STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an overall effective pressure ulcer prevention program to prevent the development and worsening of pressure ulcers, implement interventions for pressure injuries and effectively assess and monitor for new or worsening pressure injuries for 7 residents (Resident #41, #53, #61, #45, #7, #18 and #4) of 7 residents reviewed for pressure ulcers, resulting in Resident #41's pressure ulcer on the sacrum (coccyx, tailbone) worsening to a Stage 4, Resident #53's Stage 3 pressure ulcer on the sacrum deteriorated, Resident #61 developed a new facility acquired pressure ulcer, and the potential for skin breakdown or continued skin breakdown for Resident's #45, #7, #4, and #18 and overall decline in health status. Findings include: Resident #41 Review of an admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral (coccyx, tailbone) region stage unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #41, with a reference date of 3/11/26 revealed a Brief Interview for Mental Status (BIMS) score of severe cognitive impairment. Review of Behaviors revealed no rejections of care. Review of the Functional Abilities revealed that Resident #41 was completely dependent on staff for toileting and transfers. Review of Resident #41's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 3/20/26 revealed, Sensory perception: slightly limited. Moisture: very moist.Bedfast (does not get out of bed). Resident is very limited. Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Excellent. Friction and shear: problem. Braden Score: 13. This evaluation indicated the resident is at moderate risk to develop a pressure ulcer. Review of Resident #41's Wound Care Plan revealed, .I have wound on my sacral buttock area, left BKA (below the knee amputation) surgical incision, left gluteus (buttocks), right gluteus. Date initiated: 12/19/25. Interventions: .Monitor ulcer for signs of infection, Monitor ulcer for signs of progression or declination, Notify provider if no signs of improvement on current wound regimen, Provide wound care per treatment order. Date initiated: 12/10/25. Additional interventions: .Air mattress DX (diagnosis) sacral decubitus (pressure ulcer). Offload wounds while laying in bed and in chair as tolerated, cushion in wheelchair. Provide wound care per treatment order. Date initiated: 1/6/26. There was no information related to Resident #41's pressure ulcer on the right foot and or the urinary catheter that was ordered to promote wound healing. (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #41's Skin Care Plan revealed, I am at risk for skin breakdown. Date initiated: 11/26/25. Interventions: Educate resident/representative about primary risk factors and prevention, Monitor for pain and medicate as necessary per physician order. Notify resident/representative of any new areas of skin alteration. Report any changes in skin status to physician. Date initiated 11/26/25. Additional interventions, Roho (air filled pressure reducing) cushion to wheelchair, Turn and reposition every 2 hours as requested and tolerated. Date initiated 1/27/26. There was no indication of why Resident #41 was at risk for skin breakdown. There was no care plan related to Resident #41 incontinence and/or urinary catheter use. Review of Resident #41's Infection Control Care Plan revealed, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO). The resident must be placed in isolation (enhanced) due to risk of spreading MDRO's via an indwelling device, chronic/non-healing wound. Date initiated: 1/6/26. Interventions: .Staff are to wear PPE (gown and gloves) before entering room if they are providing high contact care. Date initiated: 1/6/26. In an interview on 04/14/2026 at 10:17 AM, Family Member (FM) VV reported that Resident #41 was on an antibiotic for a bad infection in her sacral wound and had recently been hospitalized for the wound. FM VV reported that the resident's family had not been visiting due to their fear of getting sick due to Resident #41's infection. During an observation and interview on 04/14/2026 at 11:03 AM Resident #41 was lying in her bed and Hospice Nurse (HN) M was performing wound care and a wound dressing change for Resident #41's sacral wound. Resident #41 verbalized that the wound was painful. Observed a foley catheter bag hanging from the bed frame. HN M was not wearing a gown. In an interview on 04/14/2026 at 11:20 AM, HN M reported that he had just finished wound dressing changes for Resident #41. HN M reported that Resident #41 had recently signed onto hospice services and that day was Resident #41's first wound visit. Review of Resident #41's Hospice Progress Note dated 4/14/26 revealed, .Communicates verbally very effectively.Rates sacral wound pain 8/10.Wound care provided: Sacrum – stage 4 pressure wound – 6 x 6 x1 cm, right heel – stage 1 pressure wound 2 x 2 cm, right lateral foot – stage 1pressure wound 0.3 x 0.3 cm. At end of lengthy visit, patient confirms that her pain is unimproved. It was noted that Resident #41's pressure ulcer on her sacrum had worsened since previous observations. There was no documentation to indicate the pressure ulcers were unavoidable. During an observation and interview on 04/15/2026 at 11:39 AM Resident #41 was lying in her bed with the head of bed (HOB) elevated to approximately 45 degrees (an upright position) and slightly turned to her left side. There was a pillow in place behind her back. Resident #41 reported that she was uncomfortable, had been vomiting earlier that day and had not been cleaned up yet. Observed Resident #41's chin and gown with dried yellow substance. Resident #41's right foot was covered with a blue protective boot. During an observation on 04/15/2026 at 11:50 AM Resident #41's roommate was observed notifying Licensed Practical Nurse (LPN) KK that Resident #41 needed help. LPN KK replied, they are getting her. In an interview on 04/15/2026 at 12:12 PM, Certified Nursing Assistant (CNA) W reported that (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #41 does not get out of her bed, was not able to feel when she was incontinent, but was otherwise able to make her needs known. CNA W reported that she had checked on Resident #41 a couple of hours ago, approximately 10:15 AM and she was dry, so she let the resident rest, and did not reposition her. CNA W reported that Resident #41 had big sores on her buttocks and would be repositioned after lunch around 2:00 PM. During subsequent observations on 04/15/2026 from 11:39 AM-1:23 PM when Resident #41 received lunch, she remained in the same position. At 1:23 PM Resident #41's HOB was raised so that she could eat lunch. Resident #41 remained in this position until approximately 2:42 PM (4 1/2 hours) when this surveyor requested to observe Resident #41's wound dressings along with LPN KK. In an interview and observation on 04/15/2026 at 2:42 PM, LPN KK reported that she had changed Resident #41's wound dressing on her sacrum early that morning and flushed her foley catheter. LPN KK reported that the wound did not look good, there was a lot of slough (white dead tissue) and green drainage. LPN KK reported that Resident #41 was on an oral antibiotic for the wound. Observed Resident #41 still lying in bed, positioned on her left side, with the HOB at 45-90 degrees. Observed a large adhesive bandage covering Resident #41's sacrum, and bandages covering her right foot and heel. During observations on 04/15/2026 at 2:49 PM and again at 3:36 PM Resident #41 was observed lying in her bed, in the same position as when first observed at 11:39 AM that day; positioned on her left side with HOB approximately 45 degrees. In an interview on 04/16/2026 at 8:14 AM, Unit Manager (UM) D reported that the facility had been following orders from the wound clinic for Resident #41's sacrum and right foot wounds until yesterday when the hospice nurse saw the resident for the first time and changed the treatment orders. UM D reported that Resident #41's last wound clinic visit was 4/6/26 and an antibiotic was ordered due to Resident #41's sacral wound infection at that time. UM D reported that Resident #41 was hospitalized [DATE]-[DATE] for UTI (urinary tract infection) and returned to the facility with a foley catheter in place to help with sacral wound healing. UM D reported that the facility did not have a wound provider or nurse that specialized in wounds and expected that the floor nurse assigned to daily care for residents, should also be completing the weekly wound assessments when they are due. UM D reported that the nurse that performed the weekly assessments would not be consistent but should be able to determine wound progress by comparing the assessment details from the week prior. After reviewing Resident #41's record, UM D reported that the weekly wound assessments were not being documented as expected by the nursing staff; most of the wound information appeared to be copied and pasted from earlier assessments. UM D could not determine when the last time Resident #41's sacral (coccyx) wound and right foot wounds were formally assessed and measured by facility staff. UM D could not find any documentation to verify that staff were assessing and monitoring Resident #41's wounds, other than the treatment records that were initialed, to indicate they were completed, and the wound clinic notes that were scanned into the record did not include wound measurements and/or characteristics. UM D could not find any documentation related to concerns that Resident #41's wounds were deteriorating and/or having had signs of infection. Director of Nursing (DON) C was present for this interview and could not provide any information to support compliance for Resident #41's wounds management. Review of Resident #41's Weekly Skin Check dated 3/9/26 at 2:24 PM (prior to hospitalization) revealed, .Skin warm and dry, skin color WNL (within normal limits). No new skin issues identified. Skin issue #1: .HAS NOT BEEN EVALUTED. Location left gluteus.Issue type: Pressure ulcer/injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Wound was present on admission. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus. Issue type: Open lesion. Wound was present on admission.Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus. Issue type: Open lesion. Wound was present on admission. Staged by In-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus. Additional information: Sacrum. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 3 pressure ulcer/injury full thickness skin loss. Wound was present on admission. Review of Resident #41's Wound Clinic Visit dated 3/9/26 at 11:00 AM revealed, .Her wound has declined today. Please encourage increased repositioning from side to side. Wound Treatment: Wound #1 location: Sacrum.Peri-Wound (skin surrounding the wound) care: Triad Hydrophilic (helps to maintain moisture) wound dressing 1 x per day. Acetic Acid (kills microorganisms) 0.25% 1 x day, apply as directed as a 5-10 minute soak before dressing application. Aquacel Ag Advantage (an antimicrobial wound dressing to reduce risk of infection) . Wound #5 location: Gluteus Right.Triad Hydrophilic wound dressing.apply a thin layer to peri-wound. Review of Resident #41's Hospital Wound Consult Dated 3/12/26 revealed, .consulted for a coccyx, right heel and buttock wounds.Several more wounds that were found. Right buttock, right heel, right lateral foot, left medial thigh and left lateral thigh are all deep tissue wounds. Left buttock is a stage 2, sacral wound is a stage 3.Wound Assessment: 1. Sacral.length 5.5 cm x width 5 cm x depth 0.6 cm. 2. Left medial thigh DTPI (deep tissue pressure injury). length 5.5 cm x width 5 cm. 3. Left upper later thigh DTPI. length 5 cm x width 3 cm. 4. Left Buttock Stage 2 Pressure injury. length 1 cm x width 1 cm. 5. Right heel DTPI (deep tissue pressure injury). length 2 cm x width 1.5 cm. 6. Right lateral foot DTPI. length 2.2 cm x 1.5 cm. 7. Right buttock DTPI. length 5 cm x width 3 cm. Assessment: .General surgery was consulted for chronic sacral decubitus ulcer.There does appear to be superficial necrotic slough at the superior and right lateral aspects of the sacral decubitus ulcer. Review of Resident #41's Hospital After Visit Summary dated 3/19/26 (admitted on [DATE]) revealed, .Transfer Instructions: .Wound Site: Sacrum .Right heel, Right lateral foot, left medial thigh and left upper lateral thigh.Foley in place for maintenance of sacral wound. Review of Resident #41's re-admission Assessment dated 3/19/26 revealed, Arrived by ambulance. Urinary Catheter intact. Skin warm and dry, skin color WNL (within normal limits). No new skin issues identified. Skin issue #1: .HAS NOT BEEN EVALUATED. Location left gluteus, proximal, superior. Issue type: Pressure ulcer/injury. Wound was present on admission. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus, distal, inferior. Issue type: Open lesion. Wound was present on admission.Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus, inferior, distal. Issue type: Open lesion. Wound was present on admission. Staged by In-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus, middle, inferior, distal. Additional information: Sacrum. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 3 pressure ulcer/injury full thickness skin loss. Wound was present on admission. It was noted that the information was copied from the 3/9/26 skin check and did not include the wounds from the hospital after visit summary. Review of Resident #41's Skilled Nursing Evaluation dated 3/21/26 revealed, .Skin issue #1: .HAS NOT BEEN EVALUATED. Location left gluteus, proximal, superior. Issue type: Pressure ulcer/injury. Wound was present on admission. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus, distal, inferior. Issue type: Open lesion. Wound was present on admission.Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus, inferior, distal. Issue type: Open lesion. Wound was present on admission. Staged by In-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus, middle, inferior, distal. Additional information: Sacrum. Issue type: Pressure (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	ulcer/injury. Pressure ulcer staging: Stage 3 pressure ulcer/injury full thickness skin loss. Wound was present on admission. It was noted that the information was copied from the 3/19/26 skin check and did not include all of Resident #41's wounds. Review of Resident #41's Wound Clinic Visit dated 3/23/26 at 11:00 AM revealed, Her wound has declined today. Wound Treatment: Wound #1 location: Sacrum.Peri-Wound (skin surrounding the wound) care: Triad Hydrophilic wound dressing 1 x per day. Acetic Acid 0.25% 1 x day, apply as directed as a 5-10 minute soak before dressing application. Aquacel Ag Advantage. Wound #5 location: Gluteus Right.Triad Hydrophilic wound dressing.apply a thin layer to peri-wound. Review of Resident #41's Skilled Nursing Evaluation dated 3/22/26, 3/23/26, 3/24/26, and 3/26/26 all revealed a duplicate of the skin documentation from 3/21/26. Review of Resident #41's Weekly Skin Check dated 3/26/26 revealed a duplication of the skin documentation from the previous weekly skin checks. Review of Resident #41's Wound Clinic Visit dated 4/6/26 revealed, .Based on culture results of the sacrum we would like to begin Ciprofloxin (antibiotic) 500 mg twice a day for 10 days to treat the pseudomonas (bacteria).Her wound on her sacrum has declined today. Please encourage increased repositioning from side to side. If dressings are soiled they need to be changed or risk for infection will increase. Do not wipe them off. New dressings are needed. Wound Treatment: Wound #1 location: Sacrum.Peri-Wound (skin surrounding the wound) care: Triad Hydrophilic wound dressing 1 x per day. Acetic Acid 0.25% 1 x day, apply as directed as a 5-10 minute soak before dressing application. Aquacel Ag Advantage 4 x 5 inch 1 x per day, place directly onto wound bed as directed. Secondary dressing: Abdominal pads 7.5 x 8 inch, place over wound or other dressings as directed for protection and absorption. Wound #5 location: Gluteus Right.Triad Hydrophilic wound dressing.apply a thin layer to peri-wound. Wound #6 location: Calcaneus (heel) right. use skin prep to peri-wound and wound. Mepilex Ag 4 x 4 inch.place directly onto wound bed. It was noted that an additional wound was assessed on the right heel during the visit. Review of Resident #41's most recent Weekly Skin Check dated 4/9/26 revealed, Skin warm and dry, skin color WNL (within normal limits) .Skin issues: Skin issue #1: Skin issue HAS NOT BEEN EVALUATED. Location: left gluteus. Issue type: pressure ulcer/injury. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus. Issue type: Open lesion. Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus. Issue type: Open lesion. Staged by: in-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus. Additional location information: SACRUM. Issue type: pressure ulcer/injury. Skin issue #5: NEW SKIN ISSUE. Location: Coccyx. Issue type: Pressure ulcer/injury. Progress: Improving. Overall wound characteristics improved. Wound was present on admission. Length 1 (cm), width 1.5 (cm), depth 0 (cm). During an observation on 04/17/2026 at 8:45 AM Resident #41 was lying in bed, positioned slightly to her left with the HOB at approximately 45 degrees. In an interview on 04/17/2026 at 9:16 AM, CNA G reported that she had not been in with Resident #41 since the start of her shift at 7:00 AM (2 hours ago). CNA G reported that she would have to look at Resident #41's care plan to know what care needed to be done. During a subsequent observation and interview on 04/17/2026 at 10:27 AM Resident #41 remained in the same position, lying in bed, positioned slightly to her left with the HOB approximately 45 degrees. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Resident #41 reported that she was finished with her breakfast tray and that her bottom was sore and she could not change positions on her own. Review of Resident #41's Physician Orders revealed, Ciprofloxacin HCl Oral Tablet 500 MG (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for sacrum infection per wound center for 10 Days. Start 4/6/2026, Stop 4/16/2026. Resident #53 Review of an admission Record revealed Resident #53 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: Pressure ulcers of sacral region and heel, both unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #53, with a reference date of 2/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #53 was cognitively intact. Review of the Functional Abilities revealed that Resident #53 required substantial/maximal assistance (>50%) for moving in bed and was completely dependent on staff for toileting needs. Review of Resident #53's Braden Scale for predicting Pressure Ulcer Risk Evaluation dated 2/5/26 revealed, 12 indicating at high risk to develop pressure ulcers. Review of Resident #53's Skin Care Plan revealed, I am at risk for skin breakdown. Date initiated: 10/31/25. Interventions: Monitor for pain and medicate as needed per physician's order. Date initiated: 10/31/25. There was no documentation related to Resident #53's risk for pressure ulcers and/or interventions in place to reduce the risk. There was no care plan related to Resident #53's need for assistance with bed mobility, toileting and or status of bowel and bladder continence. There was no care plan related to Enhanced Barrier Precautions (EBP). Review of Resident #53's Wound Management Care Plan revealed, Bilateral heels, Coccyx. Date initiated: 11/6/25. Interventions: Measure ulcer on regular intervals. Monitor ulcer for signs of infection. Monitor ulcer for signs of progression or declination. Notify provider if no signs of improvement on current regimen. Provide wound care per treatment orders. Date initiated 11/6/25. There were no updates made to this care plan. During an observation on 04/15/2026 at 7:15 AM Resident #53 was lying in bed with her eyes closed and the HOB at approximately 45 degrees. Observed a pillow behind Resident #53 near her back, keeping her positioned slightly on her left side. There was no signage posted for enhanced barrier precautions (EBP). In an interview on 04/15/2026 at 8:36 AM, LPN LL reported that Resident #53 does not get out of bed anymore, her heel sores have completely resolved, but the wound on her buttocks is not doing good at all. LPN LL reported that Resident #53 is incontinent of bowel and bladder, very compliant with cares and repositioning, but the protective boots do not stay on her feet well. LPN LL reported that Resident #53 also has pressure point wounds on the tips of her toes, therefore staff had to constantly watch so that her feet don't press up against the end of the bed. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During an observation on 04/15/2026 at 12:50 PM Resident #53 was lying in bed with her eyes closed, and remained positioned slightly to her left side. Observed a pillow behind Resident #53's back and the HOB was 45 degrees. Observed blue protective boots partially in place on Resident #53's feet. In an interview on 04/16/2026 at 9:25 AM, UM D reported that Resident #53 had wounds on her heels and buttocks, and at one time a couple months ago had concerns for osteomyelitis (infection in the bone caused by infected tissue) because the wounds on her feet were not healing. UM D did not know the status of Resident #53's wounds. Reviewing Resident #53's records with UM D and there was no documentation of wound assessments that measured size, no pressure wound interventions listed, and all weekly skin checks were noted as normal. UM D reported that the facility did not have a dedicated wound nurse or provider, and that the floor nurse was expected to complete all wound assessments during the weekly skin check and notify UM D or a provider if there was a concern. UM D reported that the facility also uses a Wound Log to document when a concern was identified. During an observation and interview on 04/17/2026 at 9:49 AM Resident #53 was sitting up in bed eating breakfast. Resident #53 reported that her butt was sore. Resident #53 was not wearing the blue protective boots on her feet. There was no signage observed to indicate that Resident #53 had orders for EBP. Review of the facility Wound Communication Log revealed, (Resident #53) 4/2/26 Sacral wound purulent (liquid substance indicative of infection) drainage 3x2cm, new bruise right upper thigh/hip, new wound to right of current wound .5x.2cm. There was no documentation in the blanks for dressing orders or risk management completed. In an interview on 04/17/2026 at 10:04 AM, UM D reported that she was not aware of the wound communication log note from 4/2/26 related to Resident#53's wounds. UM D reported that Resident #53's orders had not changed since then and there were no progress notes or physician notes to correlate that the wound concern was assessed and being monitored. This surveyor requested to observe Resident #53's wounds and UM D agreed to collect supplies to complete assessments and wound care for all of Resident #53's wounds. During an observation on 04/17/2026 at 10:26 AM Resident #53 was still sitting up in her bed and her breakfast tray was in front of her and her blue protective boots were not in place on her feet. UM D was gathering supplies for wound care. CNA CC was gathering supplies to provide incontinence care for Resident #53. There was still no signage indicating that Resident #53 had EBP in place. At 10:46 AM UM D, CNA CC, and Nurse Practitioner (NP) N were in the room at the bedside, donned gloves and began explaining to Resident #53 that they would be doing incontinence care and looking at her wounds. UM D removed the wound dressings from Resident #53's right and left heels, and NP N assessed the wounds. This surveyor observed nickel size brown scabs on both heels. NP N reported that the right heel wound measured 1 cm x 1 cm and the left heel wound measured 2 cm x 1 cm, and called the wounds deep tissue injuries. This surveyor observed Resident #53's toes on her left foot, they were discolored and scabbed, the staff did not assess that area. CNA CC and UM D rolled Resident #53 to her left side to provide incontinence care and assess her buttocks wound. There was an extra-large bandage covering Resident #53's coccyx area dated 4/17/26 that was visibly soaked with drainage from the wound. UM CC removed the bandage which revealed a large open wound with slough (moist white dead tissue) and eschar (black hard dead tissue) in the center of the wound. NP N reported Resident #53's coccyx wound was 8 cm x 9.5 cm and called it a Stage 3 pressure ulcer and said that it was deteriorating since there was tissue exposed now. There was a large purple discolored wound on Resident #53's right upper thigh that followed the line of an incontinence brief. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	UM D reported that she was not aware of the wound on the right upper thigh. NP N reported that Resident #53's wound on the right upper thigh appeared to be from shearing (a wound affecting deep tissue layers due to lateral shifts in movement). Resident #53 was soiled with BM and urine and CNA CC completed incontinence care with assistance from UM D. UM D continued with wound care after the incontinence care, cleansing the coccyx wound and applying the wound dressing. It was noted that all staff in the room provided direct care and were not wearing proper PPE (gowns) related to EBP standards for wounds. In an interview on 04/17/26 at 11:10 AM, NP N reported that she did not know how long Resident #53 had the wounds that were observed that day. NP N reported that at this time they would continue the same wound treatment as previously ordered. In an interview on 04/17/26 at 11:11 AM, CNA CC reported that Resident #53 was very compliant with care and would stay in whatever position we place her in; she does not refuse repositioning or the protective boots. CNA CC reported that Resident #53 was always incontinent and that the last time she had completed incontinence care for Resident #53 was the day before. CNA CC noted that the wound on her upper thigh was red yesterday and did not have the purple and black area in it. CNA CC was not aware that Resident #53 should have EBP in place. In an interview on 04/17/2026 at 11:17 AM, Infection Preventionist (IP) E reported that she would expect staff to notify her when there was a concern for wound infection and stated, a lot of the time I don't know until I find out on my own. IP E reported that residents with pressure wounds are not automatically placed in EBP. IP E reported that if a wound is diagnosed as a certain stage or was found to be infectious, then EBP are implemented at that time. IP E reported that Resident #53 wounds were not open and she does not require EBP. In a subsequent interview on 04/17/26 at 11:40 AM, IP E reported that she was informed Resident #53's wounds were deteriorating therefore she would be placed on EBP. In an interview on 04/17/2026 at 12:01 PM, NP N reported that she had not seen Resident #53's toes in the earlier observation and was not aware that she had any wounds on her toes. In an interview and observation on 04/17/2026 at 12:04 PM, Registered Nurse (RN) I reported that they were applying betadine (antiseptic for infection prevention) to Resident #53 toes. Observed Resident #53 lying in her bed; her left great toe had a thick scab covering the tip, and the 2nd and 3rd toes were discolored black at the tips. RN I reported that Resident #53's left great toe was an unstageable pressure injury. Review of Resident #53's Physician Note dated 2/9/26 revealed, .Staff concerned with skin issues on her bilateral feet. Bilateral heel wounds were being treated with Dakins (helps reduce infection and promote healing) solution on bilateral heels while floating and has an air mattress to offload pressure. Now concern with discoloration of toes.Physical exam: .Bilateral heels have stage 3 pressure injury with beefy red wound base and macerated (softening and breaking down of skin) edges surrounding both wounds are individually the size of a nickel, right great toe has deep purple scab to the tip of the toe, right 2nd digit has small area on the pad of the toe which is dark purple, left great toe appears to have gangrene (tissue death) at the tip, left 2nd digit has gangrene nearly to the DIP (distal interphalangeal: closest to tip of toe) joint, bilateral legs have venous insufficiency (lack of blood circulation) with skin color changes.Assessment and Plan: 1. Impaired skin integrity. New orders placed for wounds on bilateral heels and toes. X-ray of bilateral feet. Vascular referral ASAP. Concern with gangrene. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Review of Resident #53's X-ray of bilateral feet dated 2/10/26 revealed, .No osteomyelitis (infection of the bone) is seen.Medicine (sic) bone scan are more sensitive for detecting osteomyelitis. Review of Resident #53 Progress Notes&rd

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to fully implement a policy regarding use and storage of resident foods brought in from outside sources resulting in potentially hazardous foods being held passed their discard date, increasing the risk of contamination and food borne illness among residents who store food in resident refrigerators.Findings Include:On 4/14/26 at 10:06 AM, observation of the East Nourishment room found a plastic bag with containers of leftover dinner and dessert items labeled with a resident's name and dated 4-6-26. Further observation of the unit found an unopened package of yogurt labeled with a resident's name and having best by dates of March 23, 2026. At this time, an interview with Dietary Manager V found that staff come down to this room in the morning and after lunch to check on the snack items but probably get used to only looking at the items dietary regularly stocks. On 4/14/26 at 10:18 AM, observation of the [NAME] Nourishment room found three, four-packs of yogurt, with best by dates of [DATE] and March 6, 2026. A record review of the facility provided policy entitled Use and Storage of Food Brought in by Family or Visitor, revised on 3/11/26, found that, Food brought in by family or other visitors is permitted, provided care is taken to ensure food is handled properly for safe and sanitary storage, as well as consumption. A further review of the policy found that, Foods should be consumed or used by 72 hours or per facility food storage policy. Resident/Patient and family should be informed that if the food is not consumed within the designated storage time the food item will be discarded for food safety concern.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and record review, the facility failed to: 1) effectively identify quality deficiencies, develop, and implement appropriate action to correct deficiencies; and 2) sustain a system to ensure corrective measures related to resident rights, bowel/bladder incontinence/catheter care, infection control, monthly medication reviews, pressure ulcers, and quality of care as evidenced by repeated deficiencies on the past three surveys. This deficient practice has the potential to affect all residents that reside in the facility. Findings include: During an interview on 4/17/2026 at 1:01 PM, Nursing Home Administrator (NHA) B reported that the facility was currently working on performance improvement projects (PIPS) related to resident falls and new employee orientation. NHA B reported the facility was not currently working on any performance improvement projects (PIPS) related to the repeat deficiencies that the facility had been cited for on the last three recertification and abbreviated surveys. NHA B confirmed that the facility had repeat deficiencies related to resident rights, bowel/bladder incontinence/catheter care, infection control, monthly medication reviews, pressure ulcers and quality of care, but that all of those areas had not been brought to QAPI as PIPs for the facility to work to improve on. NHA B confirmed that the repeat deficiencies that the facility had been cited for on the past surveys were high priority areas. Review of the facility's Quality Assurance and Performance Improvement Committee policy dated 3/11/26 revealed, Purpose/Objective:(The Facility) will maintain an ongoing and active Quality Assessment and Performance Improvement program . It will also focus on the care of all residents in the facility . 6. PERFORMANCE IMPROVEMENT PROJECTS (PIPs) a. A PIP is a concentrated effort on a particular problem in one area of our facility or facility wide; it involves gathering information systematically to clarify issues or problems, and intervening for improvements. We conduct PIPs to examine and improve care or services in areas that we identify as needing attention. The facility will set priorities for PIPs that focus on high-risk, high-volume, or problem-prone areas; consider incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to effectively implement an effective infection control program to include: 1). ensuring Enhanced Barrier Precautions (EBP) (an infection control intervention that uses targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs) were implemented in 3 residents (Resident #41, #45 & #53), 2). ensuring Contact Precautions (Transmission based infection control measure used to prevent the spread of infectious agents through direct or indirect contact) were implemented in 1 resident (Resident #61), 3.) maintain standard infection control measures in 1 resident (Resident #5) and 4.) an active and ongoing plan for reducing the risk of legionella and other opportunistic pathogens of premise plumbing (OPPP), from a total of 18 resident reviewed for infection control, resulting in the potential for cross-contamination, the development and spread of infection to a vulnerable population, and increased risk of respiratory infection among all residents in the facility. Findings include: Resident #41 Review of an admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral (tailbone) region stage unspecified. Review of Resident #41's Infection Control Care Plan revealed, Enhanced barrier precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO). The resident must be placed in isolation (enhanced) due to risk of spreading MDRO's via an indwelling device, chronic/non-healing wound. Date initiated: 1/6/26. Interventions: .Staff are to wear PPE before entering room if they are providing high contact care. Date initiated: 1/6/26. In an interview on 04/14/2026 at 10:17 AM, Family Member (FM) VV reported that Resident #41 was on an antibiotic for a bad infection in her sacral wound and had recently been hospitalized for the wound. FM VV reported that the resident's family had not been visiting due to their fear of getting sick due to Resident #41's infection. During an observation and interview on 04/14/2026 at 11:03 AM Resident #41 was lying in her bed and Hospice Nurse (HN) M was performing wound care and a wound dressing change for Resident #41's sacral wound. Resident #41 verbalized that the wound was painful. Observed a foley catheter bag hanging from the bed frame. HN M was not wearing a gown. Observed signage outside of Resident #41's room indicating EBP were required. In an interview on 04/14/2026 at 11:20 AM, HN M reported that he had just finished wound dressing changes for Resident #41. Review of Resident #41's Hospice Progress Note dated 4/14/26 revealed, .Communicates verbally very effectively.Rates sacral wound pain 8/10.Wound care provided: Sacrum – stage 4 pressure wound – 6 x 6 x1 cm, right heel – stage 1 pressure wound 2 x 2 cm, right lateral foot – stage 1 pressure wound 0.3 x 0.3 cm. At end of lengthy visit, patient confirms that her pain is unimproved. In an interview on 04/16/2026 at 8:14 AM, Unit Manager (UM) D reported that Resident #41's last (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of an admission Record revealed Resident #53 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: Pressure ulcers of sacral region and heel, both unspecified. Review of Resident #53's Wound Management Care Plan revealed, Bilateral heels, Coccyx. Date initiated: 11/6/25. Interventions: Measure ulcer on regular intervals. Monitor ulcer for signs of infection. Monitor ulcer for signs of progression or declination. Notify provider if no signs of improvement on current regimen. Provide wound care per treatment orders. Date initiated 11/6/25. There was no care plan for EBP. During an observation on 04/15/2026 at 7:15 AM Resident #53 was lying in bed with her eyes closed and the HOB (head of bed) at approximately 45 degrees. There was no signage posted for enhanced barrier precautions (EBP). In an interview on 04/16/2026 at 9:25 AM, UM D reported that Resident #53 had wounds on her heels and buttocks, and at one time a couple months ago had concerns for osteomyelitis (infection in the bone caused by infected tissue) because the wounds on her feet were not healing. During an observation and interview on 04/17/2026 at 9:49 AM Resident #53 was sitting up in bed eating breakfast. There was no signage observed to indicate that Resident #53 had orders for EBP in place. During an observation on 04/17/2026 at 10:26 AM Resident #53 was lying in bed in a sitting position. UM D was gathering supplies for wound care. CNA CC was gathering supplies to provide incontinence care for Resident #53. There was still no signage indicating that Resident #53 had EBP in place. At 10:46 AM UM D, CNA CC, and Nurse Practitioner (NP) N were in the room at the bedside, donned (put on) gloves and began explaining to Resident #53 that they would be doing incontinence care and looking at her wounds. UM D removed the wound dressings from Resident #53's right and left heels, and NP N assessed the wounds. CNA CC and UM D rolled Resident #53 to her left side to provide incontinence care and assess her buttocks wound. There was an extra-large bandage covering Resident #53's coccyx area dated 4/17/26 that was visibly soaked with drainage from the wound. UM CC removed the bandage which revealed a large open wound with slough (moist white dead tissue) and eschar (black hard dead tissue) in the center of the wound. NP N reported Resident #53's coccyx wound was 8 cm x 9.5 cm and called it a Stage 3 pressure ulcer and said that it was deteriorating since there was tissue exposed now. Resident #53's brief was soiled with BM and urine and CNA CC completed incontinence care with assistance from UM D. UM D continued with wound care after the incontinence care, cleansing the coccyx wound and applying the wound dressing. It was noted that all staff in the room provided direct care and were not wearing proper PPE (personal protective equipment) related to EBP standards for wounds. In an interview on 04/17/26 at 11:11 AM, CNA CC reported that she was not aware that Resident #53 should have EBP in place. In an interview on 04/17/2026 at 11:17 AM, Infection Preventionist (IP) E reported that she would expect staff to notify her when there was a concern for wound infection and stated, a lot of the time I don't know until I find out on my own. IP E reported that residents with pressure wounds are not automatically placed in EBP. IP E reported that if a wound is diagnosed as a certain stage or was found to be infectious, then EBP would be implemented at that time. IP E reported that Resident #53 wounds were not open and she did not require EBP. In a subsequent interview on 04/17/26 at 11:40 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	AM, IP E reported that she was informed Resident #53's wounds were deteriorating therefore she would now be placed on EBP. Resident #61 Review of an admission Record revealed Resident #61 was originally admitted to the facility on [DATE]. Review of Resident #61's Infection Control Care Plan revealed, Contact Precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO). Date initiated: 4/16/26. Interventions: .Staff are to wash hands with soap and water before and after providing care. Staff are to wear PPE (gown and gloves) before entering room and discard before leaving room. Date initiated: 4/16/26. During an observation on 04/15/2026 at 1:15 PM Resident #61's door was closed and signage was posted that indicated Contact Precautions. The lunch cart arrived and CNA H delivered Resident #61's lunch tray to her and set the tray up on the table over the bed. CNA H did not don gloves or a gown and did not perform hand hygiene before or after contact with Resident #61. In an interview on 04/15/2026 at 1:26 PM, LPN FF reported that Resident #61 had a urinary tract infection and the culture showed an MDRO (multidrug resistant bacteria) ecoli (a bacteria found in the intestines), was on an antibiotic and had contact precautions in place. During an observation on 04/15/2026 at 1:58 PM CNA W entered Resident #61's room with linens and then came back out to retrieve wash cloths. CNA W did not don a gown or gloves prior to entering and/or exiting the room. At 2:08 PM CNA W entered the room with additional supplies and was not observed donning a gown or gloves. At 2:19 PM this surveyor donned a gown and gloves and entered Resident #61's room. CNA W was at the bedside performing incontinence care for Resident #61. CNA W was not wearing a gown. In an interview on 04/15/2026 at 2:31 PM, CNA W reported that she was not aware that Resident #61 had an infection, and she had not been informed that contact precautions were in place, until she saw this surveyor with a gown on. In an interview on 04/16/2026 at 8:48 AM, UM D reported that Resident #61's lab results from the urine sample were received on 4/15/26 via phone and contact precautions were put in place right away due to culture positive for an MDRO. UM D reported that staff were only required to don a gown when performing direct care and did not need to do such when delivering a meal tray. (It was noted that this information was not consistent with infection control standards of practice.) According to the Centers for Disease Control and Prevention (CDC), use contact precautions for patients with known or suspected infections that represent an increased risk for contact transmission .Wear a gown and gloves for all interactions that may involve contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens .Remove and dispose of contaminated PPE and perform hand hygiene prior to transporting patients on Contact Precautions. [NAME] clean PPE to handle the patient at the transport location .If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient .patients on contact precautions ensuring rooms are frequently cleaned and disinfected (e.g., at least daily or prior to use by another patient if (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	outpatient setting) focusing on frequently-touched surfaces and equipment in the immediate vicinity of the patient . www.cdc.gov/infectioncontrol/basics Review of Centers for Disease Control and Prevention (CDC) dated March 20,2024, revealed, .Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities .EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing .EBP are indicated for residents with any of the following: o Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or o Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO .Effective Date: April 1, 2024 . www.cdc.gov/infectioncontrol/basics Review of Centers for Disease Control (CDC) poster for Enhanced Barrier Precautions, revealed, .Enhanced Barrier Precautions: Everyone Must .Clean Their Hands, including before entering and when leaving a room .Providers and Staff Must Also .Wear Gown and Gloves for the following High Contact Resident Care Activities .Dressing .Bathing/Showering .Transferring .Changing linens .Providing hygiene .Changing briefs or assisting with toileting .Device care or use: central line, urinary catheter, feeding tube, tracheostomy .Wound Care: any skin opening requiring a dressing . www.cdc.gov/infectioncontrol/basics Resident #5: Review of an admission Record revealed Resident #5 was a female with pertinent diagnoses which included altered mental status, diabetes, peripheral vascular disease (circulation disorder involving narrowed or blocked vessels), anxiety, heart failure, dementia, and muscle weakness. Review of Orders for Resident #5 revealed, .Monitor foley catheter 16fr/30cc (a device that drains urine from bladder to a collection bag outside of your body) r/t (related to) Urine retention. Change PRN (as needed) for obstruction every shift for infection control/hygiene AND as needed for infection control, hygiene Review of Orders for Resident #5 revealed, .Enhanced Barrier Precautions are in place to prevent the spread of MDRO's (multi drug resistant organisms) every shift for Safety All staff are to wear Gown and Gloves when providing high contact care. During an observation on 04/14/2026 at 4:01 PM, Resident #5 was seated in her recliner in her room. The catheter bag was partially lying on the floor with the bottom one third on the floor. During an observation on 04/15/2026 at 12:04 PM, Resident #5 catheter bag had bottom 1one third on the floor while she was seated in the recliner. It was located on the left front side of the recliner. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	In an interview on 04/17/2026 11:55 AM, Certified Nursing Assistant (CNA) T reported a resident's catheter bag should not be on the floor as there was dirt, debris, and could cause the bag to be contaminated. In an interview on 04/17/2026 at 12:15 PM, CNA TT reported the catheter bag should not be touching the floor as to ensure to keep it clean and prevent damage to the bag and it should have a dignity bag. In an interview on 04/17/2026 at 11:51 AM, Registered Nurse (RN) HH reported a catheter bag should not be on the floor due to infection control concerns as all the bacteria on the floor would contaminate the bag. In an interview on 04/17/2026 at 12:43 PM, Infection Preventionist (IFP) E reported a catheter bag should never be on the floor unless there was a barrier underneath of it due to the potential contamination. On 4/14/26 at 9:45 AM, observation of the three-compartment sink found that the cold-water handles for both faucets and the overhead spray were removed from the fixtures. When asked why they did not have handles, Dietary Manger V stated that staff only use hot water at these fixtures. On 4/14/26 at 10:50 AM, an interview with Facility Director (FD) Q, found that staff flush some unused and minimal use fixtures in the facility, but were not aware that kitchen staff were not using those cold-water fixtures in the kitchen and will add them to a flushing schedule. On 4/14/26 at 11:10 AM, observation of the housekeeping closet on the East South wing, found a chemical dispense system no longer in use. At this time, an interview with Housekeeping Lead UU found that her staff use the main housekeeping area in the basement with the chemical dispense and do not use the sinks on the floor anymore. At this time, the surveyor turned on the handles to the mop sink faucet in the closet and found that discolored water momentarily dispensed from the faucet when the hot water handle was turned on. On 4/14/26 at 11:16 AM, observation of the East North soiled utility room found a hopper with the fixture's hot water line off, and the hoppers sprayer turned off, both of which would leave stagnant lines if left unattended. On 4/14/26 at 11:40 AM, observation of the [NAME] South soiled utility room found that the hopper and hopper spray was not operable, making the fixtures stagnant water lines. At this time, an interview with FD Q found that he was unaware the janitor sinks and hoppers were not getting some regular use and would need to be on the flushing schedule. On 4/14/26 at 11:46 AM, observation of the [NAME] South housekeeping closet found that the hot water handle had been removed and the cold-water handle dispensed discolored water momentarily when turned on. On 4/14/26 at 1:50 PM, observation of the [NAME] North nurses station supply room found hot and cold-water lines protruding from the back wall and running to the room next door. Observation of the medical records room, next door, found the water lines capped off behind a short filing cabinet positioned in the corner of the room. On 4/14/26 at 2:27 PM, a review of Water Management Plan documentation found that the facility (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	tests for free chlorine in the domestic water system. When asked if the facility ever tests the domestic hot water system, FD Q stated that they only test free chlorine in the cold-water system. A record review of the facility provided document entitled, Water Management Program, last revised on 1/31/2022, found that, The WMP will include the following elements: .The identification of situations that can led to Legionella growth, such as: .7. Water stagnation. 8. Inadequate disinfection. A further review of the document found that it states, Quarterly Free chlorine monitoring will include, but not limited to: .4. Monitor water leaving the boiler. (the hot water supply).

