STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215160	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ellicott City Healthcare Center	3000 North Ridge Road Ellicott City, MD 21043

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, pertinent document review, and interview it was determined that the facility failed to maintain a safe, comfortable and homelike environment. This was evident for 7 (Resident #1, #8, #40, #66, #90, #127, #140) of 15 residents reviewed during the environmental task, in addition to multiple random observations of elevated hot water in resident rooms on both floors of the facility which put all residents at risk of being affected by this deficient practice.The findings include: 1) On 2/10/26 at 9:35 AM, the surveyor interviewed Resident #127 and observed that the resident's bathroom had a loose plastic threshold on the floor of the shower and a shower chair with a jagged piece of plastic protruding in the area that a person would sit. The surveyor also noted the sink is extremely discolored with a brown circular stain and is cracked. The drywall had multiple gouges. During this observation, GNA #27 confirmed the surveyor's observations. On 2/10/26 at 10:00 AM, the surveyor interviewed roommates (Residents #66 and #90), who pointed out a large, thick area of thick spackle on the wall that was rough in texture (had not been sanded) and without paint. They also identified several additional areas around the bedroom and bathroom with unsanded or unpainted spackling, gouges in the drywall, sink and toilet stains, and gouges in the toilet bowl. The surveyor noted a gap in the wall near the pipes under the sink. On 2/10/26 at 1:02 PM, during an interview with Resident #1, the surveyor observed their bathroom, noting extensive drywall damage with gouges, rough spackling, and holes around the piping under the sink. On 2/10/26 at 10:33 AM, Resident #8 pointed out that their bedroom had wear and tear, with paint and drywall pulling away, and a handle on their dresser drawer was coming off (it was hanging by one screw). Multiple areas of chipped paint were observed, and the bathroom sink had cracks and discoloration. On 2/10/26 around 11:00 AM, the surveyor noted during the initial screening that the sink in Resident #40's room was slow to drain, cracked, and stained. On 2/13/26 at 4:08 PM, the surveyor interviewed the Maintenance Director (MD #8) regarding the process for keeping the building in good repair and whether environmental rounds are conducted. He stated that they are trying to play catch-up for needed repairs and are aware of many walls that need paint and drywall repair, but there is no planned date to complete these repairs. Regarding gaps around several bathroom pipes, he reported a plan to install plastic pieces that snap around the pipes, but no timeline was provided. He also noted that several sinks were cracked and stained and stated they would only be replaced if they started to leak. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/13/26 at 4:25 PM, the surveyor interviewed the Nursing Home Administrator (NHA), who expressed awareness of areas needing paint and acknowledged concerns about gaps around piping. He stated that corporate painters come periodically but was unsure when they would return. On 2/17/26 at 12:00 PM, the surveyor toured rooms with the NHA, who confirmed concerns in each area: -Resident #8: Wall damage and loose drawer handle -Residents #66 and #90: Damage to multiple walls, rough spackle without sanding, missing paint, sink and toilet cracks/discoloration, pipes exposed under sink -Resident #127: Cracked/stained sink, cracked shower chair (immediately removed by NHA), loose threshold, exposed pipes -Resident #40: Cracked/stained sink When asked if he wanted to look at Resident #1's room, the NHA stated, No, I believe this is a concern. 2) On 2/10/26 at 9:25 AM, during the initial screening process, Resident #140 stated that the facility is often out of soap, towels, and washcloths, impacting their ability to get a bath or shower. On 2/17/26 at 12:38 PM, the surveyor asked the NHA if he was aware of the facility being short of linens such as washcloths or towels. He stated that he was not aware and reported that he had recently purchased washcloths. On 2/17/26 at 12:40 PM, the surveyor interviewed GNA #27, who reported frequent shortages of washcloths and towels and reported delays in providing ADL (Activities of Daily Living) care, stating, I try to plan ahead and improvise since this has been an issue. On 2/17/26 at 12:44 PM, the surveyor interviewed GNA #37, who reported very often a shortage of towels and washcloths, impacting her ability to give bed baths and showers. On 2/17/26 at 12:46 PM, the surveyor informed the NHA that residents had complained about linen shortages and that GNA staff confirmed these shortages were impacting timely care. The NHA acknowledged that the issue might be related to laundry rather than supply but stated that a systemic change was needed. On 2/19/26 at 11:39 AM, the surveyor reviewed environmental concerns with the NHA and at 12:15 PM reviewed the concerns with the Director of Nursing (DON). Both confirmed that the findings were issues and reported they were working on changes. On 2/19/26 at 1:48 PM, the NHA stated he was unable to find a policy about maintaining a home-like environment or conducting environmental rounds but would continue looking. At survey exit, no policy was provided to the surveyor. 3)On 2/10/2026 at 10:55 AM, the water temperature was taken in the bathroom of resident room [ROOM NUMBER]. The temperature was 125 degrees Fahrenheit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 2/10/26 at 10:56 AM, the water temperature was taken in the bathroom of resident room [ROOM NUMBER]. The temperature was 126.3 degrees Fahrenheit. On 2/10/26 at 10:59 AM, the water temperature was taken in the bathroom of resident room [ROOM NUMBER]. The temperature was 123.7 degrees Fahrenheit. On 2/10/26 at 11:06 AM, maintenance staff (Staff #44) was interviewed. Staff #44 reported checking water temperatures in one room on every unit early each morning. Staff #44 stated that water temperatures should be maintained between 110 and 120 degrees Fahrenheit. Staff #44 reported taking water temperatures on the morning of 2/10/26 and provided a copy of the readings to the survey team. Staff #44 confirmed the temperature readings were in Fahrenheit. Staff #44 stated that the temperatures taken that morning had not been reported to the supervisor or the facility administrator. Staff #44 could not recall the specific rooms tested. On 2/10/26 at 11:08 AM, review of the water temperature document taken the morning of 2/10/26 revealed the following readings, which Staff #44 confirmed were degrees Fahrenheit: Apple Blossom Unit: 124.5Cherry Unit: 120.9Cedar Unit: 126.7Dogwood Unit: 125.1 On 2/10/26 at 1:13 PM, during a brief interview, the Administrator and the Maintenance Director reported they were unaware of the temperatures taken by Staff #44. On 2/10/26 at 1:14 PM, the surveyor, Administrator, and Maintenance Director observed the water temperature in room [ROOM NUMBER]. The temperature was 122 degrees Fahrenheit. The Maintenance Director confirmed that water temperature checks were conducted first thing each morning. On 02/10/26 at 1:33 PM, the Administrator reported that the water temperature at the boiler had been lowered and that a plumbing company had been contacted to resolve the issue. On 2/11/26 at 12:00 PM, a request was made to the Maintenance Director for a copy of the morning water temperatures. The Maintenance Director reported that morning temperatures had not been taken. On 2/11/26 at 1:00 PM, the surveyor obtained random bathroom sink water temperatures in resident rooms using a calibrated digital thermometer. The following temperatures were recorded: room [ROOM NUMBER]: 128.9 degrees F room [ROOM NUMBER]A: 124.3 degrees F room [ROOM NUMBER]A: 127.4 degrees F At 1:09 PM, Resident #140 stated, Be careful if you are checking the water temperatures, implying the water became excessively hot. On 2/11/26 at 1:40 PM, the Maintenance Director provided water temperature log dated 2/11/26 at 1:40 PM. Review of the log revealed the following: (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	room [ROOM NUMBER]: 125 degrees [NAME] 142: 137 degrees [NAME] 222: 127 degrees F On 2/11/26 at 2:20 PM, the surveyor returned to the unit to recheck water temperatures after the facility announced the hot water system was being shut down for repair. The following temperatures were recorded: room [ROOM NUMBER]: 121.8 degrees [NAME] 200: 120.9 degrees F On 2/11/26 at 4:57 PM, the Administrator confirmed that the hot water had been shut off; however, some residual hot water remained in the pipes. The Administrator reported that staff were aware of the issue. He reported that the hot water would be shut of until the repairs have been completed. On 2/17/2026 from 10:37 AM to 11:38 PM, the Administrator reported that all plumbing repairs had been completed. Surveyors and the Administrator took water temperatures in rooms on every unit in the facility. All temperatures were within normal limits of 110-120 degrees Fahrenheit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews, and record review, it was determined that the facility failed to ensure medication carts were kept secured and failed to ensure controlled medications were stored in an affixed lock box. This was found to be evident during one random observation; and for five of five medication storage refrigerators reviewed during the medication storage task.The findings include: 1) On 2/13/26 from 1:21 to 1:30 PM this surveyor observed various staff and residents pass by an unattended and unlocked medication administration cart on the Dogwood Unit. At 1:30 PM Licensed Practical Nurse (LPN #6) confirmed the unlocked medication cart. He stated, this is not my unit. He, then, informed Dogwood's Unit Manager, LPN #10; she confirmed it was unlocked and then locked the cart. The Director of Nursing was made aware of the concern. 2) 483.45(h)(2) requires that the facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976. On 2/13/26 at 7:54 AM, the surveyor, accompanied by Licensed Practical Nurse (Nurse #42), observed the medication refrigerator in the medication storage room on the Magnolia Unit. The surveyor requested that Nurse #42 demonstrate how controlled medications were secured. She pulled out Lorazepam, which was not secured, and attempted to place it in a lock box. The box was not permanently affixed to the refrigerator, and the medication did not fit within the box. Nurse #42 confirmed that medications are expected to be secured in a lock box but stated she did not realize the box needed to be permanently affixed. A second locking-type box was also observed in the refrigerator. Nurse #42 removed it and showed the surveyor that the lid was broken, making it impossible to use for securing medications; this box was also not permanently affixed. On 2/13/26 at 8:08 AM, the surveyor observed the medication storage room on the Apple Unit. Registered Nurse (Nurse #43) opened the refrigerator and removed a bubble-wrapped narcotics lock box. She stated it was a new box that had never been unwrapped from its packaging and was not affixed to the refrigerator. She further stated, Only nurses are allowed in the medication refrigerator, so it doesn't matter if the narcotics box isn't locked. On 2/13/26 at 10:43 AM, the surveyor interviewed the Director of Nursing (DON) regarding the expectation for locking controlled medications. The DON stated that controlled medications should be secured with a double lock. When asked if it was acceptable to have a loose box for storing narcotics, she stated she would need to check the policy but acknowledged that it should likely be secured. The surveyor and DON toured all five medication storage rooms (Dogwood, Cedar, Cherry, Magnolia, and Apple Units) and the DON confirmed that none of the facility's medication storage refrigerators contained permanently affixed and locked storage containers for controlled medications. The DON further confirmed that controlled medications, including Lorazepam and Methadone, were placed loosely in the refrigerators or in boxes that could be removed. She also confirmed that one box was (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	broken and that the bubble-wrapped box had never been permanently affixed. The DON acknowledged that this represented a regulatory concern.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on staff interviews, review of pertinent documentation, and survey findings, it was determined the facility failed to ensure that an effective Quality Assurance Performance and Improvement (QAPI) program was in place to identify Quality concerns and develop effective plans of correction.This has the potential to affect all residents.The findings include:Review of the statement of deficiencies for the past two recertification surveys and the findings for the current survey revealed that deficient practice was identified during each of these surveys in the following areas:F 550 Resident RightsF 582 Beneficiary Protection NoticeF 600 AbuseF 656 Comprehensive Care PlansF 657 Care Plan Revision and TimingF 679 ActivitiesF 684 Quality of CareF 761 Medication StorageF 880 Infection ControlReview of the Plan of Correction for the survey ending 9/10/24 revealed the plan related to F 582 for failure to provide the appropriate beneficiary protection notices stated the social service department was educated on the importance and need to issue the Beneficiary Protection Notices. There was no indication in the plan that any systemic change to the facility's process regarding the issuing of these notice was going to occur. The plan indicated Quality Assurance auditing was going to be conducted by the Social Service Director, thus auditing his/her own work.Review of the Plan of Correction for the survey ending 9/10/24 revealed the plan related to F 656 for the failure to develop comprehensive care plans indicated the Social Service Director would re-educate the Interdisciplinary team members on the need and importance of developing comprehensive care plans for residents. There was no indication in the plan of correction that there was going to be any systemic change to the facility's process in developing care plans.On 2/19/26 at 3:08 PM the Nursing Home Administrator (NHA) reported the Assistant Director of Nursing, who left the facility in December, was certified in Quality Assurance. He went on to report that at the last QA meeting, held in January, that he requested training for all the departments in quality assurance. Surveyor reviewed the concern that deficient practice has been identified for the third time in a row for multiple regulations and that the plans of correction have failed to actually address the identified issues and QAPI program has failed to adequately monitor.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observations, interviews, and medical record review, it was determined that facility staff failed to follow infection control protocols of the laundry process, maintain laundry dryers in a sanitary and hazard-free condition, and retain a copy of the original manufacturer's instructions for the washer and dryer; failed to ensure staff donned personal protective equipment and prevented other residents from entering the rooms of residents on contact precautions; and failed to perform hand hygiene during medication administration. These findings were evident in two of two dryers observed during the infection control task, for one (Resident #150) of eight residents reviewed for infection control, and for one (Nurse #41) of two staff observed during the medication administration task.The findings include: 1)During an observation of the laundry service on 02/17/26, at 1:06 PM, it was noted that no washer/dryer service logs or original commercial manufacturer handbooks were available in the laundry room. There were 2 dirty laundry karts covered waiting to be washed. An interview was conducted on 02/17/26 at 1:10 PM with the Environmental Manager (Staff #7). During our discussion, the manager described the protocol for transferring covered dirty linens from the floors to the laundry area. This process includes sorting and washing items based on their classification, specifically distinguishing between contaminated and dirty linens. Additionally, it was noted that once the wash cycle is complete, yellow carts are used to transfer the wet, clean items to the dryer room. In the dryer room surveyor noticed dryers inside drums with melted diapers and multiple objects, presenting a safety hazard and unsanitary condition. the Environmental Manager Staff #7 acknowledged this as an omission of service, noting that the drums have not been cleaned. Requested last three of the washer/ dryers' service records and the original manufactory handbooks as for the facility to follow. During a record review conducted on 02/17/26 at 2:10 PM, service records indicated that dryer ductwork cleaning and inspections were performed on 08/04/25, 11/13/25, and 02/05/26. However, the records show no service was conducted on the dryer drums. Additionally, the original manufacturer handbooks were unavailable for review. Interview with Maintenance Manager (Staff #8) on 02/17/26 at 3:30 PM, it was confirmed that debris with melted diapers and multiple objects were present in the dryers' drums. The Maintenance Manager agreed that the laundry service has failed to maintain the equipment in a sanitary and hazard-free condition and lacked keeping the original manufacturer handbooks to follow the regular maintenance and care. All above deficient practice is a significant concern that needs to be addressed. On 02/17/26 at 3:50 PM, the Administrator was made aware above finding as a deficiency practice. 