STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	215365	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Complete Care at Hagerstown	14014 Marsh Pike Hagerstown, MD 21742

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on medical record review and interview with facility staff, it was determined that the facility staff failed to enhance residents' dignity by failing to address a resident's activities of daily (ADL) needs in a timely fashion (Resident #7) and respect their preferences regarding the time frame they did not want to be disturbed while sleeping (Resident #4). This was evident during a random for 2 of 8 residents reviewed for abuse allegations. The findings include:Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care. MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. Activities of daily living care can include: bathing, dressing, toileting, transferring/mobility, continence, and eating. 1) During a tour of the facility on 1/14/26 at 11:03 AM upon arriving at the [NAME] unit, a resident was observed sitting at the nurses station loudly stating I gotta go to bathroom, help, I'm gonna poop. A nurse was observed on the other side of the nurses station who addressed the resident and stated you cant stand [resident] you have to let the girls get the lift. During this time the nurse was observed continuing to gather medications at the cart and pass them. This surveyor continued to tour the unit and when circled back to the resident, identified now as Resident #7, s/he could still be heard stating 'I have stomach pains, please help.' The nurse seen earlier, identified as licensed practical nurse (LPN) #4 was observed walking around the nurses station then sitting at the desk on the phone not addressing Resident #7. At 11:15 AM Resident #7 was still loudly stating that s/he didn't want to 'poop my pants, help me please God help me.' All the while LPN #7 was still at the nursing station and was not interacting, trying to soothe or even taking Resident #7 the bathroom. At 11:24 AM the assigned geriatric nursing assistant/registered nurse (GNA/RN) #5 came to provide care to Resident #7. This surveyor introduced herself as did the GNA who stated that she is an RN but working as a GNA today. She took Resident #7 into his/her room located across from the nurse's station to place them on the toilet, as they were able to stand and pivot. After seeing Resident #7 was provided with ADL care, this surveyor went to the nursing home (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administrator (NHA) and the Director of Nursing (DON) to notify them of the observed concerns. At the time of the observations of Resident #7 sitting at the nurse's station, not only did this surveyor witness the resident requesting assistance with staff sitting there, but there were also visitors walking by that were concerned as well. The DON was interviewed regarding this incident again on 1/27/26 at 3:01 PM. She stated that Resident #7 was known to the staff, and was care planned, for having behaviors of saying s/he has to go to the bathroom, will sit on the commode and not go and s/he fixates on going to the bathroom. However, that does not dismiss the lack of response from the nurse that day. 2) On 1/16/26 at 3:38 PM a review of the facility's investigation file for the facility reported incident #2652852 was conducted. According to the report Resident #4 reported that s/he had a preference not to be disturbed on night shift and RN #26 came into his/her room, while they were asleep, and pulled down the covers to inspect the resident's colostomy bag. A review of RN #26's statement revealed they had gone into the resident's room to check the colostomy bag at 6:15 AM. A statement from RN #27 regarding the incident on 10/20/25 revealed that she asked RN #26 about the incident and then went to the resident and explained to him/her why the nurse came into his/her room, but that the resident wouldn't listen. She failed to recognize the resident's right to have his/her preference to not be disturbed during the hours of 11 p – 7 am honored. A medical record review on 1/20/26 at 11:25 AM for Resident #4 revealed a quarterly Minimum Data Set (MDS) with an assessment reference date of 8/30/25 that documented the resident had no cognitive impairment and was able to voice his/her needs. A review of the resident's care plan for an activity of daily living and self-care deficit revealed it included the resident's preference not to be woken between the hours of 11:00 PM and 7:00 AM as of 2/12/25. A review of the treatment administration record (TAR) revealed a physician's order dated 2/12/25 that read the resident was not to be woken between 11:00 PM – 7:00 AM. However, further review of the TAR revealed staff had entered orders to be completed between 11:00 PM and 7:00 AM, which required them to wake the resident up during this time. These orders included but were not limited to turning and repositioning the resident, performing catheter care, and giving the resident 120 milliliters of fluid on the shift. On 1/20/26 at 12:13 PM an interview with Resident #4 revealed the resident did not want to be woken once s/he went to sleep at night until about 7:00 AM. The resident reported that s/he had never seen RN #26 before, so assumed the nurse was new, however, the resident felt that staff should have reported to the nurse that s/he wasn't to be disturbed at night. The resident reported, that s/he asked staff to empty the colostomy bag prior to going to bed, so no one needed to check it until morning. In addition, the resident stated he/she was fully capable of asking for help when needed. The Unit Manager, RN #28 was interviewed on 1/20/26 at 10:47 AM regarding the incident. She reported that Resident #4 wanted staff to honor, his/her preference not to be woken at night. However, RN #26 had not worked on the unit and was called down during the shift to help cover. She stated that she would have expected RN #26 to look at the resident's medical record for preferences or the off-going nurse to report that information. An interview with the DON on 1/29/26 at 1:38 PM revealed that if a resident asked not to be disturbed during certain times, then a review of the resident's orders should have been conducted to remove any orders that were unnecessary during the preferred times. Reviewed the findings.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on the review of facility reported incidents, interview and review of facility policy, it was determined that a facility staff member failed to treat a resident with respect and dignity by failing to provide care to a dependent resident (Resident #10) and free from intimidation (Resident #1) . This was evident during the review of 2 of 10 residents reviewed and the related facility reported incidents. The findings include:1. Review of the facility reported incident #2711297 regarding an allegation of neglect revealed that on 1/7/26 at approximately 3:15 PM the facility social worker (SW) notified the unit nurse that Resident # 10 was alleging that his/her assigned GNA #16 did not provide care all day.According to the facility investigation, GNA #16 admitted that he did not provide care for Resident #10 all day though he was assigned to that resident. GNA #16 alleged that he thought Resident #10 was a 'no male' care giver and confirmed that 'no' he did not provide any care to Resident #10 all shift. Although according to the documentation survey report reviewed on 1/28/26 at 10:30 AM, GNA #16 signed off as providing activities of daily living (ADL) care to Resident #10 the previous day and earlier in the month.Interview on 1/28/26 at 10:35 AM with LPN staff # 11 who was assigned to care for Resident #10 on 1/7/26 stated that the resident never complained to her, and she did not notice the resident soiled. According to the medication administration record (MAR) LPN #11 had signed off that she applied powders and creams to various areas of the residents' body that would have warranted assessment and identification of any incontinence that needed tending to.Review on 1/28/26 at 11:00 AM of the minimum data set (MDS is a standardized assessment tool in skilled nursing facilities for resident info, care planning, and compliance), completed on 1/14/26, which includes looking back at the residents abilities during the time frame of the allegation, revealed that s/he is dependent on staff for all ADL care and is noted as frequently incontinent of bladder and always of bowel.2. Review on 1/15/26 at 2:00 PM of the facility reported incident regarding Resident #1, revealed allegations of abuse and intimidation implemented by the facility respiratory therapist (RT).Review of the electronic medical record revealed a respiratory progress note entered by RT #8 on 12/6/25 at 2:06 PM, noting that Resident #1 was repeatedly disconnecting him/herself from the ventilator and that Resident #1 was combative towards RT with RN and GNA present with the suggestion to send the resident to the