STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Williamsport Health and Rehabilitation Center	154 North Artizan Street Williamsport, MD 21795

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 a review of pertinent documents, the facility failed to follow the required procedure for addressing residents' grievances. This was evident for 1 (Resident #6) out of 3 residents reviewed for personal property during a survey.The findings include:On 7/15/2025 at 10:09 AM, Resident #6, who was admitted to the facility for rehabilitation, reported that one of her/his long pants was missing. S/he stated that this had been reported to a facility staff member.On 7/17/2025 at 11:20 AM, the Director of Social Services and Discharge Planning (Staff #3) was interviewed. She confirmed that she did not have a grievance form regarding the resident's missing pants.On 7/17/2025 at 11:24 AM, the Director of Social Work & Discharge Planning (Staff #3) was interviewed. She reported that a resident or family member can report grievance either electronically or verbally to a staff member. A staff member who receives a grievance is expected to document it online. The grievance is then sent to the appropriate department, and the actions taken to resolve the grievance are documented on the electronic form.On 7/17/2025 at 11:52 AM, a follow-up interview was conducted with the Director of Social Work & Discharge Planning Director(SSD) (Staff #3). During the interview, she confirmed that the facility's grievance procedure does not require the person filing the grievance to sign that they received the resolution. Additionally, the person does not receive a written copy unless they specifically request one. She also confirmed that she had never provided a written copy of the grievance form to the person filing the grievance during her tenure at the facility. In a second interview with the SSD, she confirmed that there is no place on the document for the residents to sign.On 7/17/25 the Director of Social Work & Discharge Planning Director (Staff #3) provided 8 completed grievance forms from 4/7/25 to 7/3/25. Review of the grievance forms failed to reveal a space on the form for the residents to sign that they reviewed and or received a copy of the completed grievance form. On 7/17/2025 at 12:15 PM, the Administrator was interviewed. During the interview, she reported that she reviews and approves all grievance resolutions. The Administrator confirmed that their grievance process does not include having the person filing the grievance sign to indicate agreement with the resolution, nor do they receive a written copy of the resolution.On 7/17/2025 at 3:38 PM, the Director of Nursing provided a policy titled Service Concerns/Grievances with an effective date of 3/1/25.On 7/17/2025 at 3:41 PM, a review of the Service Concerns/Grievances policy revealed that it does not include a requirement for the residents to sign or receive a copy of their grievance.On 7/24/2025 at 1:11 PM, the concern that there was no documentation showing that the resident received a written copy of the grievance resolution was shared with the Director of Nursing. She reported that she was unaware a written copy was required to be provided to the person filing the grievance. She stated that she would review the requirements and discuss them with her management team.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interviews with facility staff and review of the dietary supervisor credentials, it was determined the facility staff failed to ensure a full-time qualified dietetic service supervisor for oversight of food preparation and daily kitchen operation.The findings include:On 7/15/25 at 8:10AM an observation of the facility kitchen was made. During the interview the kitchen manager (Staff #13) reported that her highest level of credentials were in serv safe. She reported that she was in the process of taking the Certified Dietary Manager (CDM) class. She reported that she received consultation from the Regional Dietary Manager. On 7/18/25 at 10:17 AM an interview was conducted with the Regional Dietary Manager (Staff #31). He reported that he was just filing in with the regular dietary manager. Dietary Manager (Staff #31) reported he was not sure he reviewed his certificated dietician certification (CDM), but he would look for it and provided it to the survey team. No CDM certification was provided prior to the end of the survey.On 7/21/2025 9:32 AM during an interview with the Regional Dietary Manager (Staff #7), she reported that she is responsible for oversight of the Kitchen for the facility. She reported she was not a CDM. On 7/18/2025 at 11:37 AM during a brief Interview the Administrator reported that she wanted to take responsibility for not having a CDM. She thought the current kitchen manager was a CDM. On 7/23/2025 at 8:59 AM during an interview with Registered Dietician (RD) (Staff #18) reported she provided services to the facility on site, 2 days a week and remotely. The RD (Staff # 18) reported that she does not provide oversite of the kitchen but does collaborate with the dietary manager on resident's diets. On 7/24/2025 at 11:31 AM during an interview with Registered Dietician (Staff #32) he reported that he works on site at the facility one day a week and has remote hours. He reported he is certified as a CMD but had not had any oversight responsibilities of the facilities kitchen.On 7/24/2025 at 1:11 PM the above concerns were shared with the Director of Nursing. No additional information was provided prior to the end of the survey.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations and interviews, the facility failed to maintain a clean and comfortable homelike environment. This was evident for eight of eight days of environmental observations.The findings include: On 7/15/2025 at 8:20 a.m., the surveyor noted a strong odor of urine in the C-wing and observed stains on the carpeting throughout the C-wing.On 7/15/2025 at 10:20 a.m., the surveyor interviewed Resident #33 and their family member. Both expressed concerns about the facility's cleanliness. The family member pointed to the carpet near the resident's bed and stated that it was filthy. The surveyor observed heavy staining on the carpet in that area.On 7/15/2025 at 3:37 p.m., Resident #33's family member called the surveyor to express continued concerns, stating that the facility had drastically gone downhill, especially regarding cleanliness. They commented, We knew something was going on because there was more cleaning and staff here today than ever, referring to the presence of surveyors in the building.On 7/16/2025 at 9:56 a.m., the surveyor noted that the strong urine smell observed the previous day remained present in the C-wing.On 7/17/2025 at 8:05 a.m., the surveyor again observed a strong urine odor in the C-wing, accompanied by a stale, wet smell. Others on the survey team agreed that they had noticed a strong urine smell.On 7/22/2025 at 8:45 a.m., the surveyor noted a very strong urine odor in the C-wing and observed intermittent stains throughout the first-floor carpeting. Stains on the C-wing carpeting remained visible.On 7/23/2025 at 2:18 p.m., the surveyor continued to observe a strong urine odor in the C-wing. Dirt-stained carpets were also noted intermittently throughout the 1st, 2nd, and 3rd floors, as well as in the elevator. Resident #33's room continued to have heavily stained carpet on both sides of the bed.On 7/24/2025 at 9:34 a.m., the surveyor observed a strong urine odor in hallways A and C. Continued staining was noted on the carpet from the administrative offices through to the elevator on the main floor, as well as on the 2nd floor outside the elevator and in the C hallway.On 7/24/2025 at 9:43 a.m., the surveyor observed stains on the 3rd-floor carpeting just off the elevator and before the transition to laminate flooring. Resident #33's room remained unchanged, with heavily soiled, worn carpet on both sides of the bed. The C-wing hallway carpeting also remained soiled and worn.On 7/24/2025 at 9:50 a.m., the surveyor interviewed the Regional Director of Clinical Operations. When asked about the urine odors in A and C hallways, she confirmed awareness. When asked about the carpet condition, she stated that the facility was aware of the staining and wear.On 7/24/2025 around noon, the surveyor conducted a facility walkthrough to observe the condition of the carpets. The surveyor noted multiple areas with visible staining on the carpeting. The Maintenance Director confirmed that there are areas of the facility with stained carpet.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 observation, interview, and record review, it was determined that the facility failed to ensure the proper storage of medications. This was evident for 1) three of five medication storage areas reviewed, 2) one unsecured storage room (C-Wing), 3) inappropriate temperature control and ice buildup in two refrigerators (C-Wing and A-Wing), and 4) the presence of food items in a medication refrigerator (West View Heights).The findings include: Based on observation, interview, and record review, it was determined that the facility failed to ensure the proper storage of medications. This was evident for 1) one medication room that was unable to be secured (C-Wing) of three medication rooms reviewed, 2) two medication refrigerators kept at inappropriate temperatures in two of three medication storage rooms (C-Wing and A-Wing), 3) one medication refrigerator that contained food on one (West View Heights) of three medication rooms observed, 4) one unlocked medication cart of two medication carts reviewed on canal side terrace B unit, and 5) one unlocked treatment cart of one treatment cart observed on A wing. The findings include: 1). On 7/17/25 at approximately 8:50AM, the surveyor observed that the C-Wing Medication Storage room didn't have a lock. Nurse #15 confirmed that there was no lock on the door. On 7/17/2025 at approximately 10:00 AM, the surveyor toured the facility's medication storage areas in the A-Wing, C-Wing, and [NAME] View Heights, accompanied by the Director of Nursing (DON). At 10:09 AM, the surveyor entered the C-Wing medication storage room and observed that the room was not secured, as the door handle did not lock. Inside the room, neither the medication refrigerator nor the cabinets were secured with locks. When questioned, the DON stated, they are