2) Personal Protective Equipment (PPE) refers to protective items such as masks, gowns, gloves, eye protectors, shoe covers, hair caps worn to protect the body or clothing from hazards and to protect residents and staff from cross-transmission. Contact precautions are infection control measures used to prevent the spread of bacteria and viruses transmitted through direct or indirect contact with a diseased person or contaminated surface. On 2/12/26 at 10:46 AM Resident #150 was in bed watching TV. Licensed Practical Nurse (LPN #17) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	was in the hall preparing to administer this resident's medications. Surveyor observed LPN #17 enter the resident's room without gloves, without a gown and without washing hands before and after administering the medications. Surveyor observed a contact precaution sign posted on the resident's door and PPE supplies and dedicated patient-care equipment outside of the room. On 2/12/26 at 10:57 AM in an interview, LPN #17 acknowledged that the resident recently returned from the hospital with a diagnosis Clostridioides difficile (C-diff) that required Resident #150 to be on contact precautions. She conveyed that contact precautions required gloves, gown and handwashing with soap and water. LPN #17 confirmed that she failed to don PPE and wash her hands. On 2/12/26 at 11:02 AM Resident #150 reported a diagnosis of C-diff that required isolation. During resident interview, the Activities Director (Staff #13) entered the room without PPE. The Infection Preventionist (Nurse #4) was made aware of the above. On 2/12/26 at 3:29 PM surveyor observed Resident #150 and Resident #107 in Resident #150's room. Resident #107 was in an unusual kneeling position while in a wheelchair. This positioning placed Resident #107's head and upper body in very close proximity to Resident 150's person and bed. Resident #107 did not wear any PPE. On 2/12/26, two facility staff, LPN #17 and the Infection Preventionist Nurse #4, confirmed Resident #107 was in the isolation room without PPE. On 2/13/26 at 9:15 AM the Activities Director (Staff #13) confirmed that she had entered the room previously without donning PPE and acknowledged the resident's infectious disease requires PPE when entering the room. The Director of Nursing was made aware of the concern. 3) The Centers for Disease Control and Prevention (CDC) recommend that hand hygiene be performed immediately before resident contact, before preparing or administering medications, after removing gloves, and between each resident contact during medication administration. On 2/13/26 at 8:16 AM, the surveyor conducted a medication administration observation of Licensed Practical Nurse (Nurse #41). During medication preparation, a pill fell from the packet onto the cart. Nurse #41 applied gloves, retrieved the pill, disposed of it, and removed the gloves without performing hand hygiene. She handled multiple other pill packets while preparing medications, touching each without performing hand hygiene. She then prepared medications for Resident #122, handed the resident a medication cup, discarded the empty cup in the trash, and proceeded to the next resident without performing hand hygiene. Hand sanitizer was observed on top of the medication cart and readily accessible. At 8:45 AM, while administering medications to Resident #129, Nurse #41 prepared 14 medications and was observed touching multiple surfaces, including pill packets, the computer keyboard, the medication cart, keys, and medication cups, without performing hand hygiene. She administered the medications, discarded the empty cup in the trash, and again did not perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	At 9:09 AM, the surveyor asked Nurse #41 when hand hygiene should be performed. She stated the surveyor threw her off by observing the medication pass and said, I normally do it, but did not identify appropriate hand hygiene intervals. On 2/13/26 at 1:55 PM, the surveyor reviewed these concerns with the Director of Nursing, who confirmed that staff are expected to perform hand hygiene at multiple points throughout medication administration.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and staff interview it was determined the facility failed to provide the resident, and the resident's representative, in writing of the required transfer documents when the resident was transferred/discharged from the facility to an acute care facility. This was evident for two (Resident #14 and #150) of four residents reviewed for hospitalization during the survey.The findings include:1) Review of Resident #14's medical record revealed that as of 9/25/25 the resident was determined to be incapable of making informed decisions regarding the provision, withholding or withdrawing of all treatments due to vascular dementia. Further review revealed there were family members involved in the residents care planning. Review of the medical record revealed that the resident was transferred to the hospital due to a mental status change on 1/21/26. Further review of the medical record failed to reveal documentation to indicate a written notice of transfer or a bed hold policy was provided to either the resident or a responsible representative. On 2/17/26 at 4:39 PM Unit Nurse Manager #16 was interviewed in regard to documentation provided at time of transfer. Surveyor discussed the concern that record review failed to reveal documentation that a bed hold or a transfer notice was provided. The Unit Manager #16 indicated they do provide resident's bed hold policy at transfer, but did not indicate that she was aware there was a need to provide a written notice of transfer. On 2/18/26 surveyor requested documentation of the Bed Hold Policy and the Transfer notice for the 1/21/26 hospitalization from the Director of Nursing. Review of the Bed Hold Authorization Form, provided in response to surveyor request, revealed the following statement: This serves as your notice of bed hold days the resident currently has remaining that will be paid by Medicaid: 30 days. Maryland Medicaid stopped paying for bed holds in July of 2012. Further review of the Bed Hold Authorization Form revealed it was dated 1/27/26 and included Resident #14's name (last name written first) in the signature section. No documentation was found to indicate a responsible representative was informed or provided the hold policy for the 1/21/26 hospitalization. No documentation was provided to indicate a Notice of Transfer was provided to either the resident or a responsible representative. The written notice of transfer is required to include: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged ; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and [NAME] of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. On 2/19/26 at 3:30 PM after surveyor reviewed the concern regarding the failure to provide a Notice of Transfer, the Director of Nursing reported that Social Work was suppose to be doing that. 2)On 2/11/26 at 12:35 PM a record review of Resident #150's electronic health record revealed the resident was hospitalized on [DATE]. Further review revealed two unsuccessful attempts to contact the resident's family via phone regarding the hospital transfer. On 2/13/26 at 8:54 AM a review of the resident's electronic health record and paper chart lacked documentation of the hospital transfer documents and bed hold notice. On 2/13/26 at 9:37 AM Licensed Practical Nurse (LPN #26) stated when a resident gets transferred to the hospital, the nursing staff should print the paperwork which included: MOLST, Face sheet, medications, Care Plan, recent labs, a bed hold policy and orders to transfer. The nurse should document by completing an electronic Interact form in the electronic health record at time of transfer. LPN #26 and surveyor reviewed and confirmed the electronic Interact form was red and yellow that indicated it was incomplete. On 2/13/26 at 9:50 AM Social Work Designee (Staff #22) acknowledged social work was responsible for sending a written notice via certified mail to the family representative post hospital transfer. Staff #22 stated that she could not find Resident #150's paperwork and was unable to provide a certified mail receipt. On 2/13/26 at 3:05 PM in an interview, the Director of Nursing confirmed incomplete documentation, and that written notice of the bed hold was not provided to the resident/ resident representative.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interviews, observation, and record review, it was determined that the facility failed to ensure: consults were scheduled as ordered; and that medications and treatments were administered and documented as ordered. This was evident for one (Resident #2) of one reviewed for urinary catheter use; one (Resident #44) of one resident reviewed for non-pressure skin conditions; one (Resident #7) out of one reviewed for insulin use; one (Resident #8) of three reviewed for pain management and one (Resident #127) of seven reviewed for general investigations.The findings include:1)Review of Resident #2's medical record revealed the resident was cognitively intact and their own responsible party. On 2/19/26 at approximately 10:00 AM Resident #2 reported a concern regarding physician ordered referrals not being followed up on by staff. After the 2/19/26 interview. review of the medical record revealed the following physician orders for specialty consultations: 1/8/26 order for infectious disease consult 1/14/26 order for referral to urology1/14/26 order for referral to neurology2/3/26 order to arrange neurosurgery follow-up Further review of the medical record failed to reveal documentation to indicate what, if any, progress was made in scheduling these appointments. On 2/19/26 at 11:58 AM the Unit Nurse Manager #16 was interviewed in regard to the process for scheduling ordered non inhouse specialist appointments. The Unit Manager #16 reported the order is put into communications (indicating a computer system) for the secretary to arrange for the appointment. She went on to report that they use to have a secretary that arranged for the appointments but that position was currently open. After checking for the four orders listed above, the Unit Manager reported that she saw the orders and that they were put in the communications to be done, but was unable to provide information to indicate that any of the four appointments was scheduled. She indicated she would follow up with the Director of Nursing about scheduling the appointments. On 2/19/26 at 3:30 PM surveyor reviewed the concern with the Director of Nursing regarding the failure to ensure the scheduling of specialist appointments. 2) Review of Resident #44's medical record revealed the resident was seen by the wound specialist Nurse Practitioner #46 on 2/5/26. This note revealed: Erythema (redness) rash to peri area and under bilateral (both) breast, recommend nystatin powder BID (two times a day) for 14 days. A corresponding order was found, with a start date of 2/5/26, for the Nystatin External Powder 100000 Unit/GM: Apply to groin and left breast topically two times a day for rash for 14 days. No documentation was found as to why the order was put in for the powder to be applied to the left breast, when NP #46's assessment indicated the rash was under both breasts. Review of the February 2026 Medication Administration Record (MAR) revealed staff were documenting the administration of the Nystatin two times a day as ordered. However, the section of the MAR to document the location on the body where the Nystatin was administered revealed the following:2/5 AM both breasts; but failed to document that it was applied to the groin area2/5 PM (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	both breasts; but failed to document that it was applied to the groin area2/6 AM both breasts; but failed to document that it was applied to the groin area2/6 PM groin and other2/7 AM left breast and groin*2/7 PM groin; but failed to document that it was applied to under the breast2/8 AM groin; but failed to document that it was applied to under the breast2/8 PM groin; but failed to document that it was applied to under the breast2/9 AM groin; but failed to document that it was applied to under the breast2/9 PM groin; but failed to document that it was applied to under the breast2/10 AM groin; but failed to document that it was applied to under the breast On 2/10/26 at approximately 2:20 PM Resident #44 requested the surveyor inform staff that the resident had a rash under the breasts and the resident wanted to be seen by the wound nurse. On 2/10/26 at approximately 3:00 PM surveyor informed Nurse #45 of the resident's report of a rash and request to be seen by the wound nurse. Further review of the section of the MAR to document the location on the body where the Nystatin was administered revealed the following: 2/10 PM groin; but failed to document that it was applied to under the breast2/11 AM groin; but failed to document that it was applied to under the breast2/11 PM groin; but failed to document that it was applied to under the breast2/12 AM both breasts and groin2/12 PM groin; but failed to document that it was applied to under the breast2/13 AM groin; but failed to document that it was applied to under the breast2/13 PM groin; but failed to document that it was applied to under the breast2/14 AM groin; but failed to document that it was applied to under the breast2/14 PM groin; but failed to document that it was applied to under the breast2/15 AM groin; but failed to document that it was applied to under the breast2/15 PM both breasts, but failed to document that it was applied to the groin area2/16 AM left breast and groin*2/16 PM both breasts, but failed to document that it was applied to the groin area2/17 AM right breast, but failed to document that it was applied to the groin area2/17 PM both breasts, but failed to document that it was applied to the groin area2/18 AM left breast, but failed to document that it was applied to the groin area On 2/18/26 at 11:08 AM, after surveyor had reviewed the February MAR, the Unit Nurse Manager #16 was interviewed in regard to the Nystatin order. The Unit Manager #16 reported that, according to the order, the Nystatin was to be administered to the groin and left breast. After reviewing the location documentation Unit Manager #16 stated: they keep switching from breast to groin, every specific area on the body is supposed to have its own order. She confirmed the expectation is that staff read the whole order. Further review of the section of the MAR to document the location on the body where the Nystatin was administered revealed the following:2/18 PM both breasts, but failed to document that it was applied to the groin area For the 28 occasions for this medication to be administered, only on two occasions was it administered as ordered: to the left breast and groin area. Staff failed to apply the Nystatin to the area under the breast from the evening of 2/7 through the evening of 2/11; and again, from the evening of 2/12 through the morning of 2/15. On 2/19/26 at 3:30 PM surveyor reviewed the concern with the Director of Nursing regarding the failure to administer the medication as ordered. 3) On 2/10/26 at 11:26 AM Resident #7, a long-term resident receiving treatment for diabetes was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interviewed. During the interview s/he reported that s/he had been a resident at the facility for over 8 years. Resident #7 stated that during his/her stay she had received daily insulin injections, however, s/he had not received his/her insulin injection for the past couple weeks. Resident #7 Minimum Data Set assessment, dated 11/12/25, was reviewed on 2/19/26. Review revealed that the Resident was cognitively intact. On 2/10/26 at 12:08 PM review of Resident #7 medication administration record revealed documentation that the resident was administered his/her insulin daily 2/01/26 through 2/09/26. On 2/11/26 at 1:14 PM an interview was conducted with the nurse (Staff #9) at a medication cart with a computer on top. Nurse #9 reported that the medication cart contained the medications for Resident #7. The nurse was asked by the surveyor what insulin medication were ordered for Resident #7. Nurse #9 reported that one of the insulin medications ordered for Resident #7 was Tresiba Subcutaneous 100 ml 3 units to be given at bedtime. The surveyor requested that Nurse #9 locate the Tresiba Subcutaneous 100 ml 3 units in the medication cart. Nurse #9 was unable to locate the medication in the medication cart or the unit medication refrigerator. On 2/11/26 at 1:16 PM Nurse #9 asked her unit manager to assist with locating the Tresiba Subcutaneous 100 ml 3 units. Unit Nurse Manager #10 was unable to find the medication. On 2/11/26 at 1:32 PM Unit Nurse Manager #10 confirmed she could not find the residents Tresiba medication and the last time a pharmacy request for the medication was in December 2025. On 2/12/26 at 7:30 AM review of medication administration record (MAR) revealed that on 2/11/26 a check on the MAR that revealed that Tresiba Subcutaneous 100 ml 3 units was administered in the evening. Further review revealed documentation that nurse #11 administered the medication subcutaneously to the left deltoid. On 2/12/26 at 7:41 AM the Unit Nurse Manager #10 was interviewed. She reported that the Tresiba Subcutaneous 100 ml 3 units did not arrive yesterday and that the physician had changed the order. On 2/12/26 at 10:00 AM the Director of Nursing (DON) was interviewed. She confirmed that the Tresiba was not available to be administered to Resident #7 on the evening of 2/11/26. The DON reviewed the medication administration record and confirmed the documentation indicated that Tresiba was administered to the Resident #7 on 2/11//26 On 2/12/26 at 10:18 AM a phone interview was conducted with Nurse #11, who had provided care to the resident on the evening shift of 2/11/26 and documented the administration of Tresiba. He reported that he did not administer the medication and put in a note indicating. To be administered upon deliver therapeutic interchange was affected by pharmacy and will be delivered instead. He reported that he had to check the box that indicated the medication was administered because that was the only way to remove the medication form being in the red. He reported he was not aware of another code he could document to indicate the medication was not given. Nurse #11 did not address his documentation in the MAR that indicated that the Tresiba medication was administered Sub Q (under the skin) in the left deltoid. No further documentation was found in the progress notes indicating if the medication was delivered and administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/12/26 at 11:04 AM discussion with DON after reviewing the note in progress notes. She confirmed the concern that it was not communicated that the medication was not administered. She reported it was an education issue because there is a code that should be used to indicate the medication was not given. On 2/13/26 at 9:05 AM interview with Resident #7. When the Resident was asked if s/he had been receiving his/her insulin injections the resident stated yes, s/he started receiving them yesterday (9/12/26). 