hospital if restraints were not placed.An interview on 1/16/26 at 9:25 AM with GNA staff #9 who was present and caring for Resident #1 on the day in question verbalized that she came in to Resident #1's room to assist RT # 8 as he was 'loudly and aggressively' making statements that someone needs to help and 'if you're not gonna tie [resident] down I'm gonna send [resident] out.' GNA #9 continued to convey to this surveyor that the resident did have anxiety during care, but this time the resident had his/her arms up more blocking the RT, not swinging and hitting. GNA #9 then verbalized that the RT stated to the resident, my patients know not to hit me I hit back.'The nurse, LPN #12 caring for Resident #1 was interviewed on 1/28/26 at 3:38 PM. She was asked by this surveyor if she was familiar with the abuse policy. She stated yes and knows RT #8 should have left, however, working on a unit with ventilators, she stated she felt stuck. She was asked when she first let someone know something wasn't right, that they thought that RT#8 had gone too far and it wasn't just a personality or attitude issue. She pulled out her phone and verified that she had texted her unit manager RN staff #17 at 4:30 PM and the only response she got was 'oh.' When nothing came of that and her GNA #9 continued to discuss their concerns, she tried again later and it was the end of the shift, and by then RT #8 went home. The time frame for reporting abuse concerns was reviewed with her at this time, as well as keeping residents safe from future potential abuse. LPN #12 stated that she was in management and knows better.Officially the facility (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported to the OHCQ on 12/6/25 at 7:47 PM, approximately 5 hours after the start of RT's documented aggression towards Resident #1.Cross reference F609, F610, F940

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on review of facility documents, staff interview and review of facility policy it was determined the facility failed to report allegations of abuse or neglect immediately but not later than 2 hours after an allegation was made. This was evident for 5 (#8, #4, #10, #1, and #9) of 8 residents reviewed for abuse during a complaint survey.The findings include:Based on review of facility documents, staff interview and review of facility policy it was determined the facility failed to report allegations of abuse, neglect and injuries of unknown origin timely after an allegation or injury was known. This was evident for 4 (#4, #8, #1, and #9) of 8 residents reviewed for abuse during a complaint survey. The findings include: 1. On 1/16/26 at 3:38 PM a review of the facility's investigation file for the incident reported incident #2652852 revealed the initial report form that documented Unit Manager (UM) #28 was informed of an allegation of abuse from Resident #4 on 10/25/25 at 9:30 AM. A review of the email confirmation revealed the report was sent to the SA on 10/25/25 at 10:47 AM. A review of Geriatric Nursing Assistant (GNA) #35's statement revealed the Resident #8 reported to her that someone was in his/her room and touched him/her inappropriately on 10/25/25 at 6:45 AM. An interview on 1/20/26 at 10:47 AM with the Unit Manager (UM) #28 revealed that she was on call on 10/25/25 and was asked to come in early that morning due to staff calling out. She confirmed that she was aware of the allegations prior to 9:30 AM, however, she failed to report it to the Nursing Home Administrator until 9:30 AM. On 1/20/26 at 2:59 PM an interview with the NHA revealed that she was involved in abuse investigations and reviewed the final report with other administrative staff. However, she offered no rationale as to why there was a discrepancy in the time, they became aware of the allegation based on the investigation and the information reported to the SA. 2. On 1/23/26 at 10:21 AM a review of the facility's investigation file for facility reported incident #2716950 revealed on the initial report form that facility staff became aware that Resident #8 had an injury of unknown origin on 1/14/26 at 9:30 AM. They reported that staff noted the resident had discoloration on the right knee and shin. According to the email confirmation, the initial report was sent to the State Agency (SA) on 1/14/26 at 11:35 AM. A medical record review for Resident #8 on 1/21/26 at 2:50 PM revealed in the progress notes that Registered Nurse (RN) #34 wrote a note on 1/13/26 at 8:12 PM that on 1/12/26 at 8:03 PM the resident's family member reported that the resident had a bruise on their right knee, which would have required reporting to the SA within 24 hours. An interview with RN #34 on 1/27/26 at 10:32 AM revealed she was aware that when a resident has an injury of unknown origin that she should report it to the Nurse Practitioner (NP) and to the supervisor. She stated that if abuse was suspected she would contact the Nursing Home Administrator (NHA) within 2 hours. However, when asked about the injury reported by Resident #8's family member she had no rationale as to why she had not reported it to her supervisor. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An interview with Corporate Clinical Resource Nurse Staff #3 on 1/27/26 at 12:32 PM, revealed she was aware that RN #24 was aware of the injury on 1/12/26 at 8:03 PM. However documented that she became aware of the injury of unknown origin on 1/14/26 at 9:30 AM. On 1/20/26 at 2:59 PM an interview with the NHA revealed that she was involved in abuse investigations and reviewed the final report with other administrative staff. However, she offered no rationale as to why there was a discrepancy in the time, they became aware of the allegation based on the investigation and the information reported to the SA. 3. Review on 1/15/26 at 2:00 PM of the facility reported incident regarding Resident #1, revealed allegations of abuse and intimidation by the facility respiratory therapist (RT). Review of the electronic medical record revealed a respiratory progress note entered by RT #8 on 12/6/25 at 2:06 PM, noting that Resident #1 was repeatedly disconnecting him/herself from the ventilator and that Resident #1 was combative towards RT with RN and GNA present with the suggestion to send the resident to the hospital if restraints were not placed. An interview on 1/16/26 at 9:25 AM with GNA staff #9 who was present and caring for Resident #1 on the day in question verbalized that she came in to Resident #1's room to assist RT # 8 as he was 'loudly and aggressively' making statements that someone needs to help and 'if you're not gonna tie [resident] down I'm gonna send [resident] out.' GNA #9 continued to report to this surveyor that the resident did have anxiety during care, but this time the resident had his/her arms up more blocking the RT, not swinging and hitting. GNA #9 then verbalized that the RT stated to the resident, my patients know not to hit me I hit back.' The nurse, LPN #12 caring for Resident #1 was interviewed on 1/28/26 at 3:38 PM. She was asked by this surveyor if she was familiar with the abuse policy. She stated yes and knows RT #8 should have left, however, working on a unit with ventilators, she stated she felt stuck. She was asked when she first let someone know something wasn't right, she pulled out her phone and verified that she had texted her unit manager RN staff #17 at 4:30 PM and the only response she got was 'oh.' When nothing came of that and her GNA #9 continued to discuss their concerns, she tried again later and it was the end of the shift, and by then RT #8 went home. The time frame for reporting abuse concerns was reviewed with her at this time, as well as keeping residents safe from future potential abuse. LPN #12 stated that she was in management and knows better. Officially the facility reported to the SA on 12/6/25 at 7:47 PM, approximately 5 hours after the start of RT's documented aggression towards Resident #1. Cross reference F610, F940 5. Review on 1/23/26 at 1:10 PM of an allegation of abuse from Resident #9 revealed that according to the facility investigation, at approximately 8:27 PM on 1/13/26 Resident #9 reported pain to his/her nurse and that they were inappropriately transferred by their assigned GNA. It was not until Resident #9's daughter called the facility notified them again that her loved one was in pain and reporting that they were inappropriately transferred to the bedside commode which inflicted pain. The GNA was moved to another assignment, management was notified, however, nothing further was (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	implemented until 1/15/26 when Resident #9 had continued concerns and left the facility against medical advice (AMA). A report was not sent to the SA regarding this allegation until 1/15/26 at 2:50 PM, although the incident occurred on 1/13/26 at 8:27 PM. The timing and incident were reviewed with the facility NHA on 1/23/26 at 1:31 PM where she verbalized understanding of the late reporting to the SA.