just over-the-counter medications in the cabinets. However, the surveyor observed several medications and needle-type devices stored in the cabinets. On 7/17/25 around noon, the surveyor interviewed the Nurse Unit Manager (Nurse #22), who confirmed that the door to the medication room on the C-Wing is unable to be locked and stated that she had told someone before that they needed a lock for the medication refrigerator as well. She confirmed that the cabinets do not lock. On 7/17/2025 at 1:04 PM, the surveyor and the survey team leader conducted a second inspection of the C-Wing medication storage area and confirmed that the door to the room was unable to be locked and that the refrigerator remained unlocked (a pad lock was now in place but not secured). The surveyors were able to enter the room and access cabinets which contained multiple bottles of over-the-counter medications, lancets, needles (syringes), alcohol pads, and medical grade disinfectant wipes, wound care cleaner and an unsecured plastic storage container on the floor, which was full of resident prescription medications in blister packs. On 7/17/2025 at 3:37 PM, the surveyor addressed concerns with the DON regarding the unlocked C-Wing door, cabinet, and medication refrigerator. The DON confirmed the issue, stated that the medications would be relocated until the room could be secured, and acknowledged that replacing the lock was not in her toolbox of duties, but assured it would be addressed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a). When looking at the medication refrigerator/freezer in the C Wing medication room the surveyor observed significant ice buildup, the DON confirmed this finding. The surveyor asked how often the facility defrosts the refrigerator and she stated it is to be done during monthly cleaning. She pointed to the temperature log on the refrigerator which had a place to write the cleaning date (nothing written) but failed to include any type of documentation about defrosting the refrigerator. When the surveyor asked what temperature range the medications were to be kept, she stated I think it is 34-42 degrees, but I need to check the manufactures directions. 2b.) On 7/17/2025 at 10:21 AM, the surveyor, accompanied by the Director of Nursing (DON), observed the A-Wing medication room. The surveyor again noted a buildup of ice within the medication refrigerator/freezer. Additionally, the surveyor observed that the refrigerator temperature was not recorded on 7/3/25 or 7/4/25. The temperature log posted on the refrigerator indicated that the internal temperature should be 40 degrees or less. When asked about the procedure for addressing temperature deviations, the DON stated that staff are expected to close the refrigerator and retake the temperature. If the temperature is still off after an hour, they should try adjusting the temperature. If it remains out of range, they are to notify maintenance. 3). On 7/17/2025 at 10:32 AM, the surveyor, accompanied by the DON observed the medication storage area on the [NAME] View Height (WVH-Wing). The DON opened the medication refrigerator/freezer and noted that raspberry sherbet and chocolate ice cream were being stored with medications. The DON stated that she was aware that food was not to be stored with medications and immediately threw the items away. The Manufacturer's for Use (MFU) instructions are the official guidelines provided by the drug manufacturer outlining how a medication must be stored, handled, and administered to maintain its safety, stability, and effectiveness. On 7/18/2025 at 9:13 AM, the DON provided the surveyor with the facility MFU's for the medications within the facility that requiring refrigeration. The findings are as follows: All the following medications should be stored between 36-46 degrees. Latanoprost Ophthalmic Solution Aformeoterol Tartrate Inhalation Solution Veltessa The following medication storage instructions state: Do not freeze, do not thaw and use, and discard if frozen: Novolog, Humalog, Humalog, Novolin, Humulin, Lantus, Levemir, Insulin Epogen Cyletzo Vancomycin (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/18/2025 at 9:22 AM, the DON provided the surveyor with the medication refrigerator cleaning and temperature logs. Below is a summary of findings for Units A and C from January through May 2025: Unit A (Jan–May 2025): Missing Temperature Documentation: 1/2, 1/7, 1/15–1/18, 1/21–1/22, 1/26, 1/30, 2/4, 2/8, 2/13–2/14, 2/18, 2/22–2/23, 2/27–2/28, 3/4, 3/8, 3/13, 3/18, 3/22–3/23, 3/27–3/28. (No logs were provided for April or May.) Out-of-Range Temperature: 1/6 recorded at 32°F. No documentation for cleaning or defrosting. Unit C: Missing Temperature Documentation: 5/21–5/23, 5/27–5/28. (No logs were provided for January through April.) Out-of-Range Temperatures: 5/5: 35°F 5/12: 28°F (adjusted but not rechecked) No documentation for cleaning or defrosting. On 7/24/2025 at 10:03 AM, the surveyor performed a review of facility policies and procedures as follows: Administration Procedures for all Medications effective date 9-2018 and revised on 8-2020 (Policy 9.1) which states: Security- All Medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide. Medication Room Temperature Log (policy #1016) effective date 1/29/24 :The medication room refrigerator temperature will be recorded twice daily and will ensure that the temperature is between 36-46 degrees. Out of range temperatures are to have the temperature adjusted and rechecked within one hour to verify the effectiveness of the temp adjustment. Maintenance should be notified if the temp remains out of range. Medications should be stored in a separate refrigerator until the unit has been repaired. Medication Rooms (policy #506) effective date 2/6/20: The refrigerators in the medication rooms are to be cleaned every night and defrosted weekly unless frost free. Storage of Medications (policy 4.1) effective 9/2018: The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Refrigerated medications should be stored between 36-46 degrees Refrigerated medications are kept in closed and labeled containers with internal and external medications separated from each other and from fruit juices, applesauce, and other foods used in administering (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications. On 7/18/2025 at 12:13 PM, the surveyor discussed medication storage and temperature monitoring concerns with the DON. The DON confirmed that medication refrigerators were not being properly monitored, with no documentation of corrective actions when temperatures dropped below 36°F, including instances near or at freezing. She acknowledged that some medications should not be exposed to freezing temperatures. The DON also confirmed that two refrigerators observed on 7/17/25 had visible ice buildup and had not been defrosted per facility policy. Temperature logs were not consistently completed, and staff failed to follow protocols for rechecking or escalating temperature issues. Additionally, the DON confirmed that food items were stored alongside medications, and that the C-Wing medication room door had previously been unable to be locked but was repaired the night before following surveyor feedback. 4). A medication storage observation at the canal side terrace B unit was conducted on 7/17/25 at 12:57 PM. During the observation, 1 of the 2 medication carts were unattended and unlocked. Also, there were residents wandering on the unit passing the identified medication cart. The Certified Medication Aide (Staff #6) who was working with the other medication cart at approximately 30 feet away, was interviewed about medication storage on 7/17/25 at 1 PM. She reported that the Canal side terrace B unit had 2 medication carts and 1 medication storage room. Staff #6 agreed to show the surveyor the unit's medication room. Staff #6 locked her medication cart and proceeded to walk to the medication room passing the unlocked medication cart. After showing the medication room to the surveyor, Staff #6 then proceeded to walk back to her medication cart and in process, she locked the other medication cart as she walked by it. The surveyor asked Staff #6 if that was her medication cart and she reported that it was the Licensed Practical Nurse's (LPN #5). Staff #6 also reported that LPN #5 had stepped out of the unit and stated, my practice is to always check the medication cart before walking away, I don't know why she (referring to LPN #5) left it like that. On 7/17/25 at 1:02 PM, LPN #5 returned to the unit and joined the discussion about the unlocked medication cart. LPN #5 confirmed that the identified medication cart was hers, thanked Staff #6 for locking it, and verbalized understanding that medication carts should always be locked when unattended, noting special importance in her unit with wandering residents with dementia. On 7/21/25 at 3:24 PM, the finding was discussed with Director of Nursing, and she verbalized understanding and acknowledged the concern. 5). On 7/23/25 at 7:31 AM a treatment cart was observed to be unlocked. The cart was located on the A Wing, at the end of the hall. On 7/23/25 continued observation of the treatment cart revealed the cart remained unlocked from 7:31 AM to 7:47 AM. On 7/23/25 at 7:47 AM the surveyor brought the unlocked treatment cart to the attention of Nurse (Staff #13). Nurse (Staff #13) immediately locked the cart. She confirmed that the treatment cart should be locked. On 7/23/25 at 8:48 AM a review of the treatment cart in the presence of nurse (Staff #13) revealed (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(but were not limited to) the following items: First drawer: Triamcinolone acetonide, cream, Second drawer: Hydrocortisone percent cream Betadine solution Third drawer: blood drawl tube and supplies Bottom drawer IV catheters (needles used to start an IV). On 7/23/2025 at 8:52 AM during an Interview with the Director of Nursing she confirmed that the treatment cart should be locked. On 7/24/2025 at 11:17 AM the regional director of Clinical (Staff # 9) provided the facility policy titled Storage of Medications with the effective date of 9/2018. On 7/24/2025 11:25 AM a review of the above policy revealed that only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aids) are permitted to access medications. Medication rooms, carts, and medication supplies are locked when they are not attended by people with authorized access.