4) Resident #8 has a medical history of chronic pain, heart-related conditions including hypertension, atrial fibrillation, coronary artery disease, and peripheral vascular disease, diabetes, and chronic obstructive pulmonary disease. On 2/10/26 at 1:14 PM, during the initial screening of residents, Resident #8 reported that the facility runs out of their pain medication every eight days and often must wait several days for the medication to be refilled. The resident stated they are always in pain and need their medication every day. On 2/12/26 at 2:21 PM, the surveyor reviewed Resident #8's physician orders (treatments and medications ordered by the physician) and identified multiple dates with no documentation to indicate that the orders had been completed. The review revealed the following: On 2/2/26 no documentation that the ordered medications (Ammonium Lactate lotion, Calcitriol, Ferrous Sulfate, Finasteride, Tamsulosin, and Eliquis) were administered and that vital signs (blood pressure, temperature, pulse, respirations, and oxygen saturation) were obtained. On 2/4/26, 2/9/26, and 2/11/26 no documentation that Aquaphor was applied. On 2/9/26 and 2/11/26 no documentation of monitoring for bleeding related to blood thinner use, monitoring for antidepressant side effects, or monitoring of pain. Further review of January 2026 orders revealed 23 additional instances in which staff did not document medication and treatment orders. On 2/12/26 at 2:25 PM, the surveyor's review of progress notes failed to reveal a reason for the lack of documentation. On 2/12/26 at 2:57 PM, during an interview, the Director of Nursing (DON) stated, Generally, if there are gaps to an assigned medication or treatment, it means it was not done. The surveyor informed the DON that Resident #8 had multiple gaps in order documentation. On 2/12/26 at 4:27 PM, during a follow-up interview, the DON stated that gaps in the order record indicate that the care was not provided or not documented, if it was provided. She stated she would determine who was responsible and agreed it was a concern, stating, The expectation is that they document as they provide the medication or treatment. 5) Resident #127 has a medical history of a recent cholecystectomy (gallbladder surgery) and has a drainage bag, a medical collection device used to collect bile and fluids drained from the gallbladder. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/10/26, at approximately 9:30 AM, the surveyor conducted an initial resident screening as part of the recertification survey. Resident #127 reported feeling frustrated because the nurse who had performed care on their cholecystostomy bag had left it open, resulting in leakage onto the bed. The surveyor observed yellowish-brown liquid on the resident's sheets. On 2/18/26, at 12:38 PM, the surveyor conducted a record review and identified a care plan for Resident #127. The care plan included multiple goals for managing the cholecystectomy drainage bag, including, in part: - Resident is at risk of complications related to cholecystectomy - Monitor amount of drain On 2/18/26, at 12:46 PM, the surveyor reviewed the medication administration record (MAR) and noted there was no documentation to support that the following interventions had been performed on 2/4 and 2/15/2026: -Document cholecystostomy output each shift -Empty abdominal drain every shift and record output On 2/18/2026, at 1:11 PM, the surveyor interviewed the Director of Nursing regarding the gaps in care on 2/4 and 2/15. The Director confirmed that the lack of documentation indicates that care was not provided or not recorded on the Medication Administration Record (MAR).

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on review of staff records and a staff interview, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received annual performance evaluations. This was evident for two (GNAs #28 and #29) of two GNA employee records reviewed during the survey. The findings include:During the survey, two Geriatric Nurse Assistants (GNA #28 and #29) employee files were reviewed. The records reviewed on 2/17/26 revealed GNA #28's hire date was 4/22/19 and GNA #29's hire date was 3/12/23. Both of the employee files lacked annual performance evaluations. In a subsequent interview, the Director of Nursing acknowledged that GNA performance evaluations had not been completed and stated, they're in Workday, its on my list.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff and resident interviews, record review and observations, it was determined that the facility failed to have a process in place to separate the Arbitration Agreement from the admission Agreement and failed to ensure that the person signing the Arbitration Agreement was cognitively capable or had legal authority. This was evident for three (Residents #6, #41, #52) of six residents reviewed for arbitration agreements.An arbitration agreement is a legal document used in long-term care facilities. It requires that disputes or injuries be resolved through private arbitration instead of through the court system. By signing, a resident waives their constitutional right to have a judge or jury decide the case. The arbitrator's decision is usually final and cannot be appealed.A Brief Interview for Mental Status (BIMS) is quick assessment that indicates how well you think, learn and remember. Scores range from 0 to 15. Low scores 0-7 indicate severe cognitive impairment.The findings include:On 2/10/26 at 10:19 AM the Nursing Home Administrator (NHA) confirmed that the facility had Arbitration Agreements but denied that any residents were bound by it. He also reported that the admission Office would be responsible for implementing the Arbitration Agreement. On 2/18/26 at 3:30 PM in an interview, the Clinical admission Director (Staff #39) stated that Arbitration Agreement was completed during the admission process. She stated the admission and Arbitration Agreements were together in one packet. She explained that she verbally reviewed/read the packet while the resident follows along using an electronic tablet. She said, all residents sign the Agreements except those who are not cognitively capable. On 2/19/26 at 9:01 AM the NHA and Regional Sales Manager (Staff #38) provided signed Arbitration Agreements for Residents #6, #41, #52. 1) On 2/19/26 at 12:16 PM in an interview, Resident #6 stated that s/he would need to carefully read the Arbitration Agreement before signing it and that s/he had no recollection of seeing or signing an Arbitration Agreement before. On 2/19/26 at 1:02 PM a review of Resident #6's Arbitration Agreement revealed electronically printed initials on the signature line of the last page. In a follow-up interview at 1:29 PM, Resident #6 confirmed that they were her/his initials but added, I don't remember that part. I thought it was just the admissions. On 2/19/26 at 3:35 PM surveyor asked Clinical Admissions Director #39 since resident stated s/he did no know that they signed an Arbitration Agreement, can you check with the resident because it its still within 30 days of original Agreement. On 2/19/26 at 3:41 PM surveyor observed the admission Director verbally read and review a hard copy of the Arbitration Agreement to Resident #6. Resident #6 acknowledged that s/he does not agree to the terms and declined to enter into the Arbitration Agreement and reported to the Clinical admission Director #39, that when the first lady came around, I did not know I was signing an Arbitration Agreement. On 2/19/26 at 4:04 PM a review of the document confirmed by Resident #6's signature that the resident did not agree to arbitration. (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) On 2/19/26 a review of Resident #41's record revealed: a face sheet that showed admission was 10/12/23, physician certification that indicated the resident lacks adequate decision-making capacity dated on 10/13/23, and an admission BIMS of 5 that indicated severe cognitive impairment. Resident #41's Arbitration Agreement was dated 10/13/23 and revealed her/his electronic signature. 3) On 2/19/26 AM a review of Resident #52's record revealed: a face sheet that showed initial admission was 6/12/24, physician certification that indicated the resident was unable to comprehend information and make decisions dated on 11/26/25, and an admission BIMS of 7 that indicated severe cognitive impairment. Resident #52's Arbitration Agreement was dated 6/24/24 and revealed an electronic signature of an unknown person. On 2/19/26 at 11:27 AM in an interview, the Regional Sales Manager #38 stated, I don't have any documents indicating signing authority for [Resident #52.] On 2/19/26 at 1:42 PM in a telephone interview, a temporary admission Director (Staff #40) confirmed that she was working at [NAME] City January 6- January 23, 2026. She explained that residents use a tablet to accept the contract by signing a one-time electronic signature at the first screen-page of the contract. The software then auto populates and fills in all other signature lines throughout the packet. She also acknowledged that it is possible for others to check the agree/disagree boxes throughout the packet without the resident's awareness. On 2/19/26 at 1:52 PM the Clinical Admissions Director #39 verified the process above. The Director of Nursing and NHA were made aware of the concern.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to maintain the call light/bell system in working order to allow residents to request assistance when needed. This was evident during environmental observation on 2 of 2 nursing units. The findings include: 1) On 2/10/26 at 3:35 PM review of complaint # 2682304 revealed a concern that from 11/28/25 through 12/2/25 Resident # 159 resided in a room without a call light or a tap bell. Review of census revealed that Resident #159 was assigned to a room that currently did not have a working call light/ bell system. Further observation of the room revealed a silver tap bell. On 2/18/26 at 12:48 PM Interview with the Maintenance Director (Staff #8) reported that he distributes the tap bells to the nursing staff, and the nursing staff distributes them to the residents that do not have working call lights. He reported that he first started giving them out only a couple weeks ago. He cannot remember the exact date that he started to give them out. 2) On 02/10/26 at 1:50 PM, during an interview, Resident #165 reported that her/his call light/bell broke today, and that s/he was waiting to get it fixed, Resident #165 reported that s/he was not given anything to use in place of the failed call light system. At the time of the above interview, an observation in resident #165's room failed to reveal a tap bell or call light system. The place on the wall for the call bell revealed that the call light was missing from the wall. On 2/11/26 at 9:14 AM, the light over Resident #165's room was on with no audio alert. During a brief interview, Resident #165 reported to the surveyor and the Corporate Senior Activity Director (Staff #50) that when s/he uses the bell no one comes, s/he does not think the staff can hear the bell. On 2/11/2026 11:57 AM An observation of the hall call light/bell was made. The bell was rung with the residents' permission on 2/11/2026 11:58 AM. The bell rang 5 times in row. On 2/11/26 at 12:15 PM LPN Staff #41 was the nurse working on the floor at the time that Resident #165 rang her/his light/bell. She reported she was in another resident's room with a provider and was unable to hear the bell. 3) On 2/10/26 at approximately 9:45 AM, the surveyor interviewed Resident #127, who expressed concerns that the wall call [NAME]/light did not work in the bathroom. The resident stated that they are often left on the toilet for at least 30 minutes because staff cannot hear the manual bell when it rings. The surveyor observed a manual hand bell on the bathroom sink counter and confirmed the wall-mounted call bell system did not activate when pulled. GNA #27 later entered the room and confirmed that the wall call bell had not been working. On 2/10/26, between 10:00 and 11:00 AM, during the initial screening of residents, Residents #10 and #67 reported non-working call bells. On 2/11/26 at 10:04 AM, the surveyor interviewed Resident #10 and observed a call bell tied to the bed rail. While discussing call bell/light response time, the resident pointed out that staff had tied a non-working call bell to the bed rail. The surveyor observed that the wall end of the call bell was not (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plugged into the wall and was instead draped over a wheelchair. On 2/11/26 at 12:39 PM, the surveyor interviewed GNA #30 regarding Resident #10's call bell. She stated that it falls out of the wall. The surveyor observed her pick up the disconnected box and reinsert it into the wall. When asked if she had ever reported the issue, she stated that she had not. When asked about the process for reporting broken equipment, she stated that she might tell a manager, but she usually just plugs it back into the wall. When asked if she was aware of the facility's TELS system for reporting broken equipment, she stated that she was not sure. The surveyor followed GNA #30 to the nurse's station, where GNA #31 asked if assistance was needed. GNA #30 explained that Resident #10's call bell had been falling out of the wall. GNA #31 stated, I will put it into the TELS system now. When asked whether all staff had received training on the TELS system, GNA #31 stated she was unsure and said, I just know that I know how to do it. GNA #30 again stated that she had never been shown how to use the system. On 2/13/26 at 3:35 PM, the surveyors interviewed the Nursing Home Administrator (NHA). He confirmed that it is the facility's expectation that all call bells/lights be functional and stated that because call bells are vital to resident safety, broken bells should be immediately reported and either fixed or escalated to management rather than relying solely on the TELS system. When asked what staff had been instructed to do when call bells were not functioning, he stated that residents were to be provided with manual bells. He acknowledged that staff had received only verbal instruction and confirmed that no formal education or in-service had been provided. The surveyor informed him that residents reported staff could not hear the manual bells and had experienced delays in assistance, including being left on the toilet for extended periods. He stated that he was not aware of those concerns and would instruct staff to make more frequent rounds. Regarding the scope of the issue, he stated that the facility became aware that multiple rooms had non-functioning call bells/lights just a few days prior to the survey entrance on 2/10/26. He explained that the facility has two separate call systems requiring specific parts and that one system would require reprogramming. He stated that a quote had been obtained and parts had been ordered but was unsure if this had been completed prior to surveyor entrance or around the time of entrance. On 2/13/26 at 4:08 PM, the surveyor interviewed the Maintenance Director (MD #8) and asked how he is notified when something needs repair. He stated that unit managers put things in TELS and that he might also notice issues himself. When asked about formal environmental rounds, he stated that rounds focus on items such as fire safety or vents. When asked whether he had assessed the call bells, he stated that he had been made aware of an issue and had informed the regional director. On 2/17/26 at 10:36 AM, the surveyor interviewed the Nursing Home Administrator (NHA) for clarification regarding when the call bell/light issue was first identified. He stated that it had been an intermittent issue since approximately July 2024 when he first arrived at the facility, but it became significantly worse about one week prior to the start of the survey. He stated that a full facility audit had been completed and would be provided to the surveyors. On 2/18/26 at 1:30 PM, Resident #127 asked to speak with the surveyor and reported, I was left on the toilet again this weekend. The resident stated that they had to use their personal cell phone to call the nurses' station because no one responded when they rang the manual bell. The resident (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	showed the surveyor the call log on their cell phone, which reflected an outgoing call to the facility on 2/14/26 at 10:27 PM. On 2/18/26 at 1:38 PM, the surveyor notified NHA and the Director of Nursing (DON) of Resident #127's report. Communicating that they had been left on the toilet over the weekend and had used their personal phone to call the facility for assistance. Both acknowledged that this was a concern. On 2/19/26 at 11:39 AM the surveyor spoke with the NHA, and at 12:15 PM with the Director of Nursing to review concerns identified during the recertification survey. Both confirmed that the call bell system issues were valid concerns. 