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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 record review, interview and review of facility policy, it was determined that the facility failed to ensure the safety of all residents by sending an employee home or away from patient care immediately when there was an allegation/concern of abuse. This was evidenced by the review of 1 of 10 facility reported incidents. The findings include:1. Review of the facility reported incident # 2686981 occurring on 12/6/25 revealed an allegation of intimidation acted out by the facility contracted Respiratory therapist. He was witnessed by multiple staff stating towards the resident I tell you like I tell all my patients, if you hit me, I hit back.Interview with Staff GNA # 9 on 1/16/26 at 9:25 AM revealed that she was present on 12/6/25 with Resident #1 and RT #8. She stated that Resident #1 was agitated and was putting his/her hands up but more blocking RT#8 not swinging at or attempting to hit RT#8. She further verbalized to this surveyor that the incident really upset her, and the RT was loud and agitated that entire day, so she was glad he didn't come back. She was asked why she didn't report him sooner and she stated that she thought the nurse had reported him.The GNA was relieved by the nurse who came in to give the resident his/her ordered anxiety medication. GNA # 9 said when she got to the hall, she heard a loud ‘smack' sound. When the nurse exited the room, she asked if RT #8 hit the resident, to which the nurse stated ‘no, he just ‘clapped at [resident] ears.'The nurse, LPN #12 caring for Resident #1 was interviewed on 1/28/26 at 3:38 PM. She stated that she remembers the incident very well and they discussed, her and GNA # 9, what to do. They were both very uncomfortable and since RT #8 was the only RT they felt stuck. LPN #12 was asked by this surveyor if she was familiar with the abuse policy. She stated yes and knows he should have been removed from patient care, however, working on a unit with ventilators, she felt stuck.According to interview statements, the unit manager, staff # 17, documented that she was first notified of the concerns related to RT #8 at 6:28 PM, not 4:30 according to LPN #12. The DON was notified of the concerns on 1/30/26 at approximately 1:00 PM.Cross reference with F600, F609

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on medical record review and interview with facility staff, it was determined that the facility staff failed to report a medication error when they became aware, putting the resident at risk of discomfort and even death. This was evident during the review of 1 of 3 residents (R#16) reviewed during a complaint survey. The findings include:During the medical record review of Resident #16 on 1/21/26 at 12:37 PM a medication error was identified while specifically reviewing the residents Medication Administration record (MAR). This error was immediately reported to the facility DON. Resident #16 was ordered a double dose of Oxybutynin Chloride extended release, 20mg, instead of 10mg, of which the resident was receiving from 1/9/26 until the date of this review.According to the National Institute of Health, Oxybutynin is an anticholinergic medication used to treat overactive bladders, dosing starts at 5mg with a max of 30mg a day. Symptoms of oxybutynin overdose may include central nervous system overactivity (which includes Rapid heartbeat, high blood pressure, anxiety, headaches), fever, cardiac arrhythmia, vomiting, respiratory failure, paralysis, and coma.On 1/22/26 this surveyor continued the review of Resident #16's medical record and noted that a nephrology consultation was completed on 1/13/26 at the facility by a nurse practitioner, identifying as a nephrology consultant, staff #13, who noted on that day that Resident #16 was receiving a duplicate dose of the Oxybutynin.Follow up interview with the DON on 1/27/26 at 3:00 PM revealed that she met with the NP providing nephrology consultations. She further inquired why the medication error she found was not brought to anyone's attention. The DON stated that she said, ‘she didn't want to get anyone in trouble.' Further they discussed moving forward who the point of contact will be at the facility for the consultant.However, in Consultant Staff #13's consultation she didn't recommend that Resident #16 continued the Oxybutynin, as she did the other 2 urinary medications, additionally, she recommended that Resident #16 be monitored for Lower urinary tract symptoms (LUTS). However, she never followed up or passed this information on and then uploaded the consult into the resident's electronic health record. This consult was completed on 1/13/26 and uploaded 1/15/26 so the information was not even available for review for 2 days after she completed it.These collective concerns were reviewed with the DON and NHA throughout the survey and with the facility Medical Director on 1/29/26 at 11:33 AM.Cross reference F711

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview it was determined that the facility failed to identify a cognitively impaired resident as an elopement risk and implement interventions to prevent elopement. This was evident for 1 (#6) of 1 resident reviewed for elopement. As a result of these findings, a state of immediate jeopardy (IJ) was declared on 1/15/26 at 3:50 PM and an IJ summary tool was provided to the facility at that time. The facility submitted the first draft of their plan to remove the immediacy on 1/15/26 at 5:35 PM and it was not accepted. The facility submitted a second draft at 6:23 PM, and it was not accepted. The third draft was submitted at 6:38 PM and the facility's written plan to remove the immediacy was accepted on 1/15/26 at 7:00PM. After the immediacy was removed, the noncompliance was determined to continue with a scope and severity of D.The findings include:Care plan - is a guide that addresses the unique needs of each resident. It is used to plan, assess, and evaluate the effectiveness of the resident's care.MDS (Minimum Data Set) - is a complete assessment of the resident which provides the facility information necessary to develop a plan of care, provide the appropriate care and services to the resident, and to modify the care plan based on the resident's status. 1. On 1/15/26 at 10:30 AM a review of the facility's policy titled, Elopements and Wandering Residents that was implemented on 3/14/24 and last reviewed on 4/4/25 was conducted. The policy read that the facility was equipped with door locks and alarms to avoid elopements, the alarms were not a replacement for necessary supervision, and the facility established a systematic approach to monitoring and managing residents at risk for elopement or unsafe wandering. The policy further noted that this included identification and assessment of risk and implementing interventions. According to the policy residents were to be assessed for risk of elopement and unsafe wandering on admission and throughout their stay by the interdisciplinary team, staff were to provide adequate supervision, residents assessed as a high risk would have an alarm bracelet placed on them, and a care plan with interventions was to be developed and implemented. According to the policy if a resident was a moderate risk then the Interdisciplinary team would review for interventions to possibly include an alarm bracelet and if deemed necessary the alarm bracelet would be placed on the resident. The alarm bracelet causes an alarm to sound if a resident was too close to an exit door that was armed. A medical record review for Resident #6 on 1/15/26 at 9:00 AM revealed a discharge summary from the acute care hospital documenting the resident was admitted to the hospital for a hemorrhagic stroke (a stroke caused by bleeding in the brain). Further review of the report revealed the resident was living at home, driving a car, and working a job prior to going to the hospital. The physical therapy (PT) notes from the hospital dated 11/12/25, revealed the resident was able to walk 2 feet with a rolling walker with maximum assistance of 2 people while at the hospital. A review of the facility's nursing admission assessment dated [DATE] revealed in the section for elopement, that Licensed Practical Nurse (LPN) #18 marked the resident was unable to ambulate (walk) and therefore the rest of the assessment was locked; deeming the resident no risk for elopement. A review of the progress notes revealed the resident had fallen on 11/15/25 at 3:15 AM and 3:40 AM. The nurse documented the resident tried to get out of bed and walk, but was unsteady