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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 interview and record review, the facility failed to ensure Certified Nursing Assistants (CNAs) employed by the facility received at least 12 hours of annual in-service education, resulting in the potential for inadequate care and unmet needs of residents. This had the potential to affect all residents who reside in the facility. Findings include:In an interview on 04/17/2026 at 1:46 PM, Staff Scheduler (SS) L reported that she was not familiar with CNA in-service hour requirements. In an interview on 04/17/2026 at 1:59 PM, Director of Nursing (DON) C reported that CNA's were assigned monthly trainings through an online platform and the HR (Human Resource) person tracked those. In an interview on 04/17/2026 at 2:25 PM, Interim-Chief Executive Officer (I-CEO) B reported that he was not able to provide tracking information for CNA in-service hours. I-CEO B reported that Infection Preventionist (IP) E was also responsible for staff education but the task was not being completed. I-CEO B reported that he would provide a report to show the lack of in-service tracking. Review of CNA In-service Reports provided by the facility failed to confirm that all CNA's employed by the facility received the required 12 hours of annual in-service. Numerous CNA's that were listed did not complete the assigned monthly trainings.Review of The Importance of Continuing Education Credits in Healthcare, www.leaderstat.com, 2024, revealed: According to The Institute For Health Care Improvement, CE (continuing education) is a vehicle for spreading best practices and how to improve patient outcomes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement resident focused care plans based on a comprehensive assessment for 5 (Resident #41, #45, #53, #61, and #10) of 18 residents reviewed for comprehensive care plans, resulting in unidentified care needs and the potential for worsening of medical conditions. Findings include: Resident #41 Review of an admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral (tailbone) region stage unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #41, with a reference date of 3/11/26 revealed a Brief Interview for Mental Status (BIMS) score of severe cognitive impairment. Review of Behaviors revealed no rejections of care. Review of the Functional Abilities revealed that Resident #41 was completely dependent on staff for toileting and transfers. Review of Resident #41's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 3/20/26 revealed, Sensory perception: slightly limited. Moisture: very moist.Bedfast (does not get out of bed). Resident is very limited. Makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently. Nutrition: Excellent. Friction and shear: problem. Braden Score: 13. This evaluation indicated the resident is at moderate risk to develop a pressure ulcer. Review of Resident #41's Skin Care Plan revealed, I am at risk for skin breakdown. Date initiated: 11/26/25. Interventions: Educate resident/representative about primary risk factors and prevention, Monitor for pain and medicate as necessary per physician order. Notify resident/representative of any new areas of skin alteration. Report any changes in skin status to physician. Date initiated 11/26/25. Additional interventions, Roho (air filled to reduce pressure) cushion to wheelchair, Turn and reposition every 2 hours as requested and tolerated. Date initiated 1/27/26. There was no indication of why Resident #41 was at risk for skin breakdown. There was no care plan related to Resident #41 incontinence and/or urinary catheter use. Review of Resident #41's Wound Care Plan revealed, .I have wound on my sacral buttock area, left BKA (below the knee amputation) surgical incision, left gluteus, right gluteus. Date initiated: 12/19/25. Interventions: .Monitor ulcer for signs of infection, Monitor ulcer for signs of progression or declination, notify provider if no signs of improvement on current wound regimen, Provide wound care per treatment order. Date initiated: 12/10/25. Additional interventions: .Air mattress DX (diagnosis) sacral decubitus (pressure ulcer). Offload wounds while laying in bed and in chair as tolerated, cushion in wheelchair. Provide wound care per treatment order. Date initiated: 1/6/26. There was no information related to Resident #41's pressure ulcer on the right foot and/or the use of a blue protective boot and did not include the use of an indwelling urinary catheter to promote wound healing. Review of Resident #41's Infection Control Care Plan revealed, Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(MDRO). The resident must be placed in isolation (enhanced) due to risk of spreading MDRO's via an indwelling device, chronic/non-healing wound. Date initiated: 1/6/26. Interventions: .Staff are to wear PPE (personal protective equipment) before entering room if they are providing high contact care. Date initiated: 1/6/26. There was no indication of what type of indwelling device was being used. Review of Resident #41's Kardex (care guide for direct care staff) and the record did not include that Resident #41 should have a blue boot on her right foot for pressure ulcers and did not include that she had an indwelling urinary catheter. During an observation and interview on 04/14/2026 at 11:03 AM Resident #41 was lying in her bed and Hospice Nurse (HN) M was performing wound care and a wound dressing change for Resident #41's sacral wound. Resident #41 verbalized that the wound was painful. Observed a foley catheter bag hanging from the bed frame. HN M was not wearing a gown. Review of Resident #41's Hospice Progress Note dated 4/14/26 revealed, .Communicates verbally very effectively.Rates sacral wound pain 8/10.Wound care provided: Sacrum – stage 4 pressure wound – 6 x 6 x1 cm (centimeters), right heel – stage 1 pressure wound 2 x 2 cm, right lateral foot – stage 1pressure wound 0.3 x 0.3 cm. In an interview on 04/15/2026 at 12:12 PM, Certified Nursing Assistant (CNA) W reported that Resident #41 does not get out of her bed and was not able to make her needs known related to being incontinent. CNA W reported that she had checked on Resident #41 a couple of hours ago, approximately 10:15 AM and she was dry, so she did not reposition her, she just let the resident rest. CNA W reported that Resident #41 had big sores on her buttocks and would be repositioned after lunch around 2:00 PM. During subsequent observations on 04/15/2026 from 11:39 AM-1:23 PM when Resident #41 received lunch, she remained in the same position. At 1:23 PM Resident #41's HOB (head of bed) was raised so that she could eat lunch. Resident #41 remained in this position until approximately 2:42 PM (4 1/2 hours) when this surveyor requested to observe Resident #41's wound dressings along with LPN KK. In an interview and observation on 04/15/2026 at 2:42 PM, LPN KK reported that she had changed Resident #41's wound dressing on her sacrum early that morning and flushed her foley catheter. LPN KK reported that the wound did not look good, there was a lot of slough (white dead tissue) and green drainage. LPN KK reported that Resident #41 was on an oral antibiotic for the wound. Observed Resident #41 still lying in bed, positioned on her left side, with the HOB at 45-90 degrees. Observed a large adhesive bandage covering Resident #41's sacrum, and bandages covering her right foot and heel. Observed Resident #41's catheter tubing pulled tight and laying across her right leg; there was no catheter securement device observed to anchor the tubing in place. In an interview on 04/16/2026 at 8:14 AM, Unit Manager (UM) D reported that Resident #41's last wound clinic visit was on 4/6/26 and an antibiotic was ordered due to Resident #41's sacral (coccyx, tailbone) wound infection at that time. UM D reported that Resident #41 was hospitalized [DATE]-[DATE] for UTI (urinary tract infection) and returned to the facility with a foley catheter (an indwelling device to drain urine from the bladder) in place to help with sacral wound healing. Review of Resident #41's Wound Clinic Visit dated 3/9/26 at 11:00 AM revealed, .Her wound has declined today. Please encourage increased repositioning from side to side . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident #41's Hospital After Visit Summary dated 3/19/26 (admitted on [DATE]) revealed, .Transfer Instructions: .Wound Site: Sacrum .Right heel, Right lateral foot, left medial thigh and left upper lateral thigh.Foley in place for maintenance of sacral wound. Review of Resident #41's Hospital Wound Consult Dated 3/12/26 revealed, .consulted for a coccyx, right heel and buttock wounds.Several more wounds that were found. Right buttock, right heel, right lateral foot, left medial thigh and left lateral thigh are all deep tissue wounds. Left buttock is a stage 2, sacral wound is a stage 3.Wound Assessment: 1. Sacral.length 5.5 cm x width 5 cm x depth 0.6 cm. 2. Left medial thigh DTPI (deep tissue pressure injury). length 5.5 cm x width 5 cm. 3. Left upper later thigh DTPI. length 5 cm x width 3 cm. 4. Left Buttock Stage 2 Pressure injury. length 1 cm x width 1 cm. 5. Right heel DTPI (deep tissue pressure injury). length 2 cm x width 1.5 cm. 6. Right lateral foot DTPI. length 2.2 cm x 1.5 cm. 7. Right buttock DTPI. length 5 cm x width 3 cm. Assessment: .General surgery was consulted for chronic sacral decubitus ulcer.There does appear to be superficial necrotic (dead) slough at the superior and right lateral aspects of the sacral decubitus ulcer. Review of Resident #41's Wound Clinic Visit dated 4/6/26 revealed, .Based on culture results of the sacrum we would like to begin Ciprofloxin (antibiotic) 500 mg twice a day for 10 days to treat the pseudomonas (bacteria).Her wound on her sacrum has declined today. Please encourage increased repositioning from side to side. If dressings are soiled they need to be changed or risk for infection will increase. Do not wipe them off. New dressings are needed. In an interview on 04/17/2026 at 9:16 AM, CNA G reported that she had not been in with Resident #41 since the start of her shift at 7:00 AM (2 hours ago). CNA G reported that she would have to look at Resident #41's kardex/care plan to know what care needed to be done. Resident #45 Review of an admission Record revealed Resident #45 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #45, with a reference date of 3/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #45 was cognitively impaired. Review of the Functional Abilities revealed that Resident #45 required partial to moderate assistance with toileting and hygiene. Review of Resident #45's Skin Care Plan revealed, I am at risk for skin breakdown.Date initiated: 4/19/21. Interventions: .Report any changes in skin to physician. Date initiated: 5/10/23. There was no mention of skin breakdown on buttocks, wound on chin, and/or pressure ulcer prevention. There was no personalized skin care plan related to Resident #45. During an observation on 04/14/2026 at 11:27 AM Resident #45 was lying in his bed, his gown was soiled with flakes of dried blood and there was a large open wound on his left chin/neck. In an interview on 04/15/2026 at 1:40 PM, LPN KK reported that the wound on Resident #45's chin/neck was a skin cancer that he elected not to get treatment for several years ago. LPN KK reported that there are no orders for wound care and/or a dressing. LPN KK reported that Resident #45 stayed in bed most of the time. During an observation on 04/15/2026 at 4:09 PM Resident #45 was lying in his bed. UM D and LPN KK (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	entered the room to complete a wound assessment. Observed a large deep open wound on his right chin/neck area that was beefy red and crusted along the edges. UM D measured the chin/neck wound; 5.5 cm x 5.5 cm. In an interview on 04/15/2026 at 4:25 PM, CNA W reported that Resident #45 needed encouragement for ADL's (activities of daily living), usually was incontinent of urine and occasionally used the toilet for bowel movements. In an interview on 04/16/2026 at 7:32 AM, CNA GGG reported that Resident #45 rarely gets out of bed or moves around in bed. CNA GGG reported that Resident #45 is always incontinent of urine but at times will use the toilet for a bowel movement. CNA GGG reported that Resident #45 has open areas on his bottom on and off. CNA GGG reported that direct care staff did not perform any type of wound care or cleansing of the open wound on Resident #45's chin. In an interview on 04/17/2026 at 9:12 AM, CNA G reported that Resident #45 is incontinent in his brief but will also use the toilet. CNA G reported that she had not provided care to Resident #45 yet that day and was not familiar with the resident's wounds and to her knowledge he is not on any type of infection control precautions. In an interview on 04/16/2026 at 7:44 AM, UM D reported that she had just completed a thorough skin check and wound assessments for Resident #45. UM D reported that she did observe a stage 1 pressure wound on Resident #45's buttocks and she would be entering orders for barrier cream and repositioning. UM D reported that she would also be adding EBP for Resident #45 due to the chronic open wound on his chin/neck. Resident #53 Review of an admission Record revealed Resident #53 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: Pressure ulcers of sacral region and heel, both unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #53, with a reference date of 2/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #53 was cognitively intact. Review of the Functional Abilities revealed that Resident #53 required substantial/maximal assistance (>50%) for rolling in bed and was completely dependent on staff for toileting needs. Review of Resident #53's Braden Scale for predicting Pressure Ulcer Risk Evaluation dated 2/5/26 revealed, 12 indicating at high risk to develop pressure ulcers. Review of Resident #53's Skin Care Plan revealed, I am at risk for skin breakdown. Date initiated: 10/31/25. Interventions: Monitor for pain and medicate as needed per physician's order. Date initiated: 10/31/25. There was no documentation related to Resident #53's risk for pressure ulcers and/or interventions in place to reduce the risk. There was no personalized care plan related to Resident #53's need for assistance with bed mobility, toileting and or status of bowel and bladder continence. There was no care plan related to Enhanced Barrier Precautions (EBP). Review of Resident #53's Wound Management Care Plan revealed, Bilateral heels, Coccyx. Date initiated: 11/6/25. Interventions: Measure ulcer on regular intervals. Monitor ulcer for signs of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection. Monitor ulcer for signs of progression or declination. Notify provider if no signs of improvement on current regimen. Provide wound care per treatment orders. Date initiated 11/6/25. There were no updates made to this care plan and no personalized interventions. In an interview on 04/15/2026 at 8:36 AM, LPN LL reported that Resident #53 does not get out of bed anymore and the wound on her buttocks was not doing good at all. LPN LL reported that Resident #53 was incontinent of bowel and bladder, very compliant with cares and repositioning, but the blue protective boots do not stay on her feet well. LPN LL reported that Resident #53 also had pressure point wounds on the tips of her toes, therefore staff had to constantly watch so that her feet don't press up against the end of the bed. It was noted that this information was not included in Resident #53's care plan. In an interview on 04/16/2026 at 9:25 AM, UM D reported that Resident #53 had wounds on her heels and buttocks, and at one time a couple months ago had concerns for osteomyelitis (infection in the bone caused by infected tissue) because the wounds on her feet were not healing. UM D did not know the status of Resident #53's wounds. Reviewing Resident #53's records with UM D and there was no documentation of wound assessments that measured size, no pressure wound interventions listed, and all weekly skin checks were noted as normal. Review of Resident #53's Physician Note dated 2/9/26 revealed, .Staff concerned with skin issues on her bilateral feet. Bilateral heel wounds were being treated with Dakins (helps reduce infection and promote healing) solution on bilateral heels while floating and has an air mattress to offload pressure. Now concern with discoloration of toes.Physical exam: .Bilateral heels have stage 3 pressure injury with beefy red wound base and macerated edges surrounding both wounds are individually the size of a nickel, right great toe has deep purple scab to the tip of the toe, right 2nd digit has small area on the pad of the toe which is dark purple, left great toe appears to have gangrene at the tip, left 2nd digit has gangrene nearly to the DIP (distal interphalangeal: closest to tip of toe) joint, bilateral legs have venous insufficiency with skin color changes.Assessment and Plan: 1. Impaired skin integrity. New orders placed for wounds on bilateral heels and toes. X-ray of bilateral feet. Vascular referral ASAP. Concern with gangrene. The wounds on Resident #53's toes were not included in the care plan. During an observation and interview on 04/17/2026 at 9:49 AM Resident #53 was sitting up in bed and reported that her butt was sore. Resident #53 was not wearing the blue protective boots on her feet. During an observation on 04/17/2026 at 10:26 AM Resident #53 was still sitting up in her bed and her blue protective boots were not in place on her feet. UM D was present in the room, preparing to complete wound care. In an interview on 04/17/26 at 11:11 AM, CNA CC reported that Resident #53 was very compliant with care and would stay in whatever position we place her in; she does not refuse repositioning or the blue protective boots. CNA CC reported that Resident #53 was always incontinent and that the last time she had completed incontinence care for Resident #53 was the day before. CNA CC was not aware that Resident #53 should have EBP in place. In an interview on 04/17/2026 at 11:40 AM, Infection Preventionist (IP) E reported that she had just been informed that Resident #53's wounds were deteriorating therefore the resident would be placed on EBP. In an interview and observation on 04/17/2026 at 12:04 PM, Registered Nurse (RN) I reported that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they were applying betadine (antiseptic for infection prevention) to Resident #53 toes. Observed Resident #53 lying in her bed; her left great toe had a thick scab covering the tip, and the 2nd and 3rd toes were discolored black at the tips. RN I reported that Resident #53's left great toe was an unstageable pressure injury. Resident #61 Review of an admission Record revealed Resident #61 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #61, with a reference date of 1/12/26 revealed a Brief Interview for Mental Status (BIMS) score of 15, out of a total possible score of 15, which indicated Resident #61 was cognitively intact. Review of the Functional Abilities revealed that Resident #61 required substantial/maximal assistance to roll in bed and was dependent on staff for toileting. Review of Resident #61's Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated 4/9/26 revealed .Occasionally moist. Activity: bedfast. Resident is slightly limited, makes frequent though slight changes in body or extremity position independently.Score 14. This indicated Resident #61 was low-moderate risk. Review of Resident #61's Skin Care Plan revealed, At risk for skin breakdown related to dependence on staff for assistance with bed mobility, morbid obesity, incontinence.Date initiated: 1/5/22. Revision on: 9/7/23. Interventions: Apply barrier cream to left hip q (every) shift and PRN (as needed). Date initiated: 12/21/23. Apply Calmoseptine (moisture barrier cream) to left gluteal fold every shift and PRN with incontinence episode for friction shearing. Dated initiated: 4/24/24.Standards of care for pressure relief and skin breakdown prevention. Date initiated: 1/5/22. Revision on: 6/17/24. There were no personalized care plans related to toileting needs and/or prevention of pressure wounds. The most recent revisions were approximately 2 years ago and did not include current physician orders. During an observation on 04/15/2026 at 1:58 PM CNA W was at the bedside performing incontinence care for Resident #61. CNA W positioned Resident #61 on her right side and 2 raised crusted areas of skin were observed near the resident's gluteal crease (butt crack) with the entire surrounding skin on the buttocks and upper thighs bright red. Resident #61 winced in pain when CNA W touched the area. CNA W applied a thick coating of antifungal powder to the buttocks area and reported that Resident #61 did not have any topical treatments ordered. CNA W reported that staff applied the powder after each incontinent episode. In an interview on 04/16/2026 at 8:48 AM, UM D reported that Resident #61 should have A&D barrier cream at the bedside to be used after incontinence care and as needed. After further review of Resident #61's record, UM D reported that the resident had a pressure ulcer on her buttocks and the antifungal powder should not be applied to that area. UM D could not report when the last time Resident #61's pressure wound on her buttocks had been assessed. Review of Resident #61's Physician Orders revealed, Cleanse excoriation on buttocks with wound cleanser. Apply A&D (skin protectant) ointment to area with each incontinence episode and PRN. Every day and night shift for excoriation healing. Start date: 2/16/26. Apply anti-fungal powder to peri-area and inner thighs leave brief open until resolve two times a day. Start date: 2/28/25. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to Fundamentals of Nursing ([NAME] and [NAME]) 9th edition, The care plan (see Chapter 18) is a map for nursing care and demonstrates your accountability for patient care. By making accurate nursing diagnoses, your subsequent care plan communicates a patient's health care problems to other professionals and ensures that you select relevant and appropriate nursing interventions .A well-planned, comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation (see Chapter 20). The plan of care communicates nursing care priorities to nurses and other health care providers. The care plan (see Chapter 18) is a map for nursing care and demonstrates your accountability for patient care. By making accurate nursing diagnoses, your subsequent care plan communicates a patient's health care problems to other professionals and ensures that you select relevant and appropriate nursing interventions. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 16159-16161). Elsevier Health Sciences. Kindle Edition. A well-planned, comprehensive nursing care plan reduces the risk for incomplete, incorrect, or inaccurate care. As a patient's problems and status change, so does the plan. A nursing care plan is a guideline for coordinating nursing care, promoting continuity of care, and listing outcome criteria to be used later in evaluation (see Chapter 20). The plan of care communicates nursing care priorities to nurses and other health care providers. [NAME], [NAME] A.; [NAME], [NAME] Griffin; Stockert, [NAME]; Hall, [NAME]. Fundamentals of Nursing - E-Book (Kindle Locations 16878-16882). Elsevier Health Sciences. Kindle Edition. Resident #10 Review of an admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks) and anxiety disorder. Review of Resident #10's Care Plan revealed, Focus: I (Resident #10) have impaired cognitive function/dementia, Alzheimer's disease, or impaired thought processes Date Initiated: 03/30/2021. Goal: I will maintain current level of cognitive function through the review date. Date Initiated: 03/30/2021. interventions: Administer meds (medications) as ordered, Monitor/document /report to MD (Medical Doctor) any changes in cognitive function, specifically changes in: decision making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, mental status. Date Initiated: 03/30/2021. During an interview on 4/17/2026 at 12:56 PM, Manager of Case Management (MCM) BB reported that she was responsible for creating resident care plans. MCM BB reported that Resident #10's dementia care plan was the facility standard dementia care plan, and that Resident #10's care plan interventions did not include comprehensive and individualized goals because Resident #10 had a behavior care plan that addressed Resident #10's dementia diagnosis. Review of Resident #10's Behavior Care Plan revealed, Focus: I (Resident #10) have a mood/behavior problem r/t (related to) my distressing delusions/hallucinations . Date initiated: 3/30/21. Goal: I will be without s/s of adverse side effects of my psychotropic medications as evidenced by observation (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and documentation. Date Initiated: 07/22/2021. Interventions: Assure me that I am safe and I do not have to leave the SNF (skilled nursing facility) Date Initiated: 07/22/2021, Call my niece. Date Initiated: 10/04/2022, encourage care, food and weights. Date Initiated: 10/18/2022, Introduce self and reason for visit. Date Initiated: 04/17/2026, and Review in Behavior WellnessDate Initiated: 03/30/2021. Noted that Resident #10's Dementia and Behavior care plan was not individualized and did not address Resident #10's medical, nursing, or mental and psychosocial needs identified in her most recent comprehensive assessment. During an interview on 4/17/2026 at 1:01 PM, Nursing Home Administrator (NHA) A reported that he had recently discovered that resident care plans at the facility needed improvement, as many were not individualized and person-centered based on resident needs. NHA A reported that the facility had not initiated any changes to resident care plans at the time of the interview.