4) On 2/12/26 at 10:17 AM, the surveyor observed that the call bell indicator light above Resident #2's door was on. Nurse #17, who was at the medication cart located near Resident 2's room, reported that the light malfunctions, indicating it was always on. When asked, if the residents needed assistance, how they would alert staff. Nurse #17 responded that the resident would come out to the hall. Review of Resident #2's medical record revealed that the resident had resided in the current room for more than 4 weeks prior to the start of the survey. The resident's diagnosis included paraplegia, which means the resident is unable to stand or walk. On 2/12/26 at 12:47 PM Resident #2 reported that the call bell has been broken since they were moved into the current room. The resident also reported s/he did not have a wheelchair for mobility on the first night they were in the room. On The administrator provided an invoice by an outside company for the repair and parts for the call bell/light system. The quote was dated 2/10/2026 and an invoice date of 2/12/26.However, the residents' complaints regarding the broken call light systems began to be documented in November 2025. The administrator reported that the facility has installed a temporary call light system for the first floor on the weekend of February 14th and 15th. On 2/13/2026 3:56 PM, during an interview with Administrator, he reported that the facility is still working on repairing the call light system. He confirmed the concern that multiple rooms on each nursing unit had call light/bell system not in working order.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review and resident and staff interviews, it was determined that the facility failed to provide quality care that promotes resident respect and dignity. This was evident for one (Resident #67) out of five residents reviewed for dignity during the survey.The findings include:On 2/11/26 Resident #67 was observed sleeping in bed. Fingernails were long and unkept with dark build up underneath.On 2/13/26 at 1:26 PM this surveyor observed Resident #67's uncovered foot and noted exceptionally long toenails. The resident stated, I want them cut. They hurt me.On 2/13/26 at 1:29 PM this surveyor observed Licensed Practical Nurse (LPN #26) assess Resident #67 toenails. The resident pulled the foot away and stated, that hurts.In a follow-up interview, LPN #26 verified that the toenails are very long. He reported that the process to schedule a podiatry appointment was to verbally report it to social work.On 2/13/26 at 3:12 PM in an interview, Director of Social Service (DSS #21) explained the process to schedule a podiatry appointment for a resident. He stated that nurses should retrieve a Health Drive form from his office, complete it, have it signed by a Physician or Nurse Practitioner and also get a nurse signature and return it to his office. He, in turn, uploads the completed form to Health Drive and waits to receive an email confirming receipt of the request. If completed accurately and financial clearance is verified, then Health Drive schedules the appointment. He confirmed that he had not received any Health Drive forms today.On 2/17/26 at 9:15 AM this surveyor observed Resident #67's toenails remained very long. On 2/17/26 at 9:17 AM in an interview with DSS #21 confirmed that a completed Health Drive form was received and uploaded; Resident #67's podiatry appointment was scheduled for 2/20/26.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on resident and staff interviews, record review and observation, it was determined that the facility failed to demonstrate prompt action in response to residents' grievances; provide a written response to residents of the grievance outcome; ensure an anonymous means to submit grievances; and post the Grievance Official name and contact information. This was evident for six of six Activities Team's grievances that were reviewed during this survey. The findings include: On 2/12/26 at 10:01 AM in an interview with the Resident Council President (Resident #129,) the following was reported: Resident Council meetings held every second Tuesday of each month at 3:00 PM On average 25 residents attend Staff are invited to the meetings, but often they don't attend, especially nursing leadership Minutes are recorded by me (Resident #129) and kept in my personal journal On the day before the meeting, I (Resident #129) personally and physically go throughout the building via wheelchair to verbally invite residents to the meeting. It was stated; the facility won't allow posted signs from residents. Resident #129 referred to the minutes in her/his journal and complained about the following as persistent grievances: Geriatric Nurse Assistants are disrespectful Call bell response is slow- sometimes hours Food is cold, nobody answers the phone to change orders, dirty utensils Elevator walls are dirty Some people (residents) run out of medications Resident #129 stated that to make a grievance, a concern form gets filled out, and goes to Social Work, after that, nothing happens! Resident #129 was not aware of the Grievance Official's (GO) name or contact information. On 2/18/26 at 1:28 PM Social Work Assistant (Staff #22) acknowledged that she attended the meetings when invited and confirmed Resident #129 extended an invitation to last meeting. She was unable to identify the process for responding to residents' grievances discussed at the meetings. On 2/18/26 at 1:34 PM, an interview with newly hired Activities Director (Staff #13) confirmed the information provided by Resident #129. She stated that she took attendance of residents and staff. She noted that the last regularly scheduled Resident Council meeting was in November 2025. When the grievances listed above were discussed, she reported that she completed concern forms and submitted them to the Director of Social Work (Staff #21). They have 7 days to investigate and (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mitigate the grievance and return it to Director of Social Work. He, in turn, gives the completed forms to me and I file them with the minutes. On 2/18/26 at 2:11 PM Director of Social Work (Staff #21) stated that the residents do not receive written resolutions, but they should. He identified himself as the GO. He stated, residents stay informed about the grievance process I guess by education, although he, himself, denied educating residents. He indicated that grievance forms are located outside of Social Service door and at the main entrance door. He confirmed that his contact information identifying himself as the GO was not posted next to the grievance forms. When asked, how does one file a grievance anonymously, he stated, they give the form to me or my assistant. On 2/18/26 at 2:33 PM, on the first floor, this surveyor observed no grievance bins or posters; on the second floor, this surveyor observed a plastic bin with grievance forms outside of Director of Social Work #21's door with a Compliance poster, but without the GO contact information. A similar plastic bin labeled grievance was observed to the right of the main entrance door without any poster or contact information. Next to this bin, hung a small black locked metal box. An interview with the receptionist, whose desk was directly in line of sight, reported that she had never seen anyone access that box, denied knowing the purpose of it and acknowledged that she didn't know it was there. In subsequent interviews, the Director of Nursing and Nursing Home Administrator acknowledged that they were unaware of the location of grievance boxes. A review of the Grievance Policy approved on 2/3/26 revealed, in part, the facility will prominently post and make information available to all residents the right to file grievances orally and in writing; the right to file grievances anonymously; contact information of the Grievance Official (GO); a reasonable time frame for review; the right to obtain a written decision regarding the grievance; etc. It continued: Section 1. b. The facility will maintain a secure box for reporting grievances in writing anonymously. Multiple boxes may be required to ensure all residents are able to exercise their right to file grievances in writing or anonymously. Grievance forms and instructions for using the box will be posted near or on the grievance box. The box will be checked daily during business hours, at a minimum, by the GO or designee. Section 4. b. The GO will complete a written grievance decision that includes specific criteria such as a summary of pertinent findings or conclusions regarding the concerns; whether the grievance was confirmed or not; and whether corrective action is taken and why and what that action is; and the date the written decision was made. Section 4. c. The GO will meet with the resident and inform the resident of the results of the investigation and how the resident's grievance was resolved or will be resolved. 4.c.i. A copy of the written grievance decision will be provided upon request. On 2/19/26 a review of Concern forms dated 2/11/26 revealed partial completion of the form; it included date, name of resident, person presenting the concern, a description of the concern and the department representative to notify. The information not included was actions taken to resolve the concern, investigator's signature and Administrator's signature. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of the Grievance form dated 2/11/26 revealed incomplete information and that it was resubmitted on 2/18/26, still incomplete. In an interview, Director of Social Work #21 acknowledged that the process didn't work. And the Activity Director #13 stated, sometimes, I have to hound them to get things done.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and medical record review it was determined that the facility failed to inform the resident's responsible party (RP) of a change in condition. This was found to be evident for one (Resident #12) out of one resident reviewed for notification of change.The findings include:Resident #12 has resided at the facility for more than one year. Review of the medical record revealed the resident has moderate cognitive impairment as evidenced by a brief interview for mental status score of 10 out of 15. Review of the 9/22/25 Minimum Data Set (MDS) assessment revealed the resident reported that it was very important to have family or a close friend involved in discussions about his/her care. Review of the resident's medical record revealed two family members were listed as contacts.On 2/11/26 at 2:47 PM the resident's family member reported that they were not sure if the facility always contacted them when there were changes in the resident's condition.Review of the medical record revealed a change in condition note dated 1/10/26 that indicated the nurse practitioner had ordered blood tests and a chest x-ray due to tachypnea (rapid breathing). In the section of the note to document Name of Family/Health Care Agent Notified staff documented self, indicating the resident was notified.Further review of the medical record failed to reveal documentation to indicate the resident's family member was notified of the 1/10/26 change in condition.On 2/19/26 at 12:09 PM the unit nurse manager #16 was asked if the family was notified about the change in condition that occurred on 1/10/26. She proceeded to review the medical record and reported the notification was noted as self but that there was an emergency contact person listed. The unit nurse manager went on to report that they have to obtain permission from the resident to notify the family. When asked if there was any documentation to indicate the resident did not want family notified, the unit manager responded that she did not see a progress note stating that.On 2/19/26 at 3:30 PM surveyor reviewed the concern with the Director of Nursing regarding the failure to notify the family of the change in condition that occurred on 1/10/26.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on review of pertinent records and interview it was determined that the facility failed to ensure Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) and Notice of Medicare Non-Coverage (NOMNC) were provided to residents prior to the end of skilled services. This was found to be evident for two (Resident #89 and #115) out of three residents reviewed for Skilled Nursing Facility Beneficiary Protection Notification Review.The findings include:Review of the list of residents, provided by the facility, of residents who were discharged from a Medicare covered Part A stay with benefit days remaining in the past 6 months revealed Resident #89 and Resident #115 were discharged from services and remained in the facility for long term care. If a resident remains in the facility long term care they are expected to be issued a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN) and a Notice of Medicare Non-Coverage (NOMNC).Notice of Medicare Non-Coverage (NOMNC) The NOMNC, Form CMS-10123, is given by the facility to all Medicare beneficiaries at least two days before the end of a Medicare covered Part A stay or when all of Part B therapies are ending. The NOMNC informs the beneficiaries of the right to an expedited review by a Quality Improvement Organization.Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF ABN). It is the facility's responsibility to inform the beneficiary about potential non-coverage and the option to continue services with the beneficiary accepting financial liability for those services.1.Review of Resident #89's Notice of Medicare Non-Coverage revealed that on 11/21/25 the facility informed the resident's responsible representative that skilled services would end on 11/25/25. The facility provided a statement that the Medicare Part A Service Termination/Discharge was determined because The facility/provider initiated the discharge from Medicare Part A services because the resident was remaining long term care. They also provided a statement that the SNF ABN Form was not provided to the resident because the resident discharged from the facility and did not receive non-covered services.Resident #89 was residing in the facility at the start of the survey on 2/10/26. No documentation was found to indicate the resident was discharged and then re-admitted after 11/25/25.2. Review of Resident #115's Notice of Medicare Non-Coverage revealed that on 1/20/26 the facility left a message for the resident's responsible representative that skilled nursing facility services would end on 1/20/26. The facility failed to provide this notice in time for the representative to appeal the decision.The facility provided a statement that the Medicare Part A Service Termination/Discharge was determined because The facility/provider initiated the discharge from Medicare Part A services because the resident was remaining long term care. They also provided a statement that the SNF ABN Form was not provided to the resident because the resident discharged from the facility and did not receive non-covered services.Resident #115 was residing in the facility at the start of the survey on 2/10/26. No documentation was found to indicate the resident was discharged and then re-admitted after 1/20/26.On 2/12/26 at 2:10 PM Surveyor reviewed with the Social Service Director #21 the concern that they failed to provide the SNF-ABN to the Resident # 89 and #115; and failed to provide the NOMNC prior to the day services were ending for Resident #115. Social Service Director #21 confirmed he did not have any additional documentation to provide regarding these concerns.As of time of survey exit on 2/19/26 at 6:00 PM no additional documentation was provided regarding the failure to provide the appropriate notifications prior to the end of skilled services.