on his/her feet. A review of the care plan revealed nursing staff initiated a care plan for the resident on 11/17/25 for noncompliance with using his/her walker. On 11/18/25 the resident had a Brief Interview for Mental Status conducted and it was determined the resident had severe cognitive impairment. A review of the miscellaneous section revealed the resident was deemed incapable of comprehending information and making decisions due to the stroke by the attending physician on 11/17/25 and by Nurse Practitioner (NP) #19 on 11/18/25. It was noted in the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medical record under the census tab that the resident was moved from Longmeadow nursing unit to the Paramount nursing unit. A review of the physical therapy notes on 1/15/26 at 5:02 PM revealed that on 11/17/25 the resident had ambulated 70 feet with a rolling walker with minimum assistance. This was a change in the resident's condition. On 1/15/26 at 10:30 AM a review of the facility's investigation file for the facility reported incident #2675133 revealed that staff documented on the the initial report form that on 11/20/25 at 5:18 PM a nurse found Resident #6 in the parking lot of the facility. A statement written by the interim Director of Nursing Staff #3 revealed she interviewed the resident's spouse on 11/20/25 at 7:00 PM and when asked if the resident talked about leaving the facility, the spouse reported that s/he usually does, but not on that day. The spouse further reported that the resident was usually worked up when the family was getting ready to leave and asked repeatedly if they could go home. A review of the interview with LPN #25 on 11/20/25 conducted by the Nursing Home Administrator (NHA) revealed he was assigned to the resident on 11/20/25. He reported he was checking other resident's blood sugars and passing out dinner trays at the time the resident left the unit and had not seen Resident #6 leave the unit. A review of the interview with GNA #21 conducted by the NHA on 11/20/25 revealed she was assigned to the resident that day. She was passing out trays to other residents and had not observed Resident #6 leaving the unit. During the interviews, staff had not been asked if the resident had talked about going home or observed wandering. A review of the interview on 11/20/25 with the receptionist conducted by the NHA revealed that she saw the resident coming down the hallway carrying a basin with some items in it and a shoe box, but was not sure if it was a resident or not. She stated that after the resident went out the door, she walked over and saw a truck parked outside near the front door and thought the resident had gotten in the truck. On 11/20/25 the NHA interviewed the visitor who found Resident #6 lying in the parking lot. The visitor reported that when they drove into the visitor parking lot they noticed the resident lying on the ground. The visitor reported that the resident had a wash basin with some items in it and a shoe box with a pair of shoes in it. Another statement collected on 11/20/25 by the NHA was from LPN #2 who was leaving the facility and saw the resident lying on the ground in the parking lot behind a parked car. A review of the final report form revealed that based on the facility's investigation Resident #6 left the faciity on [DATE] at 5:09 PM in 41 degree weather and it was dark. The resident had not been wearing a coat and was found at 5:18 PM lying on the ground in the visitor parking lot. A review of the elopement assessment completed on 11/20/25 revealed the resident was deemed high risk for elopement and an alarm bracelet was placed on the resident. Further review of the investigation file revealed the facility staff had started educating all staff regarding the elopement policy and educating the nurses about the elopement assessments, but failed to ensure that all staff received the education. An interview with GNA #1 on 1/15/26 at 11:31 AM revealed she had been taking care of Resident #6 on a regular basis since 11/18/25 and the resident was constantly talking about going home. She reported it was worse on the days his/her family visited. She stated the resident would frequently get up out of bed with no assistance and ambulate, but the resident was not steady on their feet. When asked if she thought the resident could make it down the hallway to the front door, she stated it did not surprise her. Nurse Practitioner (NP) #19 was interviewed on 1/15/26 at 12:08 PM regarding Resident #6 and she reported she remembered the resident being confused, agitated, and impulsive. An interview with GNA #21 on 1/15/26 at 4:51 PM revealed she was assigned to Resident #6 on 11/20/25. She stated she remembered the resident would walk unassisted, but was unsteady. She stated the resident would get up and walk without any purpose and seemed confused. She stated that the resident talked about going home everyday. She stated that on the evening the resident had eloped, she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	gave him/her their dinner tray and then went on down the hall passing trays to the other residents on the unit. She stated when she finished and went back to check on the resident she was unable to find him/her. She stated that with the Thanksgiving event there were a lot of people in the building and it would have been easy for the resident to walk off the unit unnoticed. During an interview on 1/15/26 at 4:37 PM with Occupational Therapy Assistant Staff #22 it was reported that Resident #6 frequently talked about wanting to go home. An interview with the Occupation Therapist Staff #23 on 1/15/26 at 4:37 PM revealed the resident had poor safety awareness and was independent prior to coming to the facility. She stated that on 11/20/25 the resident was able to walk 50 feet with contact assistance. She stated the resident frequently stated s/he wanted to go home. She reported she was present on the day of the elopement and the resident stated s/he went outside to go home. On 1/15/26 at 11:41 AM an interview with LPN #2 revealed she was not assigned to Resident #6 on 11/20/25, but when she was leaving for the day, they drove through the visitor parking lot and saw the resident lying on the ground behind a parked car. She stated they first noticed the crowd of bystanders around him/her. She stated it was dark out and several visitors were coming to the facility for a Thanksgiving event. She stated at first she had not recognized the resident, but when she saw a brief (adult diaper) sticking out of his/her sweatpants she realized it was a resident and called for assistance. An interview with Corporate Clinical Resource Nurse Staff #3 on 1/15/26 at 1:29 PM she was the interim DON at the time of Resident #6's elopement. She reported that staff were expected to conduct elopement assessments on all new admissions/readmissions, quarterly, and with a change in condition/behavior. Review of the interviews conducted with staff and Staff #3 reported that the resident was displaying behaviors that should have triggered staff to reassess for elopement. When asked if she was aware of the behaviors, she stated that when the resident was first admitted she was told about the behaviors, but was then told during the morning meeting that the resident was talking about going home less and adjusting to the facility. On 1/15/26 at 1:47 PM an interview with the Nursing Home Administrator (NHA) revealed that she was present when the elopement occurred because it was the night of the facility's Thanksgiving event. She reported that a visitor found the Resident #6 in the parking lot lying on the ground. She stated that when she interview Resident #6, s/he said they were trying to go home. She reported that the resident was not someone they were watching for elopement because his/her elopement assessment on admission determined the resident was not an elopement risk. However, when asked the behaviors she considered to be high risk for elopement she reported the resident mentioning they wanted to go home, packing their things, and exit seeking behaviors. This deficient practice led to a cognitively impaired resident leaving the facility while it was dark, in 41 degrees (F) weather without appropriate outerwear and the resident fell on the ground in a visitor parking lot that was not well lit at the time visitors were arriving for a facility event. As a result of the fall the resident sustained an abrasion to the right side of his/her face and scrapes on both hands. As a result of these findings, a state of immediate jeopardy (IJ) was declared on 1/15/26 at 3:50 PM. The facility