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to revise care plan interventions for pressure ulcer prevention for 1 (Resident #18) of 18 residents reviewed for care planning, resulting in staff being unaware of current pressure ulcer prevention interventions for the resident, and a potential for the resident to experience worsening of pressure ulcers. Findings include: Resident #18Review of an admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (an umbrella term for a decline in mental ability, such as memory, language, problem solving skills) and heart failure (chronic condition in which the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs).Review of a Minimum Data Set (MDS) assessment for Resident #18 with a reference date of 2/20/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 1/15, which indicated the resident was severely cognitively impaired. Section M of the MDS revealed Resident #18 was at risk of developing pressure ulcers.Review of a Care Plan for Resident #18 with a reference date of 10/9/25 revealed the following focus/goal/interventions: Focus: I am at risk for skin breakdown r/t (related to) dependence on staff for assist with bed mobility.Goal: To minimize or prevent skin breakdown during residents stay.Interventions: Float heels on pillow as tolerated and skin prep to R (right) heel for prevention of breakdown. There was no intervention for the use of heel protector boots.Review of Physician Orders for Resident #18 with a reference date of 4/2/26, revealed Heel protectors at all times, every day and night shift for prevention of skin impairment. Further review revealed Resident #18's roommate did not have orders for use of heel protectors.In an interview on 4/15/26 at 2:20pm, Certified Nursing Assistant (CNA) H reported she worked on units throughout the building and referred to each resident's Kardex to know their care needs. CNA H reported the information for the Kardex came from the resident's care plan. When queried regarding pressure ulcer prevention strategies that were in place for Resident #18, CNA H reported he used a specialty mattress. When further queried, CNA H stated they were using boots for his feet at one point, then confirmed it was her understanding the resident no longer needed the heel protector boots.Review of a Kardex (summary of care needs) for Resident #18 revealed Resident Care: Float heels on pillow as tolerated and skin prep to R heel for prevention of breakdown. The Kardex did not include information about the physician's order for heel protectors.During serial observations on 4/16/26 at 8:16am, 8:42am, 8:55am, 9:15am, 9:36am and 9:50am, Resident #18 was lying supine in bed with both heels resting directly on the mattress. Resident #18's heel protector boots were in a chair by his roommate's bed.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake 2642352. Based on observation, interview, and record review, the facility failed to ensure assistance with activities of daily living (ADL) care was provided for 4 (Resident #1, #57, #16, #26) of 7 residents reviewed for ADL care, resulting in the potential for avoidable negative physical and psychosocial outcomes for resident's dependent on staff for assistance. Findings include: Resident #1: Review of Care Plan for Resident #1, revised on 3/3/26, revealed the focus, .I have an ADL (activities of daily living) deficit and need assistance with daily care r/t (related to) weakness/debility. with the intervention .ADL care to meet my needs. During an observation and interview on 04/14/2026 at 10:55 AM, Resident #1 reported she was scheduled to get her showers on Thursdays and Saturdays. Resident #1 was observed to have greasy appearing hair, her face appeared as if it needed to be washed, hair needed to be combed, and when this writer questioned if staff had offered to get a basin or washcloth for her to wash her face she indicated they had not on this day. Review of Shower Sheets revealed Resident #1 received bed baths on 4/4/26, 4/2/26, 2/28/26, and 2/22/26. Resident #1 received a shower on 3/28/26. It was noted on a shower sheet dated 3/14/26. Resident #1 was admitted on [DATE] which indicated she had 16 opportunities for staff to provide her with a shower/bed bath. Resident #1 was provided with a total of 5 shower/bed baths during this time. During an observation and interview on 04/16/2026 at 3:02 PM, Resident #1 reported she had received a bed bath earlier, but her hair appeared dirty and greasy still. When this writer queried when the last time was, she had her hair washed, Resident #1 reported it had been a couple weeks at least. Resident #57: Review of an admission Record revealed Resident #57 was a male with pertinent diagnoses which included dementia and physical debility. During an observation on 04/14/2026 at 9:52 AM, Resident #57 was observed seated in his reclining broda chair (specialized adjustable wheelchair or positioning chair designed for residents with mobility challenges) in the TV room area. Resident #57 was observed to have fingernails which extended far beyond the fingertips, the nails were jagged and misshapen, with dark dried material under the nails gathered at the hyponychium (seal of skin located just beneath the free edge of the nail plate, acts as a barrier to bacteria, fungi, and debris from entering the nail bed). During an observation on 04/15/26 at 4:01 PM, Resident #57 was observed seated in the tv room area and he had dark dried material under his fingernails, his fingernails extended far beyond the fingertips and were broken and jagged. During an observation on 04/17/2026 at 11:50 AM, Resident #57 was observed seated in the tv room (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	area and he had dark dried material under his fingernails, his fingernails extended far beyond the fingertips and were broken and jagged. In an interview on 04/17/2026 at 12:53 PM, UM D reported the nurses were able to cut the fingernails for a resident when asked. UM D reported the nail clippers were not kept in the nurse's cart, and the nurse would have to go to downstairs to supply to obtain them. UM D reported the CNAs were able to use the wooden nail cleaning tool to clean under a resident's fingernails during a resident's scheduled shower. Resident #16 Review of an admission Record revealed Resident #16 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: schizoid personality disorder (chronic mental health condition characterized by limited emotional expression, strong preference for isolation and lack of motivation), depression (a serious, common mental illness causing persistent sadness) and body max index (BMI) 40-44.9 (morbid obesity). Review of a Minimum Data Set (MDS) assessment for Resident #16 with a reference date of 2/6/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section D of the MDS revealed Resident #16 felt down, depressed, or hopeless during 12-14 days of the 14-day assessment period. Section GG of the MDS revealed Resident #16 was dependent (helper does all of the effort) for bathing. Review of a Care Plan for Resident #16 with a reference date of 1/27/26 revealed the following focus/goal/interventions: Focus: I have an ADL (activities of daily living) deficit and need assistance with daily care.I prefer a bed bath.Goal: I will have my needs met on a daily basis as evidenced by my neat, clean, well groomed appearance.Interventions: ADL care to meet my needs. During an observation and interview on 4/14/26 at 4:15pm, Resident #16's hair appeared tangled and disheveled, and facial hairs were noted on her chin. Resident #16 reported she preferred to have a bed bath rather than a shower but was only being assisted with getting cleaned up (bed bath or shower) about once a week and she felt that was not enough. Review of Shower Sheets for Resident #16 revealed the resident was a shower or bed bath on 4 occasions between 2/15-4/15/26. Review of a Kardex (brief overview of a resident's care needs) revealed Bathing: Bed bath 2 person assist with care at all times, on Saturday afternoon to late evening. Review of an electronic communication received on 4/15/26 at 1:02pm revealed Chief Executive Officer (CEO) B reported the facility did not have any additional shower sheets for Resident #16 for the period of 2/15-4/15/26. Resident #26 Review of an admission Record revealed Resident #26 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: congestive heart failure (progressive condition where the heart muscle is too weak to pump blood efficiently) and major depressive disorder (serious mental health condition characterized by at least 2 weeks of persistent, severe sadness, loss of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interests, fatigue). Review of a Minimum Data Set (MDS) assessment for Resident #26 with a reference date of 3/7/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 11/15, which indicated the resident was moderately cognitively impaired. Section GG of the MDS revealed Resident #26 required maximal assistance (helper does more than half) for bathing. Review of a Care Plan for Resident #26 with a reference date of 12/5/25 revealed the following focus/goal/interventions: Focus: I have an ADL deficit and need assistance with daily care.I often refuse bed baths, showers.Goal: I will maintain my current level of function through the review date. Interventions.no male caregivers, staff to assist me with ADLs.PRN (as needed) . Review of a Summary of Complaint with a reference date of 10/14/25 at 9:42am revealed Complainant stated the staff are not taking care of (Resident #26) .Complainant states that (Resident #26) has an odor. (Resident #26's) hair has been observed filthy. (Resident #26) smells of body odor. Efforts to contact the complainant were unsuccessful prior to the conclusion of the survey. Review of a Task Description for Resident #26 revealed ADL-Bathing Mondays and Thursday AM; I often refuse to take a shower/bath in the shower room; I would rather have a bed bath most of the time on my shower days. During an observation and interview on 4/14/26 at 4:22pm, Resident #26 was in bed, was wearing a hospital gown and appeared disheveled. Resident #26 reported she does not get cleaned up as often as she would like and isn't offered the opportunity twice a week. Review of Shower Sheets provided by the facility for Resident #26 revealed the resident was offered or received bathing during 10 of 17 opportunities between 2/15-4/25/26. Review of an electronic communication received on 4/15/26 at 1:02pm revealed Chief Executive Officer (CEO) B reported the facility did not have any additional shower sheets for Resident #26 for the period of 2/15-4/15/26. In an interview on 4/16/26 at 8:49am, Certified Nursing Assistant (CNA) MM reported when staffing numbers fall below what was scheduled, staff were not able to offer residents shower/bathing assistance at times. In an interview on 4/16/26 at 2:49pm Unit Manager (UM) D reported CNAs were expected to complete a shower sheet each time they offered residents assistance with bathing. UM D reported after the CNA completed a shower sheet; the nurse was expected to sign it and then turn it in for the UM to review it. UM D reported each resident was scheduled to receive at least 2 opportunities for bathing each week and could request additional opportunities per their preference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake #2616992Based on observation, interview and record review, the facility failed to ensure residents achieved their highest practicable physical well-being and follow professional standards of practice by: 1. ensure staff assess and monitor non-pressure wounds, 2.) recognize and assess symptoms of infection, 3.) follow physician's orders for use of medication, and 4.) recognize episodes of hypoglycemia(low blood sugar level)/hyperglycemia(elevated blood sugar level) requiring physician's notification in 5 (Resident #29, #45, #3, #18 and #10) of 18 residents reviewed for quality of care, resulting in Resident #29 not being assessed or treated for potential eye infection, the potential for infection of a wound for Resident #45, Resident #3's elevated blood sugar levels going unreported to the physician, Resident #18's low blood sugar level not being reported to the physician, and Resident #10 receiving medications outside ordered parameters. Findings include:Resident #29: Review of an admission Record revealed Resident #29 was a male with pertinent diagnoses which included diabetes, mild cognitive impairment (noticeable memory or thinking changes), acquired absence of left eye, strep group B (bacteria can cause sepsis) in left knee, and arthritis due to bacteria in left knee. Review of current Care Plan for Resident #29, revised on 3/11/26, revealed the focus, .I am at risk for skin breakdown. with the intervention .Notify resident/representative of any new areas of skin alteration. During an observation and interview on 04/14/2026 at 1:13 PM, Resident #29 was dressed and observed seated in his wheelchair. This writer observed Resident #29's left eye which had thick dried green eye discharge matted on his top and bottom eyelashes. Resident #29 had moist, stringy green material which stretched from the top to bottom lashes. His bottom and top left eye lids appeared irritated and swollen. Resident #29 reported he believed the issue with his eye was a blocked tear duct and reported he does not have an ointment placed in his eye, and the nurse sometimes put drops in his eye. Review of Medication Administration Record (MAR) for Resident #29 revealed, he was prescribed on 3/11/26, Refresh Tears Ophthalmic Solution.Instill 3 drops in both eyes three times a day for dry eyes. Review of the MAR for March 2026 and April 2026, revealed it was documented Resident #29 had received drops in his eyes three times per day at 0900, 1400 (2:00 PM), 2100 (9:00 PM). In an interview on 04/17/2026 at 11:14 AM, Director of Nursing (DON) C reported the nurse should clean the resident's face and eyes, complete an assessment and notify the provider to do a follow up. Review of Resident #29's medical record revealed there was no physician communication note for the physician to follow up with the resident on his left eye discharge. In an interview on 04/16/2026 at 9:42 AM, Infection Preventionist (IFP) E reviewed the infection tracking report and reported she did not have Resident #29 on the tracking. IFP E reported due to the lack of documentation by the floor nurses quite frequently a resident would be started on an antibiotic or require precautions and they would not complete the necessary documentation, and she would not (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	be notified and therefore she would not be tracking the resident. IFP E reviewed Resident #29's medical record and reported there was nothing there which indicated a concern for infection with his left eye. This writer explained the observation had of Resident #29's eye and IFP E reported the resident should have been assessed and the provider contacted to assess further. IFP E reported she had provided education to the nurses on 2/12/26 using the assessment and documenting findings in progress notes. Review of Resident #29's provider progress notes revealed no assessment or documentation of a concern for potential infection in Resident #29's left eye. In an interview on 04/17/2026 at 12:12 PM, Interim Chief Executive Officer (CEO) B reported Nurse Practitioner (NP) N stated she was not aware Resident #29 had unusual drainage from the removal of his left eye. In an interview and review of Resident #29's medical record on 04/17/2026 at 11:15 AM, Director of Nursing (DON) C reported she was unable to locate a progress note, and/or an assessment for possible infection in the medical record. DON C reported there was not a physician communication note for the concern with Resident #29's eye. Resident #45 Review of an admission Record revealed Resident #45 was originally admitted to the facility on [DATE]. Review of a Minimum Data Set (MDS) assessment for Resident #45, with a reference date of 3/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 5, out of a total possible score of 15, which indicated Resident #45 was cognitively impaired. Review of the Functional Abilities revealed that Resident #45 required partial to moderate assistance for hygiene. Review of Resident #45's Skin Care Plan revealed, I am at risk for skin breakdown.Date initiated: 4/19/21. Interventions: .Report any changes in skin to physician. Date initiated: 5/10/23. There was no mention of a wound on Resident #45's chin. During an observation on 04/14/2026 at 11:27 AM Resident #45 was lying in his bed, his gown was soiled with flakes of dried blood and there was a large deep open wound on his left chin/neck. There was no signage indicating that Resident #45 had Enhanced Barrier Precautions (EBP) in place for the open wound that was not covered. Review of Resident #45's Weekly Skin Check dated 4/6/26 revealed, Skin warm & dry, skin color WNL and turgor is normal. No new skin issues identified . # 3 Skin issue has NOT been evaluated. Location: chin, left.open wound that resident picks at non-stop.Wound is greater than 3 months . Resident #45's Weekly Skin Checks dated 3/27/26 and 3/20/26 are exactly the same as 4/6/25. In an interview on 04/15/2026 at 1:40 PM, LPN KK reported that the wound on Resident #45's chin/neck was a skin cancer that he elected not to get treatment for years ago. LPN KK reported that there were no orders for wound care and/or a dressing. Review of Resident #45's Dermatology (skin specialist) Visit Note dated 7/19/23 revealed, .Basal Cell Carcinoma (skin cancer), nodular type on the left inferior medial buccal cheek (lower cheek/chin). We (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommend the following: Schedule [NAME] (a type of surgery to remove skin cancer and preserve tissue). Due to size of lesion we were not able to operate today, this is being referred to plastics for treatment. Review of Resident #45's Provider Visit Note dated 4/7/26 revealed, .Noted to have a basal cell carcinoma on his jaw line. However, this skin cancer has progressed from a small lesion, which would have been usually excised under local anesthetic to the deep ulcerative lesion that swell (sic) into the subcutaneous tissue. In an interview on 04/15/2026 at 3:38 PM, UM D reported that Resident #45 had a skin cancer on his left chin/neck a few years ago and declined surgical interventions. UM D reported that they do not currently have orders in place to clean the wound, no wound dressing orders, and there are no orders in place for monitoring the wound. UM D reported that Resident #45's left chin/neck wound was not being documented in the weekly skin checks; the assessment details were copied from the week before. During an observation on 04/15/2026 at 4:09 PM Resident #45 was lying in his bed. UM D and LPN KK entered the room to complete a wound assessment. Observed a large deep open wound on his left chin/neck area that was beefy red and crusted along the edges. There were flakes of crusted blood covering the front of Resident #45's gown and his fingernails had blood underneath them. UM D measured the chin/neck wound; 5.5 cm x 5.5 cm. In an interview on 04/16/2026 at 7:32 AM, CNA GGG reported that direct care staff did not perform any type of wound care or cleansing of the open wound on Resident #45's chin. In an interview on 04/16/2026 at 7:44 AM, UM D reported that she had just completed a thorough skin check and wound assessments for Resident #45. UM D reported that she would also be adding EBP for Resident #45 due to the chronic open wound on his chin/neck. In an interview on 04/16/2026 at 7:57 AM, Director of Nursing (DON) C reported that she understood the concern for non-compliance with wound management and that the facility would be implementing a new program going forward to ensure that wound assessments were completed accurately and that there was a qualified provider driving the treatment of wounds. Resident #3 Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: type 2 diabetes (chronic condition in which the body cannot use insulin (hormone produced by the pancreas that regulates blood sugar levels in the blood properly) resulting in high or low blood sugar levels), and hyperglycemia. Review of a Minimum Data Set (MDS) assessment for Resident #3 with a reference date of 3/20/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12/15, which indicated the resident was moderately cognitively impaired. Section N revealed Resident #3 received daily insulin injections. Review of a Care Plan for Resident #3 with a reference date of 3/23/26 revealed the following focus/goal/interventions: Focus: I have Diabetes Mellitus.refuse my insulin at times.Goal: I will be free from any s/sx (signs and symptoms) of hyperglycemia through the review date. Interventions: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness.report to MD (Doctor of Medicine) s/sx of hypoglycemia.repot to MD PRN (as needed) s/sx of hyperglycemia. Review of a complaint filed on 9/15/25 at 10:02am revealed Complainant states the nurse broke the rules by not calling the doctor due to a reading (blood sugar over 500) . Review of a Blood Sugar Graph for Resident #3 with a date range of 9/1/25-4/17/26 revealed the resident's blood sugar level registered at over 500mg/dL (milligrams per deciliter of blood) 3 times during that time period. Review of a Blood Sugar Summary for Resident #3 revealed the resident's blood sugar registered at 523mg/dL on 12/11/25, 547mg/dL on 12/29/25 and 541mg/dL on 3/12/26. Review of Progress Notes revealed no documentation of physician notification related to Resident #3's episodes of critical blood sugar levels on 12/11/25, 12/29/25 and 3/12/26. In an interview on 4/16/26 at 2:46pm, Unit Manager (UM) D reported it was the expectation that the responsible nurse would contact the physician if a resident's blood sugar registered less than 70mg/dL or greater than 350 mg/dL. UM D reviewed the documentation for Resident #3, confirmed his blood sugar registered greater than 500mg/dL on 3 occasions and there was no documentation that the physician was notified or that further action was taken. Resident #18 Review of an admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnosis which included: type 2 diabetes. Review of a Minimum Data Set (MDS) assessment for Resident #18 with a reference date of 2/20/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 1/15, which indicated the resident was severely cognitively impaired. Section N of the MDS revealed Resident #3 received daily injections of insulin. Review of a Care Plan for Resident #18 with a reference date of 10/9/25 revealed the following focus/goal/interventions: Focus: I have a nutritional problem r/t (related to) .DM (diabetes) with insulin.Goal: I will be free from hunger.Interventions: Administer medications as ordered. Monitor/Document for side effects and effectiveness. Review of a Blood Sugar Summary for Resident #18 with a reference date of 4/1-4/17/26 revealed the resident experienced hypoglycemia (blood sugar below 70mg/dL) on 4/1, 4/6, 4/9, and 4/14/26. Review of Progress Notes for Resident #18 on 4/1, 4/6, 4/9 and 4/14/26 revealed no documentation of physician notification of the resident's low blood sugar. In an interview on 4/16/26 at 9:44am, Licensed Practical Nurse (LPN) FF reported the nurse should contact the physician if a resident's blood sugar level was less than 70mg/dL or greater than 250mg/dL. LPN FF reported blood sugar levels outside these parameters required physician guidance. LPN FF reported the nurse should also document in a progress note that the physician was contacted and any new orders given/guidance given. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 4/16/26 at 9:47am, Registered Nurse (RN) I reported the nurse should contact the physician immediately if a resident's blood sugar level registered below 70mg/dL or above 350mg/dL unless there was already further guidance for the nurse to follow in the physician's orders for the resident. RN I reported the nurse should also document contacting the physician and the guidance they provided in a progress note. In an interview on 4/17/26 at 10:43am, Nurse Practitioner (NP) N confirmed it was an expectation that a provider would be contacted by the nurse if a resident's blood sugar was higher than 350 mg/dL or lower than 70 mg/dL because it may be necessary to further medical direction in order to maintain the well-being of the resident. Resident #10 Review of an admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks) and hypotension (low blood pressure). Review of Resident #10's Orders revealed, Midodrine (medication used to treat low blood pressure) 10 mg (milligrams). Give 1 tablet by mouth before meals for hypotension. Hold if systolic (the top (first) number in a blood pressure reading, measuring the maximum pressure in your arteries when the heart muscle contracts and pumps blood) blood pressure above 130. Review of Resident #10's Medication Administration Record (MAR) revealed that Resident #10 had received the midodrine medication when her blood pressure was out of order parameters on the following dates: 2/7/26, 2/12/26, 3/1/26, 3/7/26, 3/20/26, two administrations on 3/21/26, 3/23/26, 3/24/26, 3/25/26, 4/4/26 and 4/8/26. It was also noted that on 3/27/26 the midodrine order was documented as given without vital signs documented to indicate if Resident #10's vital signs were in parameters to administer the medication.