting 10/2025, Perineal Care 10/2025, Staff to Knock before Entering 10/2025, Linen Carts 10/2025, Surgical Mask wearing properly 10/2025, Foley empty before Resident leaves for appt 10/2025, Tube Feeding 10/2025, Med Pass 10/2025, Nursing admission Evaluation 10/2025, Glucometer 10/2025, Perineal Care 10/2025, 1-1 Monitoring for RM [ROOM NUMBER] A 10/2025, Address abnormal vital signs 4/2025, Staff answer call bell timely 4/2025, Staff not using cell phone while providing care to residents 7/2025, Bed Safety 7/2025, 24 hour report 7/2025, Check sites (IV, G-tube, peg tube, trach, etc.) and communicate changes 7/2025, Perineal Care 12/2025, Fall Prevention and Management 11/2025, Transfer to Hospital: Bed Hold, MOLST, Med List 6/2025, Heat Advisory 6/2025, Resident Falls 6/2025, Ice Machine 6/2025, Dementia 6/2025, O2 (oxygen) tubing, nebulizer, filters 6/2025, Nurses not to label water bottles on G-Tube 6/2025, ADT 6/2025 (ADT= Electronic System where you bring residents in or discharge them out and shows their status in the facility (Admission, Discharge, Transfer), Signing Off Medications 6/2025, Staff to Report any occurrences on the Resident and Report to the Nurse 6/2025, Wound Interventions and Shower Documentation 4/2025.Review of all manilla folders failed to reveal any communication training.On 1/12/26 at 2:08 PM in an interview with IP/ SE #10, she verified and confirmed as second time, that the 5 manilla folders and white 3-ring binder provided included all the training, in-services, and education for facility staff outside of the Relias trainings which were provided as transcripts for the employees.On 1/12/26 at 4:26 PM in an interview with IP/ SE #10, a dual observation was conducted of the Relias trainings staff completed upon hire. There were three pages provided for Licensed Staff and three pages for GNAs. When asked if any of the upon hire Relias training included communication training listed, she stated for nurses there was Expanding your Communication Skills training, and it would be on the staff's Relias transcript if they completed it. She verified and confirmed that the Relias training required for GNAs did not include communication training.On 1/12/26 at 4:30 PM in an interview with IP/ SE #10, a dual observation was conducted of each employees' Relias transcript along with the attendance sheets from the 3-ring binder and manilla folders. During the interview and observations, when asked if there was evidence for: LPN #45 of communication training, she stated no. When asked how many hours of (continued on next page)

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cognitive impairment/mental illness training direct patient care staff needed to complete annually, she stated, I'm not really sure. When asked how many hours of cognitive impairment/mental illness training direct patient care staff needed to complete within 90 days of hire, she stated, 30 minutes quarterly based on this paper. GNA #46 of communication training, she stated no. GNA #47 of communication training, she stated no. GNA #48 of communication training, she stated, No, I'm not sure who's scheduling these modules. There's no consistency. The surveyor pulled out and shared the 2025 Annual Relias Course & Skills 2 page document provided by the facility and shared that based on these documents, there were communication trainings listed such as Expanding Your Communication Skill Set; however, not all employees were completing the courses. When asked whose responsibility it was to ensure assigned modules were monitored to ensure that staff were completing them timely, IP/SE #10 stated, I don't assign the modules, someone from corporate does that. The surveyor shared that some employees who were hired the same month and for the same position had a different number of courses completed. When asked whose responsibility it was to ensure staff completion of the assigned modules, IP/SE #10 stated, Myself, the nurse managers, but usually it's myself that checks.The surveyor shared these findings were concerns. The IP/SE #10 verbalized and acknowledged understanding of the concerns.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interviews with facility staff, it was determined that the facility failed to provide residents with information to formulate an advanced directive and ensure that a current copy of residents' advanced directives was in the residents' medical record. This was evident for 1 (Resident #1) out of 5 residents reviewed during the facility's recertification/complaint survey. The findings include:An advance directive is a set of written instructions that allows you to make decisions about your future medical care, and/or to designate somebody to make those decisions for you if you are no longer able to do so because of illness, injury, or incapacity. It includes the appointment of a health care agent or advocate, your healthcare instructions, and a signature page where you and two witnesses sign the form to make the document official. Essentially, it is a way to ensure everyone knows what you want and that your healthcare preferences are followed, even when you cannot communicate them directly. MOLST (Medical Orders for Life-Sustaining Treatment) is a form for right now, not for the future. The MOLST form is followed as soon as the form is completed. It is a portable and enduring medical order form (similar to a prescription) that relays instructions between health professionals about a patient's care. It translates a patient's end-of-life care wishes into specific, actionable medical orders signed by a doctor, ensuring their preferences for treatments such as CPR, intubation, or feeding tubes are followed across different healthcare settings.The MOLST form is not an advance directive because it is a medical document that contains actionable medical orders that are effective immediately based on a patient's current medical condition. Advance directives, including living wills, are legal documents that are effective only after the patient has lost capacity. In other words, a health care representative can make decisions for a person only after he or she has been determined to lack capacity; a living will is relevant only after the patient can no longer be consulted. A MOLST form, on the other hand, is a medical document signed by both the clinician and the patient, and is effective as soon as it is signed, regardless of a patient's capacity to make decisions.On [DATE] at 9:54 AM review of Resident #1's medical record failed to reveal an advance directive and/or documented evidence or information indicating that an opportunity to formulate an advance directive was provided to the resident. Further review revealed a bolded heading under the Miscellaneous tab in the electronic medical record titled, Advance Directives; however, there was no advanced directives documentation observed and under the heading were two MOLST's (Medical Orders for Life-Sustaining Treatment, a form is used for documenting a resident's specific wishes related to life-sustaining treatments). On [DATE] at 9:34 AM an interview was conducted with the Social Services Designee (SSD#1). During the interview when asked about the process for advance directives in the facility, she stated when a resident was admitted to the facility, they are asked if they have advance directive. She stated, If they say yes, they'll give it to us, and we upload it in PCC (Point Click Care, facility's electronic medical record). If they don't have one, we'll do one if they are alert and oriented. If they're not alert and oriented, we do a health care surrogate form. When asked if this process was documented, SSD #1 stated, It should say if they have an advance directive or if they refused to do one. It would be documented as a social services note. When asked if she could provide a copy of Resident #1's advance directive, she stated, I have to check on [previous Social Worker's first name]'s desk. He just left last Friday. The surveyor shared that Resident #1 was admitted to the facility on [DATE] and when asked if it would have been scanned and uploaded in almost a year's time, SSD #1 stated, Yeah, it should have been done. On [DATE] at 9:49 AM review of Resident #1's medical record revealed five social services notes; however, failed to reveal any social services note indicating that an opportunity to formulate an advance directive was provided to the resident. On [DATE] at 10:18 AM in an interview with the Director of Nursing (Director of Nursing) when asked if she could provide a copy of Resident #1's advance directive, she stated, I don't think (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he/she has an advance directive. He/she's alert and oriented and has the capacity to make his/her own decisions. When asked about advance directives, she stated it was a federal form for what to do when you become incapacitated. Additionally, she stated that some people do not have it, so we do certifications. When asked to explain more, she stated, We have physicians evaluate if they have capacity. If a resident did not have capacity, a surrogate would be signed, if that person accepted the responsibility. Furthermore, she stated Resident #1 does not have one [an advance directive], but he/she's alert and oriented times three, has a MOLST, and has not been deemed incapable, so he/she does not need one. The surveyor shared this was a concern. The DON acknowledged understanding of the concern. On [DATE] at 10:55 AM review of the facility's policies and procedures for Advance Directive (Resident's Right to Choose) revealed, It is the policy of this facility to support and facilitate a resident's right to request, refuse, and/or discontinue medical or surgical treatment and to formulate an advance directive. On admission, the facility will determine if the resident has executed an advance directive and if not, determine whether the resident would like to formulate an advance directive. Additionally, the review revealed, The facility will provide the resident or resident representative with information on how to formulate an advance directive.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure each resident's medication regimen was free from unnecessary medication/chemical restraints. This was evidenced by the facility utilizing psychotropic medication without appropriate assessment and documentation. This deficient practice was identified in one (Resident #17) of five residents reviewed for unnecessary medication regimens during the recertification/complaint survey.The findings include:Psychosis is a symptom involving a loss of contact with reality (e.g., hallucinations or delusions) that can occur in various conditions.Schizophrenia is a chronic mental health disorder characterized by psychosis and additional symptoms such as disorganized thinking and impaired daily functioning lasting over six months.Risperidone (Risperdal) is an atypical antipsychotic medication primarily indicated for schizophrenia, bipolar disorder, and irritability associated with autism. It functions by balancing dopamine and serotonin levels to stabilize mood and behavior.On 1/07/26 at 7:32 AM, the surveyor reviewed Resident #17's medical records. The review revealed that the resident had diagnoses including, but not limited to, anxiety and unspecified psychosis not due to a substance or known physiological condition. However, as of 10/22/25, the resident was prescribed Risperdal 1ml by mouth twice daily for a diagnosis of Schizophrenia. The records confirmed that Resident #17 did not have a clinical diagnosis of Schizophrenia to support the use of Risperdal for that indication.A review of the Minimum Data Set (MDS) assessments for Resident #17 on 1/07/26 at 1:00 PM revealed inconsistent coding for Schizophrenia:-12/03/24: Schizophrenia was coded.-05/25/25, 08/21/25, and 09/09/25: Schizophrenia was NOT coded.-12/13/25: Schizophrenia was not coded, but psychotic disorder was coded.On 1/09/26 at 7:59 AM, the MDS Coordinator (Staff #3) stated that Resident #17 had a diagnosis of Schizophrenia upon admission. Staff #3 explained, The corporate office directed us to inactivate schizophrenia diagnoses for residents due to a CMS memo. We were told to complete a new schizophrenia evaluation before re-activating the diagnosis. Since the psychiatrist has not completed the evaluation yet, I coded it as 'no schizophrenia.'The facility provided a copy of CMS Memorandum QSO-23-05-NH issued 01/18/23, which outlines audits to verify the accuracy of schizophrenia diagnoses. The memo addresses concerns that facilities may erroneously code schizophrenia to mask high antipsychotic use, as these residents are often excluded from quality measures.On 1/09/26 at 11:43 AM, the Psychiatrist (Staff #11) confirmed that the corporate office required a full re-assessment for all residents with a schizophrenia diagnosis. Staff #11 noted that while Resident #17 had a Provider Attestation for Schizophrenia form completed on 10/20/22, the corporate mandate required a new evaluation, which was currently in process.In a review of Risperdal administration on 1/09/26 at 1 PM showed the dosage and indication fluctuated frequently between 11/09/23 and 1/09/26 without consistent clinical justification. Notably:-From 11/09/23 to 10/11/25, 0.5mg by mouth twice a day (BID) for unspecified psychosis-From 10/12/25 to 10/14/25, 1mg BID for unspecified psychosis.-From 10/14/25 to 10/18/25, 0.5mg BID for unspecified psychosis.-From 10/22/25 to 1/09/26, 1mg BID for schizophrenia.-From 1/09/26, 0.5mg BID for unspecified psychosis.On 1/12/26 at 9:38 AM, the surveyor reviewed all psych notes from January 2025 to current. The review revealed that:-On 1/20/25, the initial mental health visit in-person by Staff #12 documented that Resident #17 had diagnosis of Schizophrenia and Risperidone 0.5mg BID was used for Schizophrenia.