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on interviews and pertinent document review, it was determined that the facility failed to promptly respond to and resolve a resident grievance. This was evident for one (Resident #100) of one resident reviewed for general concerns during the survey.The findings included:On 2/10/26 at 12:46 PM, Resident #100, a long-term resident of the facility, was interviewed. During the interview, Resident #100 reported that while at the facility, there was a plumbing water emergency in their room. This resulted in a short-term transfer for the resident to another facility. Resident #100 reported that upon return there were items missing. They reported the missing items of clothing and personal documents (including an ID card, Social Security card, and a birth certificate), to social services. On 2/13/26 at 11:30 AM, a second interview was conducted with Resident #100 in their room. The resident reported that when transferred to another facility, the ID card, birth certificate, and Social Security card were left in their drawers. Resident #100 stated that the missing items were reported to the Social Services Designee (Staff #22). On 2/13/26 at 11:35 AM, observation of the resident's room revealed two large cardboard boxes containing clothing. The resident lifted a shirt from one box, revealing an unopened medication bubble pack, containing Tylenol 325 mg tablets. On 2/13/26 at 11:40 AM, the resident gave permission for the surveyor to bring the medication to the nurse. On 2/13/26 at 11:40 AM, the Unit Manager (#10) on the Dogwood nursing unit received the medication and stated that it was from Resident #100's residence prior to admission at this long-term care facility. On 2/13/26 at 3:00 PM, the Director of Social Work (Staff #21) was interviewed. The Director reported awareness that the Social Services Designee had previously completed a grievance form for Resident #100, regarding the missing clothing. The additional concerns about the missing documents that were reported to the surveyor were shared with the Director. On 2/13/26, the Director of Social Work (Staff #21), was interviewed. The Director reported that when a resident was moved out of a room, nursing staff were responsible for packing belongings not transferred with the resident. Environmental Services (EVS) staff were responsible for moving packed belongings to the storage room. Items were to be stored in a bin or plastic tub labeled with the resident's room number and name. When a resident returned, EVS staff were to deliver the items to the residents new room, and nursing staff were to assist with unpacking of the returning resident's items. The Director stated that if EVS or nursing staff had assisted the resident in unpacking or searching for missing items, medications should have been removed from the room and secured with the Unit Manager or nurse. The director of Social Work confirmed that Resident #100 would require assistance with packing and unpacking belongings in their room. On 2/18/26 at 8:35 AM, the Social Services Designee (Staff #22), reported that a grievance form had been completed for the resident, regarding missing clothing, but the form could not be located. The Designee stated a review of the grievance records would be conducted and follow-up provided to the surveyor. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/26 at 8:37 AM, the Director of Social Work reported that from 2/13/26 to present (2/18/26), the resident had not been interviewed regarding the missing documents, and no attempt had been made to locate Resident 100's reported items. The Director confirmed that no action had been taken since the surveyor reported the missing items and that the resident had not been re-interviewed. The Director stated the standard expectation is that items are to be searched for within 24 to 72 hours. On 2/18/26 at 9:01 AM, the Social Services Designee (Staff #22) reported remembering that the resident had reported missing clothing, but that she was unable to locate a previously completed grievance form for Resident #100. On 2/18/26 at 1:47 PM, the Director of Social Work was interviewed. The Director reported that the resident's room had been searched; however, the staff were unable to locate the missing vital documents or clothing. Additional medications were found in the residents' boxes. The Director reported plans to recheck the storage room and stated collaboration with the resident's family, was underway to obtain or replace the missing documents. A new grievance form dated 2/18/26, was provided. On 2/18/26 at 2:05 PM, the above concerns were discussed with the Director of Nursing (DON), including the lack of documentation of a grievance form, at the time the resident reported missing items and the failure to conduct a thorough search. No additional information was provided prior to the end of the survey.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on record review, observations, and interviews, it was determined that the facility failed to protect residents from verbal abuse. This was evident for two (Residents #90 and #111) out of six residents reviewed for abuse allegations.The findings include:1) Resident #90 has a medical history of heart failure, depression, and post-traumatic stress disorder.On 1/28/26 at 5:26 PM, the facility submitted a facility-reported incident to the Office of Health Care Quality (OHCQ) stating that an Activities Assistant (AA #29) had a verbal altercation with Resident #90 (Incident #2729623).On 2/12/26 at 4:22 PM, the surveyor reviewed the facility's investigation regarding the allegation of verbal abuse. The report indicated that Resident #90 informed Unit Manager (UM #10) that AA #29 had delivered cigarettes to another resident. When Resident #90 asked to borrow one, the other resident stated that AA #29 had told them Resident #90 takes advantage of other residents and declined to share. Upset by this accusation, Resident #90 approached AA #29 to ask why this was said. Resident #90 reported that AA #29 responded, I bought the f&$king cigarettes, and I don't care who the f&$k gets mad, I paid for them, followed by additional profanity. Resident #90 stated the verbal attack upset her, and she chose to report the incident rather than respond.On 2/12/26 at 4:00 PM, the surveyor interviewed Resident #90, who stated she clearly remembered the event. She reported seeing AA #29 bringing cigarettes into another resident's room and asking to borrow one. She stated the other resident told her that AA #29 had accused her of taking advantage of others. When she questioned AA #29 about this, AA #29 became irate and screamed at her using a lot of bad language. Resident #90 further stated she had not reported prior concerns but that there had been three previous incidents involving the staff member.On 2/12/26 at 4:36 PM, the surveyor interviewed the Director of Nursing (DON), who conducted the investigation. The DON stated AA #29 was immediately suspended pending investigation. She reported the allegation was substantiated through staff and resident interviews, which revealed additional concerns regarding the staff member's treatment of non-favorite residents. The DON stated AA #29 had also been heard telling another resident, I wouldn't give you sh$t if you asked for it.2) Resident #111 has a medical history significant for a stroke with left-sided hemiplegia (severe weakness or total loss of function), heart disease, depression, and dysphagia (difficulty swallowing).On 2/10/26 at 12:26 PM, an OHCQ nurse surveyor and survey coordinator were standing outside the second-floor nurse station conducting general observations when they overheard a staff member loudly state, You need to get your s&it together and eat, you are a grown a$$ [sex of resident removed]. The surveyors observed a resident seated in a geri-chair with a lunch tray in front of them and two staff members walking away toward the food cart. The surveyors were unable to determine which staff member made the statement. The tray ticket identified the resident as Resident #111. The surveyor noted the resident had a blank expression. When asked if assistance was needed, the resident responded, no.On 2/10/26 at 1:46 PM, the surveyors reported the incident to the Nursing Home Administrator (NHA), who stated an investigation would be initiated and the DON notified. Shortly thereafter, the DON informed the surveyors that both staff members observed near the resident would be suspended pending investigation and confirmed that they had completed an initial self-report (Incident #2740371) to OHCQ.On 2/10/26 at 4:15 PM, the surveyors interviewed Resident #111 regarding the incident. The resident stated, the nurse (identified as Nursing Assistant (NA #14)) gets like that with her sometimes. When asked if she felt safe in the facility, she responded, sometimes.On 2/19/26 at 11:39 AM, the surveyor interviewed the Nursing Home Administrator (NHA). The NHA stated the facility was unable to conclusively identify which staff member made the abusive statement because Resident #111 later recanted the allegation. He acknowledged that residents have expressed fear of retaliation from staff and stated this fear may have contributed to Resident #111 withdrawing her statement. Despite the recant, he confirmed he believed the incident did occur based on the firsthand observations and written statements of the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	OHCQ surveyor and survey coordinator. He reported both suspected staff members denied involvement and, due to the lack of resident confirmation, he could not take definitive disciplinary action but stated the facility would continue to monitor the suspected staff. The NHA acknowledged the language used constituted verbal abuse and stated the allegation was amended from unsubstantiated to substantiated, as the abusive event itself was verified even though the specific perpetrator could not be identified.On 2/19/26 at 12:20 PM, the NHA notified the surveyor that the final report had been updated and amended accordingly.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. Based on medical record review and interview it was determined that the facility failed to ensure discharge planning was updated and facilitated by staff. This was found to be evident for one out (Resident #12) of two resident's reviewed for disharge.The findings include: Resident #12 has resided at the facility for more than one year. Review of the medical record revealed the resident has moderate cognitive impairment as evidenced by a brief interview for mental status score of 10 out of 15. Review of the 9/22/25 Minimum Data Set (MDS) assessment revealed the resident reported that it was very important to have family or a close friend involved in discussions about his/her care. Review of the resident's medical record revealed two family members were listed as contacts.During an interview on 2/11/26 at 2:47 PM the resident's family member reported that the facility was too far away, s/he is often unable to get a ride to the facility, and they want to have the resident transferred to a facility nearby. The family member also reported that the social worker claims she is working on it and that it is about bed availability.Review of the resident's care plans revealed a plan with the following focus: [Resident's name] has no plans for discharge secondary to need for 24/7 care and support. The goal of this care plan, which was revised on 10/22/25, was that the resident will not have adjustment issues with not returning to previous living status. Review of the interventions section of this plan revealed that in August of 2024 the resident's family indicated they would like to transfer the resident to a facility closer to them and requested assistance with locating a facility that is close to the family. No documentation was found in the care plan to indicate what social services would be doing to help facilitate the resident's transfer to a facility closer to family.Review of the progress notes revealed a care conference note, dated 3/25/25 that included: .family wants [him/her] to move to a nursing home closer to home. Family wants [resident] to [name of specific] facility that is close to them. No documentation was found to indicate social services contacted the identified facility in the 6 months following this meeting.Review of the 9/23/25 care conference note revealed Resident preferences discussed/updated: . Wants to go to another facility. The note also indicated that the resident requested family be in attendance, however the documentation indicates only the resident and the SSD were in attendance at this meeting.Further review of the electronic health record revealed documentation entered by the Social Services Director (SSD #21) on 10/22/25 indicating that three of the resident's family members requested the resident be transferred to a specific identified facility. The note documented that social services contacted the admission director at the requested facility, who confirmed the availability of an appropriate long-term care bed. Social services indicated that the resident's information would be faxed to the receiving facility to initiate the transfer process.Further review of the electronic health record, on 2/12/26, failed to reveal documentation to indicate there was follow-up by social services regarding the October contact with the other facility. No social service or care plan notes were found in the electronic health record after the 10/22/25 progress note.During an interview with the SSD #21, on 2/12/26 at 11:29 AM, he reported that that the goal for the resident and the family is to move closer but when they call the facilities they don't have long term care beds available. Surveyor then reviewed the 10/22/25 note and that no follow up documentation was found. SSD #21 confirmed nothing recent was going on in regard to potential transfer and indicated he would check to see if the information was faxed, as indicated in the October note.Further review of the medical record revealed a social service note, written by SSD #21 on 2/12/26 at 2:04 PM, that revealed Social Service spoke to the admission director at the facility named in the 10/22/25 note. The admission director instructed them to fax over the referral again and they would review the case to see if they will accept the resident for long-term care.On 2/13/26 SSD #21 provided a copy of the FAX TRANSMITTAL, dated 10/22/25 that was sent to the facility identified in the 10/22/25 progress note. The SSD #21 also provided a copy of a FAX TRANSMITTAL that was sent on 2/12/26 to the same (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. Review of the Clinicals for admission Referral that was sent on 2/12/26 revealed they were the same documents as were sent in October 2025, they failed to include the current order summary, or the more recent primary provider notes.On 2/18/26 further review of the medical record revealed that on 2/16/26 the referred facility requested additional documentation, which was sent by the Social Services Designee #22. On 2/17/26 at 8:41 AM Social Service Designee #22 documented that the admission Director from the referred facility called to report that after review of the clinical documents their Director of Nursing stated they were not able to accept [name of Resident #12]. Further review of the medical record failed to reveal documentation to indicate the family was made aware that their facility of choice was not going to accept the resident.On 2/18/26 at 3:18 PM interview with Social Service Designee #22 revealed that she follows up with family when they request a transfer to another facility, letting them know if they have been accepted or denied. When asked about Resident #12, the Social Service Designee #22 reported that the facility called the day after she sent clinical information to say the resident was denied, and that this had recently happened so she had not yet called the family. On 2/19/26 at 3:30 PM surveyor reviewed the concern with the Director of Nursing regarding the failure to ensure facility staff follow up with discharge planning.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on medical record review and interview it was determined that the facility failed to ensure a Preadmission Screening and Resident Review (PASARR) was completed prior to admission to the facility. This was found to be evident for one (Resident #2) out of two residents reviewed for PASARR.The findings include: PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long-term care. PASARR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental disorder and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and 3) receive the services they need in those settings. Review of Resident #2's medical record on 2/11/26 revealed the resident was originally admitted to the facility in January 2026. No documentation was found to indicate a PASARR screen was completed for this resident prior to, or after, the admission to the facility. Interview with the Director of Social Services (DSS) #21 on 2/12/26 at 11:17 AM revealed that the PASARRs are supposed to come from the hospital with the admission documentation. If there isn't a PASARR included, DSS #21 reported he would ask the admission director to request one from the hospital. If the hospital refuses to complete one then the DSS can complete the PASARR himself. DSS #21 confirmed he has access to the electronic system of the organization (Telligen) that currently reviews the PASARRs to determine if a PASARR Level 2 review if required. Surveyor then reviewed the concern with DSS #21 that no PASARR was found in the medical record for Resident #2. On 2/17/26 11:17 AM further review of the medical record failed to reveal documentation that a PASARR screening was completed for this resident. At 1:25 PM surveyor requested the PASARR documentation for Resident #2 from the DON. At 3:45 PM the DON reported that DSS #21 had to go into Telligen. On 2/17/26 at 4:45 PM DSS #21 provided documentation to indicate the PASARR assessment was completed and submitted to Telligen, by DSS #21, on 2/17/26 at 4:26 PM.