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. Based on record reviews and interviews, it was determined that the facility failed to honor the resident's/resident representative's right to access personal and medical records. This was evident for 1 (Resident #133) of 2 residents reviewed for neglect. The findings include:A review of the intake information related to MD00217274 indicated that Resident #133's representative had requested medical records after the resident's death and was wrongfully denied the request.In an interview with the resident representative on 7/17/25 at 12:31 PM, s/he reported filling out a medical records request form at the front desk of the facility. Then after some time, had received a phone call from a facility staff informing him/her that the request was denied and no further explanation was provided.The Director of Nursing (DON) was interviewed on 7/23/25 at 2:16 PM. During the interview, she reported the process to request medical records and indicated that a record request form is filled out and submitted to the medical records coordinator (Staff #44) to be processed.On 7/23/25 at 2:45 PM, Staff #44 was interviewed. During the interview, she reported that she had been with the facility since February of 2025. She also provided a copy of the records request form to the surveyor and reported that she kept the filled-out forms for her records.When Staff #44 was asked about resident #133, she immediately pulled out the record request form that was filled out by the resident representative dated 4/28/25 and indicated that the DON had already informed her of what the surveyor was looking for. Staff #44 reported that the medical records request was denied because the representative only had a financial Power of Attorney (POA) and was ultimately decided by a third-party company (Rytes company) that the representative lacked the clearance to obtain the medical records.Staff #44 further explained the process for records request, indicating that once the form is filled out, she sends them to Rytes company via email for determination, then after Rytes company reviews the request and the resident's medical record, they would inform Staff #44, via email, if the records can be released.Staff #44 provided the surveyor with a copy of the email received on 4/29/25 from Rytes company, addressed only to her, stating records could not be released due to: The request lacks supporting documents demonstrating that the person signing the authorization and/or making the request is the personal representative of the resident and has the authority to request/release medical records. Qualifying documents could include a power of attorney for healthcare, health care surrogacy or proxy, guardianship document or advanced directive. Instructions on the email stated, In the event that you have additional relevant documents in your file, please provide to Rytes by responding to this email with the additional documents.Subsequently, Resident #133's medical records were reviewed with Staff #44 on 7/23/25 at 2:58 PM. The review revealed the resident's advanced directive with an upload date of 3/19/25, that stated the representative's name as appointed POA for healthcare in the event that the resident cannot make healthcare decisions him/herself. Staff #44 reported that she did not see the advanced directive because she does not review resident records. She indicated that she solely relies on Rytes company to figure that out.On 7/23/25 at 3:41 PM, the findings were discussed with the Regional Director of Clinical (Staff #9). Staff #9 confirmed that both Rytes company and Staff #44 had complete access to Resident #133's medical record that included the advanced directive.Staff #9 agreed that based on the advanced directive, the representative should have been deemed eligible for the medical records request by Rytes company. Also, the medical records coordinator should have reviewed Resident #133's medical record and provided the advanced directive document to Rytes company, as instructed in the email and inform the Director of Nursing and Nursing Home Administrator. Staff #9 verbalized understanding of the concern and stated, I will contact Rytes and find out what happened.On 7/24/25 at 8:56 AM, Staff #9 reported that she had talked to staff from Rytes company and investigated the concern. They indicated that they had made a mistake and were looking at the wrong resident. Staff #9 indicated that she had instructed Staff #44 to contact Resident #133's representative about providing the medical records as initially requested.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to protect residents from verbal and psychosocial abuse. This was evident for two (Resident's #13 and #52) out of six residents reviewed for abuse.The findings include:1. Resident #13 has a medical history of heart failure, type 2 diabetes, chronic kidney disease, anxiety, and depression.On 7/15/2025 at 2:06 PM, the surveyor reviewed Facility-Reported Incident (FRI) #335325 in which Resident #13 alleged they were subjected to verbal and emotional abuse. The facility investigated the allegation and substantiated findings of verbal and psychosocial abuse by a nursing assistant (GNA #20).According to the facility report, Resident #13 stated that GNA #20 consistently acted rudely, refused to assist, stated she did not have time to help, and told the resident to stop going home because all [you] do is fall. The facility investigation included a statement from GNA #20, who admitted to making inappropriate comments, including that other staff avoided caring for the resident and would ask to switch assignments. Specifically, GNA #20 stated, People [other GNAs] ask to switch [assignments] with me and make me take [Resident #13]. Another staff member, GNA #39, corroborated the abuse, stating that she heard GNA #20 say to Resident #13, This is why no one comes in [your room] and no one likes you.On 7/16/2025 at 8:51 AM, the surveyor interviewed Resident #13 regarding the incident. The resident stated that GNA #20 told them that they were disliked by both staff and other residents and alleged that the GNA ignored their call bell in retaliation. Resident #13 further stated that the GNA called them ugly and that the verbal abuse caused them to cry. They initially responded with anger but later became emotional, stating, I cussed them out, but then I cried-it was really hurtful. The resident reported that GNA #20 resigned while under investigation. Resident #13 stated, I used to be fearful to be here, but things have improved.On 7/21/2025 at approximately 2:00 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding the facility's process for handling allegations of abuse. The NHA explained that any staff member accused of abuse is immediately suspended pending an internal investigation, which includes collecting written statements from staff and other residents and conducting a full examination and assessment of the involved resident. When asked about the incident involving Resident #13, the NHA confirmed familiarity with the case and stated that the employee no longer worked at the facility. The surveyor explained that despite the investigation and reporting being completed, the incident still constituted a deficiency, as the facility failed to prevent the abuse from occurring. The NHA verbalized understanding.2. Resident #52 has a history of insulin-dependent type 1 diabetes, heart failure, asthma, chronic obstructive pulmonary disease (COPD), anxiety, depression, syncope (fainting), and chronic pain.On 7/15/2025 at 1:56 PM, the surveyor reviewed Facility-Reported Incident (FRI) #335296, in which Resident #52 alleged verbal and psychosocial abuse. The facility investigated and determined the allegations were substantiated for both verbal and psychological abuse.According to the complaint, Resident #52 reported to the evening shift nurse supervisor (Nurse #40) that another nurse (Nurse #38) made threatening and inappropriate comments. Specifically, the nurse reportedly said, Be careful how you treat people who are going to be giving you insulin.Review of the facility's investigation revealed that the facility believed Nurse #38's statements were considered threatening and intimidating. The facility's report stated: The facility concludes that employee [Nurse #38] was in violation of abuse. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes deprivation by an individual, including a caretaker, of goods or services necessary to maintain physical, mental, and psychosocial well-being.The report further detailed specific statements made by Nurse #38 that supported the abuse finding, including: Cursing in the hallway is not going to get me to you any sooner, and If it were me and I wanted my medication, I would be a little nicer. The facility determined that these remarks (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	were delivered in a tone and manner that could cause fear and intimidation, especially given that the resident was dependent on the nurse for critical medications. The report noted that Resident #52 explicitly asked the nurse, Is that a threat? and expressed feeling fearful because of the interaction.On 7/15/2025 at 2:49 PM, the surveyor interviewed Resident #52, who stated, They fired the person that threatened to withhold my medications. I feel safer now that he is gone.On 7/21/2025 at 1:47 PM, the surveyor interviewed Resident #52 and their spouse. The spouse, tearfully, stated they [the spouse] were in constant anguish worrying over the care [Resident #52] is receiving and expressed ongoing concern for the resident's safety. They further stated that they were fearful to report issues for fear that [Resident #52] will be retaliated upon.On 7/21/2025 at approximately 2:00 PM, the surveyor interviewed the Nursing Home Administrator (NHA) regarding the abuse allegation. The NHA explained that when an abuse report is received, the implicated employee is suspended pending investigation. The facility collects statements from staff and residents and performs a full examination and assessment of the resident involved. The NHA confirmed that she was familiar with the case involving Resident #52 and that the employee in question no longer worked at the facility. The surveyor explained that despite the investigation and reporting being completed, the facility remained responsible for preventing abuse and ensuring the safety of residents, including protection from [NAME] employees. The NHA verbalized understanding.