-On 4/16/25 and 6/18/25, follow up assessment by Staff #44 (Psych NP) documented no schizophrenia but history of present illness narrative contained Risperdal 0.5mg BID for schizophrenia.-On 8/13/25, 8/25/25, 9/01/25, 9/11/25,and 9/15/25, psych notes written by Staff #12 showed that there was no diagnosis of Schizophrenia but Risperdal was used for Schizophrenia.-On 9/23/25, a psych note written by Staff #12 documented as this is a facility requested mental health assessment to review resident's mental health diagnosis. Staff reports ongoing concerns regarding disorganized thoughts and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviors noted over the past several months. No documentation of a schizophrenia diagnosis was found in the chart, despite the current use of Risperidone.Presentation does not meet full criteria for schizophrenia, Assign diagnosis: Unspecified psychosis not due to a substance or known physiological condition. Also, the indication of current medication for risperidone was changed to unspecified psychosis.-On 9/30/25 and 10/08/25, psych notes written by Staff #12 documented that Resident #17 was on Risperdal 0.5mg BID for psychosis, however, no diagnosis of psychosis.There was no documentation around 10/12/25, regarding increasing Risperdal dose from 0.5mg BID to 1mg BID.-On 10/13/25, Staff #12 wrote a note with adjusting risperidone to 0.5mg BID.-On 10/31/25, Staff #12's note included Risperdal 1mg BID for psychosis, however no evaluation/assessment documented about increasing dose from 0.5mg to 1mg started on 10/22/25.On 1/12/26 at 10:00 AM, the Director of Nursing (DON) was informed of the concerns regarding the lack of proper, timely assessment and documentation for Resident #17's antipsychotic medication. The DON validated these findings.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of pertinent documents and interview with facility staff, it was determined that the facility failed to timely report to the State Survey Agency, the Office of Health Care Quality (OHCQ), an allegation of suspected resident abuse, and an allegation of misappropriation. This was evident for 2 (Resident # 164 and #163) of 2 residents reviewed for abuse during the recertification/complaint survey.The findings include:The OHCQ is the agency within the Maryland Department of Health charged with monitoring the quality of care in Maryland's health care facilities and community-based programs. Allegations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, are to be reported to the OHCQ in a timely manner.1) On 01/07/26 at approximately 1:35 PM, a review of the facility concern forms for the month of October 2025 revealed a concern form dated 10/30/2025 filed by Resident #164 of a concern that an assigned geriatric nursing assistant was roughly handling Resident #164. The facility's resolution was that the assigned Geriatric Nursing Assistant was removed from the assignment, and the Director of Nursing was made aware. However, the facility failed to report this allegation of abuse/neglect to the Office of Health Care Quality. 2) On 01/07/26, at approximately 1:45 PM, a review of October 2025 facility concern forms revealed an allegation dated 10/15/25 from Resident #163's complainant regarding a missing wallet/purse and wigs. The facility's resolution was searching the room, and Staff #21 (Unit Manager RN) requested a receipt from the complainant. However, the facility failed to report this alleged misappropriation to the Office of Health Care Quality. On 01/07/26 at 2:49 PM, during an interview with the administrator, he identified himself as the Grievance Officer responsible for handling concerns. He outlined the following grievance process: A resident, family member, or staff member completes a form detailing the concern, which is then submitted to him. He subsequently distributes the form to the relevant department for follow-up and resolution. The complainant should then be notified of the resolution. However, the Administrator acknowledged that while allegations of abuse, neglect, or misappropriation should be reported to the Office of Health Care Quality (OHCQ), the specific allegations concerning Residents #163 and #164 were not reported. On 01/08/26 at 11:06 AM, during an interview, the Director of Nursing (DON) confirmed that both the rough handling of a resident (constituting physical abuse) and a missing purse or wallet (constituting misappropriation) are mandatory reportable events to the Office of Health Care Quality and were not reported. The concern was communicated at the time of the interview.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on review of facility records and interview with staff it was determined the facility failed to thoroughly investigate an allegation of suspected resident abuse and an allegation of misappropriation. This was evident for 2 (Resident # 164 and #163) of 2 residents reviewed for abuse during the survey. The findings include:1) On 01/07/2026 at approximately 1:35 PM, a review of the facility concern forms for the month of October 2025 revealed a concern form dated 10/30/2025 filed by Resident #164 about a concern that an assigned geriatric nursing assistant was roughly handling Resident #164 and was not assisting with dinner. The facility's resolution was that the assigned geriatric nursing assistant was removed from the assignment, and the Director of nursing was made aware. However, the only accompanying documentation was a statement from the alleged geriatric nursing assistant perpetrator, which solely addressed not receiving assistance with the dinner meal.2) On 01/07/2026, at approximately 1:45 PM, a review of October 2025 facility concern forms revealed an allegation dated 10/15/2025 from Resident #163's complainant regarding a missing wallet/purse and wigs. The facility's resolution was searching for the room, and Staff #21 (Unit Manager RN) requested a receipt from the complainant. However, there was only a Personal Effects Inventory sheet for Resident #163 dated 08/18/2025 attached to the concern form that indicated Resident #163 had belongings of a pocketbook and wig. On 01/09/2026 at 9:21 AM during an interview, the Director of Nursing (DON) described the investigation process: The DON/Administrator reports to the Office of Health Care Quality; the social worker interviews residents and screens the affected resident for psychosocial effects; nursing assesses the resident; police, the responsible party, and the physician are notified; staff are interviewed; and any staff perpetrator is removed from the schedule. In-service training is completed if applicable. For misappropriation, the facility searches and interviews staff, family, roommates, and other residents; notifies police; and provides in-service training if applicable. The DON further stated staff must immediately report any allegation of abuse, neglect, or misappropriation to the Administrator or DON, and an investigation would need to occur. The DON confirmed a thorough investigation did not occur for Resident #163's misappropriation allegation or Resident #164's abuse allegation. This concern was shared with the DON at this time.

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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 review and interviews, it was determined that the facility failed to provide documented evidence to support that the facility notified a representative of the Office of the State Long-Term Care Ombudsman that the resident was discharged . This was evident for 1 (Resident #162) of 2 Residents reviewed for discharge during the recertification/complaint survey process.Findings Included:On 01/09/2026 at 8:39 AM, a review of Resident #162 medical records revealed that the resident was discharged to home on [DATE]; however, there was no documented evidence to support that the facility notified the State Ombudsman's Office in writing.On 01/09/2026 at 9:35AM, in an interview with the Director of Nursing (DON), she was asked who was responsible for transfer and discharge notification to the Ombudsman and she explained that the social worker was responsible for ombudsman notification and it was done via email.On 1/9/2026 at 11:05 AM, in an interview with the social work designee (Staff #1), she explained that the previous social work designee (SWD) was responsible for notifying the ombudsman of Resident's transfer and discharge for the month of November 2025 and she was not copied on the ombudsman notification email sent by the previous SWD. Therefore, she was unable to verify if the ombudsman was notified of Resident #162's discharge. She stated that she tried to call the ombudsman to verify but she was not available. On 1/9/2026 at 11:35AM the surveyor called and left a voice message for the ombudsman to call back. The facility was unable to provide documentation to support that the Ombudsman was notified of Resident #162's discharge.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the medical record and interview with facility staff, it was determined that the facility failed to ensure a Minimum Data Set (MDS) assessment was accurately coded to reflect a resident's status. This was evident for 2 (Resident #8 and #17) out of 32 residents reviewed during the facility's recertification survey.The findings include:The Minimum Data Set (MDS) is a federally mandated, standardized assessment tool used to comprehensively evaluate a resident's functional, medical, psychosocial, and cognitive status. It is administered to all residents at admission, quarterly, annually, and whenever a significant change in an individual's condition occurs. It is the foundation for creating an individualized care plan and ensures the appropriate care and services are provided to each resident. MDS assessments must be accurate to ensure each resident receives the personalized and resident specific care they need.Psychosis: A symptom involving a loss of contact with reality (e.g., hallucinations or delusions).Schizophrenia: A chronic mental health disorder characterized by psychosis, disorganized thinking, and impaired daily functioning lasting over six months. 1) On 1/5/26 at 9:56 AM review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Further review revealed the following weights: 12/9/24 214.0 lbs (pounds) 6/8/25 181.6 lbs The above weights reflected that Resident #8 experienced a 32.4lb or 15.14% weight loss in 6 months. On 1/8/26 at 9:06 AM review of Resident #8's 8/17/25 MDS revealed Section K0300 'Weight Loss'- Loss of 5% or more in the last month or loss of 10% or more in the last 6 months was coded as no. On 1/9/26 at 9:59 AM in an interview with the MDS Coordinator (MDSC #3) when asked if she had a dashboard when she logged into PCC (Point Click Care, the facility's electronic medical record) she stated yes. During the interview when asked what type of alerts and/or information was on the dashboard, she stated, I don't look at alerts because it doesn't affect my department, but yes, there are alerts on the dashboard. When asked if any alerts and/or notifications related to a resident's nutritional status showed on her dashboard she stated, No, I do not see if a resident loses weight on my dashboard. When asked if she was part of the facility's interdisciplinary team (IDT) she stated yes. When asked if she attended the daily clinical meetings, she stated yes and confirmed that residents' weight loss was discussed at those meetings. When asked what information she used to code she stated, Remember the MDS is an IDT approach so there are different sections applied to different disciplines. When asked if she reviewing the medical record was part of the process before completing the MDS she stated, Absolutely, and depending on the section you have a look back period. A dual observation was conducted of Resident #8's weights, weight loss, and 8/17/25 MDS. When asked why she coded Resident #8 as no for weight loss she stated, The dietician did that. You'll have to ask her why she did that. On 1/9/26 at 10:14 AM in an interview with the Registered Dietician (RD #20) when asked Resident #8's weight on 12/9/24, she opened her laptop, pulled up the resident's chart, and stated 214 lbs. When asked his/her weight on 6/8/25 she stated 181.6 lbs. When asked if from 12/9/24 through 6/8/25 the resident had weight loss she stated yes. When asked what percentage weight loss she stated 15% and verified and confirmed it was significant weight loss. During the interview a dual (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observation of Resident #8's 8/21/25 MDS was conducted and it was noted that Section K0300 'Weight Loss'- Loss of 5% or more in the last month or loss of 10% or more in the last 6 months was coded as no. When asked if that was accurately coded she stated no. When asked what it should have been coded as she stated, number 2. Yes, and the resident is not on a prescribed weight loss regimen. The surveyor shared this was a concern. RD #20 verbalized and acknowledged understanding of the concern. 2) On 1/07/26 at 7:32 AM, a review of Resident #17's medical records revealed diagnoses of anxiety and unspecified psychosis. As of 10/22/25, the resident was prescribed Risperdal (1ml twice daily) specifically for a diagnosis of Schizophrenia. However, clinical records confirmed that Resident #17 did not have a verified diagnosis of Schizophrenia to support this indication. A review of MDS assessments conducted on 1/07/26 at 1:00 PM revealed inconsistent coding for Schizophrenia: 12/03/24: Schizophrenia was coded. 05/25/25, 08/21/25, and 09/09/25: Schizophrenia was not coded. 