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain complete and accurate medical records for 8 of 18 residents (Resident #41, #45, #53, #61, #7, #81, #18 and #4) reviewed for complete and accurate documentation, resulting in the potential for staff and providers mismanaging care for residents. Findings include:Resident #41 Review of an admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral (tailbone) region stage unspecified. Review of Resident #41's Wound Care Plan revealed, .I have wound on my sacral buttock area, left BKA (below the knee amputation) surgical incision, left gluteus, right gluteus. Date initiated: 12/19/25. Review of Resident #41's Hospice Progress Note dated 4/14/26 revealed, .Communicates verbally very effectively.Rates sacral wound pain 8/10.Wound care provided: Sacrum – stage 4 pressure wound – 6 x 6 x1 cm, right heel – stage 1 pressure wound 2 x 2 cm, right lateral foot – stage 1pressure wound 0.3 x 0.3 cm. At end of lengthy visit, patient confirms that her pain is unapproved. In an interview on 04/16/2026 at 8:14 AM, Unit Manager (UM) D reported that Resident #41's last wound clinic visit was 4/6/26 and an antibiotic was ordered due to Resident #41's sacral wound infection at that time. UM D reported that Resident #41 was hospitalized [DATE]-[DATE] for UTI (urinary tract infection) and returned to the facility with a foley catheter in place to help with sacral wound healing. UM D reported that the facility did not have a wound provider or nurse that specialized in wounds and expected that the floor nurse assigned to daily care for residents, should also be completing the weekly wound assessments when they are due. UM D reported that the nurse that performed the weekly assessments would not be consistent but should be able to determine wound progress by comparing the assessment details from the week prior. After reviewing Resident #41's record, UM D reported that the weekly wound assessments were not being documented as expected by the nursing staff; most of the wound information appeared to be copied and pasted from earlier assessments. UM D could not determine when the last time Resident #41's sacral (coccyx) wound and right foot wounds were formally assessed and measured by facility staff. UM D could not find any documentation to verify that staff were regularly assessing and monitoring Resident #41's wounds, other than the treatment records that were initialed, to indicate they were completed, and the wound clinic visit notes that were scanned into the record did not include wound measurements and/or characteristics. UM D could not find any documentation related to concerns that Resident #41's wounds deteriorating and or having had signs of infection prior to her being started on an antibiotic on 4/6/26. Director of Nursing (DON) C was present for this interview and could not provide any information to support compliance for Resident #41's wounds management. Review of Resident #41's Weekly Skin Check dated 3/9/26 at 2:24 PM (prior to hospitalization) revealed, .Skin warm and dry, skin color WNL (within normal limits). No new skin issues identified. Skin issue #1: .HAS NOT BEEN EVALUATED. Location left gluteus.Issue type: Pressure ulcer/injury. Wound was present on admission. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus. Issue type: Open lesion. Wound was present on admission.Skin issue #3: .HAS NOT BEEN (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	EVALUATED. Location: right gluteus. Issue type: Open lesion. Wound was present on admission. Staged by In-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus. Additional information: Sacrum. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 3 pressure ulcer/injury full thickness skin loss. Wound was present on admission. The wound assessments were not completed. Review of Resident #41's Wound Clinic Visit dated 3/9/26 at 11:00 AM revealed, .Her wound has declined today. Please encourage increased repositioning from side to side. Wound Treatment: Wound #1 location: Sacrum. Wound #5 location: Gluteus Right. The document did not include assessments of the wounds. Review of Resident #41's Hospital After Visit Summary dated 3/19/26 (admitted on [DATE]) revealed, .Transfer Instructions: .Wound Site: Sacrum .Right heel, Right lateral foot, left medial thigh and left upper lateral thigh.Foley in place for maintenance of sacral wound. Review of Resident #41's re-admission Assessment dated 3/19/26 revealed, Arrived by ambulance. Urinary Catheter intact. Skin warm and dry, skin color WNL (within normal limits). No new skin issues identified. Skin issue #1: .HAS NOT BEEN EVALUTED. Location left gluteus, proximal, superior. Issue type: Pressure ulcer/injury. Wound was present on admission. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus, distal, inferior. Issue type: Open lesion. Wound was present on admission.Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus, inferior, distal. Issue type: Open lesion. Wound was present on admission. Staged by In-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus, middle, inferior, distal. Additional information: Sacrum. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 3 pressure ulcer/injury full thickness skin loss. Wound was present on admission. It was noted that the information was copied from the 3/9/26 skin check and did not include all of the wounds listed on the hospital after visit summary that same day. Review of Resident #41's Skilled Nursing Evaluation dated 3/21/26 revealed, .Skin issue #1: .HAS NOT BEEN EVALUATED. Location left gluteus, proximal, superior. Issue type: Pressure ulcer/injury. Wound was present on admission. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus, distal, inferior. Issue type: Open lesion. Wound was present on admission.Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus, inferior, distal. Issue type: Open lesion. Wound was present on admission. Staged by In-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus, middle, inferior, distal. Additional information: Sacrum. Issue type: Pressure ulcer/injury. Pressure ulcer staging: Stage 3 pressure ulcer/injury full thickness skin loss. Wound was present on admission. There was no current assessment of Resident #41's wounds. It was noted that the information was copied from the 3/19/26 skin check and still did not include all of Resident #41's wounds. Review of Resident #41's Skilled Nursing Evaluation dated 3/22/26, 3/23/26, 3/24/26, and 3/26/26 all revealed a duplication of the skin issues documentation from 3/21/26. Review of Resident #41's Weekly Skin Check dated 3/26/26 revealed a duplication of the skin issues documentation from the previous weekly skin checks. Review of Resident #41's Wound Clinic Visit dated 4/6/26 revealed, .Based on culture results of the sacrum we would like to begin Ciprofloxin (antibiotic) 500 mg twice a day for 10 days to treat the pseudomonas (bacteria).Her wound on her sacrum (coccyx) has declined today. Please encourage (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	increased repositioning from side to side. If dressings are soiled, they need to be changed or risk for infection will increase. Do not wipe them off. New dressings are needed. Review of Resident #41's most recent Weekly Skin Check dated 4/9/26 revealed, Skin warm and dry, skin color WNP (within normal limits) .Skin issues: Skin issue #1: Skin issue HAS NOT BEEN EVALUATED. Location: left gluteus. Issue type: pressure ulcer/injury. Skin issue #2: .HAS NOT BEEN EVALUATED. Location: left gluteus. Issue type: Open lesion. Skin issue #3: .HAS NOT BEEN EVALUATED. Location: right gluteus. Issue type: Open lesion. Staged by: in-house nursing. Skin issue #4: .HAS NOT BEEN EVALUATED. Location: left gluteus. Additional location information: SACRUM. Issue type: pressure ulcer/injury. Skin issue #5: NEW SKIN ISSUE. Location: Coccyx. Issue type: Pressure ulcer/injury. Progress: Improving. Overall wound characteristics improved. Wound was present on admission. Length 1 (cm), width 1.5 (cm), depth 0 (cm). There was no documentation that wounds #1-4 were assessed and wound #5 (coccyx) was not an accurate description of the infected Stage 3 pressure wound noted in the wound clinic visit on 4/6/26. Resident #45 Review of an admission Record revealed Resident #45 was originally admitted to the facility on [DATE]. Review of Resident #45's Skin Care Plan revealed, I am at risk for skin breakdown.Date initiated: 4/19/21. Interventions: .Report any changes in skin to physician. Date initiated: 5/10/23. There was no mention of skin breakdown on buttocks, wound on chin, and/or pressure ulcer prevention. During an observation on 04/14/2026 at 11:27 AM Resident #45 was lying in his bed, his gown was soiled with flakes of dried blood and there was a large open wound on his left chin/neck. Review of Resident #45's Weekly Skin Check dated 4/6/26 revealed, Skin warm & dry, skin color WNL and turgor is normal. No new skin issues identified. Skin Issues: #1 Skin issue has NOT been evaluated. Location: buttocks-generalized.redness. #2 Skin issue has NOT been evaluated. Location: buttocks-generalized.middle.redness. # 3 Skin issue has NOT been evaluated. Location: chin, left.open wound that resident picks at non-stop.Wound is greater than 3 months. #4 Skin issue has NOT been evaluated. Location: genital.testicles.small open area, treatment in place. Resident #45's Weekly Skin Checks dated 3/27/26 and 3/20/26 are exactly the same as 4/6/25. There were no current wound assessments. In an interview on 04/15/2026 at 1:40 PM, LPN KK reported that the wound on Resident #45's chin/neck was a skin cancer that he elected not to get treatment for several years ago. LPN KK reported that there are no orders for wound care and/or a dressing. Review of Resident #45's Dermatology (skin specialist) Visit Note dated 7/19/23 revealed, .Basal Cell Carcinoma (skin cancer), nodular type on the left inferior medial buccal cheek (lower cheek/chin). Review of Resident #45's Provider Visit Note dated 4/7/26 revealed, .Noted to have a basal cell carcinoma on his jaw line. However, this skin cancer has progressed from a small lesion which would have been usually excised under local anesthetic to the deep ulcerative lesion that swell into the subcutaneous tissue. There was no mention of wound treatments and/or a wound on Resident #45's buttocks. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 04/15/2026 at 3:38 PM, UM D reported that Resident #45 had a skin cancer on his left chin/neck a few years ago and declined surgical interventions. UM D reported that they do not currently have orders in place to clean the wound, no wound dressing orders, and there are no orders in place for monitoring the wound. UM D reported that Resident #45's left chin/neck and/or buttocks wounds were not being documented in the weekly skin checks; the assessment details were copied from the week before. During an observation on 04/15/2026 at 4:09 PM Resident #45 was lying in his bed. UM D and LPN KK entered the room to complete a wound assessment. Observed a large deep open wound on his right chin/neck area that was beefy red and crusted along the edges. UM D measured the chin/neck wound; 5.5 cm x 5.5 cm. In an interview on 04/16/2026 at 7:44 AM, UM D reported that she had just completed a thorough skin check and wound assessments for Resident #45. UM D reported that she did observe a stage 1 pressure wound on Resident #45's buttocks and she would be entering orders for barrier cream and repositioning. UM D reported that she would also be adding EBP (enhanced barrier precautions, an infection intervention for residents with open wounds) for Resident #45 due to the chronic open wound on his chin/neck. Resident #53 Review of an admission Record revealed Resident #53 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: Pressure ulcers of sacral region and heel, both unspecified. Review of Resident #53's Wound Management Care Plan revealed, Bilateral heels, Coccyx. Date initiated: 11/6/25. In an interview on 04/16/2026 at 9:25 AM, UM D reported that Resident #53 had wounds on her heels and buttocks, and at one time a couple months ago had concerns for osteomyelitis (infection in the bone caused by infected tissue) because the wounds on her feet were not healing. UM D did not know the status of Resident #53's wounds. Reviewing Resident #53's records with UM D and there was no documentation of wound assessments that measured size, no pressure wound interventions listed, and all weekly skin checks were noted as normal. UM D reported that the facility did not have a dedicated wound nurse or provider, and that the floor nurse was expected to complete all wound assessments during the weekly skin check and notify UM D or a provider if there was a concern. UM D reported that the facility also uses a Wound Log to document when a concern is identified. Review of the facility Wound Communication Log revealed, (Resident #53) 4/2/26 Sacral wound purulent (a thick substance indicative of infection) drainage 3x2cm, new bruise right upper thigh/hip, new wound to right of current wound .5x.2cm. There was no documentation in the blanks for dressing orders or risk management completed. In an interview on 04/17/2026 at 10:04 AM, UM D reported that she was not aware of the wound communication log note from 4/2/26 related to Resident#53's wounds. UM D reported that Resident #53's orders had not changed since then and there were no progress notes or physician notes to correlate that the wound concern was assessed and being monitored. During an observation on 04/17/2026 at 10:26 AM Resident #53 was lying in bed with the HOB (head (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of bed) raised. At 10:46 AM UM D, CNA CC, and Nurse Practitioner (NP) N were in the room at the bedside to complete incontinence care and wound care. Upon observation, NP N reported Resident #53's coccyx wound was 8 cm x 9.5 cm and called it a Stage 3 pressure ulcer and said that it was deteriorating since there was tissue exposed. Observed a large purple discolored wound on Resident #53's right upper thigh that followed the line of an incontinence brief. UM D reported that she was not aware of the wound on the right upper thigh. Observed Resident #53's toes on her left foot discolored; the toes were not examined. In an interview and observation on 04/17/2026 at 12:04 PM, Registered Nurse (RN) I reported that they were applying betadine (antiseptic for infection prevention) to Resident #53 toes. Observed Resident #53 lying in her bed; her left great toe had a thick scab covering the tip, and the 2nd and 3rd toes were discolored black at the tips. RN I reported that Resident #53's left great toe was an unstageable pressure injury. It was noted that these wounds were not noted in the list of skin issues in the Weekly Skin Checks. Review of Resident #53's Physician Note dated 2/9/26 revealed, .Staff concerned with skin issues on her bilateral feet. Bilateral heel wounds were being treated with Dakins (helps reduce infection and promote healing) solution on bilateral heels while floating and has an air mattress to offload pressure. Now concern with discoloration of toes.Physical exam: .Bilateral heels have stage 3 pressure injury with beefy red wound base and macerated edges surrounding both wounds are individually the size of a nickel, right great toe has deep purple scab to the tip of the toe, right 2nd digit has small area on the pad of the toe which is dark purple, left great toe appears to have gangrene at the tip, left 2nd digit has gangrene nearly to the DIP (distal interphalangeal: closest to tip of toe) joint, bilateral legs have venous insufficiency with skin color changes.Assessment and Plan: 1. Impaired skin integrity. New orders placed for wounds on bilateral heels and toes. X-ray of bilateral feet. Vascular referral ASAP. Concern with gangrene. In an interview on 04/17/2026 at 12:44 PM, UM D reported that nursing staff notified her today of Resident #53's wounds on her toes. UM D reported that the orders were entered into the computer on 2/10/26 for her right toes instead of the left toes. UM D reported she could not explain why there was not follow up by a provider and/or wound assessments of her toes. Review of Resident #53's Health Status Note documented by UM D dated 2/13/26 revealed, wound treatment completed as ordered. Toes painted with betadine as order. Tolerated dressing change well. Wound on buttocks appears deteriorated. Wound on heels improved. Toes are stable. Wound log updated. Son and NP made aware. Review of Resident #53's Weekly Skin Check dated 3/20/26 indicated there were no new skin issues identified and listed the following wounds as not evaluated: Right inguinal region, left heel, left gluteal fold, coccyx, general bruising, left inguinal region, right gluteal fold and right heel. There was no documentation related to Resident #53's toes. Review of Resident #53's Weekly Skin Check dated 3/30/26 revealed, Skin: Skin warm & dry, skin color WNL and turgor is normal. Foot evaluation completed. No new skin issues identified. Skin issues: #1 Skin issue HAS been evaluated. Location: left inguinal region. Moisture associated skin damage (MASD). Progress: improving. #2 Skin issue has NOT been evaluated. Location: Coccyx. #3 Skin issue HAS been evaluated. Location: right inguinal region.MASD. #4 Skin issue has NOT been evaluated. Location: right heel.Unstageable pressure injuries. #5 Skin issue has NOT been evaluated. Location: left heel.Unstageable pressure injuries. There was no documentation the Resident #53's (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	coccyx, heels and toe wounds were assessed. Review of Resident #53's Weekly Skin Check dated 4/6/26 revealed, Skin: Skin warm & dry, skin color WNL and turgor is normal. Foot evaluation completed. No new skin issues identified. Skin Issues: #1: Skin issue has NOT been evaluated. Location: Coccyx. #2: Skin issue has NOT been evaluated.#2 Skin issue has NOT been evaluated. Location: Right heel. Issue type: Pressure ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury . #3: Skin issue has NOT been evaluated. Location: Left inguinal (groin) region . Moisture associated skin damage (MASD). #4: Skin issue has NOT been evaluated. Location: Right inguinal region. Issue type: Moisture associated skin damage (MASD). #5: Skin issue has NOT been evaluated. Location: Left heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstageable pressure injuries. It was noted that none of Resident #53's wounds were assessed and there were no wounds noted on her toes. Review of Resident #53's most recent Weekly Skin Check dated 4/13/2026 revealed, Skin: Skin warm & dry, skin color WNL and turgor is normal. Foot evaluation completed. No new skin issues identified. Skin Issues: #1: Skin issue has NOT been evaluated. Location: Coccyx. #2: Skin issue HAS been evaluated. Location: Right heel. Issue type: Pressure ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury . Length (cm): 7.4 Width (cm): 7.8.Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements. #3: Skin issue HAS been evaluated. Location: Left inguinal (groin) region . Moisture associated skin damage (MASD). Progress: Stable: previously deteriorating wound characteristics plateaued . Measurements not documented as part of this assessment. #4: Skin issue HAS been evaluated. Location: Right inguinal region. Issue type: Moisture associated skin damage (MASD). Progress: Stable: previously deteriorating wound characteristics plateaued . Measurements not documented as part of this assessment. #5: Skin issue HAS been evaluated. Location: Left heel. Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury.Measurements not documented as part of this assessment.Clean dressing applied. There was no documentation of the wounds on Resident #53's toes and it was noted that the coccyx wound was not assessed. Resident #61 Review of an admission Record revealed Resident #61 was originally admitted to the facility on [DATE]. During an observation on 04/15/2026 at 1:58 PM CNA W entered Resident #61's room to perform incontinence care. CNA W positioned Resident #61 on her right side and 2 raised crusted areas of skin were observed near the resident's gluteal crease (butt crack) with the entire surrounding skin on the buttocks and upper thighs bright red. Resident #61 winced in pain when CNA W touched the area. Review of Resident #61's Weekly Skin Check dated 4/15/26 at 12:49 PM documented by LPN FF revealed, Skin warm & dry, skin color WNL and turgor is normal.Foot evaluation completed. No new skin issues identified. Skin issues: #1 Skin issue has NOT been evaluated. Location: rear right thigh.Issue type: medical device related pressure ulcer.Wound acquired in house. #2 Skin issue has NOT been evaluated. Location: right lateral thigh. Issue Type: scratch. #3 Skin issue has NOT been evaluated. Location: Coccyx (upper buttock/tailbone). Issue type: redness. The wound assessments were not documented. See interview below. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsibility of all health care providers is that they keep accurate and complete medical records. From a nursing perspective, the most important purpose of documentation is communication. The standards for record keeping attempt to ensure, patient identification, medical support for the selected diagnoses, justification of the medical therapies used, accurate documentation of that which has transpired, and preservation of the record for a reasonable time period. Documentation must show continuity of care, interventions used, and patient responses. Nurses' notes are to be concise, clear, timely, and complete. Review of the facility policy Documentation in Medical Record dated 3/13/24 revealed, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Policy Explanation and Compliance Guidelines: 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. 3. Documentation may be performed manually or as per the facility's specific electronic medical record software program. 4. Principles of documentation include but are not limited to: a. Documentation shall be factual, objective, and resident centered. i. False information shall not be documented. ii. Record descriptive and objective information based on first-hand knowledge of the assessment, observation, or service provided. iii. Subjective information shall be recorded only as relevant, such as the resident's verbalizations, in quotation marks. b. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. c. Documentation shall be timely and in chronological order. d. Write legibly in black ink or follow the facility's specific electronic medical record software for inputting information. e. Record date and time of entry. f. Sign each entry with name and credentials of the person making the entry. g. Only standardized terminology, acronyms, and symbols may be used. h. Avoid generalizations and vague phrases or expressions. i. Only document conclusions that can be supported by data and avoid bias, labels, and value judgments . Resident #81 Review of an admission Record revealed Resident #81 was originally admitted to the facility on [DATE] with pertinent diagnoses which included essential hypertension (high blood pressure) and type 2 diabetes mellitus (chronic metabolic disorder characterized by insulin resistance and relative insulin deficiency, leading to high blood sugar.) Review of Resident #81's Progress Note dated 2/13/26 and documented by Registered Nurse (RN) DD revealed, Resident sent to hospital for stroke-like symptoms. This nurse contacted the daughter to inform of sending resident out . (Nurse Practitioner (NP) DDD) assessed resident and wanted resident sent out for evaluation. Noted that NP DDD's assessment of Resident #81 on 2/13/26 was not in his record. On 4/17/2026 at 10:26 AM, This writer requested NP DDD's visit note for Resident #81 on 2/13/26 to Nursing Home Administrator (NHA) A and Interim CEO B. This writer attempted to contact RN DD via telephone on 4/17/2026 at 10:28 AM. RN DD did not return this writer's call prior to survey exit. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 4/17/2026 at 12:20 PM, Interim CEO B reported that he was not able to obtain the record of Resident #81's visit with NP DD at the facility on 2/13/26. Interim CEO B confirmed that the facility was unable to provide any further information related to Resident #81's assessment which indicated a need for urgent transfer because the facility was missing documentation of Resident #81's visit with NP DD on 2/13/26. Resident #18 Review of an admission Record revealed Resident #18 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: unspecified dementia (an umbrella term for a decline in mental ability, such as memory, language, problem solving skills) and heart failure (chronic condition in which the heart muscle is too weak or stiff to pump enough oxygen-rich blood to meet the body's needs). Review of a Minimum Data Set (MDS) assessment for Resident #18 with a reference [TRUNCATED]

