STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2568667Based on interview, and record review, the facility failed to obtain informed consent for psychotropic medications for 1 of 7 (Resident #101) residents reviewed for psychotropic medications, resulting in the resident/resident representative's inability to make decisions on risk vs benefit of medication use and alternative treatment options. Findings include: Resident #101:Review of an admission Record revealed Resident #101 was a female who was admitted on [DATE] with pertinent diagnoses which included severe late onset Alzheimer's dementia with agitation, ground level fall, insomnia, and depression. Review of all Care Plans for Resident #101, revealed no focus or interventions for the use of psychotropic medications with monitoring for adverse consequences. Review of Order dated 5/9/25 for Resident #101, revealed, .Lorazepam (Ativan) tablet 0.5 mg Oral, nightly, Associated Diagnosis: Other insomnia. Review of Order dated 5/29/25 for Resident #101, revealed, .Lorazepam (Ativan) tablet 0.5 mg Oral, Once, 1200. Associated Diagnosis: Other insomnia.Anxiety Disorder.Review of Order dated 6/4/25 for Resident #101, revealed, .Lorazepam (Ativan) tablet 0.25 mg Oral, 3 times daily, PRN (As needed).Associated Diagnosis: Anxiety Disorder.In an interview on 9/24/25 at 3:27 PM, Family Member/Durable Power of Attorney (DPOA) (FM) OO reported when Resident #101 was admitted to the hospital following a fall on 6/8/25, she was informed Resident #101 was being given Lorazepam at night which she was not aware Resident #101 had been receiving that medication. FM OO reported she did not give her permission for Resident #101 to take Lorazepam and because Resident #101 was so mobile she felt that Resident #101 should not have been put on that medication.Review of Psychotropic Medication Risk/Benefit Consent dated 4/17/25 revealed, no consent for the Lorazepam orders were completed and there was no signature. The document only indicated FM OO was a participant as of 9/25/25. No documentation submitted to indicate consent was provided verbally. In an interview on 9/25/25 at 09:07 AM, Social Worker (SW) H reported consents for medications would be signed electronically by the decision maker or resident when admitted or when there was a change in medications where consents were needed. SW H reported she would be able to call the decision maker to obtain verbal permission from them with two person's present as witnesses. SW H reported also if the decision maker was not able to come to the building and electronically sign the document, the consent could be sent out to them for signature and social work would have to follow up for return. SW H reported there was not a standard of work process in place from corporate on consents. SW H was unable to locate notes for Resident #101 as well as notes which had indicated a conversation had been had with the decision maker for the prescribed lorazepam medications.During an observation and interview on 09/25/25 at 2:32 PM, Nurse Liaison C reported that there was no documentation in Resident #101's record that there was a verbal consent received for Lorazepam.

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

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

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F 0561 Level of Harm - 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. (continued on next page)