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interviews and record review, it was determined that the facility failed to report an injury of unknown origin. This was evident for one (Resident #33) out of six reviewed for abuse.The findings include: Resident #33 has a medical history of hypertensive heart disease, bladder and fecal incontinence, pressure ulcers, chronic pain, and require assistance with personal care.On 7/15/2025 at 3:37 PM, the surveyor received a phone call from Resident #33's family member, who expressed concerns regarding a prior incident they believed had not been investigated. The family member reported that, a few weeks earlier, they received a phone call from the facility around 7:00 PM. When they attempted to return the call, they were unable to reach anyone. They then contacted Resident #33 directly, who was reportedly very upset and stated that their [private] area was bleeding. The family member indicated that they had reported this concern to the facility. According to the family member, the facility checked Resident #33's fingernails to see if they had caused the injury by scratching but did not take further steps to determine the cause. The family member stated that the location of the bleeding was concerning.On 7/18/2025 at 2:40 PM, the surveyor interviewed the Director of Nursing (DON) regarding the bleeding incident involving Resident #33's [private area]. The DON stated she was familiar with the situation and had investigated it. She explained that in June 2025, a small amount of blood was found in the resident's undergarment, but the cause could not be determined. She acknowledged the family had reported the incident and noted they frequently raised concerns.On 7/21/2025 at 11:32 AM, the surveyor interviewed the DON and asked how she would define an injury of unknown origin. She stated, if it is truly unknown-a head injury or someone with a large bruise might be included. The surveyor asked if an injury to a resident's [private area] would be included, given that this is not an area where injuries typically occur. The DON responded, yes, a peri-area would be included.On 7/23/2025 at 10:29 AM, the surveyor interviewed the DON and asked her to clarify whether a formal investigation had been conducted for the unexplained [private area] bleeding, considered as an injury of unknown origin. The DON confirmed that she had not reported the incident or initiated a formal investigation to the Office of Health Care Quality (OHCQ), the ombudsman, or local law enforcement.On 7/23/2025 at 11:22 AM, the surveyor reviewed Resident #33's medical record and discovered a Change in Condition, progress note dated and signed on 6/16/2025, stated: Nurse called to room for blood noted in the resident's brief. From observation blood appears to be coming from inside [private area]. No visible source noted in the surrounding area. Clot noted to entrance to [private area]. The note was signed by Nurse #41.The surveyor reviewed the facility's policy and procedure titled Abuse/Neglect/Misappropriation/Crime - Reporting Requirements/Investigations (Policy #703), dated 2/5/2023, which stated, in part:Immediately upon notification of any alleged violations involving injuries of unknown origin, the Administrator must report to the State Agency without delay, and no later than two hours after the allegation is made.On 7/24/2025 at 1:15 PM, the surveyor spoke with the DON and reviewed concerns that an injury of unknown origin involving Resident #33 had not been reported. The DON confirmed that she understood it is required to formally report injuries of unknown origin.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interviews and record reviews, it was determined that the facility failed to investigate an injury of unknown origin. This was evident for one (Resident #33) out of six reviewed for abuse.The findings include:Resident #33 has a medical history of hypertensive heart disease, bladder and fecal incontinence, pressure ulcers, chronic pain, and require assistance with personal care.On 7/15/2025 at 3:37 PM, the surveyor received a phone call from Resident #33's family member, who expressed concerns regarding a prior incident they believed had not been investigated. The family member reported that, a few weeks earlier, they received a phone call from the facility around 7:00 PM. When they attempted to return the call, they were unable to reach anyone. They then contacted Resident #33 directly, who was reportedly very upset and stated that their [private] area was bleeding. The family member indicated that they had reported this concern to the facility. According to the family member, the facility checked Resident #33's fingernails to see if they had caused the injury by scratching but did not take further steps to determine the cause. The family member stated that the location of the bleeding was concerning.On 7/18/2025 at 2:40 PM, the surveyor interviewed the Director of Nursing (DON) regarding the bleeding incident involving Resident #33's [private area]. The DON stated she was familiar with the situation and had investigated it. She explained that in June 2025, a small amount of blood was found in the resident's undergarment, but the cause could not be determined. When asked if the incident was treated as an injury of unknown origin, the DON stated she had investigated it and would provide documentation. She acknowledged the family had reported the incident and noted they frequently raised concerns. When asked whether these concerns were documented in the grievance log, the DON stated she did not document issues she could resolve immediately but would make a note if there were ongoing concerns. She confirmed she would provide follow-up documentation.Later on, 7/18/2025, the surveyor conducted a record review and noted that a progress note had been entered at 2:48 PM-immediately following the earlier interview with the DON. The entry, titled Communication with family, was written by the DON and stated: This RN [Registered Nurse] spoke to residents [family member] regarding follow-up conversation of a previous change of condition, one time episode of [private area] bleeding, on call provider discussed biopsy with in-house provider and ordered lab work for follow up as well, no further episode of bleeding noted since then. Resident was seen by the provider on the next day for routine visit labs reviewed. The provider requested a follow-up phone call with family inquiring if they would like to have the procedure done or not. Discussed in detail about the procedure, family member has chosen not to have the procedure done at this time. If our in-house provider feels it is necessary to have this procedure done then at that time the family will discuss it with resident. Dr. made aware of follow up conversation with family. The note was signed by the DON.On 7/21/2025 at 11:32 AM, the surveyor interviewed the DON and asked how she would define an injury of unknown origin. She stated, if it is truly unknown-a head injury or someone with a large bruise might be included. The surveyor asked if an injury to a resident's [private area] would be included, given that this is not an area where injuries typically occur. The DON responded, yes, a peri-area would be included. When asked whether she interviewed Resident #33 about the incident, the DON confirmed she had, and that the resident was unsure of what had happened but exhibited no signs of bruising or other visible injury. When asked whether she documented this conversation, the DON acknowledged that she had not. She also stated that she had spoken with the family member about the incident but had not documented those conversations either.On 7/21/2025 at 1:17 PM, the DON provided the surveyor with a Skin Observation Tool that was dated 6/16/2025 but not signed by the DON until 7/21/2025. The note stated: Resident [#33] follow-up skin assessment completed related to [private area] bleeding, resident stated [they] are not sure where the bleeding was coming from.On 7/23/2025 at 10:29 AM, the surveyor interviewed the DON and asked her to clarify whether a formal investigation had been conducted for the unexplained [private area] bleeding, considered as an injury of unknown origin. The (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON confirmed that she had not reported the incident or initiated a formal investigation to the Office of Health Care Quality (OHCQ), the ombudsman, or local law enforcement. After discussing the matter with the surveyor, the DON agreed that the incident met the criteria for a formal investigation and acknowledged that a formal investigation had not been launched.On 7/23/2025 at 11:22 AM, the surveyor reviewed Resident #33's medical record and discovered a Change in Condition, progress note dated and signed on 6/16/2025, stated: Nurse called to room for blood noted in the resident's brief. From observation blood appears to be coming from inside [private area]. No visible source noted in the surrounding area. Clot noted to entrance to [private area]. The note was signed by Nurse #41.The surveyor reviewed the facility's policy and procedure titled Abuse/Neglect/Misappropriation/Crime - Reporting Requirements/Investigations (Policy #703), dated 2/5/2023, which stated, in part:The Administrator or Director of Nursing must immediately initiate a thorough internal investigation. The investigative protocol includes, but is not limited to, collecting evidence, interviewing the alleged victim and witnesses, and involving appropriate individuals, agents, or authorities as needed to assist with the investigation and determination.On 7/24/2025 at 1:15 PM, the surveyor spoke with the DON and reviewed concerns that the injury of unknown origin involving Resident #33 had not been reported or investigated. The DON confirmed that she understood it is required to formally report and investigate injuries of unknown origin.