12/13/25: Schizophrenia was not coded, though psychotic disorder was captured. On 1/09/26 at 7:59 AM, the MDS Coordinator (Staff #3) stated that the resident was admitted with a Schizophrenia diagnosis. Staff #3 explained, The corporate office directed us to inactivate schizophrenia diagnoses due to a CMS memo. We were instructed to complete new evaluations before re-activating the diagnosis. Since the psychiatrist has not completed the evaluation yet, I coded it as 'no schizophrenia.' On 1/12/26 at 9:38 AM, a review of psychiatric notes from January 2025 to the present revealed: 1/20/25: Initial assessment (Staff #12) documented a Schizophrenia diagnosis. 4/16/25 and 6/18/25: Follow-up assessments (Staff #44, Psych NP) excluded Schizophrenia from the ICD codes, yet the narrative history continued to list Risperdal for Schizophrenia. 8/13/25 through 9/15/25: Notes (Staff #12) showed no Schizophrenia diagnosis, despite continuing Risperdal for that indication. 9/23/25: Staff #12 updated the records to change the indication for Risperdal from Schizophrenia to unspecified psychosis. 9/30/25 through 11/14/25: Notes continued to document Risperdal use for psychosis. On 1/12/26 at 10:00 AM, the Director of Nursing (DON) was informed that Resident #17's active diagnoses were not accurately coded on the MDS. The DON validated these findings.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 review of medical records and interviews with facility staff, it was determined that the facility failed to ensure a baseline care plan, including a current list of medications, was provided to the resident and/or resident representative (RP) and documented in the medical record. This was evident for 2 (Resident #1 and #8) out of 52 residents reviewed during the facility's recertification survey.The findings include:A baseline care plan (BLCP) must be completed within 48 hours of a resident's admission to the facility and include the initial goals based on admission orders, physician orders, dietary orders, therapy services, and social services. A summary of the BLCP and current medication list must be given to the resident and/or RP and there must be evidence in the medical record that it was provided. Completion and implementation of the BLCP is intended to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events (undesirable outcomes) that can occur right after admission.On 1/6/25 at 9:44 AM review of Resident #1's medical record revealed he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP and/or evidence from the medical record that a copy was given to the resident and/or RP.On 1/6/26 at 9:56 AM review of Resident #8's medical record revealed he/she was admitted to the facility on [DATE]. Further review of the medical record failed to reveal a BLCP and/or evidence from the medical record that a copy was given to the resident and/or RP.On 1/6/26 at 10:07 AM in an interview with the Director of Nursing (DON) when asked the facility's process for BLCP's she stated, when residents are admitted we do a BLCP from whatever triggered from the initial assessment. There are four major BCLP's: pain, fall, skin, ADLs (activities of daily living), and if anything else triggered that would be included. She stated it was completed within 24-48 hours. When asked where the survey team could find residents' BLCPs, she stated it was in PCC [Point Click Care, the facility's electronic medical record (EMR)]. When asked what it was called she stated there was not a specific document called the BLCP. In a continued interview, the DON stated that the nurse would complete a Nursing Assessment Evaluation for any new admission or readmission and that evaluation would trigger care plans. Additionally, she stated those care plans were reviewed by the supervisor or manager to ensure that the four basic care plans were there. When asked if the BLCP was resident specific, she stated, We make sure it's resident specific before we print it and give it to the resident and family. When asked if there was evidence from the medical record that a copy was provided to the resident and/or RP, she stated, Yes, there is evidence from the medical record that the care plan is given to the resident, a signature sheet with the date. When asked whose responsibility it was to provide the resident with the BLCP and obtain their signature, she stated the Unit Managers or the Assistant Director of Nursing. She stated, They should give them the copy and have them sign. The signature sheet would be in their paper chart. When asked who was ultimately responsible for ensuring the completion of this process, she stated, From the supervisors and managers to me, the DON.On 1/6/25 at 12:05 PM review of Resident #1's paper chart and EMR failed to reveal a signature page from around the time of his/her admission to the facility.On 1/6/25 at 12:09 PM review of Resident #'8s paper chart and EMR failed to reveal a signature page from around the time of his/her admission to the facility.On 1/6/25 at 12:10 PM in an interview with Licensed Practical Nurse (LPN #14) when asked how long she had worked at the facility, she stated 5 years. When asked if she provided residents with copies of their BLCP and documented that, she stated, I'm not too sure. No, I'm not saying I give the BLCP. But I will say, resident was educated. But as far as giving them a copy of the BLCP and documenting that in the medical record, no. On 1/6/25 at 12:15 PM in an interview with LPN #24 when asked how long she had worked at the facility she stated about 2 months. When asked if she completed a BCLP when a resident was admitted , she stated yes. When asked if she was provided training on the BLCP, she stated, I wouldn't remember. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked if she provided a copy of the BLCP to the resident and/or RP she stated yes. When asked if she was trained/instructed by the facility to document in the medical record when she provided a copy of the BLCP and/or have the resident and/or RP sign off that they had received it, she stated no.On 1/7/26 at 8:38 AM in an interview with the Director of Nursing she stated she did not see a BLCP for Resident #8 or Resident #1, but that they might be in medical records. On 1/7/26 at 8:45 AM in an interview with Medical Records (MR #19), he and the surveyor went to his office. MR #19 looked through file cabinets for a several minutes and then stated there were no records for Resident #1 or Resident #8. When asked if there was any other location the records might be stored, he stated, No, there is no other place in the building where medical records were stored. The DON entered the medical records office and looked on MR #19's computer; however, was unable to provide a BLCP or evidence from the medical record that one was provided to Resident #1 or Resident #8. The surveyor shared this was a concern. The DON acknowledged understanding of the concern.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a review of complaints, medical records, and staff interviews, the facility failed to ensure a resident received necessary treatment and services to promote their highest practicable well-being: evidence by failing to 1) follow Physician orders for Gastrointestinal interventions related to appointments, and 2) arrange a critical diagnostic test and a specialty consultation as ordered by the provider. This was evident for 2 (Resident #19 and #145) of 8 residents that were reviewed during this recertification/complaint survey.The findings included:According to [NAME] Medicine, a gastrostomy tube (G-tube) is a medical procedure in which a tube is inserted through the abdominal wall and into the stomach to provide an alternative route for delivering nutrition, fluids, and medications directly into the stomach, bypassing the mouth and esophagus. A modified barium swallow study (MBSS) is a real-time X-ray (fluoroscopic) procedure that evaluates how a patient swallows different liquids and foods to determine the cause of swallowing difficulties (dysphagia) or aspiration (food/liquid entering the lungs). 1) On 01/06/26 at 1:59 PM, a review of Resident #19's medical record revealed a physician order dated 11/12/25 to please schedule a gastrointestinal (GI) appointment for evaluation for gastrostomy tube (G-tube) removal. On 01/07/26 at 9:25 AM, further review of Resident #19's medical record indicated a physician order dated 08/13/25 for a modified barium swallow study (MBSS). On 01/07/26 at 9:56 AM, during an interview, the Director of Nursing (DON) explained the process for appointments: a nurse would receive the order from the physician and give it to the Unit Secretary to be scheduled. On 01/07/26 at 12:22 PM, during an interview with Staff #21 (Unit Manager Licensed Practical Nurse LPN), described the appointment process: The unit secretary schedules the appointment after receiving the request from the nurse. The nurse is then informed of the scheduled appointment, notifies the resident/family, updates the order to include the Physician, date and time, and the Unit Secretary would schedule transportation. On 01/08/26 at 8:44 AM, during an interview with Staff #28 (Unit Secretary), the appointment scheduling process was described. A nurse provides the necessary appointment or consultation information on a form, which the secretary then uses to schedule the appointment. Following scheduling, the secretary returns the appointment details to the nurse for the ordered appointment update. Staff #28 explicitly stated that she never received a request for Resident #19's MBS or GI consult and was not aware these appointments needed to be scheduled. She further explained she only became aware of these required appointments on 01/07/26 and began making calls to schedule. On 01/09/26 at approximately 3:30 PM the Director of Nursing and Administrator were made aware of the concern. 2) A portion of investigating complaint 2689147 on 1/05/26 at 10:30 AM, the surveyor conducted a phone interview with complainant. The complainant claimed that the ENT (ear, nose, throat) appointment was scheduled more than 2 months after the hospital recommended for follow up which was delayed Resident #145's diagnosis, and active treatment had not been provided by the facility while he/she was in waiting. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/07/26 at 8:29 AM, the surveyor reviewed Resident #145's medical record. It was revealed that the resident's provider assessed him/her on 10/30/25 and ordered neck ultrasound: the test was performed at the facility on 10/30/25 with result of left neck solid mass measuring 3x2x2 cm. Recommendation for CT neck and chest. The CT neck order was placed on 10/30/25 at 11:11 PM, however it was not scheduled till the resident transferred to the hospital on [DATE]. Further review of Resident #145's medical record revealed that the resident was transferred to the hospital on [DATE] at 6:30 AM per the family's request to manage neck pain. During the hospital stay from 11/10/25 to 11/11/25, Resident #145 received a CT scan of the neck. The results indicated enlarged, partially necrotic, and enhancing left-sided level 2 and 3 lymph nodes measuring 3.4 x 2.4 x 3.7 cm, suspicious for metastatic lymphadenopathy. An ENT evaluation and possible biopsy were recommended. Additionally, the hospital discharge summary noted: You must call each provider to make/verify your appointment with [ENT doctor's name] within one week. The facility's provider wrote order for an ENT appointment and possible biopsy on 11/12/25; however, the appointment scheduled for 1/22/26. In an interview with Staff #28 (appointment scheduler) on 1/08/26 at 8:07 AM, the staff stated that 1/22/26 (more than 70 days later than the order placed) was the earliest possible date. When asked how she managed consultations requiring a specific time window, she stated she would inform the doctor's office, allowing the offices to communicate and adjust the schedule. Staff #28 verified she communicated the details of this case to the Unit Manager. On 1/08/26 at 8:48 AM, Staff #43 (Unit Manager) stated, I updated Resident #145's family member regarding the earliest ENT appointment, and the family member stated they would search for an earlier appointment themselves. Since they said that, I took no additional action to adjust the schedule. However, a progress note written by Staff #43 on 11/14/25 stated: [Resident's family member] was updated about the upcoming ENT appointment on 1/22/26, which is the earliest we can get at this time. In a phone interview on 1/12/26 at 8:53 AM, the family member stated, The nurse called me and said if I was able to look into it myself, I could seek an earlier appointment. The family member insisted they never indicated they would handle the scheduling entirely on their own. A further review of the medical record on 1/08/26 revealed the resident was transferred back to the hospital on [DATE] for neck pain management. During that visit, a biopsy was conducted, resulting in a diagnosis of oropharyngeal cancer. On 1/12/26 at 10:00 AM, the Director of Nursing (DON) validated concerns that the diagnostic CT scan and ENT consultation were not arranged in a timely manner.