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on medical record review and interview it was determined that the facility failed to develop and implement a comprehensive person-centered care plan for each resident. This was found to be evident for one (Resident #2) out of one reviewed for urinary catheter use; two (Resident #2 and #89) out of four reviewed for activities; and one (Resident #14) out of one reviewed for the use of side rails. The findings include:1) Review of Resident #2's medical record revealed the resident was admitted in early January 2026. Review of a 1/4/26 history and physical note revealed a diagnosis of neurogenic bladder requiring intermittent catheterization.Urinary catheterization involves inserting a tube into the bladder via the urethra to drain the urine from the body. Catheterization can be performed by nursing staff, or a resident can perform this procedure themselves. If performed by the resident the procedure is called self-catheterization (or just self-cath). Self-catheterization is usually performed 4 to 6 times per day.On 2/12/26 at 12:47 PM during an interview the resident reported that s/he performs self-catheterization and is supposed to have 6 catheters per day but was only being provided four per day. The resident also reported having to ask each day for the needed supplies and that they only provided three catheters yesterday (2/11/26). The resident also indicated the catheters being provided by the facility where not the correct size and s/he was trying to get a prescription for the correct size.Review of the care plan revealed that on 1/16/26 a care plan was initiated with a focus of: [name of resident] has Intermittent Catheter related to Neurogenic bladder. The care plan goal was that the resident would remain free from catheter-related trauma through the review date. The interventions included: Assess for signs/symptoms of infection and skin breakdown per practitioner order; Monitor for pain, fever, chills, purulent drainage at nephrostomy site or s/s of UTI; Document and notify practitioner if infection is suspected; Enhanced barrier precautions when dressing/bathing/showering/transferring/personal hygiene, changing linens, toileting and peri-care, providing care to urinary catheter; and Observe /document for pain/discomfort due to catheter.The interventions reference a nephrostomy site, further review of the medical record failed to reveal documentation to indicate the resident had a nephrostomy (which is a tube that drains directly from the kidney, rather than the bladder).Further review of the care plan failed to reveal documentation to indicate the resident was performing self-catheterization or that staff needed to provide catheterization supplies to the resident daily, or that the resident required assistance with obtaining the correct size catheter.Cross reference to F 6902a)Further review of Resident #2's medical record revealed in Section F, Preferences for Customary Routine and Activities, of the 1/6/26 Minimum Data Set assessment, that it was very important to the resident to listen to music that s/he likes and to go outside and get fresh air when the weather was good.On 2/11/26 at 1:32 PM Resident #2 expressed a concern to surveyor that the only time the resident could go outside was to go with the residents who smoke during prescheduled smoking times.Review of the resident's care plan failed to reveal a care plan to address activities.On 2/18/26 at 12:29 PM the Activity Director acknowledged that she had not completed a full assessment with Resident #2 yet and reported: I just have to initiate the resident's [activity] care plan.2b)On 2/13/26 at 10:06 AM, the care plan for Resident #89, a long-term resident of the facility, was reviewed. The review failed to reveal activities care plan for the resident.On 2/18/26 at 12:35 PM, the Director of Activities (Staff #13) confirmed that there was no activities care plan for the resident and that every resident should have an activities care plan. The Activities Director reported being new to the position and stated that an audit of activities care plans for all residents would be conducted going forward.Cross reference to F 6793) Review of Resident #14's medical record revealed the resident was a long term care resident with cognitive impairment and mobility issues.On 2/11/26 at 1:11 PM Resident #14 was observed in bed asleep, grab bars (small side rails) were noted to be in the up position on both sides of the bed.Even when bed rails are properly designed to reduce the risk of entrapment or falls, are compatible with the bed and mattress, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and are used appropriately, they can present a hazard to certain individuals, particularly to people with physical limitations or altered mental status, such as dementia or delirium.Review of the Procedures section of the Safe Use of Bed Rails policy revealed a care plan should be in place when side rails are used.On 2/17/26 review of the resident's care plans failed to reveal a plan to address the use of side rails for this resident.On 2/17/26 at 4:30 PM the Unit Nurse Manager #16, when asked about the process prior to the initiation of the side rails, confirmed that a care plan would be initiated.Cross reference to F 700On 2/19/26 at 3:30 PM, the surveyor reviewed with the Director of Nursing the concerns regarding the failure to develop comprehensive care plans.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on medical record review and interview it was determined that the facility failed to ensure the interdisciplinary team, including the resident's responsible representatives, participated in care conferences to review and revise a resident's care plan following Minimum Data Set (MDS) assessments. This was found to be evident for one (Resident #12) out of four residents reviewed for care planning.The findings include:Care Conferences, also known as care plan meetings, are interdisciplinary team meetings that are to occur following the completion of Minimum Data Set (MDS) assessments. The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. Review of Resident #12's medical record on 2/12/26 revealed the resident has resided at the facility for more than one year, has moderate cognitive impairment as evidenced by a brief interview for mental status score of 10 out of 15. Review of the 9/22/25 Minimum Data Set (MDS) assessment revealed the resident reported that it was very important to have family or a close friend involved in discussions about his/her care. Review of the resident's medical record revealed two family members were listed as contacts.Review of the 9/23/25 Care Conference note, written by the Social Service Director #21, revealed that the resident requested family be in attendance, however the documentation indicated only the resident and the SSD were in attendance at this meeting.Further review of the medical record revealed a MDS with an assessment date of 12/23/25 was completed on 1/5/26, indicating a care conference should have occurred after this assessment.Further review of the electronic health record failed to reveal documentation to indicate a care plan meeting had occurred since the care conference held in September 2025.On 2/12/26 at 11:29 AM the surveyor reviewed the concern with the SSD #21 that no documentation was found to indicate a care conference had occurred since the December 2025 MDS assessment. SSD #21 indicated he would follow up regarding this concern.On 2/13/26 at 1:25 PM during a follow up interview, SSD #21 reported that a care conference was held in December 2025 and provided a sign-in sheet for a meeting dated 12/11/25. This sign-in sheet revealed the Social Service Designee #22, the resident and two family members (via phone) attended the meeting. This sign in failed to indicate other members of the interdisciplinary team were present, or otherwise participated in, the care plan meeting. No documentation was found to indicate nursing, activities or dietary participated in the meeting. No documentation was found to indicate what was discussed at this meeting.On 2/13/26 the SSD #21 also provided a CARE PLAN MEETING SCHEDULE for December 2025. According to this schedule, Resident #12's meeting was scheduled for 12/12/25, not 12/11/25. He also provided documentation to indicate the resident was notified of a care plan meeting scheduled for 12/12/25. No documentation was provided to indicate the family was notified prior to the care plan meeting. SSD #21 confirmed that the family was not notified ahead of time but stated: we normally do call them the day of the care plan.On 2/13/26 at 2:10 PM the surveyor reviewed with the Director of Nursing that the care plan meeting, according to the sign-in sheet, was held on 12/11/25 and no other members of the IDT were present at the meeting. The DON acknowledged that the people that should be present at the meeting were not.An interview with the Social Service Designee #22 revealed the resident, nursing, dietary, activities and the family, if the resident requests, are supposed to be invited to the care plan meetings. Social Service Designee #22 reported they call family within a day or two of getting the notice that the meeting was scheduled but moving forward they will be mailing out a notice.As of the time of survey exit, on 2/19/26 at 6:00 PM, no additional documentation was provided to indicate other team members attended the meeting in December, or that a meeting occurred after the December 2025 MDS assessment was completed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observations, interviews, and medical record review, it was determined that the facility staff failed to adhere to professional standards of nursing practice for timely and accurate documentation of medication administration in the medical record. This deficient practice was identified for four of 32 medications reviewed during the medication administration task and affected two (Resident #122 and #129) of the five residents observed.The findings include:On 2/13/26 between 8:16 AM and 8:55 AM, the surveyor observed Licensed Practical Nurse (Nurse #41) perform medication administration for Resident #122 and Resident #129. The surveyor observed the nurse administer medications to Resident #122 and #129. On 2/13/26 at 12:34 PM, the surveyor reviewed the residents' Medication Administration Records (MARs). Review revealed Nurse #41 had not documented administration of Oxycodone 5 mg to Resident #122, despite the surveyor directly observing the medication being administered. Review of Resident #129's MAR further revealed three ordered morning medications — loratadine, fluticasone, and hydrochlorothiazide — had not been documented as administered or otherwise accounted for. On 2/13/26 at 1:25 PM, during an interview, the surveyor asked Nurse #41 about expectations for documenting medication administration. She replied, I thought I signed it off. After the surveyor brought the omission to her attention, she opened Resident #122's MAR and documented the oxycodone administration. When asked about Resident #129's omitted medications, Nurse #41 stated she had gone to central supply to obtain them and administered them after the surveyor's observation, except for the nasal spray (fluticasone), which she stated was unavailable because the facility was out of stock. When asked about the expectation for documentation, she stated she hadn't gotten to it yet. At that time, approximately four hours had elapsed since the medications were reportedly administered. On 2/13/26 at 1:55 PM, the surveyor reviewed the documentation concerns with the Director of Nursing (DON). The DON stated this was concerning and confirmed that medications are expected to be documented at the time of administration. On 2/13/26 at 2:17 PM, during an interview, Resident #129 confirmed they did not receive the nasal spray because staff stated the facility had run out of the medication. The resident also stated they remembered the nurse returning later with two additional pills. On 2/13/26 at 3:01 PM, the surveyor requested copies of the MARs for Residents #122 and #129. The Director of Nursing (DON) stated corrective action would be taken and acknowledged that, as of approximately 3:00 PM, Nurse #41 had not documented the administration of loratadine or hydrochlorothiazide and had not documented that fluticasone was unavailable and therefore not administered. The DON further confirmed the oxycodone was documented only after the surveyor brought the omission to her attention. Review of the facility policy and procedure titled Medication Administration (no policy number or initiation date listed), Section IV, Documentation, stated:a. Documentation of medication will be current for medication administration.b. Documentation of medications will follow accepted standards of nursing practice. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of professional standards from the American Nurses Association indicates that medication documentation must be accurate, timely, and complete to ensure patient safety and continuity of care. The ANA guidelines include: - Document immediately after administration and never before the medication is given. Immediate recording prevents duplicate dosing by other staff and ensures the record reflects what truly occurred. -Include medication name, dose, route, time, and nurse signature/initials -Record patient response when indicated -Document exceptions, refusals, or unavailable medications, including the reason the medication was not administered and notification of the prescribing provider.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on interviews, observations, and record review, it was determined that the facility failed to provide ADL (activity of daily living) care to residents. This was evident for two (Resident #6 and Resident #10) out of three residents reviewed for ADL care.The findings include:Activities of Daily Living (ADL) care refers to support provided to individuals who struggle with essential, routine self-care tasks necessary for basic health, safety, and hygiene.1) Resident #6 has a medical history of diabetes, end-stage kidney disease requiring dialysis, and abnormalities of gait and mobility requiring assistance with ADL care.On 2/10/26 at 4:45 PM, the surveyor interviewed Resident #6 and observed that s/he looked disheveled with greasy hair and body odor. The resident mentioned that s/he often waits up to five hours without incontinence care and stated that they get a little wet towel bath but no real cleaning. The surveyor noted that the bedding was disheveled, the resident was only wearing an incontinence brief, and a dressing on the chest was falling off.On 2/17/26 at 2:27 PM, the surveyor performed a record review of Resident #6's shower and bath records and had difficulty determining if the resident was given baths as ordered. The care plan revealed that the resident is unable to have a shower due to a dialysis port implanted in the chest.On 2/17/26 at 4:01 PM, the surveyor conducted an interview with the Director of Nursing (DON) and the Regional Clinical Director (RCD) and asked for clarification about the documentation for Resident #6's bath schedule. They presented a document titled GG Shower/Bath Self and Skin Observation. The paper asks the question, Type: Bath/Shower, with a place for a response. Several dates stated Response not Required. The RCD explained that response not required means that no bed bath was given that day. The resident did not receive a bath on 1/6, 1/13, 1/20, 1/23, and 1/27/26. Additionally, they provided evidence of one bed bath for the month of February on 2/13/26 (no other dates for February). The surveyor expressed concern that the resident had not been getting baths as ordered, and both agreed this was a valid concern.On 2/18/26 at 10:59 AM, the DON approached the surveyor and stated that Resident #6 had been given a bath. The surveyor went to the resident's room and verified that they had received a bath. The resident was very happy and thankful for the bath and stated they felt much better.2) On 2/11/26 at 10:04 AM, the surveyor conducted an interview with Resident #10, who is dependent on staff for ADL care. S/he stated that they only receive showers about every two months and would like them more often.On 2/17/26 at 2:36 PM, the surveyor conducted a record review and was unable to find evidence that the staff had provided baths or showers and requested evidence from the DON.On 2/17/26 at 4:01 PM, the surveyor conducted an interview with the DON and RCD and asked for evidence that Resident #10 had been provided showers. The RCD stated that, based on the chart, it appears that an error had been made and showers and baths had not been tracked.On 2/18/26 at 10:40 AM, the DON confirmed that they were unable to provide evidence that the resident had received a bath or shower because of the system error when showers and baths were set up. She stated she was trying to find shower sheets and would provide them if they existed. About an hour later, she provided the surveyor with skin assessment sheets that stated bed bath for 1/7, 1/27, 1/30, 2/10, and 2/13/26. There is no record of any other bed baths or of the resident receiving showers.