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, it was determined that the facility failed to accurately reflect residents skin assessment on the MDS assessment. This was evident for one (Resident #11) out of two reviewed for pressure ulcer care.The findings include: A Minimum Data Set (MDS) is a standardized assessment tool used to evaluate the health status of residents in long-term care facilities. The information gathered assists facilities in developing patient-centered care plans based on the resident's unique needs. The MDS assessment is a mandated requirement for all residents.Resident #11 is legally blind, has a medical history of a stroke (cerebral infarction), is incontinent of bowel and bladder, and requires assistance with personal care.On 7/22/25 at 10:23 AM, the surveyor performed a record review of Resident #11's MDS assessment dated [DATE]. Section M, Skin Conditions, revealed the following: Section M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage, was coded as zero or none for all types of pressure ulcers (Stages 1-4) and unstageable pressure ulcers. Section M1040, Other Ulcers, Wounds, or Skin Problems, was coded as none of the above, indicating no infection, ulcer, open lesion, rash, cuts, surgical wounds, burns, skin tears, or moisture-associated skin damage were present.The surveyor then reviewed the previous MDS assessment dated [DATE], Section M, which revealed: Section M0300 indicated one Stage 3 pressure ulcer. Section M1040 was also coded as none of the above, indicating no other ulcers, wounds, or skin problems.On 7/22/25 at 10:31 AM, the surveyor reviewed Resident #11's current care plan, which documented the following: The resident has an unstageable pressure ulcer to the sacrum and is at risk for worsening wounds or the development of additional wounds related to inability to turn and reposition independently, and moisture-associated skin damage.On 7/22/25 at 10:37 AM, the surveyor reviewed Resident #11's physician orders for wound care treatment. The following was documented: WOUND CARE ORDER: Sacrum - cleanse with wound cleanser, apply calcium alginate, and cover with silicone-bordered superabsorbent dressing every evening shift every other day.On 7/22/25 at 11:47 AM, the surveyor reviewed a wound care progress note dated 4/8/25, which stated: Sacral gluteal dermatosis continues to progress toward healing. Continue use of hydrocolloid, as the wound is responding well. Dermatosis is a general term used to describe any defect or lesion on the skin.On 7/23/25 at 3:25 PM, the surveyor interviewed Certified Resident Assessment Coordinator (RAC #26) and asked where the assessment coordinators obtain the information used to complete Section M of the MDS. She stated that they use a combination of medical records, including wound notes, shower sheets, skin assessments, and resident treatment orders.The surveyor then asked RAC #26 to review Resident #11's MDS assessment dated [DATE], Section M. She confirmed documentation of a pressure ulcer. The surveyor next asked her to review the MDS assessment dated [DATE], Section M, and she confirmed that it documented no pressure ulcers or other skin conditions.The surveyor asked RAC #26 to review wound care notes and provider treatment orders, as the documentation did not clearly indicate that the pressure wound had healed. Specifically, the progress note dated 4/8/25 referenced sacral gluteal dermatosis that continues to heal, yet this condition was not reflected in the MDS assessment. The surveyor asked whether the pressure ulcer had healed and expressed concern that Section M of the MDS failed to reflect that the resident had a current skin condition. RAC #26 stated that she would investigate further and inform her colleague that a correction to the 4/8/25 MDS assessment would be needed due to the error.On 7/24/25 at 2:01 PM, the surveyor interviewed the Regional Director of Reimbursement, who provided documentation confirming that the pressure ulcer had healed on 2/14/25. However, she acknowledged that Section M1040 of the MDS dated [DATE] should have reflected the presence of sacral gluteal dermatosis as a current skin problem.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review it was determined that the facility failed to ensure that residents received proper treatment and assistive devices to maintain their hearing abilities. This was evident for 1 resident (Resident #13) out of 2 residents reviewed for sensory/communication during a survey.The findings include:On 7/16/2025 at 9:11 AM, Resident #13, a long-term resident of the facility, reported that s/he has hearing aids but stated that staff don't have time to put them in. The surveyor observed that the resident was not wearing hearing aids.On 07/23/2025 at 10:16 AM, a review of the Care Plan failed to show any reference to Resident #13 having hearing aids.On 07/23/2025 at 10:21 AM, a review of the admission assessment dated [DATE] under the Sensory Communication section revealed that the resident was hard of hearing. Further review showed documentation stating that the resident did not have hearing aids.On 07/23/2025 at 10:24 AM, during an interview with Nurse (Staff #15), he reported that the resident sometimes wears her/his hearing aids. He stated that the hearing aids are kept locked in the medication cart. Two hearing aids were observed in the med cart.On 07/23/2025 at 11:52 AM, a review of the Treatment Administration Record revealed that there was no space available for nurses to document the use of hearing aids by the resident.On 07/23/2025 around 1:50 PM, during an interview, the Director of Nursing (DON) reported that if a resident has a hearing aid, that information should be available to the Geriatric Nursing Assistant (GNA) in the Kardex. She added that GNAs sign off every shift to confirm they have reviewed the Kardex.On 7/23/2025 at 2:10 PM, the DON provided the Kardex information for Resident #13 and confirmed that it contained no information regarding hearing aids. She acknowledged the concern that the resident had reported not receiving his/her hearing aids, and there was no documentation in the medical record indicating that s/he required or was receiving hearing aids.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on interviews and record review, it was determined that the facility failed to provide pressure ulcer wound care as ordered by a physician. This was evident in two (Resident's #11 and #33) of two reviewed for pressure ulcer care.The findings include:1). Resident #11 is legally blind and has a history of stroke (cerebral infarction), urinary incontinence, aphasia (a language disorder that affects the ability to communicate), skin disorders, and requires assistance with all personal care.On 7/22/25 at 10:31 AM, the surveyor reviewed Resident #11's care plan, which documented the following: The resident has an unstageable pressure ulcer to the sacrum and is at risk for wound deterioration and the development of additional wounds due to inability to turn and reposition independently and moisture-associated skin damage. The resident is at risk for pressure ulcers related to decreased mobility. Interventions include assessing the resident for risk of skin breakdown, keeping skin clean and dry, performing skin assessments as indicated. The resident is noted to have impaired tissue integrity related to immobility, history of pressure ulcers, incontinence, joint contractures.On 7/22/25 at 10:37 AM, the surveyor reviewed Resident #11's treatment orders, which included the following physician-ordered interventions: Alternating low air loss mattress: Check settings every shift and ensure mattress is set to resident's weight for pressure relief. Barrier cream to buttocks after each toileting episode and as needed. Turn and reposition every 2 hours and as needed, every shift. Toileting/incontinence care every 2 hours and as needed, every shift. Float heels every shift. Use a wedge cushion and position side-to-side every shift.Review of treatment documentation revealed that none of these ordered interventions were documented as completed on the evening shift of 7/7/2025.On 7/22/25 at 11:00 AM, the surveyor interviewed the Director of Nursing (DON) regarding the gaps in Resident #11's treatment record. She reviewed the documentation and confirmed that missing entries indicated the care was not provided or not documented. She was unable to provide any evidence that the treatments were completed.2). Resident #33 has a medical history of hypertensive heart disease, bladder and fecal incontinence, pressure ulcers, chronic pain, and requires assistance with personal care. On 7/15/25 at 10:30 AM, the surveyor interviewed Resident #33 and their family member. The family member expressed frustration that the resident's wound dressing had not been changed as ordered. As the family member spoke, Wound Care Nurse (Nurse #34) entered the room and was asked to clarify. Nurse #34 stated the issue was discovered when she was performing a wound assessment and noted that the wound dressing was dated 7/12/25, and had not been changed for two days, with the current date being 7/15/25. She stated that she is investigating why the dressing wasn't changed. On 7/18/25 at 2:34 PM, the surveyor reviewed Resident #33's wound treatment orders, which revealed: Sacrum wound care order: Cleanse with wound cleanser, pack with Dakin's moistened gauze, cover with silicone bordered superabsorbent dressing every evening shift. This was not documented as completed on 7/7/25, prior to order discontinuation on 7/9/25. New order effective 7/9/25: Sacrum wound care with Hydrogel gauze and silicone bordered dressing every evening shift. The treatment record was signed on 7/13/25 and 7/14/25, but the nurse noted 7 in comments, indicating the resident was sleeping and wound care was not performed.Additional pressure ulcer treatment interventions that were ordered but not documented as completed on 7/7/25 (evening shift) include:1. Use of wedge cushion for positioning in bed,2. Turn and reposition every 2 hours and as needed,3. Keep head of bed flat except during meals or if short of breath,4. Limit time out of bed to 2 hours and return to bed between meals,5. Use of low air loss mattress for pressure relief,6. Pillow boots to both feet when in bed,7. Place pillow between lower legs to relieve pressure to wound on left leg.On 7/18/25, Nurse Unit Manager (Nurse #22) confirmed the family was upset and stated she had not realized the wound care order was now daily or that it had been missed until the family brought it to her attention.On 7/18/2025 at 2:45 PM, the surveyor interviewed the Director of Nursing (DON) to discuss concerns related to gaps in the treatment record for Resident #33. She clarified that a 7 on the treatment record indicates the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was sleeping and confirmed this was the reason wound care was not performed on the evening shifts of 7/13/25 and 7/14/25. She stated that wound care should have been completed once the resident woke up.When asked about the blank entries in the treatment record, the DON explained that blanks typically indicate the treatment was either not completed or not documented. The surveyor asked whether there was a system in place to ensure treatments are not missed for residents who are asleep during their scheduled time. The DON stated that the facility uses a 24-hour report to track missed treatments but noted that the system does not generate alerts when care is missed due to a resident being asleep. When asked what would happen if a resident were asleep every time wound care was due, the DON stated it would likely be identified during the weekly wound assessment by the wound care nurse but recognized this as a potential issue in ensuring consistent delivery of care.