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on a review of medical records and staff interviews, it was determined that facility staff failed to provide and document appropriate and sufficient services, treatment, and care for a resident with an indwelling urinary catheter. This was evident for one resident (Resident #66) of three reviewed for urinary catheter care during this annual survey.The findings include:A Foley catheter is a thin, flexible tube inserted through the urethra into the bladder to drain urine, used for urinary retention, incontinence, or during/after surgery, kept in place by an inflated balloon at the tip. Foley catheter sizes are measured in French (Fr) units, indicating the tube's outer diameter, with larger numbers meaning a thicker catheter.During an interview on 1/05/26 at 11:37 AM, Resident #66 reported that their indwelling catheter had come out several times within one month. The resident stated, I felt like someone was pulling out the catheter.A review of medical records on 1/08/26 at 7:55 AM revealed that Resident #66 has a chronic indwelling catheter due to a diagnosis of paraplegia (spinal level T2). Progress notes indicated multiple incidents of the Foley catheter being dislodged in December 2025:12/02/25 (8:15 AM): Nursing staff noted that a Geriatric Nursing Assistant (GNA) reported the catheter had come out at approximately 6:00 AM. After an assessment, a new 16 Fr catheter was inserted. Telehealth was notified, and a voicemail was left for the Responsible Party (RP).12/06/25 (10:36 PM): Documentation showed the catheter came out and a new one was inserted.12/13/25 (3:37 PM): A progress note indicated that an 18 Fr Foley catheter was inserted and the balloon inflated with 10 cc of sterile water.12/23/25 (10:41 PM): Nursing staff observed the catheter in the trash. The resident stated it had come out and they had discarded it. A 16 Fr catheter was re-inserted.12/24/25 (4:48 PM): A note documented another dislodgment and subsequent re-insertion.A review of the Treatment Administration Records (TAR) on 1/09/26 at 9:13 AM revealed no records of the Foley catheter re-insertions and no documentation from medical providers addressing these recurrent issues.In an interview on 1/09/26 at 9:24 AM, Licensed Practical Nurse (Staff #35) stated that a physician's order is required to re-insert a Foley catheter unless a PRN (as needed) order is already in place.During an interview with the Director of Nursing (DON) on 1/09/26 at 9:31 AM, the surveyor asked about the expected protocol when a catheter is dislodged. The DON explained that nurses are expected to notify providers, assess and document the resident's condition, and follow provider orders regarding the specific catheter size. When asked if Resident #66 was scheduled for a urology evaluation regarding recurrent issues, the DON confirmed that no consult was planned, stating, We do not schedule for urology follow-up just because a Foley catheter came out.The surveyor shared concerns that the catheter size was changed from 16 Fr to 18 Fr and then back to 16 Fr without a specific provider order, noting the potential for urethral trauma. The DON validated these concerns.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interview with facility staff, it was determined that the facility failed to timely address and notify the provider for a resident with a significant weight change. This was evident for 3 (Resident #8, #17, and #43) of 5 residents reviewed for nutrition during the facility's recertification/complaint survey.The findings include: 1) On 1/5/26 at 9:56 AM review of Resident #8's medical record revealed the resident was admitted to the facility on [DATE]. Further review revealed the following weights: 12/9/24 214.0 lbs (pounds)3/7/25 173.2 lbs6/8/25 181.6 lbs The above weights reflected that Resident #8 experienced a 40.8 lb or 19% weight loss between in 3 months and a 32.4lb or 15.14% weight loss in 6 months. On 1/7/26 at 11:56 AM in an interview with the Registered Dietician (RD #20) when asked how weight loss for a resident was identified, she stated, I know a resident has weight loss because the system flags it. When asked what she does after a resident was identified with significant weight loss, she stated, I assess the resident and determine if it was desired weight loss. If it's not, then I will put the resident on supplements so the resident will not lose any more weight. When asked if she documented, she stated, I document in my assessment and progress note. When asked if she notified the provider, she stated, Yes, and sometimes they will even tell me. When asked if she documented when she notified a provider of weight loss and she stated, Yes, and we discuss it in the morning clinical meeting. When asked if the provider assessed a resident after significant weight loss was documented, she stated, I don't know. On 1/7/26 at 1:15 PM in an interview with the Director of Nursing (Director of Nursing) when asked about how weight loss was identified and addressed in the facility, she stated weight loss was discussed in the Morning Clinical Meeting with the Assistant Director of Nursing (ADON), Unit Managers (UMs), Infection Preventionist/Staff Educator, MDS (Minimum Data Set) Coordinator, Social Worker, Dietician, Nurse Practitioner (NP), and Rehab (Rehabilitation) staff. During the interview she stated, We look at the Dashboard and whatever triggers on the dashboard, talk about the clinical records of the patients, new admissions, appointments, concerns, change in conditions, labs, pending orders that need attention which includes any issues with weight, and go over what needs to be done. The NP is going to look at weight with the dietician and come up with a plan and stuff. Furthermore, she stated, We have a form asking them to confirm the weight loss to make sure it is an actual weight loss (reweigh within 24 hours). The NP will examine and determine if it was a desirable weight loss and then we update the care plan and go over recommendations. And a mini nutritional assessment is done. When asked if the dietician notifies the providers of weight loss she stated, Yes, and the providers are in here and they have to put notes in regarding the weight loss. When asked if meal intake was documented, she stated, Yes, on their POC tasks. When asked who reviewed the meal intakes of residents, she stated, The IDT (Interdisciplinary team) and dietician. It also triggers in our Dashboard in the morning, alerting us that the resident ate less. It's called alert documentation. On the dashboard under Clinical Alerts it says if a resident ate less and/or had weight loss. On 1/8/26 at 8:36 AM review of Resident #8's medical record revealed an abnormal Weight Loss diagnosis was created on 3/6/25. Further review of the medical record revealed a Dietary Progress Note dated 3/11/25, Note Text: WTS (weights): 3/7/2025-173.2#, 2/27-171.8#, 2/19-171.6#, (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/13/2025-171#, 2/6-170.6#, 2/3-172.8#, 1/18/2025-211.6#, 12/9/2024-214#, 11/18-214.9#. Resident has significant weight loss of 19.1% x 90 days. Current weight is within IBW of 160-196#. Will continue to monitor weight and increase Tube feeding as needed. Resident on Tube Feeding-Specialty Product Glucerna 1.5 at 65 ml/hr x 18 hrs = 1170 ml, 1755 Cal, 96 gm Protein and 888 ml free H20 (water). H20 flushes with 65 ml/hr x 18 hrs = 1170 ml. Total Volume = 2340 ml. Total free H20 = 2058 ml. Resident is on Regular diet, Dys Mech texture, Nectar Thickened Liquids consistency as a feeder and consumes 50 - 75 % of meals. Continued review of Resident #8's medical record failed to reveal a Nutritional Assessment was completed after significant weight loss was identified on 3/7/25 and 6/8/25. The first Nutritional Assessment completed after 3/7/25 was on 5/12/25 and the first Nutritional Assessment completed after 6/8/25 was on 8/11/25. On 1/9/26 at 10:14 AM in an interview with RD #20 when asked about Resident #8's weight on 12/9/24, she opened her laptop, pulled up the resident's chart, and stated 214 lbs. When asked his/her weight on 3/7/25, she stated 173.2 lbs. When asked his/her weight on 6/8/25, she stated 181.6 lbs. When asked if from 12/9/24 through 3/7/25 and from 12/9/24 through 6/8/25 the resident had weight loss she stated yes. When asked what percentage weight loss for each time period, she stated 19% and 15% and verified and confirmed Resident #8 had significant weight loss. In a dual observation with RD #20 of Resident #8's 8/21/25 MDS Section K0300 'Weight Loss'- Loss of 5% or more in the last month or loss of 10% or more in the last 6 months revealed the response was coded as no. When asked if that was accurately coded, she stated no. When asked what it should have been coded as she stated, number 2. Yes, and the resident is not on a prescribed weight loss regimen. RD #20 confirmed that the weight loss Resident #8 experienced was not intentional as the resident was prescribed a weight loss regimen. During the interview when asked what interventions were put in place for this resident after his/her significant weight loss on 3/7/25 and 6/8/25, she stated, Even though he/she lost weight, he/she's still within ideal body weight and because he/she was eating 50-75% of the meals I should have decreased his/her tube feeding, but I did not decrease the feeding because of the weight loss. He/She's eating already and getting tube feeding. The surveyor again asked what interventions were put in place after she noted in her 3/11/25 Dietary Progress Note, significant weight loss of 19.1% x 90 days and she stated, Hold on and looked through her computer. After approximately 7 minutes she stated, On 4/17/25, the intervention is that he/she continued to receive oral feeding and was eating 50-75% of those meals. When asked if on 3/7/25 Resident #8 was eating orally, she stated yes. When asked if on 4/17/25 he/she was eating orally, she stated yes. When asked if he/she was already eating orally if that was an intervention implemented after his/her 3/7/25 significant weight loss was identified, she stated, What other intervention do you want from me? RD #20 failed to share and/or provide evidence of any interventions put in place after Resident #8's significant weight loss was noted on 3/7/25 and 6/8/25. The surveyor shared this was a concern and RD #20 verbalized understanding of the concern. On 1/9/2026 at 12:39 PM in an interview with the DON when asked if the provider would be notified if a resident had severe weight loss, she stated, Yes, there would be a progress note. During the interview when asked if the expectation would be for the provider to evaluate a resident after significant weight loss was identified, she stated, Yes, the expectation is that the provider would be notified within 24 hours and would evaluate the resident within 24-48 hours. The surveyor shared the concern that there was no evidence that the provider had been notified on 3/7/25 or 6/8/25 of Resident #8's significant weight loss and requested the documentation where the provider was notified. The DON stated she would check. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additionally, when asked what were some examples of interventions she might expect to be put in place for a resident identified with significant weight loss, she stated, A dietary consult where they would review intake, calories, to make sure they are meeting their calorie goals, bloodwork or other labs to see what's going on, monitor weight to see if there were any discrepancies, if someone is eating by mouth, monitoring their intake, and determining the resident's dietary preferences. When asked if the expectation would be different if there was significant weight loss but the resident was within their ideal body weight range, the DON stated, I still want to know why you're losing weight. The DON verified and confirmed that the provider should be notified each time weight loss was identified. The surveyor shared the concerns that after Resident #8's 3/7/25 and 6/8/25 significant weight loss, there were no interventions put in place and the provider was not notified. The DON acknowledged understanding of the concerns. Review of the facility's policy, Resident Height and Weight on 1/12/2026 at 12:51 PM revealed, Weight loss concerns are reported to the practitioner. 2) A review of Resident #43's medical records on 1/07/26 at 11:20 AM revealed that the resident experienced severe weight loss between December 2024 and January 2025. Records indicated a weight of 116 lbs. on 12/06/24 and 82 lbs. on 1/07/25 (both recorded via Hoyer scale). This represents a weight loss of 34 lbs. (29%) within 30 days. Subsequent weights were documented as 83.2 lbs. on 1/15/25 and 85 lbs. on 2/03/25. Further review of progress notes revealed that a Clinical Dietitian (Staff #20) wrote a dietary progress note on 1/17/25—ten days after the severe weight loss was first noted. The note stated: Resident has significant weight loss of 28.4%, 28.2%, and 27.7% at 30, 90, and 180 days, respectively. Resident receives a regular diet with regular texture and consistency and consumes 75-100% of meals. Receives supplemental feeding (house shakes, 4 oz. QID = 800 cal and 24g protein) for nutritional needs and weight gain. No additional nutritional assessment was found until 3/07/25. Additionally, a review of Resident #43's care plan on 1/07/26 at 11:50 AM showed that a care plan regarding potential altered nutrition status was not initiated until 4/25/25. During an interview on 1/07/26 at 11:55 AM, Staff #20 explained the facility's weight loss intervention process: when the electronic medical record flags a weight loss, the dietitian should assess the resident, document progress notes, notify staff and providers, and discuss the case in clinical meetings to provide interventions. Staff #20 also stated that such residents' weights should be checked weekly for four weeks and their care plans updated accordingly. Upon reviewing Resident #43's records with the surveyor, Staff #20 validated that although the weight loss was reported on 1/07/25, the assessment was not documented until 1/17/25. Furthermore, a review of Staff #20's previous nutritional assessment from 12/05/24 revealed the same interventions as the note dated 1/17/25. In an interview with the Director of Nursing (DON) on 1/07/26 at 1:21 PM, the DON stated that the facility held daily morning meetings with the DON, ADON, unit manager, social worker, nurse practitioner, dietitian, and Infection Preventionist to review clinical records, including weight loss. She stated that weights should be re-taken to ensure accuracy, after which the dietitian should implement interventions and update the care plan. The surveyor reviewed Resident #43's severe weight loss with the DON and shared concerns that the issue was not appropriately addressed. The DON validated these concerns. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3) On 1/07/26 at 11:49 AM, a review of Resident #17's medical records revealed a significant weight change. The resident's weight was recorded as 212 lbs. via a standing scale on 9/05/25 and 183 lbs. via a bed scale on 10/07/25. This represented a 29-pound (13%) difference within one month. Subsequent weights were documented as 184.6 lbs. on 10/11/25 and 184.8 lbs. on 10/12/25. A further review of Resident #17's census records revealed multiple hospitalizations between 10/06/25 and 10/21/25 (specifically 10/06–10/07, 10/10–10/11, and 10/17–10/21). During the medical record review on 1/07/26 at 11:55 AM, it was noted that Staff #20 (Dietitian) wrote a progress note on 10/13/25 stating: It is recommended that the resident maintain a weight of 160–175 lbs. Resident receives a consistent carbohydrate diet with regular texture and thin consistency. Resident consumes less than 25–50% of meals and is assisted during mealtime. Resident receives supplemental feeding (Med Pass, 120 ml QID = 960 cal and 40g protein). In an interview with Staff #20 on 1/07/26 at 11:58 AM, the surveyor reviewed Resident #17's records with the staff member. Staff #20 stated that Resident #17's weight should have been re-checked, adding that if the weight loss were confirmed as actual, she would then begin implementing interventions. During an interview with the Director of Nursing (DON) on 1/07/26 at 1:21 PM, the DON confirmed that a resident's weight should be re-checked within 24 hours of a significant change. The surveyor shared the concern that Resident #17's severe weight loss was not addressed in a timely manner. The DON validated this concern.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on a review of medical records and staff interviews, it was determined that the facility failed to monitor, including assessment and documentation, for a resident who was on a tube-feeding program. This was evident for one (Resident #78) of three residents reviewed tube feeding during the recertification/complaint survey.The findings include:On 1/12/26 at 9:00 AM, the surveyor reviewed Resident #78's medical records. The review revealed that the resident had been receiving tube feeding since May 2025 for adequate nutrition. Further review of Resident #78's diet orders showed:5/23/25 to 8/29/25: Puree texture, nectar-thickened liquids.8/29/25 to 12/10/25: NPO (nothing by mouth).12/10/25 to Present: Regular diet, puree texture, nectar-thickened liquids (current active order).A review of Resident #78's care plan on 1/12/26 at 9:10 AM revealed two care plans regarding tube feeding: one initiated on 5/24/25 with NPO diet, and another initiated on 5/29/25 including pleasure meals (regular diet, puree texture, nectar-thickened liquids).A review of medical records at approximately 10:00 AM on 1/12/26 revealed that Staff #20 (Clinical Dietitian) completed a nutrition assessment on 8/29/25, noting: pleasure feeding has been discontinued; the dietitian informed family members and they agreed. However, no further assessment or documentation was found regarding the diet order change from NPO back to a pleasure diet on 12/10/25. Additionally, there was no provider documentation or assessment regarding the change from a pleasure diet to NPO on 8/29/25.On 1/12/26 at 12:05 PM, the surveyor interviewed Staff #20. She stated that the dietitian should assess and document all changes to a resident's diet order. When the surveyor asked for the documentation for Resident #78, Staff #20 confirmed that she did not have it. She also stated, Since it was pleasure feeding, the system (electronic medical record) blocked the intake columns, so it was not monitored.During an interview with the Director of Nursing (DON) on 1/12/26 at 1:01 PM, the DON confirmed that staff should document diet order changes. The surveyor shared concerns regarding Resident #78's diet changes, which the DON validated.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record reviews and staff interviews, it was determined that the facility failed to ensure that attending physicians visited residents at the required frequency of at least once every 60 days following the initial 90-day admission period. This deficiency was identified for two residents (Resident #38 and #94) out of three reviewed during the extended survey of the recertification/complaint survey.The findings include:On 1/12/26 at 12:30 PM, the surveyor performed a random audit of physician service records for three residents. The review revealed the following:Resident #38: admitted on [DATE]. The physician conducted an initial assessment on 5/22/25 and a follow-up visit on 6/16/25. However, there was no documentation of any subsequent physician visits for the remainder of the year, exceeding the 60-day regulatory limit.Resident #94: admitted on [DATE]. The physician completed the initial assessment on 3/31/25. No further follow-up documentation was found in the medical record to indicate subsequent visits.On 1/12/26 at 12:55 PM, the Director of Nursing (DON) was interviewed regarding physician oversight. The DON stated that the facility utilizes two regular physicians who are responsible for assessing residents. She confirmed the requirement that physicians must document assessments every 60 days following the first 90 days of admission. Upon reviewing the medical records of Resident #38 and Resident #94 with the surveyor, the DON validated that the required 60-day physician notes were missing.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on review of medical records and interview with facility staff, it was determined that the facility failed to respond to recommendations made by consulting pharmacists in a timely manner. This was evident for 3 (Resident #4, #17, and #43) out of 5 residents reviewed for unnecessary medications during the facility's recertification survey.The findings include: The Medication Regimen Review (MRR) is a review of the medication regimen (plan) of each resident with the goal of promoting positive outcomes and minimizing adverse (negative) consequences and potential risks associated with medications. The MRR must be completed at least once a month by a licensed pharmacist and includes a review of the residents' medical record to identify, report, and resolve medication-related problems, errors, and/or other irregularities. 1) In an interview with the Director of Nursing (DON) on 1/6/26 at 10:33 AM when asked what happens during the monthly pharmacy MRR she stated the Unit Managers (UM's), Director of Nursing (DON), and Assistant Director of Nursing (ADON) receive it. It is printed and given to the physicians. We make sure the orders are in. We have a folder we put the form in by month stored in my office. When asked if that was part of the medical record she stated yes. On 1/8/26 at 5:20 PM review of Resident #4's MRR's revealed: 1/24/25 Consultant Pharmacist Review Irregularities noted and/or recommendation(s) made. Please see Consultant Pharmacist report. On 1/9/26 at 10:55 AM review of the Long Term Care Pharmacist Recommendations document from 1/25/25 revealed Issues/Concerns: This resident has an active PRN (as needed) order for APAP (acetaminophen), which has not been used in the past 30-60 days. Recommendation: Please review and continue discontinuing. Further review revealed the Physician/Prescriber Response documented as will d/c (discontinue) order. On 1/9/26 at 11:03 AM review of Resident #4's medical record revealed an active order for Acetaminophen Oral Tablet 325 MG (milligrams) Give 2 tablet by mouth every 6 hours as needed for pain/fever with an order date of 9/26/24. On 1/9/2026 at 1:40 PM in an interview with the DON, a dual observation of Resident #4's active orders was conducted. The PRN acetaminophen order was observed. When asked if this 1/24/25 MRR was addressed, the DON stated she would have to see why it was not addressed. The surveyor shared this was a concern and the DON acknowledged and confirmed understanding of the concern. 2) On 1/08/26 at 11:06 AM, the surveyor reviewed Resident #17's MRR history for the preceding year. On 5/29/25 and 6/27/25, the pharmacist recommended a review of the antipsychotic agent Risperidone, noting that the resident lacks an allowable diagnosis to support its use. The physician documented responses were as follows: For the 5/29/25 MRR: The physician wrote addressed and signed the response on 6/20/25. For the 6/27/25 MRR: The physician wrote addressed—(duplicate) but did not provide a date for the signature. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A further review of Resident #17's medical record on 1/08/26 at 11:30 AM revealed the resident had been prescribed Risperidone 0.5 mg twice daily (BID) for unspecified psychosis not due to a substance or known physiological condition since 11/09/23. Despite the pharmacist's recommendations on 5/29/25 and 6/27/25, there was no evidence of a medication adjustment or a clinical rationale provided for the continued use of the medication. On 1/09/26 at 12:10 PM, the surveyor interviewed the Psychiatric Nurse Practitioner (Staff #12). Staff #12 confirmed she had reviewed and signed the pharmacist's recommendations. When asked to clarify the meaning of addressed, Staff #12 stated that because the corporate office had mandated a re-evaluation of all residents with a schizophrenia diagnosis, she was waiting for a psychiatrist to complete that evaluation. She confirmed that, in the interim, no adjustments had been made to the Risperidone prescription. On 1/12/26 at approximately 6:00 PM, the surveyor informed the Director of Nursing (DON) of the concerns regarding the incomplete and inadequate provider responses to Resident #17's MRR recommendations. 3) On 1/06/26 at 1:33 PM, a review of Resident #43's medical records revealed a pharmacist recommendation dated 1/24/25. The pharmacist noted: This resident has an active PRN (as needed) order for Senna (stool softener), which has not been used in the past 30–60 days. Please review and consider discontinuing. The MRR form lacked both a provider's signature and a documented response. On 1/08/26 at 1:04 PM, the Director of Nursing (DON) was interviewed regarding the facility's MRR procedures. The DON outlined the following protocol: The pharmacist reviews medication regimens and emails recommendations to the management team (DON, ADON, and Unit Managers). Facility staff print the recommendations and provide them to the attending physician or practitioner. The provider must review, sign, and provide a response within seven days. The completed forms are returned to facility staff, documented in the resident's medical record, and filed in the pharmacy binder. Upon further review of Resident #43's records and current orders, the surveyor verified that no response had been documented or updated following the 1/24/25 recommendation. The DON validated these findings and acknowledged the lack of a provider response.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on medication administration observation, medical record review and staff interview, it was determined the facility staff failed to ensure a medication error rate of less than 5 percent for 2 (Resident #129 and Resident #99) of 11 residents observed with 30 medication administration opportunities which resulted in an error rate of 6.67% by 2 of 5 nurses observed during the recertification survey.Findings Included:The national library of medicine indicates that Faster Insulin Aspart (Fiasp) is a novel formulation of insulin aspart with an accelerated time-action profile. This results in twice the insulin exposure and 74% greater insulin action within the first 30 minutes post-injection compared to conventional insulin aspart. This highlights a critical difference in the absorption rate and clinical effect between Fiasp and standard insulin aspart.On 01/06/2026 at 09:35 AM, surveyor's observation of medication pass for Resident #129 revealed that Licensed Practical Nurse (LPN) Staff #24 administered scheduled morning medications to the resident. Further observation revealed the administration of Duelera 20mcg/5mcg inhaler 2 puffs twice a day and administration instruction stated 2 puff inhale orally two times a day for Asthma Please rinse mouth after use; however, the nurse did not educate the resident to rinse their mouth after administration and the resident failed to rinse their mouth independently.On 01/06/2026 at 11:08 AM, during a surveyor's observation of medication preparation, Registered Nurse (RN) Staff #51 was noted preparing an incorrect medication for Resident #99. He was observed using an insulin aspart pen, obtaining a new insulin syringe, and withdrawing 8 units of insulin from the pen. The nurse explained that Resident #99's blood sugar result was 218, necessitating the administration of the ordered 8 units of insulin. When asked to explain the rationale for withdrawing insulin from a single-patient use pen, Staff #51 explained that the resident's insulin pen was unavailable and he requested a new insulin pen from the pharmacy this morning. The nurse stated that he was using a facility, non-resident-specific insulin pen to provide coverage to the resident, he explained that he was doing so to prevent a significant elevation of the resident's blood sugar later.Upon closer inspection of the pen used by Staff #51, the surveyor noted that the insulin pen's label read: Insulin Aspart injection Flexpen prefilled, for single patient use only, and the pen was tagged with Resident #118's name. The surveyor informed Staff #51 that using a pen prescribed for another resident (Resident #118) for a different individual (Resident #99) was a serious concern. Staff #51 reiterated the urgency due to Resident #99's high blood sugar and questioned whether the surveyor wished for the resident's blood sugar to continue increasing. The surveyor then directed Staff #51 to contact the unit manager before administering the insulin to Resident #99.On 01/06/2026 at approximately 10:20 AM, a review of Resident #99's medical records revealed an order for Fiasp FlexTouch 100 UNIT/ML Solution pen-injector, Inject 8 unit subcutaneously with meals for diabetes. This review confirmed that Staff #51 had withdrawn the incorrect medication (insulin aspart instead of Fiasp).On 01/06/2026 at 10:28 AM, in an interview with Unit Manager (Staff #43), the unit manager (Staff #43) was informed of the above-mentioned surveyor's findings. When questioned about the facility's procedure for obtaining unavailable medications, she stated that she would need to consult with the Director of Nursing.On 01/06/2026 at approximately 1:31 PM, in an interview with Director of Nursing (DON), the DON was interviewed regarding medication administration policies and procedures. The DON stated that nurses must adhere to the 5 Rights of Medication Administration, perform proper hand hygiene, and inform the residents of the task being performed. Regarding the procedure for unavailable medication, the DON outlined the following steps:Check the Omnicell medication storage.Call the pharmacy for a refill if the medication is not available.Notify the DON and the onsite Nurse Practitioner regarding the medication's unavailability.The DON explicitly explained that the facility policy prohibits the use of one resident's medication for another resident.