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on interview, observation and record review, it was determined that the facility failed to develop, or update, activity care plans to address and facilitate residents' activity interests. This was evident for 3 (Resident #12, #2 and #89) of 4 residents reviewed for activities during the survey. The findings included:A care plan was a guide that addressed the unique needs of each resident. It was used to plan, assess, and evaluate the effectiveness of the resident's care. 1) Review of Resident #12's medical record revealed the resident has resided at the facility for several years, is dependent on staff for mobility, has some cognitive impairment, and prefers family involvement in care discussions. Review of the 9/22/25 MDS assessment, Section F, revealed it was somewhat important to the resident to get fresh air when weather is good. Review of the 9/23/25 Care Conference note revealed the following statement in the Activities section: I need to go outside. On 2/13/26 review of the resident's care plan addressing activities failed to reveal interventions related to taking the resident outside. On 2/13/26 at 11:35 AM when asked what she does if the resident indicates going outside for fresh air is important to them, the Activity Director reported she would add to the care plan to take the resident outside depending on the amount of time the resident wanted to go out. She went on to report that she has been taking people out for fresh air upon request since she started and confirmed that she documents when this occurs. Surveyor reviewed the concern that the resident had expressed a desire to go outside during the September care plan meeting but the care plan fails to address that request. Review of activity documentation for the previous 90 days failed to show any activities offered from 12/7/25 through 12/15/25. Additionally, no documentation indicated the resident had been offered opportunities to go outside for fresh air during the 90-day review period. 2) Review of Resident #2's medical record revealed the resident was admitted in January 2026, was cognitively intact and their own responsible party. The resident was observed on 2/10/26 wheeling self independently in the hallway. Further review of Resident #2's medical record revealed, in Section F of the 1/6/26 Minimum Data Set assessment, that it was very important to the resident to listen to music that they like and to go outside and get fresh air when the weather was good. On 2/11/26 at 1:32 PM Resident #2 reported to a surveyor that the only way the resident could go outside was to go with the residents who smoke during the pre-scheduled supervised smoking times. The smoking area is located in an enclosed courtyard accessible from the lower level of the facility. An interview with the Unit Nurse Manager (UM) #16 on 2/12/26 at 4:22 PM, regarding residents going outside for fresh air, revealed the residents are not suppose to go out front by themselves due to danger of falling and if they are by themselves they are suppose to go to the courtyard. The UM #16 did not know of any reason why Resident #2 would not be able to go outside and reported that she thought the courtyard was accessible during non-smoking times. On 2/12/26 at 4:42 PM surveyor and UM#16 observed that access to the courtyard required a code and could not be accessed by residents without staff assistance. On 2/13/26 at 9:33 AM the receptionist (Staff #25) at the front desk reported the policy is that residents cannot sit out front unless they are supervised but they can go out in the courtyard. Surveyor requested that the receptionist have the Nursing Home Administrator (NHA) provide a copy of this policy to the surveyor. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/13/26 at 3:30 PM, when asked whether residents are permitted to sit outside, the NHA stated that smoking is not allowed in the front of the building but that residents are allowed to sit outside. He explained that nursing staff would notify the receptionist when a resident planned to go outside so the resident could be permitted access. After the surveyor shared the receptionist's statement that residents were not allowed to sit outside in the front of the facility unsupervised, the NHA said the receptionist was mistaken and reported that one resident sits out front regularly. However, during periods of icy weather, he had instructed that resident not to sit outside due to safety concerns. The NHA confirmed he had not spoken directly with Resident #2. When informed that Resident #2 reported the only opportunity to go outside was during scheduled smoking times, the NHA attributed this to poor communication and recent weather conditions and stated he would follow up with Resident #2 regarding the concern. Review of the resident's care plans, on 2/18/26, failed to reveal a care plan to address activities. During an interview on 2/18/26 at 12:29 PM, the Activity Director (#13) reported she typically assesses residents within 24 hours of admission and develops an activity care plan. She confirmed that all residents are expected to have opportunities for activities based on their preferences. She acknowledged she had not yet completed a full assessment or initiated an activity care plan for Resident #2. The Activity Director reported that, beginning the previous day, the facility initiated two supervised 45-minute non-smoking patio sessions daily, which would be added to the March activity calendar. 3) On 2/13/26 at 10:06 AM, the care plan for Resident #89, a long-term resident of the facility, was reviewed. The review failed to reveal activities care plan for the resident. On 2/13/26 at 11:00 AM, the surveyor requested the activities care plan from the Director of Nursing (DON). On 2/13/26 at 1:28 PM, the DON reported that Resident #89 did not have activities care plan. On 2/18/26 at 12:35 PM, the Director of Activities (Staff #13) confirmed that there was no activities care plan for the resident and that every resident should have activities care plan. The Activities Director reported being new to the position and stated that an audit of activities care plans for all residents would be conducted going forward.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interviews, it was determined that the facility failed to implement medical recommendations for a resident to wear a splint. This was evident for one (Resident #111) of two residents reviewed for rehabilitative services.The findings include: A hand contracture in a long-term care (LTC) resident is a permanent or semi-permanent, often painful stiffening of the joints and tightening of muscles, tendons, or skin in the hand and wrist, which reduces range of motion. This condition is often due to prolonged immobility, muscle disuse, or neurological conditions such as stroke. Resident #111 has a history of stroke that has impacted function on their left side. On 2/10/26 at 4:23 PM, the surveyor observed that Resident #111 had a contracture of the left hand and was not wearing a splint. When asked, the resident stated that s/he did not have one and reported that their left hand gets very red and smelly. On 2/18/26 at 9:58 AM, the surveyor interviewed the Rehab Director (RD #20), who reported that Resident #111 had received Occupational Therapy services on 10/20/25 and was discharged with the following recommendations:Please place a soft towel roll between the left trunk and arm, left elbow extension, and left hand splint (blue) as tolerated daily after morning care for up to 6 hours, with the assistance of another person to distract the patient and hold the right arm to prevent resistance gently. On 2/18/26 at 10:02 AM, the surveyor reviewed the resident's care plan and medical orders and found no documentation of these recommendations. On 2/18/26 at 10:40 AM, the surveyor interviewed the Director of Nursing regarding Resident #111's therapy recommendations. She stated that she had recently started reviewing therapy orders and had identified other residents with similar issues. She confirmed that the orders for Resident #111 had not been entered and were not being followed. She stated, At the end of the day, we didn't do the right thing, and we need to fix it.

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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 medical record review and interview it was determined that the facility failed to accurately assess, plan and provide for a resident's urinary catheterization needs. This was found to be evident for one (Resident #2) out of one resident reviewed for urinary catheterization.The findings include: Review of Resident #2's medical record revealed the resident was cognitively intact and their own responsible party.Urinary catheterization involves inserting a tube into the bladder via the urethra to drain the urine from the body. Catheterization can be performed by nursing staff, or a resident can perform this procedure themselves. If performed by the resident the procedure is called self-catheterization (or just self-cath). Self-catheterization is usually performed 4 to 6 times per day.On 2/12/26 at 12:47 PM during an interview the resident reported that s/he performs self-catheterization and is supposed to have 6 catheters per day but was only being provided four per day. The resident also reported having to ask each day for the needed supplies and that they only provided three catheters yesterday (2/11/26). The resident also indicated the catheters being provided by the facility where not the correct size and s/he was trying to get a prescription for the correct size.Review of a Nursing admission Evaluation, dated 1/2/26, failed to identify that the resident required intermittent catheterization. Intermittent Catheterization was a check off option in the Bladder Assessment section of the admission evaluation, but it was noted to be blank. This form was signed as completed by Licensed Practical Nurse #26.Review of a 1/4/26 history and physical note revealed a diagnosis of neurogenic bladder requiring intermittent catheterization. The note also revealed the resident was being treated at that time with antibiotics for a urinary tract infection.Review of the admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date of 1/6/26, revealed Section H Bladder and Bowel was signed as completed by Registered Nurse #18 on 1/16/26. This assessment failed to reveal documentation that the resident required intermittent catheterization. In Section H Bladder and Bowel H0100 D. Intermittent Catheterization the nurse documented NO. The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. On 2/18/26 at 1:07 PM Nurse #18 reported that there were no orders written at that time (of the assessment period) for the catheters, but the physician referenced it in the History and Physical. Nurse #18 went on to state: probably got overlooked; we should of mentioned it to get an order to do those caths. On 2/19/26 the MDS Director (Nurse #19) reported that there had to be a physician order in place to code the catheterization use on the MDS assessment, indicating the MDS did not capture the catheterization due to lack of supporting documentation.Review of the January treatment administration record (TAR) revealed nursing staff signed off on 1/9/26 as completing an order to Please observe patient for education and return demonstration of self-catheterization and document in PCC [name of electronic health record system].Review of the nursing progress notes revealed that on 1/15/26 at 2:33 PM Nurse #16 documented: Writer witnessed resident successfully perform self-catheterization safely using aseptic technique at 9 am for a total of 200 ml clear yellow urine. Review of the care plan revealed that on 1/16/26 a care plan was initiated with a focus of: [name of resident] has Intermittent Catheter related to Neurogenic bladder. The care plan goal was that the resident would remain free from catheter-related trauma through the review date. Further review of the care plan, including the interventions, failed to reveal documentation to indicate the resident was performing self-catheterization or that staff needed to provide catheterization supplies to the resident daily.On 2/12/26 further review of the medical record failed to reveal a physician order for urinary catheters or that the resident performed self-catheterization.On 2/12/26 at 4:19 PM the Unit Nurse Manager #16 confirmed that the resident performs self-catheterization and that the facility is supplying the catheters from central supply. When asked how the process of supplying the catheters to the resident (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred the Unit Manager #16 reported that the Nurse Practitioner was supposed to write an order, after nursing confirmed that the resident could do it. Unit Manager #16 then confirmed that she did not see an order for catheters in the medical record. Surveyor then reviewed the resident's report that the resident has to ask daily for the catheters, needs 6 per day but sometimes only receives 3 of them.On 2/19/26 at approximately 10:00 AM Resident #2 reported continuing concerns with not being provided adequate number of catheters per day. The resident also expressed concerns regarding the size of catheters being too large, experiencing some bleeding related to catheter use and suspected a current urinary tract infection was present.Further review of the medical record revealed an order, with a start date of 2/13/26, for VaPRo Plus Catheter insert 1 application in the urethra four times a day for urinary retention. The nurses failed to sign off this order when due on Saturday 2/14/26 at 9:00 PM. This order was discontinued on 2/16/26 at 5:22 PM. No documentation was found to indicate there was an order to catheterize the resident, or provide needed supplies, from the evening of 2/16/26 until 6:00 PM on 2/17/26 when a new order was put in place for catheterization every 4 hours (six times a day).On 2/18/26 the following order was put in place: It is okay for patient to self-catheterize and report output to nursing; Nursing to document urinary output in PCC every 4 hours.On 2/19/26 at 12:22 PM the Unit Nurse Manger #16 reported the catheters are brought to the unit daily from central supply and they are of a standard size. In regard to the process for the weekends, the Unit Manager reported the resident is supposed to tell the nurse, who is then supposed to contact the supervisor who would gather the supplies that were needed. The Unit Manager #16 confirmed that she is currently working on assisting the resident with obtaining a different supply of catheters. The Unit Manager acknowledged she was aware of the resident's report of bleeding and suspicion of a urinary tract infection.On 2/19/26 at 3:30 PM surveyor reviewed with the Director of Nursing the concerns related to the failure to include the intermittent catheterization on the MDS assessment, failure to develop a comprehensive care plan to address the resident's need related to self-catheterization and failure to ensure needed supplies were regularly provided to the resident.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, it was determined that the facility staff failed to follow proper tube feed management; to secure a feeding tube free from pulling to prevent dislodgement. This was evident for 1 (Resident # 13) out of 2 residents reviewed for tube feed management during the annual survey. The findings include: Percutaneous Endoscopic Gastrostomy (PEG)tube is a surgical procedure where physicians use an endoscope to insert a plastic flexible feeding tube through the upper abdominal wall directly out of the stomach. Proper care of the PEG tube is necessary to prevent infections, pulling, and clogging of the tube. The external fixation plate of a PEG tube should be positioned 0.5 cm to 1 cm roughly a finger's width away from the skin to avoid pressure necrosis (Necrosis is the death of the cells in one's body tissues. Necrosis can occur due to injuries, infections or diseases). A light dressing normally applied around the PEG tube side and changed daily. Contractures are structural changes to patients' soft and connective tissues that cause them to stiffen, tighten and contract. Tissues affected by contracture lose their former elasticity and range of motion.Sepsis is a patient body's overwhelming response to an infection. It happens when an infection a patient has triggers a serious chain reaction throughout the body.During an observation on 02/10/26 at 10:28 AM, it was noted that Resident #13's feeding pump was turned off while still connected to the resident's percutaneous endoscopic gastrostomy (PEG) site. A record review conducted on 02/13/26 at 08:55 AM, revealed the following summary for Resident #13: The resident was readmitted to this facility on 09/30/25 with diagnoses including stroke with right-sided hemiplegia, contractures, and dysphagia, vascular dementia, myasthenia gravis, diabetes and seizures disorder. On 12/07/25, the resident was hospitalized for sepsis, anemia, and a malfunctioning gastric tube. During this hospitalization, a new PEG feeding tube had to be placed. The resident was subsequently readmitted to the facility on [DATE]. Further record review of Physician Staff #5's admission orders on 12/26/25 indicated that daily PEG tube feedings are scheduled to start at 2:00 PM and end at 10:00 AM, along with daily tube feeding care. Additionally, on 02/11/26 Physician Staff #5's progress note indicated that the feeding tube requires a securement device, discreet tubing routing, and a daily site check.On 02/13/26 at 12:02PM, observations of the PEG site care revealed that Nurse (Staff #24) opened Resident #13's gown found that the PEG tube's external fixation plate was pulled more than 3 cm out from to the stomach wall. It was noted that Resident #13's contracted left arm was constantly pulling on the tube because Nurse Staff #24 had positioned the tube feed pump on the left side of the bed. A follow-up interview was conducted with Nurse Staff #24, who stated the PEG tube was out like that for a while and she was aware of the situation, but she did not recognize that it may cause the PEG tube to be dislodged. Staff #24 failed to ensure the tube was secured, to identify the risk of the tube being pulled out and failed to report it. On 02/13/26 at 12:38 PM, an interview with the Unit Nurse Manager (Staff #6) was conducted to share findings regarding Resident #13's PEG tube. During this discussion, Staff #6 agreed that the PEG tube, which was replaced on 12/07/25, is currently positioned too far from the stomach wall. Unit Nurse Manager Staff #6 also acknowledged the risks associated with the current setup; the tube is not properly secured, and the feeding pump is positioned on the same side as the resident's contracted arm, causing constant pulling and pinching. Unit Nurse Manager Staff #6 stated that nursing staff must properly secure the tube and utilize the best practices, specifically by ensuring the feeding pump is not initially set up on the left side. Unit Nurse Manager Staff #6 also confirmed that he was to follow up with the nursing staff that day regarding maintaining the PEG tube in a securement device and proper feeding pump setup. Additionally, he reported the matter to the attending physician and will conduct re-education for the nursing staff. During the final interview on 02/13/26 at 2:16 PM, the Administrator was made aware of the above findings regarding the identified deficiencies. He agreed and stated that he makes sure the nurse manager followed up.