submitted their plan to remove the immediacy. The provisions of the plan to remove the immediacy included the following: Resident #6 no longer resides in the facility.Updated elopement evaluations for all current residents will be completed by 1/15/26 to determine if any other residents are at risk for elopement. Updated elopement evaluations will be completed by the Unit Managers and DON. All residents determined to be at risk for elopement will have their [alarm bracelet] rechecked for proper placement and function. Any resident identified at increased risk for elopement will be placed on appropriate elopement precautions with a care plan updated.Education of all facility licensed staff working 3-11 shift on 1/15/26 was immediately performed by DON and Regional (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resource Nurse on the elopement policy and procedure including the elopement risk evaluation process to ensure elopement risk is reassessed. All licensed nurses will be educated by 1/16/25. Any licensed staff member unable to be educated by 1/16/26 (i.e., call-out and vacation) will be educated upon arrival to the facility; DON will ensure that education has been provided to them prior to beginning their shift. The DON, Regional Resource Nurse, NHA, RDO (Regional Director of Operations), and Facility Department Heads will continue to educate all non-clinical staff on elopement policy and procedures including identifying elopement risk signs and symptoms and reporting to appropriate clinical staff.Any facility staff member unable to be educated by 1/16/26 (i.e., call-out and vacation) will be educated upon arrival at the facility; DON will ensure that education has been provided to them prior to beginning their shift.Education will be validated by quizzes performed randomly by DON, Unit Managers, Supervisors, or Regional Resource Nurse with 10% of staff weekly for a period of 3 months. The DON, Unit Managers, and Nursing Supervisors will conduct audits monthly x 3 months. Findings will be reported by the DON at the monthly QAPI (Quality Assurance Performance Improvement) meeting to monitor progress towards improvement and recommendations. On 1/27/26 at 10:00 AM, after validation of the implementation of the facility's plan of removal, which included staff interviews and record reviews, it was determined the facility completed the removal plan with a compliance date of 1/23/26.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on medical record review and interview with facility staff, it was determined that the physicians failed to have their notes in the medical record timely after seeing residents and complete a total review of the residents' plan of care and appropriately implement said plans and treatment. This was evident for 2 of 2 (R#16, R#15) residents reviewed and 4 of 4 physicians reviewed during a complaint survey.The findings include:1a. Medical record review on 1/21/26 at 12:37 PM the medical record of Resident #16 revealed admission to the facility after a fall with subsequent rib fractures, for monitoring and routine healing. On 1/22/26 this surveyor continued the review of Resident #16's medical record and noted that a nephrology consultation was completed on 1/13/26 at the facility by NP staff #13, however, that note was not available and uploaded to the system for staff access until 1/15/26.Interview with a facility unit manager, staff #28 on 1/23/26 at 10:43 AM revealed the facility process for consultations is that they come in 2 times a week and give orders. The nephrologist comes in and they put in their own orders and upload their own consultations; she also verbalized that it's a new process. She said previously for consultations they would receive the report, review it and if there are orders it would go to the physician/NP for review. Further she stated that they have not received anything directly since nephrology has been coming about 2 months ago.Interview with the facility DON on 1/23/26 at 10:55 AM, she stated that the consultations should go to the unit manager or the ADON for review and then entered by that individual. This surveyor reviewed with the DON that the consultant for nephrology NP#13 is uploading her own consultation reports, and it is days later after she sees residents and there are noted recommendations in those consultations that are not getting passed on. This concern was noted for all the nephrology consultations that NP staff #13 completed.1b. The facility NP staff #19 was interviewed on 1/23/26 at approximately 11:15 AM regarding Resident #16. She stated that she attempts to always get her notes in at the time she sees the resident unless there are extraneous circumstances. The concern about a noted medication error in Resident #16's chart was also reviewed at this time as she had seen the resident and noted that his/her medications were reconciled as well as the chart on 1/21/26, 8 days after NP #13 saw Resident #16 and identified the error. The NP stated that she does not review the medication administration record (MAR) and was not aware of him/her needing or seeing a nephrology consult so was not looking for one and therefore was not aware there was a medication error until it was brought to the attention of the DON by this surveyor. 1c. Continued medical record review of Resident #16 revealed that physician #29 started a history and physical note on 1/12/26 for Resident #16 at 9:15 AM, however did not complete and sign the note until 1/13/26 at 10:01 PM. The history and physical was available 36 hours after initiation and noted that all medications, allergies and problems reconciliations are reviewed and reconciled. Additionally, it noted that an order of 10mg of Oxybutynin was to be discontinued, while continuing the 2 tabs of the 5mg Oxybutynin and a new medication was ordered ‘Trospium' for overactive bladder that was never started. This was not implemented as Resident #16 continued on a duplicate dose of the Oxybutynin through 1/21/26 when it was brought to the facility's attention by this surveyor. The concern that there was a medication error in the record and attending physician reviewed the record, made changes to the orders, uploaded the note a day later and failed to implement the orders was reviewed with the DON on 1/23/26.Multiple attempts and requests were made to interview the NP #13 that completed the nephrology consults, however, she was never available when the surveyors were in the building, despite waiting for her expected arrival time. 2. Review of the medical record for Resident #15 on 1/16/26 revealed that attending physician #29 entered an effective date of 1/12/2026 at 12:15 PM for Resident #15, however, the created (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	date for that note was not until 1/14/26 at 22:54 PM, 2 days after the resident was supposedly seen, therefore any orders noted in physician note would not be available to the staff until 1/14/26 at 22:54. On 1/23/26 at 10:55 AM the DON was interviewed regarding the concerns of physician notes being uploaded to the resident medical records later than when the resident was being seen. There was a plethora of physician's notes presented from November and December 2025 that were uploaded days after completion. The DON stated that attending physician no longer works at the facility, however, they are aware and will continue to follow up with their practitioners on the identified concerns.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on the review of resident records, a facility reported incidents and a review of employee files and interviews, it was determined that the facility failed to ensure Geriatric Nursing Assistants (GNAs) were competent with their skill sets. This was found to be evident for 2 of 2 employee files reviewed for competencies and skill sets.The findings include:1. During the comprehensive review of residents during an immediate jeopardy, Resident #20 was reviewed on 1/21/26 at 9:30 AM. This review revealed a fall occurring in the bathroom where the resident was left alone on the toilet by the assigned GNA staff #14, who then attempted to transfer his/herself off the toilet and had a fall, the second fall while attempting to use the toilet in a week. According to the residents' care plan, reviewed on 1/22/26 at 9:56 AM, Resident #20 required moderate assistance of 1 staff for toileting-implemented on 4/4/2025.The fall investigation was requested by the facility and received on 1/22/26 and was discussed with the facility DON at 10:56 AM. It was noted in the investigation that the GNA failed to follow the residents care plan and appropriately stay with and transfer the resident, as confirmed with the DON at this time. The employee was provided a 'teachable moment' regarding this incident to ensure to check care plans and Kardex for patient. The Corporate Clinical Resource Nurse who was the acting NPE/IP/QA nurse, staff #3 was interviewed on 1/29/26 at 10:45 AM. GNA staff #14 was hired in 2020. The concern that there were no annual evaluations of GNA skill sets or online training in GNA #14's file was reviewed. Staff #3 previously stated that she was not aware where all the employee certificates were kept. Any additional information was requested at this time, however, upon exit on 1/29/26 no new information was provided. 