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, medical record review, and interviews, it was determined that the facility failed to provide Dental services timely. This was evident for 1 (Resident #19) of 2 residents in review of dental during the recertification/complaint survey. The findings include:On 01/05/2026 at 11:57 AM, during an observation, Resident #19 pointed to his/her mouth and said, hurt. On 01/06/2026 at 9:59 AM, a review of Resident #19's physician orders revealed two separate orders for a dental consultation. The first order was a dental consult dated 10/3/2025 for teeth complications, and the second order, dated 12/9/2025, was for a dental consult due to the resident complaining of difficulty chewing.On 01/07/2026 at 12:22 PM, during an interview, Staff #21 (Unit Manager, Licensed Practical Nurse LPN) detailed the process for dental consultations. The unit manager initiates the process by completing a Health Drive form and submitting it to Health Drive. A provider from Health Drive then visits the facility to examine the residents. The health drive compiles a list of residents to be seen and sends it to the unit manager two to three days before their monthly visit. The surveyor requested the current dental consult list from Health Drive at the time of the interview.On 01/07/2026 at 1:12 PM, Staff #21 (Unit Manager, Licensed Practical Nurse LPN) presented the surveyor with the Health Drive Dental sheet. This sheet documented that Resident #19 had an initial dental visit on 01/06/2026. This visit occurred three months following the initial dental consultation and nearly 30 days after the second dental consultation order was placed. On 01/07/2026 at 1:54 PM, during an interview, the Director of Nursing (DON) stated that the procedure for resident dental concerns (teeth complications or difficulty chewing) involves the nurse completing an oral and pain assessment, notifying the physician, and implementing a care plan. She explained her expectation that a dental consult must be scheduled immediately for any discomfort or difficulty chewing. The DON was informed of the concern at this time.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of medical records and interviews with facility staff, it was determined that the facility failed to maintain medical records that were complete and accurately documented for residents. This was evident for 2 (Resident #8 and #55) out of 52 residents reviewed during the facility's recertification/complaint survey.The findings include:The Health Care Decisions Act, which became effective 10/1/1993, applies in all healthcare settings. In Maryland a patient is presumed to have capacity until 2 physicians, one of whom shall have examined the patient within 2 hours before making the certification, shall certify in writing that the patient is incapable of making an informed decision. The certification shall be based on a personal examination of the patient after which the physician attests that a patient lacks the mental ability to understand or make informed decisions about their healthcare or personal affairs, often triggering legal processes like guardianship or activating advance directives for treatment, ensuring someone else can legally act on their behalf. 1) On 1/6/25 at 9:44 AM review of Resident #8's medical record revealed he/she was admitted to the facility on [DATE]. Further review revealed 2 Physician's Certifications Related to Medical Condition, Decision Making, and Treatment Limitations forms. The forms were signed and dated; however, the section titled, Certification Regarding Decision Making Capacity first question, where the provider checks if the resident either has adequate decision making capacity (including decisions about life-sustaining treatments) or lacks adequate decision making capacity (including decisions about life-sustaining treatments) for both forms was blank. The provider had not checked a box to certify whether or not the resident had or lacked adequate decision making capacity on either of the two forms. On 1/7/26 at 9:21 AM in an interview with Regional Director Clinical Services (RDCS #22) in a dual observation of the 2 physician certification forms, when asked if Resident #8 had or lacked capacity as neither box was checked, she did not respond. During the interview when asked if the forms were completed, she stated no. When asked if it was the expectation of the facility that the physician checks one of the boxes to indicate a resident had or lacked adequate decision making capacity, she stated yes. When asked what the date was on the form completed by the Medical Director she stated, 11/6/25 or 11/5/25. The surveyor stated the date was illegible and not easy to decipher and she acknowledged understanding. The surveyor shared these were concerns and the RDCS #22 confirmed understanding of the concerns. 2) On 1/10/26 at 5:00 PM review of facility reported incident #2695485 revealed on the initial report form submitted to the Office of Healthcare Quality, GNA (Geriatric Nursing Assistant) called the assigned nurse to resident room and reported laceration to resident's right pinky finger with bright red blood and swelling. On 1/11/26 at 1:49 PM review of Resident #55's progress notes revealed a note from Physician Assistant (PA #41) dated 12/16/25 8:05 PM CST (Central Standard Time) from a 20 minute video visit, [AGE] year old male/female presenting with laceration to left leg with bone exposure. The mechanism of injury is unknown as the nursing staff were unaware of how the injury was sustained. The patient is experiencing pain, and the wound is actively bleeding. The patient has a history of vascular dementia and serves as a poor historian due to cognitive impairment. The left fifth digit specifically shows active bleeding with bone exposure at the base. On 1/12/26 at 8:52 AM review of Pain Observation Tool dated 12/16/25 revealed RN #43 documented No for question number 1: Does the resident verbalize and/or exhibit non-verbal symptoms of pain. On 1/12/26 at 8:56 AM in an interview with Licensed Practical Nurse (LPN #24) when asked how she assessed pain for non-verbal residents or residents who for whatever reason was unable to verbally express their pain level, she stated, I look at their facial expressions expression such as are they grimacing? During the interview when asked if there was a scale that the facility used for non-verbal residents, she stated, Yes, let me see. The name just went out of my memory. I can't think of it right now, but there is one we use where it rates (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their facial grimacing. On 1/12/26 at 9:00 AM in an interview with LPN #14 when asked how she assessed pain for non-verbal residents or residents who for whatever reason was unable to verbally express their pain level, she stated, Facial expression, the way they look, some will nod their head, some will not even eat, some will hold the part that is hurting such as their belly. During the interview when asked if there was a scale that the facility used for non-verbal residents, she stated they used the faces scale where they point to a face that represents a pain rating from 1-10. On 1/12/26 at 9:03 AM in an interview with Wound Nurse (WN #6) when asked how she assessed pain for non-verbal residents or residents who for whatever reason was unable to verbally express their pain level, she stated, I use the facial scale and they nod. I will also say, are you in pain? If yes, wink your eyes. And some can wink their eyes to tell me they are in pain.On 1/12/26 at 9:24 AM in an interview with the Director of Nursing (DON) when asked how non-verbal residents or residents who for whatever reason were unable to verbally express their pain level were assessed for pain, she stated there was a scale. Furthermore, she stated that once a nurse documented that a resident was showing signs of pain, a nonverbal pain scale would pop up. She searched through several examples and was unable to find one with a nonverbal pain scale to share with the surveyor. During the interview the survey requested a dual observation of Resident #55's 12/16/25 Pain Observation Tool. The surveyor also shared PA #41's note documenting the resident was in pain and asked the Director of Nursing to read question #1. The DON read it aloud and when asked if RN #43 had documented accurately for question 1, she stated no. The question does not simply ask does the resident verbalize pain, it also asks if the resident exhibits non-verbal symptoms of pain, so for nonverbal residents who are exhibiting signs of pain, when asked what would be considered accurate documentation, she stated to have answered the question as Yes. Additionally, in Section G, Pain Relief of the Pain Observation Tool, RN #43 documented Yes for Does the resident receive scheduled pain medication? and No for Does the resident receive a PRN (as needed) medication?. In a dual observation of Resident #55's December 2025 MAR revealed the resident was not ordered a scheduled pain medication and furthermore, that he/she was ordered a PRN pain medication, Tylenol Oral Tablet 325 MG (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for pain/ fever Do not exceed 3gm of Tylenol in 24 hours. -Start Date-07/11/2022. During the interview the DON verified and confirmed RN #43's documentation was not accurate as Resident #55 was not ordered a scheduled pain medication and was ordered a PRN pain medication. The surveyor pointed out that PA #41's note documented a left leg laceration as well as a laceration to the left pinky finger. The DON stated that was not accurate documentation and the resident only had a laceration to his/her right pinky finger. A dual observation of Resident #55's hospital Discharge summary dated [DATE] verified that Resident #55 was seen for a laceration to the right pinky. The surveyor shared these were concerns and the DON acknowledged understanding of the medical records concerns.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on surveyor observation, interview with facility staff, and review of medical records, it was determined that the facility failed to ensure that they maintained an effective infection control program evidence by: 1) failing to ensure appropriate personal protective equipment (PPE) was worn when entering a resident's room who was on Contact Precautions, and 2) failing to implement appropriate infection prevention and control practices during the medication administration task. This was evident for 1 (Staff #6) out of 1 employees observed entering the Contact Precautions room, and 1 License Practical Nurse (LPN#29) of 5 Staff observed during the medication administration task during the recertification/complaint survey.The findings include: Contact Precautions are infection control measures, used in addition to Standard Precautions, to prevent the spread of germs spread by touching an infected person or contaminated surfaces. Contact precautions require anyone entering the room to wear a gown and gloves, use dedicated equipment, and practice meticulous hand hygiene to contain and prevent the spread of pathogens. Necrotizing fasciitis, or flesh-eating disease, is a rare, severe bacterial infection that rapidly destroys skin, fat, and tissue surrounding muscles (fascia), causing extreme pain, swelling, fever, and skin changes like redness, blisters, or black spots, requiring immediate medical attention with aggressive surgery to remove dead tissue and strong IV (intravenous) antibiotics to save the patient's life. Methicillin-Susceptible Staphylococcus aureus (MSSA) is a bacterial infection and highly contagious, spreading easily through direct skin-to-skin contact, contaminated surfaces (like towels, razors, sports gear), or touching pus from open sores. 