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview and medical record review it was determined that the facility failed to ensure informed consent was obtained from a resident/responsible representative prior to the initiation of side rails; to obtain a physician order ; or develop a care plan related to side rail usage. This was found to be evident for one (Resident #14) out of one resident reviewed for use of side rails.The findings include:Review of Resident #14's medical record revealed that as of 9/25/25 the resident was determined to be incapable of making informed decisions regarding the provision, withholding or withdrawing of all treatments due to vascular dementia. Review of the 1/28/26 Minimum Data Set Assessment revealed the resident was severely cognitively impaired based on a Brief Interview for Mental Status (BIMS) score of 6 out of 15. There are family members involved in the residents care planning.On 2/11/26 at 1:11 PM the resident was observed in bed asleep, grab bars (small side rails) were noted to be in the up position on both sides of the bed.Even when bed rails are properly designed to reduce the risk of entrapment or falls, are compatible with the bed and mattress, and are used appropriately, they can present a hazard to certain individuals, particularly to people with physical limitations or altered mental status, such as dementia or delirium.Review of the facility's Safe Use of Bed Rails policy revealed the following definition for bed rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of type, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths.Examples of bed rails include but are not limited to: side rails, bed side rails, and safety rails; grab bars and assist bars.Review of the Procedures section of the Safe Use of Bed Rails policy revealed 6. Documentation: a. Physician order is required; b. Completion of Bed Safety Evaluation; c. Consent obtained for bed rail use; d. Education provided to the resident or, if applicable , resident representative; and e. Care Plan for the use/need for bed rails.On 2/17/26 review of the medical record revealed no documentation in the orders or the care plan to address the use of the side rails; and no documentation found to indicate the risks were addressed with the resident or the RP prior to the initiation of the side rails. The medical record revealed multiple Bed Safety Evaluations were completed between June 2024 and February 2026. Review of these assessments failed to reveal documentation to indicate side rails were in use prior to 12/2/25.Review of the 12/2/25 Bed Safety Evaluation revealed documentation that yes the resident was capable of decision making and that a grab bar was in use. This evaluation was completed by Licensed Practical Nurse #47. This form failed to reveal a section to document that education/consent was provided or that family was notified.Review of the 1/17/26 Bed Safety Evaluation revealed documentation that the resident was not capable of decision making and that no device was currently in use for bed mobility. This evaluation was completed by Registered Nurse #48.Review of the 1/26/26 Bed Safety Evaluation revealed documentation that yes the resident was capable of decision making and that a grab bar was in use. This evaluation was completed by Licensed Practical Nurse #47.Review of the 2/4/26 Bed Safety Evaluation revealed documentation that the resident was not capable of decision making and that 1/4 side bar for repositioning was currently in use. This evaluation was completed by Registered Nurse #16.On 2/17/26 at 1:21 PM GNA #49 confirmed that the grab bars are in the up position on the resident's bed. Surveyor noted at this time that the mattress was not flush with the grab bars.On 2/17/26 at 2:19 PM surveyor reviewed the concern with the Therapy Director #20 that the current rails appear to have a gap between the rails and the bed.On 2/17/26 at 3:50 PM surveyor reviewed with the Director of Nursing (DON) the concern that the resident has grab bars with no order and nothing found in the care plan addressing the use of these side rails or documentation to indicate the risks were reviewed with the resident or family. The DON reported there is a form that should be used for the consent and proceeded to provide a blank copy of Informed Consent Installation of Bed Rail or Assist Bar not used as a Restraint.On 2/17/26 at (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4:30 PM the Unit Nurse Manager #16 confirmed that there was no current order for the side rails. When asked about the process prior to the initiation of the side rails, the Unit Manager reported that an assessment is completed and it is care planned, the physician is notified and approves the order and then they call maintance to apply the bars to the bed. She confirmed that during the assessment they would obtain consent from the resident or responsible representative.On 2/17/26 at 4:36 PM surveyor and Unit Manager #16 observed the grab bars on the bed and that both bars could be moved a bit (not tightly secured). The Unit Manager indicated she would notify maintenance. As of time of survey exit on 2/19/26 at 6:00 PM no additional documentation was provided to indicate informed consent was obtained prior to initiation of the side rails; or that there was an order or care plan for the side rail use prior to 2/17/26.

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	215160	A. Building B. Wing	02/19/2026

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews, observations, and record review, it was determined that the facility failed to ensure ordered medications were maintained in stock and available for administration as prescribed. This deficient practice was identified for one (Resident #8) of three residents reviewed for pain management and for one (Resident #129) of five residents observed during the medication administration task.The findings include:1) Resident #8 has a medical history of chronic pain. On 2/10/26 at 1:14 PM, during the initial screening of residents, Resident #8 reported that the facility runs out of their pain medication approximately every eight days and that s/he must wait several days for the medication to be refilled. The resident stated they experience pain daily and require the medication consistently. The resident further stated that staff are aware of this need but do not ensure the medication is always available.Medical record review revealed Resident #8 is prescribed Oxycodone, two tablets by mouth as needed for moderate to severe pain, scheduled to be available at 5:30 AM and 1:30 PM.Further review of February 2026 Medication Administration Record (MAR) showed the medication was not administered on the following dates and times:2/1/26 at 1:30 PM2/3/26 at 5:30 AM and 1:30 PM2/7/26 at 1:30 PM2/10 /26 at 1:30 PMOn 2/12/26 at 10:48 AM, the surveyor observed a posted notice at the nurse's station that read: Effective 8/20/25 Please restock your medications as they are getting low! Yes, even if you are a CMA! Yes, even if you are PRN! We are a team and it's annoying not to have what you need when you need it! Let's do better today! Thank you, Management.On 2/12/26 at 2:57 PM, during an interview, the Director of Nursing (DON) stated, Generally, if there are gaps within the MAR to an assigned medication or treatment, it means it was not done. The surveyor informed the DON that Resident #8 had multiple gaps in the medication administration record and that although the pain medication is ordered as needed, the resident reported requesting it daily.On 2/12/26 at 4:27 PM, during a follow-up interview, the Director of Nursing (DON) confirmed the gaps in the medication administration record and acknowledged prior awareness of concerns that nurses were not reordering medications before supplies were depleted. She stated, It's not that hard to reorder the medications.2) On 2/13/26 at 8:45 AM, the surveyor observed a medication pass and followed Licensed Practical Nurse (Nurse #41) during medication administration for Resident #129. During this observation, the nurse administered 14 medications to the resident.On 2/13/26 at 12:34 PM, the surveyor compared the medications administered with the physician's orders and the Medication Administration Record (MAR) and noted that fluticasone propionate nasal suspension 50 mcg/actuation, ordered as one spray in each nostril daily in the morning, had not been administered and was not signed off on the MAR.On 2/13/26 at 1:28 PM, the surveyor asked Nurse #41 about the omitted medication. Nurse #41 stated the facility was out of the medication and therefore she was unable to administer it as prescribed.On 2/13/26 at 1:55 PM, the surveyor interviewed the Director of Nursing (DON) and expressed concern that Resident #129 did not receive prescribed medication. The DON stated it was likely related to nurses not reordering medications when supplies are low and identified issues with central supply stocking over-the-counter medications. She stated she is working on changing the process when a new management company takes over in April.On 2/13/26 at 2:17 PM, during an interview, Resident #129 confirmed they did not receive the nasal spray because staff told them the facility had run out. The resident stated, It is not unusual for the facility to run out of medication and take three to four days to get the medications in again. The resident further stated this concern has been discussed in resident council meetings multiple times without resolution.On 2/13/26 at 4:34 PM, the surveyor informed the Nursing Home Administrator of concerns related to residents not having prescribed medications available. The administrator stated the DON had informed him of the findings and agreed it was a valid concern.

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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 record review and staff interviews, it was determined that the facility failed to acknowledge a pharmacist's recommendation with a physician signature and define timely manner by which the consulting pharmacist's recommendations must be reviewed. This was evident for one (Resident #150) of five residents reviewed for unnecessary medications during the survey.The findings include:On 2/13/26 at 10:13 AM a record review of Resident #150's Pharmacy monthly review revealed the following:On 9/12/25- irregularities, clinically significantA record review of the paper chart revealed no physician signed hard copy of pharmacist recommendations. A review of the Medication Regime Review Policy revealed, in part:Clinically significant irregularities will be addressed with the Medical Director and Director of Nursing the day the notification is received or communicated from the Consultant Pharmacist.If the medical practitioner fails to address the irregularity in a timely manner the Director of Nursing will escalate the concern to the Medical Director.On 2/13/26 at 2:34, in an interview, the Director of Nursing (DON) acknowledged and was unable to produce evidence that the physician received/saw the irregular pharmacist recommendations dated 9/12/25. The DON acknowledged that the definition for timely manner was vague.

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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. Based on medical record review and interview it was determined that the facility failed to ensure social service notes were completed in a timely manner and readily accessible. This was found to be evident for one (Resident #12) out of four residents reviewed for care planning.The findings include: Resident #12 has resided at the facility for more than one yearOn 2/12/26 review of Resident #12's Care Conference notes for meetings held in March, June and September 2025 revealed each note was entered as a LATE ENTRY, indicating the notes were not completed on the date the meetings occurred.Further review of the details of the note written for the meeting held 9/23/25 revealed it was created (i.e. written) by the Social Service Director (SSD) #21 on 1/16/26.Care Conferences are interdisciplinary team meetings that are to occur following the completion of Minimum Data Set (MDS) assessments. The MDS is a complete assessment of the Resident that provides the facility with the information needed to develop a care plan, deliver the appropriate care and services, and modify the care plan based on the Resident's status. MDS assessments are to be completed at least quarterly (every three months).Further review of the electronic health record failed to reveal documentation to indicate a care plan meeting had occurred since the care conference held in September 2025.On 2/12/26 at 11:29 AM surveyor reviewed the concern with the SSD #21 that no documentation was found to indicate a care conference had occurred since the December 2025 MDS assessment. SSD #21 indicated he would follow up regarding this concern.On 2/13/26 at 1:25 PM, during a follow up interview, SSD #21 reported that a care conference was held in December 2025 and provided a sign-in sheet for a meeting dated 12/11/25. SSD #21 reported the Social Service Designee #22 did hold the meeting but has not entered the note for the meeting. SSD #21 acknowledged that there is a pattern of entering their notes late and they are trying to clean that up. SSD #21 was unable to speak about what occurred at the December meeting since it was held by Social Service Designee #22.On 2/19/26 at 3:30 PM surveyor reviewed with the Director of Nursing the concern regarding the failure to ensure social service notes were written in a timely manner.

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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. Based on record review and interviews, it was determined that the facility failed to ensure that employees received the mandatory training for quality assurance and performance improvement. This was evident for one employee (LPN #35) out of five employee files reviewed during this survey.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 takes a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving residents and families in practical and creative problem solving.The findings include:During the survey, a review of Licensed Practical Nurse (LPN #35) employee file revealed a hire date of 6/30/22. The facility provided required training via an online service called Relias. On 2/13/26 at 2:25 PM a review of LPN #35's Relias transcripts revealed a lack of Quality Improvement training. The Director of Nursing was made aware of the concern.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview it was determined that the facility failed to ensure required staffing information was posted on a daily basis. This was found to be evident during a random observation made on the first day of the survey and has the potential to affect all residents.The findings include: The survey team entered the facility on 2/10/26 at 8:30 AM. On 2/11/26 at 11:09 AM, observation of the Daily Staffing posting located on the front desk counter revealed the most recent staffing sheet displayed was dated Thursday, 2/5/26, five days prior, and did not reflect the current day's staffing levels. At that time, the receptionist (Staff #25) reported nursing is responsible for posting this information. The receptionist then provided a copy of the February 5th Daily Staffing sheet. No current staffing information was posted at the front desk. On 2/19/26 at 3:30 PM surveyor informed the Director of Nursing of the concern regarding the failure to ensure the Daily Staffing information was posted daily.

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F 0843 Level of Harm - Potential for minimal harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on interview and failure of the facility to provided required documentation, it was determined that the facility failed to have a transfer agreement with a local hospital. This has the potential to affect all residents.The findings include: On 2/19/26 at approximately 5:10 PM surveyor informed the Director of Nursing (DON) that the survey team needed to review the transfer agreement with a local hospital. The Nursing Home Administrator (NHA) was not present in the facility at this time but was contacted by the DON via phone. The DON conveyed that the NHA asked if this information could be forwarded to the survey team the next day. DON later provided some transfer agreements to the survey team, but these agreements were with other skilled nursing facilities, not with a hospital. During the exit conference on 2/19/26 at 6:00 PM surveyor reviewed the concern with the DON regarding the failure to have a transfer agreement with a hospital. As of close of business on 2/23/26 no additional documentation was provided by the facility to indicate they had a written transfer agreement with a hospital. Facility