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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 record reviews, interviews and observations, it was determined that the facility failed to ensure a urine collection bag was secured below the bladder. This was evident for 1 (Resident #73) of 3 residents reviewed for urinary catheters. The findings include:A Foley catheter is a device that drains urine (pee) from your urinary bladder into a collection bag outside of your body when you can't pee on your own or for various medical reasons. Another name for a Foley catheter is an indwelling urinary catheter.Resident #73 was admitted in early 2023 with diagnoses that include chronic kidney disease. On 7/15/25 at 9:54 AM, Resident #73 was observed during the initial pool of the survey. The resident was in bed in the lowest position and a tube was observed sticking out on the side of the bed from the resident's blanket. An amber colored fluid was observed on the tubing.The Licensed Practical Nurse (LPN #5) assigned to care for Resident #73 was interviewed on 7/15/25 at 9:57 AM, in the resident's room. During the interview, LPN #5 lifted the resident's blanket and revealed that the tubing was connected to a urine collection bag that was laying on the resident's bed. LPN #5 stated, The aides must have forgotten to secure it after giving continence care. She also verbalized understanding that the urine collection bag needed to be below the level of the resident's bladder to promote proper flow of the urine, preventing it from flowing back to the resident.On 7/21/25 at 10:44 AM, a review of Resident #73's care plan for indwelling foley catheter revealed interventions that include to position catheter bag and tubing below the level of the bladder.On 7/21/25 at 11:42 AM, the Director of Nursing (DON)was interviewed about the finding of the placement of the urine collection bag. The DON confirmed that it should be secured below the level of the resident and acknowledged the concern.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on record review and interview, it was determined that the facility failed to provide proper monitoring of a resident receiving nutrition through a gastrostomy tube. This was evident for 1 (Resident #6) of 1 resident reviewed for tube feeding during the survey.Findings include:On 7/16/25, a review of Resident #6's medical records revealed that s/he was admitted to the facility for rehabilitation and received nutrition via a gastrostomy tube.A gastrostomy tube (G-tube) is a flexible plastic tube inserted through a small opening in the abdomen directly into the stomach. It enables delivery of nutrition, fluids, and medications when a person cannot eat or swallow normally.On 7/16/25, a review of Resident #6's weight records revealed the following:On 6/6/25, the resident weighed 180 lbs.On 7/1/25, the resident weighed 177 lbs.On 7/21/25, a review of medical orders failed to reveal an order for weights. However, further review revealed the following order: Check for residual prior to feeding every shift. If it is greater than 120 mL, hold feeding for 1 hour and recheck. If residual remains over 120 mL, call MD.Residual volume from a G-tube refers to the amount of liquid or food remaining in the stomach from a previous feeding. It helps determine how well the stomach is digesting the last meal. If the residual is too high, it may indicate delayed gastric emptying, and feeding should be delayed.On 07/21/25 at 11:48 AM, an interview was conducted with the Director of Nursing (DON) regarding the facility's weight policy. The DON stated that the policy requires weights on admission and weekly thereafter unless otherwise ordered. She explained that for residents receiving nutrition through a gastrostomy tube, the registered dietitian typically enters the weight orders.On 7/21/25 at 3:30 PM, a review of the Medication Administration Record (MAR) showed a section for documenting residual volume prior to each feeding. However, no residual amounts were documented.On 7/23/25 at 9:57 AM, the DON provided a policy titled Enteral Feeding Tubes with an effective date of 1/29/24. The policy states that gastric residual volume should be assessed, measured, and documented prior to each feeding per provider order, and the measurements should be recorded in the medical record.On 7/23/25 at 8:59 AM, an interview was conducted with Registered Dietitian Staff #18. She reported that she works onsite two days per week and does not enter weight orders for residents receiving nutrition via G-tube. She confirmed that Resident #6 was a short-term stay resident and should have had an order for weekly weights. She also confirmed that the actual volume of residuals should be documented.On 7/24/25 at 1:11 PM, the concerns were shared with the DON. She confirmed that Resident # 6 was not getting weekly weights and that there was no orders for how often the resident should get weighed. In additions the DON reported that all short-term stay residents are to be weighed weekly unless there is an order indicating otherwise. She also confirmed that documentation of residual volumes should include the actual measured amount.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on record review, interviews and observation, it was determined that the facility failed to ensure oxygen therapy was provided according to the physician's order. This was evident for 1 (Resident #5) of 1 resident reviewed for respiratory care.The findings include: During the initial pool of the survey, Resident #5 was observed on 7/15/25 at 9:11 AM. During the observation, the resident was in bed receiving oxygen via nasal canula, set at a rate of 3 liters per minute.On 7/15/25 at 11:33 AM, Resident #5's medical order was reviewed and revealed an oxygen therapy order of 2 liters per minute via nasal canula.The Licensed Practical Nurse (LPN #5) assigned to care for Resident #5 was interviewed on 7/15/25 at 12:40 PM. During the interview, LPN #5 confirmed that the resident was currently receiving oxygen at 3 liters per minute. LPN #5 was asked if she knew what the order was for the resident's oxygen therapy. LPN #5 stated, I'm not sure what his/her orders are and indicated that she would check the computer.After reviewing the orders at 12:44 PM, LPN #5 confirmed that the rate for the oxygen therapy was 2 liters per minute and indicated she would adjust it down right away.The Director of Nursing (DON) was interviewed on 7/23/25 at 8:51 AM. During the interview, the DON indicated that LPN #5 had already discussed with her the discrepancy with Resident #5's oxygen therapy. The DON verbalized understanding and acknowledged the concern.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record reviews and interviews, it was determined that the facility failed to ensure pain management was provided to the resident based on professional standards of practice. This was evident for 1 (Resident #139) of 1 resident reviewed for pain management. The findings include:Resident #139 was newly admitted into the facility. In an interview with the resident on 7/16/25 at 9:24 AM, s/he reported that s/he was taking pain medication but was not helping that much.Tramadol is used to relieve moderate to moderately severe pain, including pain after surgery. It is also used to treat pain severe enough to require opioid treatment and when other pain medicines did not work well enough or cannot be tolerated. A review of Resident #139 medical record on 7/24/25 at 9:08 AM revealed an order for Tramadol to be taken every 8 hours as needed for pain. The electronic medication administration record (eMAR) for July 2025 revealed that the resident received the Tramadol 5x (7/16/25-5:20am; 7/17/25-1:10pm, 9:12pm; 7/21/25-3:13pm; and 7/22/25-4:26pm).There was no order or documentation found to indicate non-pharmacological interventions (NPI) were administered/attempted prior to giving the tramadol on the 5 instances stated above. Also, the nurse's documentation failed to indicate the location of Resident #139's pain.The Director of Nursing (DON) was interviewed on 7/24/25 at 10:25 AM. During the interview, she reported her expectations from nurses with pain management. Her expectations include but not limited to:a) To document the level of painb) To document pain locationc) Attempt/administer NPI prior to giving as needed pain medicationThe DON further explained that nurses did not need to have an order for NPI. Nurses could document their attempts/administration of NPI in the resident's progress note and indicated that whenever nurses would administer an as needed pain medication, the computer system prompts them in creating a progress note. In the progress note, they can document the level of pain, location of pain, and what kind of NPI they had administered or attempted.The DON was asked if she knew if Resident #139 was receiving any NPI prior to receiving as needed pain medication and where the resident's pain was. The DON indicated that she would review the resident's medical record and report back to the surveyor.On 7/24/25 at 12:03 PM, the DON reported that she could not find documentation to indicate that NPI's were attempted/administered prior to the as needed pain medication administration.She also reported that Resident #139 was having pelvic pain due to a pelvic fracture as she had found this information from the resident's medical history. The corresponding progress notes for the 5x as needed tramadol was administered to the resident was reviewed with the DON, and she confirmed that the nurses did not document pain location each time. Furthermore, the residents care plan for pain management also failed to specify what the pain was related to.After reviewing and discussing the findings, the DON verbalized understanding and acknowledged the concern with pain management.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on record review and staff interviews it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) received an annual performance review and 12 hours/year of in-service training for 2 (GNA #20 and GNA #21) out of 2 employee records reviewed during the survey.The findings include:Geriatric Nursing Assistants (GNA) require a performance appraisal to be completed at least every 12 months to identify the potential for and receive at least 12 hours/year of in-service education. On 7/23/25 between 1:00 and 4:00 PM six employee training records were reviewed. On 7/24/25 at 9:18 AM in an interview with the Director of Nursing (DON) it was revealed that the facility uses Relias, an online training and education application. It was also revealed that the Staff Development Coordinator (SDC) tracks employees’ compliance of the training required. On 7/24/25 at 9:31 AM in an interview with the SDC (RN #19) it was revealed that her position was started in April 2025. She acknowledged that it was her responsibility to track staff compliance via Relias. On 7/24/25 at 1:00 PM, the DON acknowledged that the employees’ files lacked documentation of required annual performance reviews and 12 hours/year in-service for calendar years 2022-2025 and that she could not locate further documentation otherwise. This concern was communicated to the DON.