2. Review of a facility reported incident #271803 on 1/22/25 at 10:26 AM revealed concern reported from a family member that their loved one was inappropriately transferred causing pain in their loved ones broken leg. Further review on 1/23/26 at 1:10 PM of the reported allegation of abuse from identified Resident #9 revealed that according to the facility investigation, at approximately 8:27 PM on 1/13/26 Resident #9 reported pain to his/her nurse and that they were inappropriately transferred by their assigned GNA. The nurse medicated the resident, but an investigation was not initiated until Resident #9's daughter called the facility and notified them again that her loved one was in pain and reported that they were inappropriately transferred to the bedside commode which inflicted pain. According to the investigation report GNA #15 stated during the first transfer back to bed that they did contact guard support and the way she did that was by supporting the residents' ankles. Contact guard support provides hover hands, light hands, or holds a gait belt, staying physically connected to the patient throughout the movement.During the second transfer the GNA reported lifting Resident #9's legs up off the bed, then Resident #9 started yelling out you hurt me, as it was noted that Resident #9 had a broken left leg. A review of GNA #15's employee file on 1/27/26 at 1:10 PM revealed that she was hired in August of 2024. There were no new hire skills checklist or annual evaluations of GNA skills. The DON was interviewed on 1/27/26 at 1:56 PM and notified of the concerns related to the lack of training and education. She stated that she too was concerned about the lack of training and education and new steps were going to be implemented. The education concerns were presented to staff #3 and the NHA throughout the survey as they were identified.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on record review and interview, it was determined that facility staff failed to develop a process to ensure that nurse aides had annual performance evaluation of their skills to allow them to determine weaknesses in the nurse aide's performance and provide training based on those weaknesses. This was evident for 3 (#37, #14, and #36) of 3 staff reviewed for performance evaluations.The finding include:On 1/22/26 at 11:43 AM a review of Geriatric Nursing Assistant (GNA) #37's employee file revealed she was hired on 11/2018, and there was no evidence of a performance evaluation in the last 12 months. A review of GNA #14's employee file revealed she was hired 2/2019, and there was no evidence of a performance evaluation in the last 12 months.A review of GNA #36's employee file revealed she was hired 4/2023, and there was no evidence of a performance evaluation in the last 12 months.An interview with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) on 1/22/26 at 12:21 PM revealed the facility had no process in place to ensure that nurse aides had an annual performance evaluation.Cross reference: F947

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on medical record review, interview and review of facility policies and procedures it revealed that the facility failed to ensure that the facility staff administered medication without ensuring there was duplicate therapy being administered. This was evident for 1 of 3 residents reviewed during the complaint survey for medication errors. The findings include:Review on 1/21/26 at 12:37 PM the medical record of Resident #16 revealed admission to the facility after a fall with subsequent rib fractures, for monitoring of routine healing. Additionally, Resident #16 was noted with an overactive bladder and benign prostatic hyperplasia (enlargement of the prostate gland affecting urination).A review of the residents' physician orders at this time and corresponding medication administration record (MAR) revealed an order for Oxybutynin Chloride ER (extended release) 5mg (2 tabs) every morning for bladder spasms and Oxybutynin Chloride ER 10mg every morning for urinary retention. Both medications were signed off by staff from 1/9/26 through the time of this review on 1/21/26. The corresponding hospital discharge records and physician notes were reviewed and only noted the single order of Oxybutynin 10 mg should be ordered, not a total of 20 mg a day. The DON was immediately made aware of the review.On 1/22/26 this surveyor continued the review of Resident #16's medical record and noted that a nephology consultation was completed on 1/13/26 at the facility by consultant NP#13 who noted that Resident #16 was receiving a duplicate dose of the Oxybutynin.Interview with the facility DON on 1/23/26 at 10:55 AM, she stated that the consultations should go to the unit manager or the ADON for review and then entered by them. This surveyor reviewed with the DON that the consultant for nephrology NP#13 is uploading her own consultation reports, and it is days later with recommendations. Follow up interview with the DON on 1/27/26 at 3:00 PM revealed that she met with the NP #13 providing nephrology consultations. She further inquired why the medication error she found was not brought to anyone's attention. The DON stated that NPT #13 said, ‘she didn't want to get anyone in trouble.' Further they discussed moving forward who the point of contact would be at the facility for this consultant.Cross reference F658

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on record review and interview, it was determined that facility staff failed to: 1) ensure appropriate conditions in place, including contracts and physician orders when having a consultant in their facility, 2) complete a facility assessment and use this information to develop and implement a training program for all staff 3) ensure that all staff, contracted staff and visitors had the required trainings on hire and ongoing, and 4) evaluate the skill performances of their nurses aides and ensure that they had 12 hours of training annually. This was evident throughout the complaint survey. The findings include:1. Review of the medical records for at least 5 residents of the facility starting on 1/21/26 revealed completed 'nephrology' consultations completed by a nurse practitioner. These consultations started back on November 9, 2025. It was also noted that after the consultation was completed, it was not being uploaded into the medical record for days even if there are recommendations or concerns. The DON was interviewed on 1/27/26 at 3:01 PM regarding the contract for the nephrology NP consultant. The DON stated that from now on the consultant was going to be seeing all the new admissions as well as all the existing residents with kidney disease. The NP consultant had stated to the DON that there was no communication open between her and the facility, however, she had not reached out or verbalized any concern while continuing to visit the facility the prior 3 months. During this interview, the NHA brought in a contract that was noted as signed the day prior (1/26/26) by the company where the NP consultant worked. The facility medical director was interviewed on 1/29/26 at 11:33 AM. He stated that the facility contracted nephrology consultant was not to be seeing every new admission and there was to be a physician order as well as an actual nephrologist following behind the NP consultations. The concern that there was no contract during the time an outside individual was coming in and seeing facility residents, and no consistent process in place all the way up until the day of survey exit that the facility administrative staff was aware of and in agreement on was verbalized as a concern. Repeated attempts were made to interview this NP consultant throughout the survey and again on 1/29/26 the survey team waited for her arrival and she did not show. 2) The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment included determining the staff competencies and skill sets that are necessary to provide the level and types of care needed for the resident population On 1/16/26 at 10:55 AM the Nursing Home Administrator (NHA) was made aware that an extended survey was being conducted, and she was asked to provide a copy of the facility assessment. During an interview with the NHA on 1/16/26 at 12:21 PM the NHA was asked if she had the facility (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessment. She reported that she was unable to find it and had to request it from their corporate office. When asked if she had reviewed the facility assessment since taking over the position on 8/25, she reported she had not. Therefore, the training and skills sets that staff needed to care for their resident population had not been determined. 