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain the cleanliness of resident shared equipment, resulting in the potential for cross contamination, infections, and bacterial harborage. Findings include: During an observation on 04/14/2026 at 9:57 AM, outside of room [ROOM NUMBER] there was a hoyer (mechanical device used to transfer limited mobility residents) in the hallway along the wall. The hoyer dried white material on the footrest base area, there as dried brownish/tannish material spots splattered on the base. During an observation on 04/14/2026 10:31 AM sit to stand outside of room [ROOM NUMBER] had dirt and debris on the based and foot board area. The knee pads had white dried smeared material on the curve of the knee pad on the inside of the pad, a gait belt on it as well as slung over the top, plastic bag with no wipes in it. There was a hoyer next to it, which had white dried material on the base of the machine on both sides, like someone had white powder on their feet and had stepped on it. There was a plastic bag with no wipes in it.During an observation on 04/15/2026 at 2:22 PM, the sit to stand outside of room [ROOM NUMBER] and room [ROOM NUMBER] was soiled as it was yesterday. There were purple wipes in the plastic bag. There was white dried material on the knee pads, and the footrests had dirt and debris on them. During an observation on 04/15/2026 at 2:24 PM, the hoyer (mechanical lift) between room [ROOM NUMBER] and room [ROOM NUMBER] had dried white material on the footrest base area, there was dried brownish/tannish material spots splattered on the base. In an interview on 04/16/2026 at 09:18 AM, Infection Preventionist (IFP) E reported the staff had recently had Customer service training on 12/23/25 and 3/27/26 which also included re-education and reminders to perform sanitization of resident shared equipment after each use to prevent the spread of potential infection.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess and ensure the right to safe self-administration of medication in 1 of 18 residents (Resident #16) reviewed for medication administration, resulting in the potential for unsafe self-administration of medication, medication errors, and medications not being stored in a secure manner.Findings include:Resident #16Review of an admission Record revealed Resident #16 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: schizoid personality disorder (chronic mental health condition characterized by limited emotional expression, strong preference for isolation and lack of motivation) and depression (a serious, common mental illness causing persistent sadness).Review of a Minimum Data Set (MDS) assessment for Resident #16 with a reference date of 2/6/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section D of the MDS revealed Resident #16 felt down, depressed, or hopeless during 12-14 days of the 14-day assessment period.Review of a Care Plan for Resident #16 with a reference date of 1/27/26 revealed the following focus/goal/interventions: Focus: I have acetaminophen (brand name omitted) at the bedside that I have been approved to self-administer. Goal: I will have relief from any pain on a daily basis.Interventions: evaluate continued appropriateness for self-administration of meds per facility policy.Review of Physician Orders for Resident #16 revealed a medication order with a reference date of 5/16/24: Acetaminophen Oral Tablet, give 650 tablets by mouth every 8 hours as needed for pain unsupervised self-administration Not to exceed 3000mg daily.During an observation and interview on 4/14/26 at 10:32am, Resident #16 was supine in bed (on her back), the bedside table was across her bed at chest level. A clear plastic medication cup was on the table, filled with what appeared to be chocolate pudding with flecks of a white substance throughout the brown pudding. Resident #16 reported unknown medications had been left for her in the pudding mixture in the medication cup. No staff were present in the room.In an interview on 04/15/26 at 2:29 PM, Nursing Home Administrator (NHA) A reported a resident would need to have a self-administration assessment completed annually and with a change of condition, to self-administer medications.Review of the most recent Medication Self-Administration Assessment for Resident #16, revealed the resident was last assessed for self-administration of medications on 6/20/24.Review of a Self-Administration of Medications by Residents policy with a reference date of 6/10/2008, revealed Each resident has the right to self-administer medications unless the interdisciplinary team (IDT) has determined, for that resident, that this practice is unsafe.The IDT determines the resident's ability to self-administer medications by means of a skill assessment conducted on admission, annually or significant change.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview, and record review, the facility failed to provide an environment that promoted resident dignity in 1 (Resident #29) of 4 residents reviewed for dignity, resulting in the potential of feelings of humiliation, embarrassment, and loss of self-worth.Findings include:Resident #29:Review of an admission Record revealed Resident #29 was a male with pertinent diagnoses which included diabetes, mild cognitive impairment (noticeable memory or thinking changes), acquired absence of left eye, strep group B (bacteria can cause sepsis) in left knee, and arthritis due to bacteria in left knee. Review of current Care Plan for Resident #29, revised on 3/24/26, revealed the focus, .I am at risk for falls d/t (due to) impaired safety awareness. with the intervention .Anticipate my needs, round to my room frequently and ask if there is anything I need.Remind resident to push call light and wait for assistance.In an interview on 04/14/2026 at 9:58 AM, Resident #29 reported when he pressed his call light it would take the staff too long to respond even though he would press the call light well before he was going to need them, but he would end up going doo doo in his pants because it would take too long for the staff to get there. Resident #29 reported he did not like going doo doo in his pants as it was embarrassing and he felt bad for the staff to have to clean him up but he couldn't help going in his pants as the staff took too long. Resident #29 reported he was a one person assist with his wheelchair because of his leg.In an interview on 04/16/2026 at 8:49 AM, CNA MM reported recent staffing levels had made it challenging to meet resident needs.Review of policy, Accommodation of Needs approved on 3/5/2024, revealed, .The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to arrange room furniture in a functional manner, provide adequate power outlets for adaptive equipment and implement low-vision modifications to promote independence for one (Resident #2) of three residents reviewed for accommodation of needs, resulting in feelings of frustration, loss of independence and lack of an individualized environment.Findings include:Resident #2Review of an admission Record revealed Resident #2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: legal blindness (severe visual impairment with some usable vision, often able to see light, shapes or large print) as defined in the USA (United States of America), diabetic retinopathy (damage to the retina caused by high blood sugar levels, resulting in blurry vision, dark floaters in the visual field, poor night vision and color changes), and surgical amputation of right leg.Review of a Minimum Data Set (MDS) assessment for Resident #2 with a reference date of 2/2/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section B revealed Resident #2's vision was highly impaired- object identification in question, but eyes appear to follow objects. Section E revealed Resident #2 had no behaviors.Review of a Care Plan for Resident #2 with a reference date of 11/18/24 revealed the following focus/goal/interventions: Focus: I have impaired visual function. Goal: I will have no indications of acute eye problems through next review. Interventions: Arrange consultation with eye care practitioner as required. No other interventions were present.During an observation and interview on 4/14/26 at 11:26am, it was noted that there was a narrow space of approximately 2 feet between the end of Resident #2's bed and his chest of drawers. Resident #2's stereo sat atop the chest of drawers. Resident #2 had access to 1 electrical outlet, with 2 sockets, on his half of the room. Resident #2's laptop and a phone charger were plugged into the outlet. A talking book machine sat nearby but was not plugged in. Resident #2 reported he was frustrated by the set up of his room and reported he had to thread himself backwards between his bed and his chest of drawers, while in his powerchair, then lean his torso forward in order to see the dials on his stereo. Resident #2 reported he was also frustrated by the lack of electrical outlets within his reach in his room, because he could not charge his devices and use his talking book player at the same time. Resident #2 reported he had voiced his concerns regarding the lack of accessibility in his room to several staff members, but nothing had been done. Resident #2 stated this room feels like a cage. Resident #2 reported he wanted to do more than lay in bed like a lazy bum and felt he could do the things he wanted to do in his room if some modifications were made. Resident #2 stated I don't like to ask the staff to do things for me that I could do for myself if the room was set up better. Resident #2 reported he owned a braille writer (mechanical typewriter-like device that allows the user to emboss braille directly onto paper), enjoyed writing greeting cards with it in the past, but had not been able to use it at the facility due to the lack of outlets and workspace. Resident #2 reported he had asked for a power strip several times but was always told they were illegal. Resident #2 reported he had also asked if he could have a LED (light-emitting diode) bulb in his overhead light because it would reduce glare and allow him to adjust the light level, but no one had followed up. Resident #2 reported he felt the facility was not willing to meet the needs of residents who were visually impaired.In an interview on 4/15/26 at 3:39pm, Nursing Home Administrator (NHA) A reported the facility provided power strips to residents in need of them, but he was not aware Resident #2 needed extra outlets. NHA A confirmed Unit Manager (UM) D provided weekly Caring Partners visits to Resident #2.In an interview on 4/15/26 at 3:53pm, Interim Chief Executive Officer (CEO) B reported he reviewed the Caring Partners weekly check in sheets for Resident #2 and found the resident had voiced a concern about the accessibility of his room in February 2026 but there had been no follow-up.Review of a Caring Partners form with a reference date of 2/24/26 revealed (Resident #2) wants.items in room moved around; Space is (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited.In an interview on 4/16/26 at 12:04pm, UM D confirmed she provided weekly Caring Partners visits to Resident #2. UM D confirmed Resident #2 voiced concerns about the layout of his room on 2/24/26. UM D reported Resident #2 also voiced a need for a larger room due to his limited ability to access his belongings in his current room. UM D confirmed it was important for the facility to address individual resident needs, including accessibility and low vision needs, to promote independence.In an interview on 04/16/2026 at 9:41 AM Certified Nursing Assistant (CNA) MM reported Resident #2 had complained to her about not being to see well in his room due the lighting and reported he said he wished the facility was more thoughtful about the individual needs of those with vision impairments. During an observation and interview on 4/17/26 at 10:07am, the cord for Resident #2's overhead light hung against the wall, between his nightstand and the table he used for his laptop. Both the cord and the wall were white. A piece of glow in the dark tape (approximately one inch square in size) was affixed near the end of the cord that hung toward the floor. Resident #2 reported he could not see the light cord because there was no contrast between it and the wall. Resident #2 stated I need contrast in order to be able to see things like that. Resident #2 reported until recently he had a nice bright yellow privacy curtain that he could see well, but the facility changed it without asking him and hung a dull curtain, that looked like a dingy grey color to him. The privacy curtain Resident #2 referenced was a pale light green with a faint blue floral pattern. When queried, Resident #2 reported he could not see any pattern in the curtain, and the color looked depressing.In an interview on 4/17/26 at 12:07pm, Occupational Therapist (OT) XX reported she placed glow in the dark tape on the end of Resident #2's overhead light cord so he would be able to see it at night. When queried, OT XX reported she was not aware of any concerns Resident #2 had related to accessibility/low vision modifications needed in his room.Review of an Accommodation of Needs policy with a reference date of 3/5/24 revealed .The facility will make reasonable accommodations to individualize the resident's physical environment including their personal bathroom and bedroom.facility staff shall make efforts to reasonably accommodate the needs.of the resident as they make use of their physical environment.based on individual needs.the facility will assist the resident in maintaining and/or achieving independent functioning, dignity and well-being.Review of A Systematic Review of Home Modifications for Aging in Place in Older Adults, https://pmc.ncbi.nlm.nih.gov/articles/PMC11988477/, revealed .The interaction between an individual's physical and cognitive abilities and the built environment significantly influences functional independence and quality of life. According to the environmental press theory, balance is maintained when the environment supports an individual's capabilities. When housing environments impose excessive demands beyond an individual's diminished functional capacity, disability and dependence increase.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on interview and record review, the facility failed to allow resident choice regarding personal care in 1 of 1 resident (Resident #1) reviewed for self-determination, resulting in Resident #1 not receiving care (showers/baths) at her preferred time of day. Findings include:Resident #1:Review of Care Plan for Resident #1, revised on 3/3/26, revealed the focus, .I have an ADL (activities of daily living) deficit and need assistance with daily care r/t (related to) weakness/debility. with the intervention .ADL care to meet my needs.Review of Kardex (care guide) for Resident #1 revealed, .ADL-Bathing 1 assist extensive Thursday and Saturday.Personal hygiene: independent following set-up. During an observation and interview on 04/14/2026 at 10:55 AM, Resident #1 reported she didn't get her shower on Saturday as the staff member came at 10:00 PM and the shower was not offered for the next day. Resident #1 reported she had declined the shower due to it being late, she was tired and not up to taking a shower that late. Resident #1 reported she was scheduled to get her showers on Thursdays and Saturdays. In an interview on 4/15/26 at 12:42 PM, Certified Nursing Assistant (CNA) AAA reported when a resident refused a shower it was documented on the shower sheet after the staff attempted multiple times to encourage the resident to obtain a shower. CNA AAA reported once completed the shower sheet was submitted to the nurse for review and signature. Review of Shower Sheets for Resident #1 revealed on 2/19/26, CNA EEE had written on the shower sheet Resident #1 wanted to take showers on day shift and the nurse on duty signed and indicated the change was requested as well. Review of Shower Sheets revealed on 2/29/26, Resident #1 had reported to CNA EEE she wanted showers to be switched to day shift showers. Review of Shower Sheets for Resident #1 revealed on 4/9/26, CNA EEE had written the request again for Resident #1's showers to be changed to the day shift. In an interview on 04/16/2026 at 2:41 PM, CNA EEE reported Resident #1 had requested she received her showers during the day shift, and she had written her preference on the shower sheet for the nurse to review, and the Unit Manager was aware Resident #1 wanted her showers during the day shift. In an interview on 04/16/2026 at 2:51 PM Unit Manager (UM) D reported the nurse would enter an alert in the resident's medical record which would notify her of the requested change of shower days for a resident. UM D reported she had educated the nurses on entering the request in that manner so she would be alerted to the change as she received several shower sheets and was not always able to review all timely.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235050	A. Building B. Wing	04/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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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 - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to provide and document evidence of prompt resolution of grievances in 2 of 2 residents (Resident #2 & #1) reviewed for resolution of grievances, resulting in the potential to experience frustration, apprehension, helplessness, and a negative psychosocial outcome for the residents impacting their quality of life.Findings include:Resident #2 Review of an admission Record revealed Resident # 2 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: legal blindness (severe visual impairment with some usable vision, often able to see light, shapes or large print) as defined in the USA (United States of America), diabetic retinopathy(damage to the retina caused by high blood sugar levels, resulting in blurry vision, dark floaters in the visual field, poor night vision and color changes), and surgical amputation of right leg. Review of a Minimum Data Set (MDS) assessment for Resident #2 with a reference date of 2/2/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 15/15, which indicated the resident was cognitively intact. Section B revealed Resident #2's visual was highly impaired- object identification in question, but eyes appear to follow objects. Section E revealed Resident #2 had no behaviors. Review of a Care Plan for Resident #2 with a reference date of 11/18/24 revealed the following focus/goal/interventions: Focus: I have impaired visual function. Goal: I will have no indications of acute eye problems through next review. Interventions: Arrange consultation with eye care practitioner as required. No other interventions were present. During an observation and interview on 4/14/26 at 11:26am, it was noted that there was a narrow space of approximately two feet between the end of Resident #2's bed and his chest of drawers. Resident #2's stereo sat atop the chest of drawers. Resident #2 had access to 1 electrical outlet, with 2 sockets, on his half of the room. Resident #2's laptop and a phone charger were plugged into the outlet. A talking book machine sat nearby but was not plugged in. Resident #2 reported he was frustrated by the setup of his room and reported he had to thread himself backwards between his bed and his chest of drawers, while in his powerchair, then lean his torso forward in order to see the dials on his stereo. Resident #2 reported he was also frustrated by the lack of electrical outlets within his reach in his room, because he could not charge his devices and use his talking book player at the same time. Resident #2 reported he had voiced his concerns regarding the lack of accessibility in his room to several staff members, but nothing had been done. Resident #2 stated this room feels like a cage. Resident #2 reported he wanted to do more than lay in bed like a lazy bum and felt he could do the things he wanted to do in his room if some modifications were made. Resident #2 stated I don't like to ask the staff to do things for me that I could do for myself if the room was set up better. Resident #2 reported he had asked for a power strip several times but was always told they were illegal. Resident #2 reported he had also asked if he could have a LED (light-emitting diode) bulb in his overhead light because it would reduce glare and allow him to adjust the light level, but no one had followed up. Resident #2 reported he felt the facility was not willing to meet the needs of residents who were visually impaired. In an interview on 4/15/26 at 3:53pm, Interim Chief Executive Officer (CEO) B reported he reviewed the Caring Partners weekly check in sheets for Resident #2 and found the resident had voiced a (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern about the accessibility of his room in February, 2026 but a grievance was never filed as it should have been, and there had been no follow-up. CEO B reported the facility had no grievances related to any of Resident #2's concerns. CEO B stated We did not follow our policy. Review of a Caring Partners form with a reference date of 2/24/26 revealed (Resident #2) wants.items in room moved around; Space is limited. In an interview on 04/16/2026 at 9:41 AM Certified Nursing Assistant (CNA) MM reported Resident #2 had complained to her about not being to see well in his room due the lighting and reported he said he wished the facility was more thoughtful about the individual needs of those with vision impairments. CNA MM confirmed she had not filled out a grievance form about Resident #2's concern regarding the lighting in his room. In an interview on 4/16/26 at 12:04pm, UM D confirmed she provided weekly Caring Partners visits to Resident #2. UM D confirmed she did not complete a grievance form for the concerns Resident #2 voiced about the layout of his room on 2/24/26. UM D reported Resident #2 also voiced a need for a larger room due to his limited ability to access his belongings in his current room, but she did not complete a grievance form for that request as she felt it was something the facility could not accommodate. UM D confirmed it was important for the facility to address individual resident needs, including accessibility and low vision needs, to promote independence. In an interview, Occupational Therapist (OT) XX reported she placed glow in the dark tape on the end of Resident #2's overhead light cord so he would be able to see it at night. When queried, OT XX reported she was not aware of any concerns Resident #2 had related to accessibility/low vision modifications needed in his room. OT XX reported she could assist Resident #2 if the facility provided a referral for assessment and treatment. Resident #1: Review of an admission Record revealed Resident #1 was a female with pertinent diagnoses which included high blood pressure, back pain, muscle weakness, depression, and pneumonia. In an interview on 04/14/2026 at 11:39 AM, Resident #1 reported her pajama tops were missing, and no one had come to speak to her about replacing them. Resident #1 reported the facility looked for them in the laundry and other resident's closets but were unable to locate them. Requested concern forms for Resident #1's missing pajama tops and was informed there were no concern forms completed for her missing pajama tops. In an interview on 4/15/26 at 12:39 pm, Life Enrichment Manager ([NAME]) U reported if a concern was brought up during resident council, if it was something easy, if she could take care of it, she would take care of it. [NAME] U reported if it was really important, she would complete a concern form for the resident who had the concern. In an interview on 4/15/26 at 1:13 PM, Director of Facility Operations (DFO) R reported a form was completed for missing items that gets filled out. DFO R reported if a resident had an item missing, laundry would search for it and usually the staff were able to find it rather quickly. DFO R reported once it was determined the item could not be found the form was completed and submitted to the Nursing Home Administrator. (continued on next page)

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Harold and Grace Upjohn Community Care Center	2400 Portage St Kalamazoo, MI 49001

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 4/15/26 at 2:29 PM, Nursing Home Administrator (NHA) A reported when a resident would report an item missing, if the staff were unable to locate it, the item information was placed on a sticky note and the grievance process was circumvented. NHA A reported if the floor staff were informed of the missing items the staff were to fill out a concern form, then during morning meeting the concern was given to the lead to follow up on. NHA A reported the Laundry staff should have followed the same process. Review of policy, Resident Grievance Process revised 3/12/26, revealed, .Blank Help Us Serve You Better forms will be maintained at the nurses stations with 24-hour access.3. Residents, families and visitors may fill out the form and give it to a staff member to return to the management team.4. Staff may assist in completing the form, if at the request of the resident, family or visitor.5. The Administrator or designee will bring the concern form to the morning meeting for IDT (Interdisciplinary Team) review After reviewing the form, it will be assigned to the appropriate staff member for action to be taken.6. The assigned staff member will investigate the concern, resolve the issue, document the findings, and return the form to the Administrator within 7 days during the IDT meeting (based on the scope of the complaint, immediate action may need to be taken to prevent further potential violations of any resident right while the alleged violation is being investigated). The assigned staff member will also contact the complainant as requested or required. Residents have the right to obtain a written decision regarding his/her grievance.