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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 observation, record review, and interview, it was determined that the facility failed to ensure the accurate documentation of controlled substances in the narcotics daily count logs. This was evident for two of two narcotic record books reviewed (A-wing and C-wing) during the medication administration observation task.The findings include:On 7/17/2025 at 8:44 AM, the surveyor observed and reviewed the narcotics log for the C-wing of the facility. The following discrepancies were identified: On 4/5/25 at 7:00 PM, 4/6/25 at 7:00 AM, and 4/10/25 at 11:00 PM, the narcotics log was not signed, and the count was not confirmed as correct. On 4/11/25 at 11:00 PM, the narcotic count was signed by only one staff member, instead of the required two signatures to validate the count.On 7/17/2025 at 9:16 AM, the surveyor conducted a further review of the narcotics log and noted that the following fields were incomplete:Narcotic Kit Sealed, Narcotic Kit Seal Number Verified, and Status of Count Exact. These fields were left blank on: 7/13/25 at 7:00 AM, 3:00 PM, and 11:00 PM 7/15/25 at 7:00 AM, 3:00 PM, and 11:00 PM (the count was confirmed at 11:00 PM)Nurse #15 confirmed the surveyor's findings.On 7/17/2025 at 9:33 AM, the surveyor continued reviewing narcotics logs, focusing on the A-wing. The surveyor identified multiple instances of incomplete or missing documentation and confirmed the findings with Nurse #28:On 7/16/25 at 7:00 AM, the narcotic count was signed by only one staff member.On 6/22/25, no time was noted, and the fields for Narcotic Kit Sealed, Narcotic Kit Seal Number Verified, Status of Count Exact, and a second signature were left blank.On 6/27/25 at 3:00 PM and 5/17/25 at 11:00 PM, the log was signed by only one staff member.On 4/1/25, the Status of Count Exact field was not completed.On multiple dates in March, NA was written in response to yes/no fields, such as Narcotic Kit Sealed and Narcotic Kit Seal Number Verified, rather than selecting an appropriate answer.On 5/26/25 at both 3:00 PM and 11:00 PM, the only documentation completed was a single staff signature; all other fields, including time, count, and verification fields-were left blank.From 4/1/25 through 4/27/25, several entries used dashes (-) in place of required responses to documentation questions. The surveyor then interviewed the RN Charge Nurse (Nurse #1). Initially, she stated that staff were unsure of what it meant to ensure the narcotic pack was sealed but then clarified that the blister pack should be checked to verify the seal. When asked what NA meant, Nurse #1 responded that it stood for not applicable. However, when the surveyor asked whether the field was applicable in these instances, she acknowledged that it was. The surveyor also inquired about the facility's expectations regarding narcotic counts. Nurse #1 stated that counts are to be conducted by two staff members. When the surveyor pointed to entries in the narcotics log where only one staff member had signed, Nurse #1 confirmed that there should be two signatures and that the count should be verified with a yes.On 7/17/2025 at approximately 9:45 AM, the surveyor asked the Director of Nursing (DON) to review both the A-Wing and C-Wing narcotics logs. The surveyor directed her attention to the A-Wing log and asked if she noticed any issues with the documentation. The DON pointed to several omissions on various dates, consistent with those previously identified by the surveyor.When asked about the use of NA in the logs, the DON initially stated that there was no clear guidance on when NA should be used and that there was no process in place to verify whether blister packs had been tampered with. However, she later acknowledged that the field Narcotic Kit Sealed-Yes/No should be completed after the blister pack has been visually inspected and staff confirmed it had not been tampered with.She further confirmed that the Narcotic Kit Seal Number Verified field should be completed, and that the Status of Count Exact should be answered with Yes when the count is accurate-not marked as NA. She also confirmed that facility policy requires two staff signatures to complete the narcotics count documentation.On 7/18/2025 at 10:44 AM, the surveyor reviewed the facility policy and procedure titled Storage of Controlled Substances (Policy 4.2), dated 9/2018. The policy states: At each shift change, or when keys are transferred, a physical inventory of all (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	controlled substances, including refrigerated items, is conducted by two licensed personnel and is documented. The emergency supply must be verified by ensuring that the seal on the supply has not been broken.On 7/18/2025 at 12:13 PM, the surveyor spoke with the Director of Nursing (DON), who confirmed that concerns regarding the narcotics records had been discussed with the team. She stated, All we can do is fix the issues as we find them.

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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 reviews and interviews, it was determined that the facility failed to ensure the provider responded to a recommendation made by a consulting pharmacist. This was evident for 1 (Resident #21) of 5 residents reviewed for unnecessary medications.The findings include: A review of Resident #21's medical record was conducted on 7/17/25 at 8:18 AM. The review revealed a medication regimen review (MRR) report was conducted by the consultant pharmacist on 6/30/25.The consultant pharmacist indicated that Resident #21's order for Risperidone lacked an allowable diagnosis to support its use and listed several diagnosis/conditions for the provider to consider adding to the order. The report was signed by the Psychiatric-Mental health Nurse Practitioner (Staff #37) on 7/7/25 but failed to indicate a response to the recommendation.A review of Resident #21's medical order for Risperidone was conducted on 7/17/25 at 10:13 AM. The review revealed that the order for risperidone was last revised on 7/29/24 and still lacked the appropriate diagnosis to support its use. The Director of Nursing (DON) was interviewed on 7/21/25 at 12:03 PM. During the interview, the concern was discussed that Staff #37 failed to respond to a recommendation made by the consultant pharmacist for the 6/30/25 MRR. Noting that Staff #37 signed and dated the report but failed to indicate a response and that further review of Resident #21's order for risperidone had not been updated to reflect the appropriate diagnosis. The DON acknowledged the concern.On 7/21/25 at 1:56 PM, the DON reported that a psychiatric provider had updated Resident #21's order for Risperidone to reflect the appropriate diagnosis.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on pertinent document review and interview it was determined that the facility failed to provide the residents with medications as ordered by the physician. This was evident for 1 Resident (resident #135) out of 4 residents reviewed for neglect during a survey. The findings include: On 7/22/25 8:00 the Review of a complaint submitted from a county agency revealed a concern that Resident #135 did not receive her/his medications on time.On 7/22/25 at 10:10 AM the surveyor requested the medication administration audit for Resident # 135 for the following dates: 2/26/25 through 3/03/25 07/22/2025 11:31 AM the Nurse Unit Manager (Staff # 8) was interviewed. She provided interpretation of the medication administration audit. She reported that the first column indicated what time the medication was ordered the second column indicated what time the medication was administered.On 7/22/2025 11:22 AM a review of the audit included but was not limited to the following medications not being administered according to professional standards.Medication: hydroxyzine HCL Oral Tablet, give 1 tablet by mouth every 6 hours for anxiety for 14 days. Ordered administration time 12:00 PM 3/1/25. The medications was administered at 2:02 PM on 3/1/25. An additional dose of hydroxyzine HCL was ordered to be administered at 6:00 PM. However, it was administered at 3:39 PM, less than 2 hours from the first dose. On 7/22/25 1:05 PM during an interview the Assistant Director of Nursing (ADON), (Staff #29) confirmed that medications administered greater than 1 hour before or 1 hour after the ordered administration time were considered too early or too late. The surveyor and ADON reviewed the medication audit sheets that were provided. The ADON confirmed that Hydorxyzine was administered less than 2 hours from its previous doses, which is a medication error.On 7/22/25 11:30 Further review of the Medication Administration audit included, but were not limited to the following medications which were administered late;1.On 2/26/25 Resident # 135 had an order for Doxycycline Monohydrate 100mg capsule (antibiotic) to be administered at 8:00 AM and 10:00 PM for pneumonia, However the medication was documented as administered at 12:00PM. 2. On 2/26/25 Resident # 135 had an order for Entresto oral tablet 0.5 tablet by mouth two times a day for atrial fibrillation to be administered at 8:00 AM, however the documented time of administration was 11:07 PM. 3. On 2/26/25 Resident #135 had an order for Trimethoprim oral tablet 100 mg by mouth once a day for urinary tract infection to be administered at 8:00AM, However, the medication was administered at 11:08 PM4. On 3/1/15 Resident #135 had an order for Entresto oral tablet 0.5 tablet by mouth two times a day for atrial fibrillation to be administered at 8:00 AM, however the documented time to administration was 11:27 PM.On 7/24/2025 at 1:11 PM the above concerns were shared with the Director of Nursing. She confirmed the above listed medications were not administered as ordered.