3a) On 1/22/26 at 12:00 PM a review of the orientation Power Point (PP) presentation revealed facility staff failed to include the required behavioral health training. On a review on 1/22/26 at 9:33 AM of the following employees' files revealed they were allowed to care for residents without completing the required behavioral health training: Licensed Practical Nurse (LPN) #38 who was hired 9/2025. Registered Nurse (RN) #39 who was hired 3/2025. Activity Assistant #40 who was hired 9/2025. Geriatric Nursing Assistant (GNA) #41 who was hired 8/2025. GNA #42 who was hired on 11/19/25. 3b) A review of the list of computer-based trainings that were offered staff each year on 1/22/26 at 11:47 AM revealed that it included all of the required training topics: effective communication, Resident Rights, Elder Abuse, Quality Assurance and Performance Improvement (QAPI), Infection Control, Compliance and Ethics, and Behavioral Health. However, the infection control module failed to include the facility's policies and procedures for infection prevention and control. On 1/22/26 at 12:43 PM a review of the following 4 employees' computer-based training transcripts revealed: Geriatric Nursing Assistant (GNA) #37 completed 4 computerized training modules in 2024, however abuse was the only required training listed. Prior to these 4 training modules she had not completed any since 2021. Licensed Practical Nurse (LPN) #43 had last completed computerized training modules in 2022. GNA #14 and GNA #36 had not completed the computerized training modules since 2024. Laundry Aid #44 had not completed the computerized training modules for Resident's Rights since 2023 or infection control that included the facility's policies and procedures. On 1/22/26 at 10:15 AM an interview with the Corporate Clinical Resource Nurse Staff #3, who was the acting Nurse Practice Educator (NPE), revealed that while they had a training process in place there was no one who was ensuring that staff completed the trainings in a timely manner. The staff listed above continued to work in the facility. 4) The facility was required to conduct annual performance evaluations for their nurse aides to determine if there were any weaknesses in their skill sets. Based on these findings nurse aides were required to receive 12 hours of training annually, based on their hire date, that included competency (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training (which is when staff demonstrate the skill to the nurse aide and the nurse aide practices the skill). Other trainings were to be added based on the skill sets needed to care for the resident population. On 1/22/26 at 11:43 AM a review of Geriatric Nursing Assistant (GNA) #37's employee file revealed she was hired on 11/2018. The file failed to reveal evidence of a performance evaluation or 12 hours of training to include competencies in the last 12 months. A review of GNA #14's employee file revealed she was hired 2/2019, and there was no evidence of a performance evaluation or 12 hours of training to include competencies in the last 12 months. A review of GNA #36's employee file revealed she was hired 4/2023, and there was no evidence of a performance evaluation or 12 hours of training to include competencies in the last 12 months. On 1/22/26 at 12:43 PM a review of the computer-based transcripts for GNA #37, GNA #14, and GNA #36 failed to reveal they had completed 12 hours of training to include competencies in the last 12 months. A review of the Nurse Aide training program/plan, provided by the NHA, on 1/16/26 at 11:33 AM revealed that it was a list of computer- based training modules that failed to include competencies. This was later determined to be the same list of annual training modules that were sent by the corporate office for all staff to complete. On 1/16/26 at 12:21 PM it was confirmed with the NHA and Corporate Clinical Resource Nurse Staff #3 that this was their Nurse Aide training program. An interview with Staff #13, who was the acting Nurse Practice Educator, on 1/22/26 at 1:48 PM revealed that the facility had not developed and implemented a training program for their nurse aides that was based on their evaluations. When this concern was reviewed with the NHA on 1/27/26 at 4:28 PM and she reported that they had no consistent person in the educator position. Cross Reference F730, F940, F947

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on record review and interview, it was determined that the facility failed to establish and implement a process for the mode of communication, how often communication occurs, and what was to be communicated between the administrator and governing body. This was evident during the complaint and extended survey.The findings include:A review of the Governing Body Policy and Procedure on 1/21/26 at 9:33 AM revealed there was no implementation date. Further review revealed that the governing body members' responsibility was to be active, engaged, and involved in the affairs of the facility; they were to have direct access to the administrator and the compliance officer by scheduling executive board sessions to allow for a free flow of information without potential conflict; and have involvement in the Quality Assurance and Performance Improvement (QAPI) program. In addition, there was a letter addressed to the administrator that designated the facility's administrator as the Compliance and Ethics Officer and the members of the Compliance and Ethics Committee were the Director of Nursing, Social Worker, and Medical Director. The QAPI meeting sign-in sheets were reviewed on 1/29/26 at 1:15 PM and there was no evidence that a member of the governing body attended the meetings.An interview with the Nursing Home Administrator (NHA) on 1/20/26 at 3:17 PM revealed that she was not aware of policy regarding the governing body's involvement with the facility. She reported that they had not attended QAPI meetings and she had not contacted them since she returned to the facility on 8/2025.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on record review and staff interview, it was determined that facility staff failed to complete a facility assessment as required. This was evident during the extended survey review.The findings include:On 1/16/26 at 10:55 AM the Nursing Home Administrator (NHA) was made aware that an extended survey was being conducted, and she was asked to provide a copy of the Facility Assessment.During an interview with the NHA and Nurse Educator/Infection Preventionist Staff #3 on 1/16/26 at 12:21 PM the NHA was asked if she had the Facility Assessment. She reported that she was unable to find it and had to request it from their corporate office. When asked if she had reviewed or developed a facility assessment since she took the position in 8/2025, she reported she had not.On 1/16/26 at 1:30 PM the NHA provided a copy of the facility assessment that was titled, Facility Assessment Tool. Upon review of the assessment, it had a date of completion of 1/5/26 and listed it had been completed by the NHA, Medical Director, Governing Body representative, and others. Further review revealed it was an incomplete assessment.A subsequent interview with the NHA on 1/16/26 at 1:46 PM confirmed that she had not reviewed or completed a facility assessment until the surveyor had requested a copy on 1/16/26. She indicated that it was because she had started in the position 8/2025; however, it was later reported she was the facility's NHA from 2020 - 2024.During an interview with the NHA on 1/20/26 at 3:17 PM regarding her communication with the governing body, it revealed she had not been in contact with the governing body since returning the facility 8/2025. Therefore, she would not have had input from a governing body member as she indicated on the facility assessment she provided to the survey team on 1/16/26. Cross Reference: F835 and F940