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F 0689 Level of Harm - Minimal harm or potential for actual harm 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 interview and record review, the facility failed to 1.) provide adequate supervision and implement appropriate care planned interventions to prevent a fall in 1 resident (Resident #57) reviewed for falls, 2.) ensure safe transfer for 1 resident (Resident #5) and 3.) ensure safe wheelchair transport in 1 resident (Resident #37) of 3 residents reviewed for safety resulting in the potential for residents to sustain a fall and/or injury.Findings include: Resident #57: Review of an admission Record revealed Resident #57 was a male with pertinent diagnoses which included dementia, physical debility, anxiety, seizures, stroke, and hearing loss. Review of Care Plan for Resident #57 revealed the focus, .I am at risk for falls d/t (due to) generalized weakness, impaired mobility, physical limitations. with the interventions .Routine visual checks.Anticipate my needs, round to my room frequently and ask if there is anything I need.Bed in lowest position.Bolster(s) (long thick pillow that is placed to provide a barrier/for support) on bed.Dycem (non-slip material used to prevent slipping and sliding) to be placed on top of broda chair (specialized wheelchair that provides comfort, support, and mobility for limited mobility patients) cushion to decrease potential for forward slide.Mat on floor at bedside when I am in bed, as long it isn't a trip hazard to me. Note: Care Plan was not updated following the falls on 3/15/26 and 3/16/26. During an observation on 04/14/2026 at 3:58 PM, Resident #57 was observed in his room lying in his bed supine position (lying flat with face up) with his blanket tucked in around him, with him appearing like a burrito. Resident #57's bed was not in a low position, and he did not have any bolsters or other items to act as a barrier to prevent him from falling out of bed. Review of Health Status Note dated 1/31/2026 at 4:37 PM, revealed, .Resident found on the floor by CNA (certified nurse aide) lying on his left side with his head partially resting on the room chair. Resident stated he needed to use the bathroom. resident was assessed and vitals taken no visible injuries was noted. resident checked for incontinent, brief was dry. suspected resident rolled out of bed as he was last observed in bed. resident unable to report pain clearly due to baseline behavior. Provider (Nurse Practitioner) NP and brother (Name) was notified. resident later reported headache pain medication was given. neuro checked was initiated. staff ensured bed was in lowest position and that call light and personal items were within reach. continue to monitor resident. Review of Post Fall Evaluation dated 1/31/2026 at 7:20 PM, revealed, .Fall Details: Date / Time of Fall: 01/31/2026 4:00 PM Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: wanted to use the toilet The reason for the fall was not evident. Did an injury occur as a result of the fall: No. Did fall result in an ER visit/hospitalization: No. Provider: (Nurse Practitioner) Time notified: 01/31/2026 Notified of: fall and actioned taken Resident's responsible party notified: Yes. Person contacted: Brother Details of notification: notified of the fall and action. Date of Resident's responsible party notification: 01/31/2026 4:25 PM Fall Details Note: resident found on the laying on left side with head partially resting on a chair. resident mentioned that he wanted to use the bathroom. resident was assessed and no visible injury was observed. resident unable to clearly report pain due to baseline behavior. provider and brother was notified. Tylenol was given for pain and neuro check initiated.Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Clutter present on the floor: No. Floor mat was on floor: No. Poor lighting in the area: No. Bed was at an improper height: No. Other furniture involved: No. Wheelchair was not involved in fall. Wearing glasses at the time of the fall: No. Footwear at time of fall: Non-skid shoes/socks. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall. Resident was using incontinence supplies at the time of the fall. Incontinent at time of fall: No. Bedside call light on when Resident was found: No. Bathroom call light on when Resident was found: No. Personal alarm sounding when Resident found: No. Other Residents were not involved in fall. Contributing factors note: unknown per the resident he wanted to use the toilet. resident was checked brief was dry.Medication Changes: Recent change to Resident's medications: No.Pain: Indicators of pain: Vocal complaints of pain. Pain Issue: #001: New. Location: Head. Pain score: 4. Unable to describe pain. Resident position changed. PRN (as needed) medication provided. Note: no indication range of motion (ROM)was performed on Resident #57. Review of Incident Report dated 1/31/26 at 4:00 PM, revealed, .Immediate Action Taken: Provider (NP) and resident brother was notified. Neuro check (assessed movement, sensation, hearing/speech, vision) initiated and resident monitored. Note: No immediate intervention to ensure Resident #57's safety. Review of Fall Risk Evaluation dated 2/8/2026 3:11 PM, revealed, .Fall Risk: History of falls (past 3 months): 1-2 falls in past 3 months. Level of consciousness / mental status: Disoriented x 3 at all times. Resident is chairbound / incontinent. Systolic blood pressure: No noted drop between lying and standing. Vision status: Adequate (with or without glasses). Predisposing disease: None present. Resident did not have a change in condition in the last 14 days. Recent hospitalization history in last 30 days: No. Gait / balance: N/A - not able to perform function. Medication: Takes 3-4 these medications (or medication classes) currently and / or within last 7 days. Fall Risk Score: 11.0. Note: Score of 7-11 would be considered low risk. Review of Health Status Note dated 3/15/2026 at 10:39 AM, revealed, .This nurse walked past (Resident #57's room) resident was in bed on side at 6:45am, was informed of the resident fell onto his knees between the bed and register(heater)at 7:50 am. This nurse did assessment on the resident to look for bleeding, have been doing neuro checks on the resident 15min, 30min, 1hour.This nurse called Brother-(Name), on call provider, and DON (Director of Nursing) to make aware of the incident. Review of Post Fall Evaluation dated 3/15/2026 at 10:46 AM, revealed, .Fall Details: Date / Time of Fall: 03/15/2026 7:50 AM Fall was not witnessed. Fall occurred in the Resident's room. Activity at the time of fall: Resident was lying on the bed, resident was sitting up on knees on the floor keeping himself up right The reason for the fall was not evident. Did an injury occur as a result of the fall: No. Did fall result in an ER visit/hospitalization: No. Provider: on call provider, (Nurse Practitioner) Time notified: 03/15/2026 Resident's responsible party notified: Yes. Person contacted (Name) Details of notification: This informed (Brother) that the resident was lying in bed and he was sitting on his knees ,keeping himself up right in between the bed and a heater. This nurse stated there was no injuries and have been taking vitals and neuro checks ,vitals are within normal limits. (Brother) Thanked me for calling him Date of Resident's responsible party notification: 03/15/2026 9:30 AM.Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: No. Poor lighting in the area: No. Bed was at an improper height: No. Other furniture involved: No. Wheelchair was not involved in fall. Wearing glasses at the time of the fall: No. Footwear at time of fall: Non-skid shoes/socks. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall. Bedside call light on when Resident was found: Yes. Bathroom call light on when Resident was found: No. Personal alarm sounding when (continued on next page)

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	235050	A. Building B. Wing	04/17/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident found: No. Other Residents were not involved in fall.Medication Changes: Recent change to Resident's medications: No Vitals: T (temperature) 97.4 - 3/15/2026 10:57 Route: Forehead (non-contact)BP (blood pressure) 142/90 - 3/15/2026 09:27 Position: Sitting l/arm P (Pulse) 75 - 3/15/2026 09:27 Pulse Type: UTD - Unable to Determine.R (respirations) 18 - 3/15/2026 10:57.O2 (Oxygen level) 96 % - 3/15/2026 10:57 Method: Room Air.W (Weight) 192.0 lb. (pounds) - 3/13/2026 09:21 Scale: Hoyer Lift (mechanical device used to transfer a resident with limited mobility).Pain: Indicators of pain: None.Skin: Skin warm & dry, skin color WNL (within normal limits) and turgor (skin's elasticity) is normal.Physical Findings: Change in diagnosis status: No. Recent diagnosis of stroke, TIA (Transient ischemic attack – short period of symptoms similar to a stroke) or arrhythmia (problem with rate and rhythm of heartbeat): No. Decrease in fluid intake: No. Change in blood glucose levels: No. Change in mental status: No. Change in behaviors: No. Change in mobility status: No. Recent weight loss: No. Sensory impairment: No. Resident does not have orthostatic BP changes. Note: no indication range of motion was performed on Resident #57. Review of Incident Report dated 3/15/26 at 07:50 AM, revealed, .Immediate Action Taken: Two CNA's put the resident back in bed, and then in his chair. This nurse did an assessment on the resident and also taking neuro checks every 15 min, 30 min, 1 hour. This nurse called DON, Brother, and On Call Provider to inform of the incidence. Note: No immediate intervention to ensure Resident #57's safety noted in the incident report. Review of Health Status Note dated 3/16/2026 at 02:32 AM revealed, .Vital signs monitored every 4 hours and have been stable throughout the night. No apparent pain or discomfort observed. Wedge placed on bed to help prevent patient rolling out of bed . Review of Health Status Note dated 3/16/2026 at 05:17 AM, revealed, .Heard resident yelling, upon entering his room, observed resident laying on floor next to his bed. Had pushed wedges off his bed when he rolled out of bed. VS (vital signs): 98.2-76-18-117/70.Resident was assessed for injury, none noted. Vital signs stable. ROM (range of motion) adequate to all extremities. Resident was transferred back to his bed by Hoyer lift and 3 staff assist. Resident is alert, orient to self and situation at times. Was aware he was laying on the floor. Review of Post Fall Evaluation 3/16/2026 at 05:20 AM, revealed, .Fall Details: Date / Time of Fall: 03/16/2026 4:30 AM Fall was not witnessed. Fall occurred bedside. Activity at the time of fall: Rolled self out of bed The reason for the fall was not evident. Did an injury occur as a result of the fall: No. Did fall result in an ER visit/hospitalization: No. Provider: (Health Facility) on-call provider Time notified: 03/16/2026 Notified of: fall without injury Resident's responsible party notified: Yes. Person contacted: (Brother) Details of notification: Resident rolled out of bed without injury Date of Resident's responsible party notification: 03/16/2026 4:50 AM Fall Details Note: Resident was heard yelling, observed laying on the floor next to his bed. No injury noted. VSS (vital signs stable).Contributing Factors: Recent change in environment: No. Was fluid spilled on floor: No. Clutter present on the floor: No. Floor mat was on floor: Yes. Poor lighting in the area: No. Bed was at an improper height: No. Other furniture involved: No. Wheelchair was not involved in fall. Wearing glasses at the time of the fall: No. Footwear at time of fall: Bare feet. Resident was not using cane/walker as instructed. Resident was not wearing oxygen as prescribed at time of fall. Resident was using incontinence supplies at the time of the fall. Incontinent at time of fall: Yes. Bedside call light on when Resident was found: No. Bathroom call light on when Resident was found: No. Personal alarm sounding when Resident found: No. Other Residents were not involved in fall. Medication Changes: Recent change to Resident's medications: No.Vitals: T 98.2 - 3/16/2026 05:34 Route: Forehead (non-contact)BP 117/70 - 3/16/2026 05:34 Position: Lying l/arm P (pulse) 76 - 3/16/2026 05:34 (continued on next page)

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	235050	A. Building B. Wing	04/17/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Pulse Type: Regular R 18 - 3/16/2026 05:34.W (weight) 192.0 lb. - 3/13/2026 09:21 Scale: Hoyer Lift.Pain: Indicators of pain: Facial expressions. Pain Issue: #001: New. Location: Generalized. Pain score: 3. Aching.Skin: Skin warm & dry, skin color WNL and turgor (skin's elasticity) is normal.Physical Findings: Change in diagnosis status: No. Recent diagnosis of stroke, TIA or arrhythmia: No. Decrease in fluid intake: No. Change in blood glucose levels: No. Change in blood pressure: No. Change in mental status: No. Change in behaviors: No. Change in mobility status: No. Recent weight loss: No. Sensory impairment: No. Resident does not have orthostatic BP changes. Review of Incident Report dated 3/16/26 at 04:30 AM, revealed, .Immediate Action Taken: Resident was assessed for injury, none noted. Vital signs stable. ROM adequate to all extremities. Resident was transferred back to his bed by Hoyer lift and 3 staff assist. Note: No immediate intervention to ensure Resident #57's safety noted in the incident report. Review of Health Status Note dated 3/17/2026 at 12:11 PM, revealed, .Nurse on unit summoned writer to assist with resident sliding out of chair. Therapy was on unit and informed staff the chair was a trial for the resident. This writer, unit nurse, CNA and therapy team member assisted resident back into chair. Chair has dycem (non-slip material used to prevent slipping and sliding), foot buddy (padded box around the footrests) in place. Resident transferred safely to previous chair with Hoyer assist x 3. No other known acute changes at this time. During an observation on 04/15/2026 at 11:51 AM, Resident #57 was observed his bed, which was not in a low position, higher than transfer position for Resident #57. During an observation on 04/16/2026 at 8:19 AM, Resident #57 was observed in bed, his rectangle bolster was sideways under his bed, it was squished by the bed, he was at an angle in bed with his head near the edge on the left side and his feet more towards the right side, fall mat was in place, his body had slid down in the bed and his head was lower than the enabler bar so Resident #57 could've easily could fallen off the bed. During an observation on 04/16/26 at 11:42 AM, Resident #57 was observed lying in his bed, the rectangle bolster was on the recliner in the corner, the blue wedge was on the floor on the right side of the foot of the bed. No bolsters, pillows were placed on his bed. He was lying in a supine position at an angle. During an observation on 04/16/2026 at 12:20 PM, Resident #57 was observed lying in his bed, the rectangle bolster was on the recliner in the corner, the blue wedge was on the floor on the right side of the foot of the bed. No bolsters, pillows were placed on his bed. He was lying in a supine position at an angle. In an interview on 04/17/2026 at 11:54 AM, Registered Nurse (RN) HH reported staff would ensure the fall interventions were in place because the facility did not want the resident to fall again and the resident could get hurt or get hurt further. In an interview on 04/17/2026 at 11:55 AM, Certified Nursing Assistant (CNA) T reported if the resident was a fall risk, he would make sure the resident received constant supervision as he would look in on them every time he would pass by the room. In an interview on 04/17/2026 at 12:56 PM, Unit Manager (UM) D reported when a fall happened this was discussed during the Interdisciplinary team (IDT) meetings. UM D reported when a fall happened (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the nurse in charge was responsible for implementing an immediate intervention for the resident's safety. UM D reported range of motion should be completed on all residents following a fall as the resident may have an injury and moving them would cause undue pain or cause further injury. Review of policy, Fall Prevention Program implemented on 3/13/24, revealed, .Each resident will be assessed for fall risk and will receive care and services in accordance with their individualized level of risk to minimize the likelihood of falls.7. When a resident who does not have a history of falling experiences a fall, the resident will be placed on the facility's Fall Prevention Program.8. Each resident's risk factors and environmental hazards will be evaluated when developing the resident's comprehensive plan of care.Interventions will be monitored for effectiveness.The plan of care will be revised as needed.8. When any resident experiences a fall, the facility will: Assess the resident.Complete a post-fall assessment.Complete an incident report.Notify physician and family.Review the resident's care plan and update as indicated.Document all assessments and actions.Obtain witness statements in the case of injury. Resident #5: Review of an admission Record revealed Resident #5 was a female with pertinent diagnoses which included diabetes, peripheral vascular disease (circulation disorder involving narrowed or blocked vessels), dementia, and muscle weakness. Review of Resident #5's Kardex (Care Guide) revealed, .Transferring: 2 assist using hoyer (mechanical device sued to safely lift and transfer patients with limited mobility) . During an observation and interview 04/15/2026 at 11:58 AM, Resident #5 was seated in her recliner, and this writer observed a large deep purple bruise, approximately 4 inches in diameter, with light green/yellow on the outer edges located midway down on her right top shin. Home Care Aide WW reported when she returned to the facility on Monday, 4/14/26 she observed the bruise and reported it to the nurse on duty. Home Care Aide WW reported the bruise was not present when she finished her shift on Friday, 4/10/26. Home Care Aide WW reported she thought the bruise occurred from when the staff transferred Resident #5 with the hoyer as the staff do not tuck her feet in, her feet were stuck straight out, and Resident #5 would hit her leg on the base of the hoyer when staff were trying to reposition her for lowering into her bed or chair. Review of Skin Check assessment dated [DATE] at 03:45 AM, revealed there was no noted bruise on Resident #5's right lower leg. Review of Resident #5's medical record revealed no skin assessment, progress note, or other documentation for the observed bruise located on Resident #5's top of her shin. Review of Incident Report dated 4/15/2026 at 6:00 PM, revealed, .4/15/2026: The resident was assessed by this nurse and the LTC (long term care) unit manager. Presents with ecchymosis (large bruise >1 CM (centimeters) characterized by skin discoloration caused by blood leaking from broke vessels.It appears as blue/purple, fading to green/yellow over 1-3 weeks) on the lateral (outside of) and anterior aspect (front side) of the right lower extremity. Bilateral lower extremities are cool in temperature and color is appropriate for ethnicity. During an observation on 04/15/26 at 2:39 PM, Resident #5 was being transferred by CNA Y and CNA TT from her recliner to the bed. CNA Y lowered the hoyer to the recliner to attach the straps on to the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hoyer. CNA Y attached the bottom straps to the hoyer while CNA TT was raising Resident #5's bed to transfer height. CNA Y requested Resident #5 hold on to her catheter bag, both CNAs attached the top straps to the hoyer, Resident #5 held her legs straight out in front of her with her feet resting on the foot rests of the hoyer on each side of the base, Resident #5 held her legs straight out in front of her while CNA Y was slowly raising her via the hoyer. Resident #5 was facing the base of the hoyer, as she was being raised CNA Y began to slowly move Resident #5 to the right so she was parallel with the bed, while he was doing this Resident #5's lower leg and feet were caught on the hoyer base and she yelled out in pain. Neither CNA had a hold of her legs or feet to guide her around the base. CNA Y apologized and maneuvered her legs and feet around the hoyer. CNA Y moved the hoyer closer to the bed and slowly lowered her to the bed while CNA TT gently guided her legs/feet while lowering her to the bed. In an interview on 04/17/2026 at 11:54 AM, Registered Nurse (RN) HH reported when staff were transferring a resident the staff were to ensure they observed where the resident's extremities were at as to prevent injuries to the resident. In an interview on 04/17/2026 11:55 AM, CNA T reported when transferring a resident, staff were to be mindful of where the legs of the resident were located so as to not cause an injury for the resident. In an interview on 04/17/2026 at 12:59 PM, UM D reported when the staff were transferring a resident they were supposed to have two people at all times. UM D reported the staff were to ensure the resident had their arms tucked in or were holding on to the bars which hold the straps, ensure not to bump the legs, and if need to support and guide the legs so they were not bumped and as the resident was being lowered to the bed or to the chair for proper positioning. Resident #37 Review of an admission Record revealed Resident #37 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: vascular dementia (disease that causes impaired thinking skills due to reduced blood flow to the brain) and legal blindness (severe visual impairment in which individuals may still have some usable vision). Review of a Minimum Data Set (MDS) assessment for Resident #37 with a reference date of 3/14/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 5/15, which indicated the resident was severely cognitively impaired. Section B revealed Resident #37's vision was severely impaired-no vision or sees only light, colors or shapes; eyes do not appear to follow objects. Section GG revealed Resident #37 was dependent (helper does all of the effort) for mobility while using a wheelchair. Review of a Care Plan for Resident #37 with a reference date of 3/17/26 revealed the following focus/goal/interventions: Focus: I am at risk for falls.Goal: To minimize risk for falls and prevent injury.Interventions.Keep in line of sight, non-skid material in seat of chair. During an observation on 4/14/26 at 12:10pm, Resident #37 was transported to the dining room via wheelchair by Certified Nursing Assistant (CNA) CC; Resident #37's feet hung unsupported, a few inches above the floor, during the transport. No footrests were present on the wheelchair. During an observation on 4/17/26 at 9:40am, CNA RR approached Resident #37 as she sat in her wheelchair at the desk area of the nurse's station. Resident #37's feet rested on the floor. The (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	footrests on the wheelchair were folded up. Without telling Resident #37 what she was going to do, CNA RR approached Resident #37, grabbed the handles on the back of Resident #37's wheelchair and moved her away from the nurse's station by turning the wheelchair, then pushed the resident down the hall to her room. Resident #37's feet were unsupported throughout the entire time CNA RR pushed her wheelchair. In an interview on 4/17/26 at 10:18am, CNA RR reported it was important to ensure residents' feet were on footrests when transporting them via wheelchair because if they were not, their feet could get caught in the wheels or bumped against obstacles. CNA RR confirmed she did not put Resident #37's feet on the foot pedals when she took her to her room earlier. In an interview on 4/17/26 at 12:04pm, Occupational Therapist (OT) BBB reported transporting residents in a wheelchair without the use of footrests put the resident at significant risk for injury, including falls with major injury.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the necessary care and services were in place for a Foley catheter (tube inserted into bladder to drain urine) for 1 resident (Resident # 41) and failed to provide timely incontinence care for 1 resident (Resident #7), from a sample of 3 residents reviewed for incontinence care, resulting in the potential for trauma due to an unsecure Foley catheter, and skin breakdown and recurrent UTI's (urinary tract infections) due to inadequate incontinence care. Findings include:Resident #41Review of an admission Record revealed Resident #41 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: pressure ulcer of sacral (tailbone) region stage unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #41, with a reference date of 3/11/26 revealed a Brief Interview for Mental Status (BIMS) score of severe cognitive impairment. Review of the Functional Abilities revealed that Resident #41 was completely dependent on staff for toileting.Review of Resident #41's Skin Care Plan revealed there was no care plan related to Resident #41 incontinence and/or urinary catheter use.Review of Resident #41's Infection Control Care Plan revealed, Enhanced barrier precautions are an infection control intervention designed to reduce transmission of multidrug resistant organisms (MDRO). The resident must be placed in isolation (enhanced) due to risk of spreading MDRO's via an indwelling device, chronic/non-healing wound. Date initiated: 1/6/26. Interventions: .Staff are to wear PPE before entering room if they are providing high contact care. Date initiated: 1/6/26. The care plan did not indicate that Resident #41's indwelling device was a urinary catheter.During an observation and interview on 04/14/2026 at 11:03 AM Resident #41 was lying in her bed and Hospice Nurse (HN) M was performing wound care and a wound dressing change for Resident #41's sacral wound. Resident #41 verbalized that the wound was painful. Observed a foley catheter bag hanging from the bed frame. HN M was not wearing a gown.In an interview and observation on 04/15/2026 at 2:42 PM, Licensed Practical Nurse (LPN) KK reported that she had changed Resident #41's wound dressing on her sacrum early that morning and flushed the foley catheter. Observed Resident #41 still lying in bed and Resident #41's urinary catheter tubing was pulled tight and laying across her right leg; there was no catheter securement device observed to anchor the tubing in place. LPN KK reported that she did not notice that earlier. In an interview on 04/16/2026 at 8:14 AM, Unit Manager (UM) D reported that Resident #41 was hospitalized [DATE]-[DATE] for UTI (urinary tract infection) and returned to the facility with a foley catheter in place to help with sacral wound healing. Review of Resident #41's Hospital After Visit Summary dated 3/19/26 (admitted on [DATE]) revealed, .Foley in place for maintenance of sacral wound.Review of Resident #41's re-admission Assessment dated 3/19/26 revealed, Arrived by ambulance. Urinary Catheter intact. In an interview on 04/17/2026 at 9:16 AM, CNA G reported that she had not been in with Resident #41 since the start of her shift at 7:00 AM (2 hours ago). CNA G reported that she would have to look at Resident #41's care plan to know what care needed to be done.Review of Resident #41's Bowel and Bladder task record completed by the direct care staff indicated that in the past 30 days, Resident #41 was incontinent and/or not rated due to indwelling catheter every day.Review of Resident #41's Physician Orders for April 2026 revealed, Monitor foley catheter (size/balloon information needed) r/t (related to) wound healing. Change PRN (as needed) for obstruction every shift for infection control hygiene. Start date 3/19/26. Change foley catheter leg securement device every night shift on Sunday for trauma prevention, at bedtime every Sunday for wound. Start date: 3/22/26. The order did not include the size of catheter and size of balloon. Resident #7Review of an admission Record revealed Resident #7 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: cerebral infarction (stroke) that caused paralysis to right side. Review of a Minimum Data Set (MDS) assessment for Resident #7, with a reference date of 4/2/26 (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revealed a Brief Interview for Mental Status (BIMS) score of 9, out of a total possible score of 15, which indicated Resident #7 was cognitively impaired. Review of the Functional Abilities revealed that Resident #7 was completely dependent on staff for toileting.Review of Resident #7's Incontinence Care Plan revealed, I have bladder incontinence r/t dementia, history of UTI, impaired mobility. Date initiated: 4/14/26. Interventions: Incontinent: Check and assist me to change as needed for incontinence. Wash, rinse and dry perineum (private area). Change clothing PRN after incontinence episodes. Monitor/document for s/sx (signs and symptoms) of UTI (urinary tract infection) . Date initiated: 4/14/26. During an observation and interview on 04/15/2026 at 9:40 AM Resident #7 was lying in her bed. Resident #7 reported that staff do not come timely when she puts her call light on, she had multiple UTI's in the past and she was sitting in a wet brief at that time. Resident #7 reported that she had a sore spot on her butt and stated, it's real sore!Review of Resident #7's Physician Communication Note dated 4/15/26 at 7:17 AM revealed, Resident has a small slit in between intergluteal cleft (butt crack), barrier cream applied.During an observation on 04/15/2026 at 11:49 AM Resident #7 was lying in her bed and CNA W and CNA RR were preparing to get her out of bed and into her wheelchair. Resident #7 asked the CNA's why couldn't you get me up earlier? CNA W replied to Resident #7, we were just working our way down the hall.In an interview on 04/15/26 at 11:50 AM, CNA W reported that Resident #7 was always incontinent of urine and bowels and did not always know when she was soiled. CNA W reported that the last time Resident #7 had incontinence care that day was at approximately 6:00 AM (greater than 5 hours earlier) that morning. CNA W reported that Resident #7 complained of a sore spot on her buttocks that day and a new thin open wound in the crease of her buttocks was observed during incontinence care. CNA W reported that she applied zinc (skin protectant) cream to the open area but was not sure if the nurse knew about it yet. CNA W reported that there were 2 call ins that morning and they were working shorthanded until 9:30 AM.