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on record review, interviews and observations, it was determined that the facility failed to provide routine dental services to a Medicaid funded resident. This was evident for 1 (Resident #21) of 3 residents reviewed for dental care.The findings include: Resident #21 was admitted into the facility in mid-2020. Medical records indicated that the resident had intact cognition.On 7/15/25 at 1:08 PM, Resident #21 was interviewed. During the interview, the resident was observed to have broken teeth and reported that s/he had not seen a dentist since being in the facility.On 7/16/25 at 3:13 PM, a review of the most recent comprehensive assessment of Resident #21, with a reference date of 5/1/25 indicated that the resident had an obvious or likely cavity or broken natural teeth.The Director of Nursing (DON) was interviewed about dental services on 7/21/25 at 11:58 AM. during the interview, the DON reported that the facility uses Healthdrive as the group providing dental services to all residents since the facility's change of ownership in October of 2024. The DON explained that Healthdrive provides almost all dental services, including routine dental visits and cleaning, in-house (in the facility).The DON was asked if she knew if Resident #21 had received routine dental services from Healthdrive. The DON indicated that she would review the resident's medical record.On 7/21/25 at 1:19 PM, the DON reported that she did not see any dental notes and confirmed that the resident had not seen a dentist through Healthdrive.On 7/22/25 at 8:25 AM, the DON reported that she had informed Resident #21's son that the resident was now enrolled for dental care through Healthdrive.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. Based on observation, interview, and record review, the facility failed to implement an effective process to ensure that residents received their preferred beverages. This was evident for 4 (Resident #108, # 17, 90, #91) out of 6 residents observed for Dinning during a survey.The findingsOn 7/17/25 at 12:26 PM an observation was made of lunch trays delivered on the terrace unit. On 7/17/25 at 12:30 PM an observation of Resident #108's meal ticket indicated that milk was listed as part of the meal. However, observation of the food tray revealed that milk was not present. GNA (Staff # 11) confirmed that the milk was missing from the tray. On 7/17/25 at 12:30 PM an observation of Resident #17s meal ticket indicated that milk was listed as part of the meal. However, observation of the food tray revealed that milk was not present. Admissions Director (Staff #12) confirmed that the milk was missing from the tray. On 7/17/25 at 12:37 PM an observation of Resident #90's meal ticket indicated that milk was listed as part of the meal. However, observation of the food tray revealed that milk was not present. GNA (Staff # 11) confirmed that the milk was missing from the tray.On 7/17/25 at 12:39 PM observation of Resident #91's meal ticket indicated that milk was listed as part of the meal. However, observation of the food tray revealed that milk was not present. The Social Service and discharge planning Director confirmed the milk was missing from the tray. On 7/17/25 during a brief interview with Kitchen Manger (Staff #13), she reported that the facility had milk available for the residents on 7/17/2025. She confirmed that residents should receive the items listed on the meal ticked.On 7/23/25 the Registered dietician provided the resident preferences documents for Resident's #108, #17, #90 and #91.7/24/25 at 8:24 AM a review of the residents' preference sheets revealed that Resident #108, #17, #90 and #91 had documentation that their preference for beverages for breakfast included milk.On 7/24/2025 at 10:59 AM the Regional Dietary Manager (Staff #7) was interviewed. During the interview she reported that it is her expectation that the residents known beverage preferences be honored. Staff #7 reported that dietary preferences were documented by the facility Kitchen Manager on admission, readmission and quarterly reviews.

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview and record review it was determined that the facility failed to ensure resident care equipment was in good working order. This was evident for 1 (R#94) of 34 residents screened on the A Wing unit during the recertification survey.The findings include:On 7/15/2025 at 9:48 AM an observation of Resident #94's room was conducted. The resident was in bed, and an air mattress pump machine was seen hanging on the footboard. The electrical wires were lying on the floor, the ends were frayed, and none of the machine's indicator lights were on. The unit nurse (Staff #1) came into the room during the observation but was unaware of the non-functioning, broken air mattress pump until the surveyor informed her. She said she would call maintenance to fix it.On 7/17/2025 at 10:45 AM the A wing unit manager (Staff #22) was interviewed regarding Resident #94's air mattress. She said she was unaware that the resident air mattress pump was broken and further explained that all resident care equipment should be checked each shift. When asked for documentation that the equipment was checked she said that nurses did not document their checks anywhere.On 7/17/2025 at 11:08 AM the Director of Nursing was interviewed to review that Resident #94's care equipment had been found in disrepair, and she acknowledged the deficiency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215198	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observations and interviews, it was determined that the facility failed to ensure residents had access to call bells and failed to ensure that call bells were maintained in working condition. This was evident for four of thirty-five residents reviewed (Residents #37, #92, and #112, #5) who did not have call bells within reach, and for two of twenty-seven residents (Residents #25 and #42) whose call bells were present but not functioning.The findings include: 1.) On 7/15/2025 at 8:20 AM, the surveyor began the initial screening of residents for the facility annual survey. On 7/15/2025 at 8:25 AM, the surveyor observed Resident #92 sitting at their bedside eating breakfast. The surveyor noted that the call bell had been placed in the resident's drawer, out of the resident's reach. Additionally, the surveyor observed their roommate, Resident #112, sleeping in bed with their call bell on the floor and out of reach. The surveyor saw the Unit Manager (Nurse #22) walking down the hallway and asked her about the facility's expectations regarding call bell placement. She confirmed that call bells are expected to be left within the resident's reach and acknowledged that both call bells were out of place. On 7/15/2025 at 8:30 AM, the surveyor interviewed Resident #42, who reported that their call bell was not working. The resident explained that they had reported the issue the previous evening and that it had not yet been repaired. The resident demonstrated to the surveyor that the call bell did not function by pressing the button; the surveyor confirmed that no alert was triggered. A nursing assistant (Staff #23) entered the room, and the surveyor asked about the call bell. Staff #23 confirmed that it had not been working since the night before and stated that maintenance was supposed to replace it. Soon after, the surveyor observed Resident #37 eating breakfast in bed and noted that their call bell had been shut inside a drawer at the bedside. Staff #23 confirmed that the call bell was out of place and moved it closer to the resident. On 7/15/2025 at approximately 9:15 AM, the surveyor observed Resident #8 lying in bed with the call bell on the floor. The surveyor notified the nursing assistant (Staff #24), who confirmed that the call bell was on the floor and relocated it within the resident's reach. On 7/15/2025 at 9:45 AM, the surveyor interviewed Resident #25, who reported that their call bell had not been working for several days. The resident stated that they informed staff, who said they would notify maintenance. They added that staff tested the call bell six times, but it still did not work—this was several days ago. On 7/15/2025 at 9:56 AM, the surveyor spoke with the Nurse Unit Manager (Nurse#22), who acknowledged that she was aware of some call bell issues and stated that she would inform maintenance. A few minutes later, she returned and told the surveyor that maintenance had been contacted and stated they would address the issue. The surveyor also informed Nurse #22 that several resident's had been found without their call bells in place. 2.) Resident #5 was admitted into the facility in early 2025. A quick look into the resident's medical (continued on next page)

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	215198	A. Building B. Wing	07/24/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record indicated cognitive impairment with limited mobility and history of falls. During the initial pool of the survey, Resident #5 was observed on 7/15/25 at 9:08 AM. Resident #5 was in bed with his/her breakfast tray almost completely consumed. The call device was observed laying on the floor, inaccessible to the resident. On 7/15/25 at 9:49 AM, a staff member was observed going into Resident #5's room to collect the breakfast tray. Upon completion of the task, the resident's call device was still laying on the floor. Later, the same day at 12:32 PM, Resident #5's room was again inspected and observed the call device was still laying on the floor. The Licensed Practical Nurse (LPN #5) assigned to care for Resident #5 was interviewed on 7/15/25 at 12:37 PM. During the interview, LPN #5 confirmed the finding of the resident's call device on the floor and not within reach. LPN #5 moved and secured the call device on the resident's bed. The concern was discussed with the Director of Nursing (DON) on 7/21/25 at 11:51 AM. The DON verbalized understanding and acknowledged 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, interview, and record review it was determined that the facility failed to post nursing staffing data on a daily basis and failed to ensure 18 months of posted nursing data were retained. This was evident for 5 of 5 nursing units.The findings include:On 7/15/25 at 8:00 AM surveyors entered the facility and observed a posted nursing staffing document at the receptionist's desk that was dated 7/10/25. The receptionist was questioned about the posting date and said she would provide an updated posting. Within the hour an updated nursing staff posting document was provided that indicated it was for 7/15/25.On 7/24/2025 at 12:14 PM an interview was conducted with the Director of Nursing (DON) to review that the daily nursing staff posting on 7/15/25 displayed data for 7/10/25. She explained that the Staff Scheduler (Staff #) posted that information and that she did not work weekends. However, she concurred that 7/15/25 was a Tuesday and that the posting for that day was not present. When the DON was asked for copies of nursing staff posted data for the previous six months, she said that the facility did not keep records of the daily nursing staff posting. She further explained that the facility's previous ownership had kept the records electronically and she did not have access to that information. She confirmed the deficiency that the facility did not post nursing staff daily and did not retain records of the nursing staff posting.