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. Based on medical record review, interview with facility staff and review of facility policy, it was determined that the facility administration allowed consultations to be completed in the facility without established contracts with said company and without an order from the residents' attending physician. This was evident for at least 5 residents reviewed (R#16, #1, #7, #10, #19) during the survey. The findings include:1. The medical record for Resident #16 was reviewed on 1/21/26 at 10:00 AM. This noted a nephology consult completed on 1/13/26 that was not uploaded until 1/15/26. Within this consultation report the nurse practitioner (NP) #13 documented finding a medication error on the resident's medication administration record. This error was brought to the attention of the DON by the survey team on 1/21/26 not the consultant 8 days earlier on 1/13/26 when NP #13 found it. This additional concern was reviewed with the DON on 1/22/26 that the consulting NP #13 was aware of the error on 1/13/26 and did not bring this information to anyone's attention. Additionally, Resident #16 had no physician order to be seen by a nephrologist or consultant.Facility policy on Provision of Physician ordered Services revised last on 2/18/25, reviewed on 1/27/26 at 12:30 PM stated that in number 1. No diagnostic tests or consultation requests will be performed without specific physician, physician assistant, nurse practitioner or clinical nurse specialists orders in accordance with State law, including scope of practice law.Cross reference F658, F7572. This surveyor continued to review 4 more random resident records. All of these residents were seen by the 'nephrology' NP #13 consultant. The dates started around 11/9/25 with her notes being uploaded days after the visit to the respective residents, none of whom had a physician order to be seen or have a nephrology consultation.On 1/29/26 at 11:33 AM the facility medical director was interviewed. He was asked about the process for the facility having a nephrology consultant. He stated over the course of the interview that it is for residents with a diagnosed need and an order from their attending physician. He was also made aware that the contract for this consultant was signed on 1/27/26 though she had been coming and seeing residents since at least November 2025. He was asked if he is the resource and following up on the NP #13's consultations and he stated 'no, that should be an actual nephrologist.' This surveyor let the medical director know at this time that there was no nephrologist signing off on the consultations being provided by NP #13, who also was reportedly seeing every 'new admission,' according to what the NP #13 has reported to the DON as NP#13 gets a list from the unit managers when she arrives.The medical director stated that he would have to circle back with the NHA with this new information that was presented to him. Cross reference F838

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on record review and interview, it was determined that facility staff failed to ensure that the Infection Preventionist was in attendance to the Quality Assurance and Performance Improvement (QAPI) committee meetings. This was evident for 5 of 10 meetings reviewed.The findings include:A review of the QAPI committee meeting sign-in sheets for 3/2025 - 12/2025 on 1/29/26 at 1:15 pm revealed that an Infection Preventionist (IP) had not attended the meetings quarterly.An interview with the Corporate Clinical Resource Nurse Staff #13 on 1/29/26 at 1:51 PM revealed she was the acting Quality Assurance coordinator and Infection Preventionist. She reported that the facility had not had a staff member assigned as an IP throughout the past 10 months.

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on record review and interview, facility staff failed to develop and implement an effective training plan to ensure that staff, contracted staff, and volunteers receive the required trainings and other appropriate training topics and frequency of training based on their facility assessment. This was evident during the extended survey.The findings include:On 1/22/26 at 12:00 PM a review of the facility's orientation Power Point (PP) presentation revealed facility staff failed to include behavioral health topics which were to be based on their facility assessment's identified behavioral health needs of their resident population. On 1/22/26 at 11:47 AM a review of the list of computer-based training modules revealed they included the required training topics: effective communication, Resident Rights, Elder Abuse, Quality Assurance and Performance Improvement (QAPI), Infection Control, Compliance and Ethics, and Behavioral Health. However, the infection control module failed to include the facility's policies and procedures for infection prevention and control.During an interview with the NHA on 1/16/26 at 12:21 PM she reported that she had no copy of the previous NHA's facility assessment and had not completed one since returning to the position in 8/2025. Therefore the training program topics had not included topics that were determined to be necessary based on the facility assessment. On 1/22/26 at 12:43 PM a review of the following employees' computer-based training transcripts revealed:Geriatric Nursing Assistant (GNA) #37 completed 4 computerized training modules in 2024, however abuse was the only required training listed. Prior to these 4 training modules she had not completed any since 2021. Licensed Practical Nurse (LPN) #43 had last completed computerized training modules in 2022. GNA #14 and GNA #36 had not completed the computerized training modules since 2024.Laundry Aid #44 had not completed the computerized training modules for Resident's Rights since 2023 or infection control that included the facility's polices and procedures.An interview was conducted with the Corporate Clinical Resource Nurse Staff #3 on 1/22/26 at 10:15 AM, she was the interim Director of Nursing (DON) until 12/1/25 and now was covering as the Nurse Practice Educator. She reported that the facility used a computer-based training program for annual training requirements. She stated that the corporate office determined the training topics and sent a list out periodically to the facility. She stated the corporate office assigned each employee a list of training modules to complete each year. However, the facility failed to have a way to ensure that staff completed these training modules as required.The concerns were reviewed with the Nursing Home Administrator on 1/27/26 at 4:28 PM and she offered no rationale for the deficient practice.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on record review and interview, it was determined that facility staff failed to develop and implement a nurses' aide training program to ensure that each nurses' aide received 12 hours of training annually and that the training was included on weaknesses that were identified during their annual performance evaluation. This was evident for 3 (#37, #14, and #36) of 3 staff reviewed for performance evaluations.The findings include:On 1/22/26 at 11:43 AM a review of Geriatric Nursing Assistant (GNA) #37's employee file revealed she was hired on 11/2018. The file failed to reveal evidence of a performance evaluation or 12 hours of training to include competencies in the last 12 months. A review of GNA #14's employee file revealed she was hired 2/2019, and there was no evidence of a performance evaluation or 12 hours of training to include competencies in the last 12 months. A review of GNA #36's employee file revealed she was hired 4/2023, and there was no evidence of a performance evaluation or 12 hours of training to include competencies in the last 12 months. On 1/22/26 at 12:43 PM a review of the computer-based transcripts for GNA #37, GNA #14, and GNA #36 failed to reveal they had completed 12 hours of training to include competencies in the last 12 months. A review of the Nurse Aide training program/plan on 1/16/26 at 11:33 AM revealed that it was a list of computer-based training modules that failed to include competencies of skills.On 1/16/26 at 12:21 PM it was confirmed with the NHA and Corporate Clinical Resource Nurse Staff #3 that this was their Nurse Aide training program.An interview with Staff #13, who was the acting Nurse Practice Educator, on 1/22/26 at 1:48 PM revealed that the facility had not developed and implemented a training program for their nurse aides.Cross reference: F730