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician (provider) supervised the medical care of residents and participated in the resident's wound assessments and treatment plans for 1 resident (Resident #53) of 18 residents reviewed for physician supervised care, resulting in the potential for a decline in overall health due to worsening of wounds. Findings include: Resident #53Review of an admission Record revealed Resident #53 was originally admitted to the facility on [DATE], with pertinent diagnoses which included: Pressure ulcers of sacral (coccyx, tailbone) region and heel, both unspecified. Review of a Minimum Data Set (MDS) assessment for Resident #53, with a reference date of 2/5/26 revealed a Brief Interview for Mental Status (BIMS) score of 13, out of a total possible score of 15, which indicated Resident #53 was cognitively intact. Review of Resident #53's Braden Scale for predicting Pressure Ulcer Risk Evaluation dated 2/5/26 revealed, 12 indicating at high risk to develop pressure ulcers.Review of Resident #53's Skin Care Plan revealed, I am at risk for skin breakdown. Date initiated: 10/31/25. Interventions: Monitor for pain and medicate as needed per physician's order. Date initiated: 10/31/25. There was no documentation related to Resident #53's risk for pressure ulcers and/or interventions in place to reduce the risk. Review of Resident #53's Wound Management Care Plan revealed, Bilateral heels, Coccyx. Date initiated: 11/6/25. Interventions: Measure ulcer on regular intervals. Monitor ulcer for signs of infection. Monitor ulcer for signs of progression or declination. Notify provider if no signs of improvement on current regimen. Provide wound care per treatment orders. Date initiated 11/6/25. There were no updates made to this care plan.In an interview on 04/15/2026 at 8:36 AM, Licensed Practical Nurse (LPN) LL reported that Resident #53 does not get out of bed anymore, her heel sores have completely resolved, but the wound on her buttocks was not doing good at all. LPN LL reported that Resident #53 also had pressure point wounds on the tips of her toes, therefore staff had to constantly watch so that her feet don't press up against the end of the bed.In an interview on 04/16/2026 at 9:25 AM, Unit Manager (UM) D reported that Resident #53 had wounds on her heels and buttocks, and at one time a couple months ago had concerns for osteomyelitis (infection in the bone caused by infected tissue) because the wounds on her feet were not healing. UM D did not know the status of Resident #53's wounds. Reviewing Resident #53's records with UM D and there was no documentation of wound assessments that measured size, no pressure wound interventions listed, and all weekly skin checks were noted as normal. UM D reported that the facility did not have a dedicated wound nurse or provider, and that the floor nurse was expected to complete all wound assessments during the weekly skin check and notify UM D or a provider if there was a concern. UM D reported that the facility also uses a Wound Log to document when a concern was identified.Review of the facility Wound Communication Log revealed, (Resident #53) 4/2/26 Sacral wound purulent (liquid substance indicative of infection) drainage 3x2cm, new bruise right upper thigh/hip, new wound to right of current wound .5x.2cm. There was no documentation in the blanks for dressing orders or risk management completed.In an interview on 04/17/2026 at 10:04 AM, UM D reported that she was not aware of the wound communication log note from 4/2/26 related to Resident#53's wounds. UM D reported that Resident #53's orders had not changed since then and there were no progress notes or physician notes to correlate that the wound concern was assessed and being monitored. This surveyor requested to observe Resident #53's wounds and UM D agreed to collect supplies to complete assessments and wound care for all of Resident #53's wounds.During an observation on 04/17/2026 at 10:26 AM Resident #53 was lying in her bed in a sitting position. UM D was gathering supplies for wound care. At 10:46 AM UM D, Certified Nursing Assistant (CNA) CC, and Nurse Practitioner (NP) N were in the room at the bedside, donned (put on) gloves and began explaining to Resident #53 that they would be doing incontinence care and looking at her wounds. UM D removed the wound dressings from Resident #53's right and left heels, and NP N assessed the wounds. This surveyor observed nickel size brown scabs on both heels. NP N (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported that the right heel wound measured 1 cm x 1 cm and the left heel wound measured 2 cm x 1 cm and called the wounds deep tissue injuries. This surveyor observed Resident #53's toes on her left foot, they were discolored and scabbed, the staff did not assess that area. CNA CC and UM D rolled Resident #53 to her left side to provide incontinence care and assess her buttocks wound. There was an extra-large bandage covering Resident #53's coccyx area dated 4/17/26 that was visibly soaked with drainage from the wound. UM CC removed the bandage which revealed a large open wound with slough (moist white dead tissue) and eschar (black hard dead tissue) in the center of the wound. NP N reported Resident #53's coccyx wound was 8 cm x 9.5 cm and called it a Stage 3 pressure ulcer and said that it was deteriorating since there was tissue exposed now. There was a large purple discolored wound on Resident #53's right upper thigh that followed the line of an incontinence brief. UM D reported that she was not aware of the wound on the right upper thigh. NP N reported that Resident #53's wound on the right upper thigh appeared to be from shearing (a wound affecting deep tissue layers due to lateral shifts in movement). In an interview on 04/17/26 at 11:10 AM, NP N reported that she did not know how long Resident #53 had the wounds that were observed that day. NP N reported that at this time they would continue the same wound treatment as previously ordered.In an interview on 04/17/2026 at 11:17 AM, Infection Preventionist (IP) E reported that she would expect staff to notify her when there was a concern for wound infection and stated, a lot of the time I don't know until I find out on my own. IP E reported that residents with pressure wounds are not automatically placed in EBP. IP E reported that if a wound is diagnosed as a certain stage or was found to be infectious, then EBP were implemented at that time. IP E reported that Resident #53 wounds were not open and she does not require EBP. In a subsequent interview on 04/17/26 at 11:40 AM, IP E reported that she was informed Resident #53's wounds were deteriorating therefore she would be placed on EBP.In an interview on 04/17/2026 at 12:01 PM, NP N reported that she had not seen Resident #53's toes in the earlier observation and was not aware that she had any wounds on her toes. In an interview and observation on 04/17/2026 at 12:04 PM, Registered Nurse (RN) I reported that they were applying betadine (antiseptic for infection prevention) to Resident #53 toes. Observed Resident #53 lying in her bed; her left great toe had a thick scab covering the tip, and the 2nd and 3rd toes were discolored black at the tips. RN I reported that Resident #53's left great toe was an unstageable pressure injury.Review of Resident #53's Physician Note dated 2/9/26 revealed, .Staff concerned with skin issues on her bilateral feet. Bilateral heel wounds were being treated with Dakins (helps reduce infection and promote healing) solution on bilateral heels while floating and has an air mattress to offload pressure. Now concern with discoloration of toes.Physical exam: .Bilateral heels have stage 3 pressure injury with beefy red wound base and macerated (softening and breaking down of skin due to prolonged exposure to moisture) edges surrounding both wounds are individually the size of a nickel, right great toe has deep purple scab to the tip of the toe, right 2nd digit has small area on the pad of the toe which is dark purple, left great toe appears to have gangrene (tissue death) at the tip, left 2nd digit has gangrene nearly to the DIP (distal interphalangeal: closest to tip of toe) joint, bilateral legs have venous insufficiency with skin color changes.Assessment and Plan: 1. Impaired skin integrity. New orders placed for wounds on bilateral heels and toes. X-ray of bilateral feet. Vascular referral ASAP. Concern with gangrene.Review of Resident #53's X-ray of bilateral feet dated 2/10/26 revealed, .No osteomyelitis is seen.Medicine (sic) bone scan are more sensitive for detecting osteomyelitis.Review of Resident #53 Progress Notes for documentation related to her toes revealed, no provider visits and/or nurse's notes related to assessment and monitoring.In an interview on 04/17/2026 at 12:44 PM, UM D reported that nursing staff notified her today of Resident #53's wounds on her toes. UM D reported that the orders were entered into the computer on 2/10/26 for her right toes instead of the left toes. UM D reported she could not explain why there was not follow up by a provider and/or wound assessments of her toes.Review of Resident #53's Weekly Skin Check dated 3/20/26 indicated there were no new skin issues identified and listed the following wounds as NOT evaluated: Right inguinal (groin) region, left heel, left gluteal (buttocks) fold, coccyx, (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	general bruising, left inguinal region, right gluteal fold and right heel. There was no documentation related to Resident #53's toes.Review of Resident #53's Weekly Skin Check dated 3/30/26 revealed, Skin: Skin warm & dry, skin color WNL and turgor is normal. Foot evaluation completed. No new skin issues identified. Skin issues: #1 Skin issue HAS been evaluated. Location: left inguinal region. Moisture associated skin damage (MASD). Progress: improving. #2 Skin issue has NOT been evaluated. Location: Coccyx. #3 Skin issue has been evaluated. Location: right inguinal region.MASD. #4 Skin issue has NOT been evaluated. Location: right heel.Unstageable pressure injuries. #5 Skin issue has NOT been evaluated. Location: left heel.Unstageable pressure injuries. Resident #53's wounds on her coccyx and heels were not evaluated.Review of Resident #53's Weekly Skin Check dated 4/6/26 revealed, Skin: Skin warm & dry, skin color WNL and turgor is normal. Foot evaluation completed. No new skin issues identified. Skin Issues: #1: Skin issue has been evaluated. Location: Coccyx. #2: Skin issue has Not been evaluated.#2 Skin issue has NOT been evaluated. Location: Right heel. Issue type: Pressure ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury . #3: Skin issue has NOT been evaluated. Location: Left inguinal (groin) region . Moisture associated skin damage (MASD). #4: Skin issue has NOT been evaluated. Location: Right inguinal region. Issue type: Moisture associated skin damage (MASD). #5: Skin issue has NOT been evaluated. Location: Left heel. Issue type: Pressure ulcer / injury. Pressure ulcer staging: Unstageable pressure injuries. It was noted that none of Resident #53's wounds were assessed and there were no wounds noted on her toes.Review of Resident #53's most recent Weekly Skin Check dated 4/13/2026 revealed, Skin: Skin warm & dry, skin color WNL and turgor is normal. Foot evaluation completed. No new skin issues identified. Skin Issues: #1: Skin issue has NOT been evaluated. Location: Coccyx. #2: Skin issue HAS been evaluated. Location: Right heel. Issue type: Pressure ulcer / injury. Progress: Stalled: previously improving wound characteristics plateaued. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury . Length (cm): 7.4 Width (cm): 7.8.Exudate amount: Light. Exudate type: Serous: clear watery fluid, which is separated from solid elements. #3: Skin issue HAS been evaluated. Location: Left inguinal (groin) region . Moisture associated skin damage (MASD). Progress: Stable: previously deteriorating wound characteristics plateaued . Measurements not documented as part of this assessment. #4: Skin issue HAS been evaluated. Location: Right inguinal region. Issue type: Moisture associated skin damage (MASD). Progress: Stable: previously deteriorating wound characteristics plateaued . Measurements not documented as part of this assessment. #5: Skin issue HAS been evaluated. Location: Left heel. Issue type: Pressure ulcer / injury. Progress: Improving: overall wound characteristics improved. Pressure ulcer staging: Unstageable pressure injuries presenting as deep tissue injury.Measurements not documented as part of this assessment.Clean dressing applied. There was no documentation of the wounds on Resident #53's toes and it was noted that the coccyx wound was not assessed.Review of Resident #53's Physician Visit Notes from 2/20/26, 3/4/26, 4/6/26 for information related to the resident's pressure wounds on coccyx, heels and toes. There were no additional physical exams or assessment/plans following the 2/9/26 visit note.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely physician follow up with pharmacy recommendations for 3 residents (Resident #3, Resident #10, and Resident #57) of 5 reviewed for medications resulting in the potential for residents to experience avoidable medication side effects and/or receive unnecessary medications.Findings include: Resident #3 Review of an admission Record revealed Resident #3 was originally admitted to the facility on [DATE] with pertinent diagnoses which included: insomnia (common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up to early, leading to unrefreshed sleep and daytime impairment). Review of a Minimum Data Set (MDS) assessment for Resident #3 with a reference date of 3/20/26, revealed a Brief Interview for Mental Status (BIMS) assessment score of 12/15, which indicated the resident was moderately cognitively impaired. Section N of the MDS revealed Resident #3 received a hypnotic medication. Review of a Care Plan for Resident #3 with a reference date of 12/29/25 revealed the following focus/goal/interventions: Focus: I have behavior problem r/t (related to) my .Dx (diagnosis) of Insomnia.I'm upset when staff enter my room before 8am.Goal: I will not experience difficulties with behavior or mood through the review date. Review of a Pharmacy Consultation Report for Resident #3 with a reference date of 2/9/26 revealed Comment: (Resident #3) has an order for Zolpidem Tartrate (sedative-hypnotic) 10mg (milligrams) QHS (every night) for insomnia that is above the maximum recommended dose for older adults. Recommendation: Please decrease the dose to Zolpidem Tartrate to 5mg QHS. No physician response to the recommendation was documented. Review of an Order Summary for Resident #3 with a reference date of 4/17/26 revealed an active order Zolpidem Tartrate Oral Tablet 10 MG. Give 1 tablet by mouth one time a day for insomnia. In an interview on 4/17/26 at 12:40pm, Chief Executive Officer (CEO) B reported the facility was not in compliance with ensuring the physician promptly responded to pharmacy recommendations; CEO B reported he was unsure how many residents may have been impacted by this deficient practice but described the situation as significant trend. CEO B confirmed the noncompliance left Residents #3, #10 and #57 at risk for receiving unnecessary medications. Review of a Medication Regimen Review policy with a reference date of 4/24/24 revealed .The Medication Regimen Review (MRR) is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication.The pharmacist shall communicate any recommendations and identified irregularities via written communication.Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. Resident #10 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of an admission Record revealed Resident #10 was originally admitted to the facility on [DATE] with pertinent diagnoses which included Alzheimer's disease (progressive, irreversible brain disorder that slowly destroys memory, thinking skills, and eventually the ability to perform simple tasks) and anxiety disorder. Review of Resident #10's Pharmacy Consultation Report dated 2/9/26 revealed, Comment: (Resident #10) receives Quetiapine Fumarate (antipsychotic medication) ER (extended release), Clonazepam (benzodiazepine used to treat seizures and panic disorder) and Trintellix (antidepressant), and has a diagnosis of dementia. Recommendation: If the current regimen is to continue, it is recommended that a) the prescriber document an assessment of risks verses benefit, and indicating that it continues to be a valid therapeutic intervention for this individual; b) the record contains documentation of the dose reduction history, specific target behavior (s), desired outcome (s), and the effectiveness of individualized nonpharmacological interventions . and c) the facility interdisciplinary team ensures ongoing monitoring for effectiveness and potential adverse consequences . Physicians Response: Empty Noted the provider did not respond to the pharmacy consultation report. This writer attempted to contact Medical Director (MD) CCC via telephone on 4/17/2026 at 12:36 PM. MD CCC did not return this writer's phone call by survey exit. During an interview on 4/17/2026 at 1:01 PM, Interim CEO B confirmed that the facility was not able to provide documentation to verify that MD CCC had reviewed Resident #10's consultation report. Interim CEO B was unable to report how the facility had missed completing Resident #10's February 2026 medication review. Resident #57: Review of an admission Record revealed Resident #57 was a male with pertinent diagnoses which included dementia, age related debility, and mild cognitive impairment (problems with memory and thinking). Review of Order dated 11/5/2025 for Resident #57, revealed, .Clotrimazole Athletes Foot External Cream 1 % (Clotrimazole (Topical)) Apply to bilateral feet topically two times a day for boot feet. Review of Resident #57's medical record revealed the consulting pharmacist had a recommendation when the monthly medication review for February 2026 was conducted. Review of Resident #57's medical record revealed no pharmacy consultation report for recommendations dated 2/9/26. In an interview on 04/15/26 at 4:15 PM, Interim (Chief Executive Officer) CEO B reported he was unable to locate the MMR report for Resident #57 for 2/9/26. Interim CEO B' reported the facility would check all scanned documents during that time frame to see if the facility can find it. CEO B reported the Director of Nursing (DON) C would receive the pharmacy consultation reports via email notification and she was to print them out and provide them to the provider to review and sign. Review of Pharmacy Consultation Report dated 2/9/2026, revealed, .Comment: (Resident #57) has received a topical anti-infective, clotrimazole, for greater than 4 weeks without a documented stop date .Recommendation: lease discontinue clotrimazole. If therapy cannot be immediately discontinued, please document a stop date .Rationale for Recommendation: Prolonged use may increase the risk of (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adverse consequences, including the development of drug-resistant organisms .References: 1) Centers for Disease Control and Prevention: The core elements of antibiotic stewardship for nursing homes. 2024. 2) [NAME] DA et al. Current and emerging topical antibacterial and antiseptics: Agents, action and resistance patterns. Clin Microbiol Rev. 2017; 30(3):827-860 . In an interview on 04/16/26 at 8:50 AM, Interim (Chief Executive Officer) CEO B reported the facility did not have documentation supporting the review of the Pharmacy monthly medication review consultation report. Interim CEO B reported the facility had receive the note but no proof it was given to the provider and reviewed. Review of policy, Medication Regimen Review approved 4/24/24, revealed, .4. The pharmacist shall document, either manually or electronically, that each medication regimen review has been completed. (See Medication Regimen Review form.) .a. The pharmacist shall document either that no irregularity was identified or the nature of any identified irregularities.b. The pharmacist does not need to document a continuing irregularity in the report each month if the attending physician has documented a valid clinical rationale for rejecting the pharmacist's recommendation. c. Each MRR shall be signed by the pharmacist 5. The pharmacist shall communicate any irregularities to the facility in the following ways:a. Verbal communication to the attending physician. Director of Nursing, and/or staff of any urgent needs .b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing 6. Written communications from the pharmacist shall become a permanent part of the resident's medical record .

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and record review, the facility failed to ensure the Medical Director fulfilled their responsibility of implementing Medication Regimen Review (MRR) policies/procedures to include coordination of care between the facility and the consulting pharmacist/pharmacy for 3 (Resident #10, #57 and #3) of 5 residents reviewed for medications. This deficient practice has the potential to affect all residents that reside at the facility. Findings include: During an interview on 4/17/2026 at 1:01 PM, Interim CEO B confirmed that the facility did not have documentation to confirm that Medical Director (MD) CCC had been completing monthly pharmacy recommendation reviews for Resident #10, #53 and #3. Interim CEO B confirmed that MD CCC was responsible for ensuring that all resident pharmacy reports were reviewed and signed by MD CCC, and he was unable to explain why MD CCC had missed completing the monthly reviews. This writer attempted to contact Medical Director (MD) CCC via telephone on 4/17/2026 at 12:36 PM. MD CCC did not return this writer's phone call by survey exit. Review of the facility's Medication Regimen Review policy dated 4/24/24 revealed, Policy: The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart. Policy Explanation and Compliance Guidelines: 1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities. b. Collaboration with other members of the interdisciplinary team, including the resident, their family, and/or resident representative . Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. For further information, see F756.

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F 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation and interview, the facility failed to ensure the most recent survey results were available to residents, family members, legal representatives, and/or visitors to the facility.Findings include:On 5/27/26 at 9:58 am, Review of a previous survey results binder located on a table, near the elevator and the entry door to the kitchen, in a hallway leading to the main dining room of the facility contained the survey results from a survey completed in September 2025. Not the most recent survey results.In an observation and interview on 5/28/26 at 12:10 pm, Manager of Case Management (MCM) W reviewed the previous survey results binder and reported she had no idea the binder even existed, nor that survey results should be available for review by resident and/or guests. MCM W confirmed the results in the binder had an exit date of 9/2025 and were not the most recent survey results.In an observation and interview on 5/28/26 at 2:00 pm, MCM W reported she had made additions to the previous survey results binder. It was noted, MCM W added the facility most recent life safety survey results.In an interview on 5/28/26 at 3:30 pm, MCM W reported she did not know how to obtain survey results, and it was not her responsibility to update the binder.In an interview on 5/28/26 at 4:30 pm, Nursing Home Administrator, (NHA) A reported he had not updated the previous survey binder. NHA A reported he had not received notification that his plan of correction was approved and the documentation was complete. NHA A reported he could not post the survey results until the plan of correction was available on the survey results. NHA A accessed his most recent survey results online and it was noted that the survey results and the plan of corrections were available.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation and interview the facility failed to ensure daily staffing information was posted daily.Findings include:On 5/27/26 at 8:30 am, 12:30 pm, and 4:45 pm staffing hours posted in the glass enclosure on the wall to the right inside the main entrance were dated 5/22/26.On 5/28/26 at 7:45 am, 12:15 pm, and 4:35 pm, staffing hours posted were still dated 5/22/26. On 5/29/26 at 7:45 am, staffing hours posted were still dated 5/22/26. In an interview on 5/29/26 at 10:27 am, Scheduler (S) FF reported she was responsible for the posting of staffing hours. S FF reported she did not work 5/23/26 through 5/26/26. S FF reported she returned to work on 5/27/26, and should have posted staffing hours, but had not done it. S FF reported she did not know who would post staffing hours when she was absent from the building.In an interview on 5/29/26 at 10:30 am, Nursing Home Administrator (NHA) A reported S FF was responsible for posting staffing hours daily. NHA A reported Director of Nursing (DON) B would be responsible when S FF was absent from the building.In an interview on 5/29/26 at 10:35 am, DON B reported any of the managers could post staffing hours, it could even be me. DON B reported there was no management staff in the building on the weekends or on holidays, and the hours did not get posted. DON B reported the staffing hours should have been posted when the management staff returned on 5/26/26.