1) On 1/5/26 at 8:00 AM the surveyor observed a Contact Precautions sign posted outside of Resident #106's room. The sign read, STOP Contact Precautions Everyone must: Clean their hands before entering and when leaving the room. In an interview with Geriatric Nursing Assistant (GNA #5) when asked why Resident #106 was on Contact Precautions she stated, I have no idea. I think that's old. I don't think that's on him/her. I'm going to have to ask Ms. [Infection Preventionist's (IP #10) last name], she's .health control. On 1/5/26 at 8:01 AM the surveyor observed Wound Nurse (Staff #6) enter Resident #106's room without donning (putting on) any PPE. At 8:05 AM in an interview with Staff #6 when asked how long she had worked at the facility she stated about 2 years. During the interview when asked if she had just entered and exited Resident #106's room she stated yes. When asked if she had put on the appropriate PPE, she stated, I was just talking to the patient. I had my mask. When asked if Resident #106 was on Contact Precautions she stated yes. When asked what PPE was required for Contact Precautions she stated, Mask, gown, and gloves. When asked if she had that on in Resident #106's room she stated, No ma'am. When asked why Resident #106 was on Contact Precautions she stated because he/she has a wound infection and was taking antibiotics. When asked what type of infection she stated, I can't remember. The surveyor shared these were concerns and Staff #6 verbalized and confirmed understanding of the concerns. On 1/5/26 at 9:41 AM review of Resident #106's medical record revealed he/she was admitted to the facility on [DATE] with diagnoses including, but not limited to, necrotizing fasciitis, unspecified open wound of right foot, and MSSA. On 1/5/26 at 1:21 PM surveyor observed a 3 drawer container outside of Resident #106's room. Upon (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	opening all 3 drawers, blue gowns were found inside each; however, no gloves were observed. In an interview with Licensed Practical Nurse (LPN #4) when asked if there were gloves, she stated they were inside the room. During the interview, the surveyor asked the LPN #4 to read the Contact Precaution sign, and she read Put on gloves before room entry. The surveyor asked if there were gloves in the 3 drawer container outside of the resident's room or anywhere so that they could be donned before entering the room and she stated no. The surveyor inquired how staff would be able to put on gloves before entering the room if there were no gloves outside of the room. LPN #4 stated she usually just gets them from another room and went into room [ROOM NUMBER] and came out with a box of XL gloves. The surveyor also noticed that the hand sanitizer in Resident #106's room was not working and there was no hand sanitizer outside the rooms. On 1/5/26 at 1:51 PM in an interview with the Unit Manager (UM #21) when asked if she had gone into Resident #106's room today she stated yes. When asked how she performed hand hygiene before exiting the room if the hand sanitizer dispenser was not working. She stated, I had a needle in my hands and sanitized after disposing the needle in the sharp's container on the [medication] cart. When asked what needle she had, she stated, I had checked his/her sugars. When asked if there were sharps containers inside the resident's room, she stated, Yes, there is one inside the bathroom. When asked if staff were supposed to perform hand hygiene before or after exiting a Contact Precautions room she stated before. When asked if staff were supposed to dispose of needles in sharps containers before or after exiting a resident's room she stated before. The surveyor shared these were concerns. UM #21 acknowledged understanding of the concerns. On 1/5/26 at 2:11 PM in an interview with the Director of Nursing (DON) when asked about the facility's expectation of when staff were to perform hand hygiene, she stated that staff perform hand hygiene before entering and exiting residents' rooms. During the interview when asked the facility's expectation of when staff should dispose of sharps, she stated, The expectation is that staff use the sharps containers in residents' rooms. The surveyor shared the abovementioned concerns at this time. The DON acknowledged understanding of the concerns. 2) On 01/06/26, the surveyor observed LPN #29 obtaining blood pressure readings using a single portable machine on multiple residents prior to medication administration: Resident #129 at 09:15 AM, Resident #112 at 09:33 AM, and Resident#76 at 9:53 AM. LPN #29 failed to clean the blood pressure machine between each patient use. On 01/06/26 at 10:03 AM, the surveyor addressed the infection control concern with LPN #29, who acknowledged the machine was not cleaned between patient usage.

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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 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with facility staff and review of facility documentation and employee files, it was determined that the facility failed to ensure staff received mandatory Quality Assessment and Performance Improvement training. This was evident for 2 (GNA #47 and HH/FT #50) out of 7 employees reviewed during the Extended Survey investigation portion of the facility's recertification survey. The findings include:Quality Assurance and Performance Improvement (QAPI) is the coordinated application of two mutually reinforcing aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI helps long-term care facilities improve the quality of life and care for residents by using a systematic, interdisciplinary, comprehensive, and data-driven approach to identify issues, address the root causes of problems, and implement solutions. It involves ongoing monitoring and teamwork at all staff levels, and continuous review and revision of plans to ensure a safe, resident-focused environment, and adherence to regulations. As a facility's QAPI program involves input and collaboration from all staff, the term staff includes all new and existing facility staff (with direct and indirect care functions); individuals providing services under a contractual arrangement; and volunteers per the State Operations Manual.On 1/8/26 at 11:32 AM in an interview with Human Resources Director (HRD #32) and the Infection Preventionist/Staff Educator (IP/SE #10), when asked if HRD #32 handles any of the staff training, HRD #32 stated, I get staff set up with a background check and orientation paperwork. I do not personally complete any trainings. IP/SE #10 acknowledged and confirmed this. On 1/8/26 at 11:34 AM in an interview with IP/SE #10 when asked the different ways trainings were provided to staff, she stated staff completed Relias training that was scheduled from corporate and that from me personally, I do handwashing, PPE (personal protective equipment), fall in-services. When asked if there was any mandatory training all staff received, she stated yes, the ones in Relias. During the interview she stated on the first day employees completed onboarding paperwork and there was no training and on the second day they did their Relias, PPD (tuberculosis skin test), and flu. Then employees were scheduled to do floor orientation. When asked how long the two orientation days were, she stated 8 hours. When asked if there were any mandatory trainings all staff received upon and/or within 90 days of hire, she stated, Yes, handwashing, donning and doffing PPE, and that is more or less it. When asked how the facility kept track of staff participation in the required trainings/education/in services, she stated, We have a form that when we have an in-service, they have to sign for it, an attendance sheet. When asked where those attendance sheets are stored, she stated, I have a binder when I have in-services and it's stored in my office. The surveyor requested all in-services and any other training/education related documentation for staff for 2024 and 2025. The surveyor and IP/SE #10 walked to her office and she provided a white, 3-ring binder titled 2025 In Service that had monthly dividers from January through December and five manilla folders with attendance sheets. When asked if there was any further documentation to provide as evidence of facility staff training, education, in-services, et cetera, she stated no. When asked if there was any competency documentation for GNAs she stated, I told you it's in Relias. When asked if there was any competency documentation for nurses, she pulled one manila folder from the pile provided, titled Med Pass Completed. When asked if this was for nurses, she stated yes. When asked if every nurse needed to complete this she stated yes. When asked if all nurses had completed it, she said, I want to say 80% did because I have not seen them all. When asked how she could verify all nurses or GNAs competed a training, in-service, education, et cetera, she stated I have a staff roster, and I check it off. When asked if she could share one example, IP/SE #10 flipped through the manilla folder. The surveyor asked if she saw the staff roster she had mentioned and she stated no. In a dual observation, the surveyor and IP/SE #10 looked through the remaining manilla folders and she verified there was no staff roster check off completed to ensure all (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff received the offered education, training, and/or in services. On 1/8/26 at 1:22 PM review of GNA #47's employee files revealed he was hired on 6/5/24; however, failed to reveal communication training, QAPI training, 8 hours cognitive impairment/mental illness training within 90 days of being hired, 2 hours of annual cognitive impairment/mental illness training for 2025.On 1/12/27 at 2:38 PM review of Heavy Housekeeper/Floor Tech (HH/FT #50's) employee files revealed she was hired on 12/21/23 however, failed to reveal QAPI, compliance and ethics, or 1 hour of annual cognitive impairment/mental illness training for 2024 and 2025.On 1/12/26 at 10:36 AM review of all training, education, in-services from the white, 3-ring binder (2025 In Service) revealed the following required trainings:12/6/24 Effective Communication Training12/19/24 Abuse/Neglect/Mistreatment/MisappropriatingFrom 8/25 through 12/25 there were no attendance sheets in the binder for any of those monthsNo QAPI training observed in 2025 binderOn 1/12/26 at 11:44 AM review of the four manilla folders revealed attendance sheets for the following training and dates:Folder #1 Med pass observations completed in 10/2025 and 12/2025Folder #2 G-tube observations completed in 10/2025Folder #3 Perineal Care 8/2025, Pain meds 10/2025, Identifying Substance Abuse 10/2025, Nurses documenting order after orders are written 11/2025, Identifying residents with a history of overdose or overdosing 11/2025 Folder #4 Abuse 9/2025, Discard sharps in room [ROOM NUMBER]/5/26, Hand hygiene 7/2025, 9/2025, 10/2025, 11/2025 and 1/2026, Perineal Care 6/2025, Dating Nebulizer Treatment 9/2025, E. coli in urine 6/2025, IDT Fall Assessment after a fall 12/2025, Infection Prevention- Ice Scoop 10/2025, Fill out inventory sheet properly 11/2025, No medical documents placed in shower book 12/2025, Nurses Not to do Sternal rub on residents complaining of chest pain 11/2025, Nurses to administer meds timely 11/2025, Narcotic signing and hand off 12/2025, Alert Charting 12/2025, Bed locked 12/2025, Dignity to residents 11/2025, Get resident out of bed every day 12/2025, HIPPA 12/2025, and Dialysis Assessment Pre and Post Dialysis 10/2025. Folder #5 PPE 10/2025, Timely call bell response times 10/2025, Staff Introduction at beginning of shift 10/2025, Town Hall Meeting 9/2025, Hot Beverages 9/2025, Disaster Plan 9/2025, Label Resident Urinal 10/2025, No Gloves in Hallway 10/2025, Room Cohorting 10/2025, Perineal Care 10/2025, Staff to Knock before Entering 10/2025, Linen Carts 10/2025, Surgical Mask wearing properly 10/2025, Foley empty before Resident leaves for appt 10/2025, Tube Feeding 10/2025, Med Pass 10/2025, Nursing admission Evaluation 10/2025, Glucometer 10/2025, Perineal Care 10/2025, 1-1 Monitoring for RM [ROOM NUMBER] A 10/2025, Address abnormal vital signs 4/2025, Staff answer call bell timely 4/2025, Staff not using cell phone while providing care to residents 7/2025, Bed Safety 7/2025, 24 hour report 7/2025, Check sites (IV, G-tube, peg tube, trach, etc.) and communicate changes 7/2025, Perineal Care 12/2025, Fall Prevention and Management 11/2025, Transfer to Hospital: Bed Hold, MOLST, Med List 6/2025, Heat Advisory 6/2025, Resident Falls 6/2025, Ice Machine 6/2025, Dementia 6/2025, O2 (oxygen) tubing, nebulizer, filters 6/2025, Nurses not to label water bottles on G-Tube 6/2025, ADT 6/2025 (ADT= Electronic System where you bring residents in or discharge them out and shows their status in the facility (Admission, Discharge, Transfer), Signing Off Medications 6/2025, Staff to Report any occurrences on the Resident and Report to the Nurse 6/2025, Wound Interventions and Shower Documentation 4/2025.Review of all documentation from the manilla folders failed to reveal any QAPI training.On 1/12/26 at 2:08 PM in an interview with IP/ SE #10, she verified and confirmed as second time, that the 5 manilla folders and white 3 ring binder provided included all the training, in-services, and education for facility staff outside of the Relias trainings which were provided as transcripts for sampled employees.On 1/12/26 at 4:26 PM in an interview with IP/ SE #10, a dual observation was conducted of the Relias trainings staff completed upon hire. There were three pages provided for Licensed Staff and three pages for GNAs. When asked if any of the upon hire Relias training included QAPI training, she verified and confirmed that it did not. On 1/12/26 at 4:30 PM in an interview with IP/ SE #10, a dual observation was conducted of each sampled employees' Relias transcript along with the attendance sheets from the 3-ring binder and manilla folders. During the interview and (continued on next page)

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	observations, when asked if there was evidence for:GNA #47 of QAPI training, she stated, QAPI training? I don't see anything related to QAPI.Heavy Housekeeper/Floor Tech (HH/FT #50) of QAPI training, she stated no.The surveyor shared these findings were concerns. The IP/SE #10 verbalized and acknowledged understanding of the concerns.

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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 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide training in compliance and ethics. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews with facility staff and review of facility documentation and employee files, it was determined that the facility failed to ensure staff received compliance and ethics training. This was evident for 2 (GNA #47 and HH/FT #50) out of 7 employees reviewed during the Extended Survey portion of the facility's recertification survey. The findings include:On 1/8/26 at 11:32 AM in an interview with Human Resources Director (HRD #32) and the Infection Preventionist/Staff Educator (IP/SE #10), when asked if HRD #32 handles any of the staff training, HRD #32 stated, I get staff set up with a background check and orientation paperwork. I do not personally complete any trainings. IP/SE #10 acknowledged and confirmed this. On 1/8/26 at 11:34 AM in an interview with IP/SE #10 when asked the different ways trainings were provided to staff, she stated staff completed Relias training that was scheduled from corporate and that from me personally, I do handwashing, PPE (personal protective equipment), fall in-services. When asked if there were any mandatory training all staff received, she stated yes, the ones in Relias. During the interview she stated on the first day employees completed onboarding paperwork and there was no training and on the second day they did their Relias, PPD (tuberculosis skin test), and flu. Then employees were scheduled to do floor orientation. When asked how long the two orientation days were, she stated 8 hours. When asked if there were any mandatory trainings all staff received upon and/or within 90 days of hire, she stated, Yes, handwashing, donning and doffing PPE, and that is more or less it. When asked how the facility kept track of staff participation in the required trainings/education/in services, she stated, We have a form that when we have an in-service, they have to sign for it, an attendance sheet. When asked where those attendance sheets are stored, she stated, I have a binder when I have in-services and it's stored in my office. The surveyor requested all in-services and any other training/education related documentation for staff for 2024 and 2025. The surveyor and IP/SE #10 walked to her office and she provided a white, 3-ring binder titled 2025 In Service that had monthly dividers from January through December and five manilla folders with attendance sheets. When asked if there was any further documentation to provide as evidence of facility staff trainings, education, in-services, et cetera, she stated no. When asked if there was any competency documentation for GNAs she stated, I told you it's in Relias. When asked if there was any competency documentation for nurses, she pulled one manila folder from the pile provided, titled Med Pass Completed. When asked if this was for nurses, she stated yes. When asked if every nurse needed to complete this she stated yes. When asked if all nurses had completed it, she said, I want to say 80% did because I have not seen them all. When asked how she could verify all nurses or GNAs competed a training, in-service, education, et cetera, she stated I have a staff roster, and I check it off. When asked if she could share one example, IP/SE #10 flipped through the manilla folder. The surveyor asked if she saw the staff roster she had mentioned and she stated no. In a dual observation, the surveyor and IP/SE #10 looked through the remaining manilla folders and she verified there was no staff roster check off completed to ensure all staff received the offered education, training, and/or in services. On 1/8/26 1:42 PM review of GNA #48's employee files revealed she was hired on 6/5/24; however, failed to reveal compliance and ethics training.On 1/12/27 at 2:38 PM review of Heavy Housekeeper/Floor Tech (HH/FT #50's) employee files revealed she was hired on 12/21/23 however, failed to compliance and ethics training.On 1/12/26 at 10:36 AM review of all training, education, in-services from the white, 3-ring binder (2025 In Service) revealed the following required trainings:12/6/24 Effective Communication Training12/19/24 Abuse/Neglect/Mistreatment/MisappropriatingFrom 8/25 through 12/25 there were no attendance sheets in the binder for any of those monthsNo Compliance and Ethics training observed in 2025 binderOn 1/12/26 at 11:44 AM review of the four manilla folders revealed attendance sheets for the following training and dates:Folder #1 Med pass observations completed in 10/2025 and 12/2025Folder #2 G-tube observations completed in 10/2025Folder #3 Perineal Care (continued on next page)

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/2025, Pain meds 10/2025, Identifying Substance Abuse 10/2025, Nurses documenting order after orders are written 11/2025, Identifying residents with a history of overdose or overdosing 11/2025 Folder #4 Abuse 9/2025, Discard sharps in room [ROOM NUMBER]/5/26, Hand hygiene 7/2025, 9/2025, 10/2025, 11/2025 and 1/2026, Perineal Care 6/2025, Dating Nebulizer Treatment 9/2025, E. coli in urine 6/2025, IDT Fall Assessment after a fall 12/2025, Infection Prevention- Ice Scoop 10/2025, Fill out inventory sheet properly 11/2025, No medical documents placed in shower book 12/2025, Nurses Not to do Sternal rub on residents complaining of chest pain 11/2025, Nurses to administer meds timely 11/2025, Narcotic signing and hand off 12/2025, Alert Charting 12/2025, Bed locked 12/2025, Dignity to residents 11/2025, Get resident out of bed every day 12/2025, HIPPA 12/2025, and Dialysis Assessment Pre and Post Dialysis 10/2025. Folder #5 PPE 10/2025, Timely call bell response times 10/2025, Staff Introduction at beginning of shift 10/2025, Town Hall Meeting 9/2025, Hot Beverages 9/2025, Disaster Plan 9/2025, Label Resident Urinal 10/2025, No Gloves in Hallway 10/2025, Room Cohorting 10/2025, Perineal Care 10/2025, Staff to Knock before Entering 10/2025, Linen Carts 10/2025, Surgical Mask wearing properly 10/2025, Foley empty before Resident leaves for appt 10/2025, Tube Feeding 10/2025, Med Pass 10/2025, Nursing admission Evaluation 10/2025, Glucometer 10/2025, Perineal Care 10/2025, 1-1 Monitoring for RM [ROOM NUMBER] A 10/2025, Address abnormal vital signs 4/2025, Staff answer call bell timely 4/2025, Staff not using cell phone while providing care to residents 7/2025, Bed Safety 7/2025, 24 hour report 7/2025, Check sites (IV, G-tube, peg tube, trach, etc.) and communicate changes 7/2025, Perineal Care 12/2025, Fall Prevention and Management 11/2025, Transfer to Hospital: Bed Hold, MOLST, Med List 6/2025, Heat Advisory 6/2025, Resident Falls 6/2025, Ice Machine 6/2025, Dementia 6/2025, O2 (oxygen) tubing, nebulizer, filters 6/2025, Nurses not to label water bottles on G-Tube 6/2025, ADT 6/2025 (ADT= Electronic System where you bring residents in or discharge them out and shows their status in the facility (Admission, Discharge, Transfer), Signing Off Medications 6/2025, Staff to Report any occurrences on the Resident and Report to the Nurse 6/2025, Wound Interventions and Shower Documentation 4/2025.Review of all documentation from the manilla folders failed to reveal any Compliance and Ethics training.On 1/12/26 at 2:08 PM in an interview with IP/ SE #10, she verified and confirmed as second time, that the 5 manilla folders and white 3 ring binder provided included all the training, in-services, and education for facility staff outside of the Relias trainings which were provided as transcripts for the employees.On 1/12/26 at 4:26 PM in an interview with IP/ SE #10, a dual observation was conducted of the Relias trainings staff completed upon hire. There were three pages provided for Licensed Staff and three pages for GNAs. When asked if any of the upon hire Relias training included Compliance and Ethics training, she verified and confirmed that it did not.On 1/12/26 at 4:30 PM in an interview with IP/ SE #10, a dual observation was conducted of each employees' Relias transcript along with the attendance sheets from the 3-ring binder and manilla folders. During the interview and observations, when asked if there was evidence for:GNA #48 of compliance and ethics training, she stated, No, I'm not sure who's scheduling these modules. There's no consistency. The surveyor pulled out and shared the 2025 Annual Relias Course & Skills 2 page document provided by the facility and shared that based on these documents, there were compliance and ethics trainings listed such as Basics of Corporate Compliance; however, not all employees were completing the courses. When asked whose responsibility it was to ensure assigned modules were monitored to ensure that staff were completing them timely, IP/SE #10 stated, I don't assign the modules, someone from corporate does that. The surveyor shared that some employees who were hired the same month and for the same position had a different number of courses completed. When asked whose responsibility it was to ensure staff completion of the assigned modules, IP/SE #10 stated, Myself, the nurse managers, but usually it's myself that checks.Heavy Housekeeper/Floor Tech (HH/FT #50) of compliance and ethics training, she stated no.The surveyor shared these findings were concerns. The IP/SE #10 verbalized and acknowledged understanding of the concerns.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on surveyor observation and interviews with facility staff, it was determined that the facility failed to post the required nursing staffing data. This was evident on 2 out of 2 units for 2 out of 2 days of the recertification survey. The findings include:An observation of the facility's nursing unit took place on 1/5/26 at 7:55 AM. During the observations, a dry erase board was found that contained staffing information on each unit. The board noted the date, the unit census, the ratio of geriatric nursing assistants (GNAs) and nurses to residents for the day shift and displayed the day shift assignment for GNAs and nurses. The board was clear and readable and displayed in a prominent place readily accessible to residents and visitors. However, the dry erase board did not display the facility name, nor the total number and actual hours worked by licensed and unlicensed nursing staff per shift. The board did not differentiate registered nurses (RNs) from licensed practical nurses (LPNs), nor did it contain information regarding other shifts. A second observation of these dry erase boards was conducted on 1/9/26 at 11:04 AM, found that the board contained the same information.On 1/9/26 at 11:11 AM in an interview with Director of Nursing (DON) when asked if staffing information needed to be posted in the facility, she stated, Yes, we post the assignments. During the interview when asked where it was posted on the units, she stated, We do it on the board and we do have the staffing on the wall. When asked what information needed to be included, she stated, Staff that is working, their assignment, special compliance things, the group that is taking care of any special assignments, the patient ratio for GNAs and nurses. For example, for Group 1 that staff member might be assigned to the clean utility room. Additionally, she stated, The date and shift. When asked if she could show where the information was posted, she showed the surveyor the dry erase board on the 2nd floor. A dual observation was conducted of the dry erase board, and when asked if the facility name appeared on the board the DON stated no. When asked if the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs (Registered Nurses), LPNs (Licensed Practical Nurses) or LVNs (Licensed Vocational Nurses), and CNAs (Certified Nursing Assistants) were included, she stated no. She stated that information was on the schedule and walked over into the back of the bulletin board in the nurse's station. The surveyor reviewed the schedule and when asked if the total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: RNs, LPNs or LVNs, and CNAs were included, she stated no. Furthermore, when asked if visitors or residents would be able to see the schedule on the bulletin board in the back of the nurse's station, she stated, No, but it's on the whiteboard. The DON and surveyor walked over to the whiteboard. When the surveyor asked if the facility name was on the whiteboard, she stated no. When asked if the total number and actual hours for licensed and unlicensed staff were included, she stated no. The surveyor shared these were concerns and the DON acknowledged and confirmed understanding.