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F 0561 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2614764Based on interview and record review, the facility failed to ensure residents maintained their right to self-determination in 1 of 1 resident (Resident #100) reviewed for choices, resulting in frustration with not being able to go to sleep at a preferred bedtime, an altercation with staff and a left fractured humerus. Findings include: Resident #100: Review of an admission Record revealed Resident #100 was a female with pertinent diagnoses which included chronic pain, contracture of the left upper arm, debility, stroke, paralysis affecting left side, and dementia. Review of current Care Plan for Resident #100, revised on 3/24/25, revealed the focus, .(Resident #100) may refuse to return to her room for incontinence care or go to bed at a reasonable time. with the intervention .Assess decision making ability.Provide a consistent daily routine.Environmental precautions (confusion).Assess for mood changes.Reality orientation as needed. Review of Event Summary Report dated 9/2/25, revealed, .Resident complained of pain with staff nurse during first shift. Nurse assessed resident's pain area, including skin. Nurse found that left arm and shoulder area was swollen compared to the right arm and shoulder area, Resident given pain medication as ordered.Resident reported that her arm was pulled during care, and she has a diagnosis of closed fracture of surgical neck of left humerus.Review of ED Course dated 9/2/25 at 12:28 PM, revealed, .presents to emergency department via EMS for acute onset left shoulder pain.at her care facility when a nurse pull on her arm, she had significant pain noted to the left shoulder.had a previous stroke and has no motor function to the left upper extremity.Patient is sitting in bed uncomfortable appearing. Significant exam findings include significant tenderness palpation of the left shoulder with overlying swelling. No significant bruising or redness to the area. Review of ED (Emergency Department) Provider Notes dated 9/2/25 at 2:37 PM, revealed, (Resident #100) is a [AGE] year old female who presents to the ED (emergency department) for evaluation of L (left) shoulder pain. Patient reports she felt like her arm got yanked and she now has LUE (left upper extremity) pain. She denies other falls or trauma. Patient reports pain is terrible; she received 100 mcg fentanyl en route. Patient is main historian.On exam, patient is awake, alert, conversant .Patient is sitting in bed, LUE abducted, no pain over the L elbow, forearm, wrist, or hand, limited ROM (range of motion) of LUE which patient reports is at baseline. Swelling and tenderness noted to the L lateral (side) shoulder. Distal radial pulse 2+, distal sensation intact.XR (x-ray) obtained of L shoulder, L elbow, L hand.Imaging shows L humeral neck fracture.Sling placed advised to follow up within 5 days with ortho. During an observation on 09/24/25 at 10:33 AM, observed Resident #100 in the dining room she had on a sling for her left arm, she had a tray table on that side of the wheelchair, she had a bag with tissues, binder, papers, clipboards in it, and she had anti-tippers on the back of her chair which were shiny and looked new. In an interview on 09/24/25 at 2:22 PM, Resident #100 reported she wasn't doing so good, she reported someone had lifted her arm up and broke her arm, and when queried further she was unable to tell this writer what had happened to her. In an interview on 09/25/25 at 10:24 AM, CNA Y reported Resident #100 was upset and agitated when she had arrived at work earlier in the day. CNA Y reported she decided to leave her alone. CNA Y reported Resident #100 never wanted to lay down or go to bed. CNA Y reported between 9:00 PM and 10:00 PM, she started to get residents in bed, and she took Resident #100 to her room to lay her down, indicated it was common for her not to want to go to bed, and Resident #100 didn't want to lie down even for brief changes. CNA Y reported so she took her to her room to take her clothes off and put her in bed, and she started to swing her right arm at me as she was taking her shirt off when she reached her left arm to raise it up to take the shirt off, Resident #100 started fighting and screaming at her. CNA Y reported when she started fighting, she had left the room to go seek assistance from other staff. CNA Y reported she was swinging her right arm at her and had a pencil in her hand. CNA Y reported she had never seen Resident #100 act like that as she usually complied when took her to her room to change her and get her into bed. CNA Y reported Resident #100 did have behaviors but nothing like she had that night. In a second interview on 9/29/25 at 2:43 PM, CNA Y reported she had Resident #100's shirt off and had one of her arms in her gown, her right arm and that was when she started to fight. CNA Y reported she just left her alone and went to go get help from another staff member. CNA Y reported she had someone else to help to try to finish her getting ready for bed, CNA Y reported Resident #100's gown was on but not on her completely, but her shirt was off. CNA Y reported CNA FF came to Resident #100's room to assist and when she came in the room and she was still wanting to fight, we didn't' do anything else to help, left the room and went to inform the nurse. CNA Y

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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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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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 0605 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to intake: 2568667.Based on interview and record review, the facility failed to prevent the use of unnecessary psychotropic medications without adequate indication for use and without resident monitoring in 1 of 1 resident (Resident #101) reviewed for psychotropic medications, resulting in an Immediate Jeopardy when on [DATE] Resident #101 was prescribed a psychotropic medication, who then sustained a fall with a impacted acetabulum (hip socket) and pelvic fracture on [DATE] and subsequent death. Findings include: Resident #101 was prescribed lorazepam daily beginning [DATE]. Resident #101 had falls on 5/12, 5/20, and 5/28 with no major injury after no falls since February admission. No monitoring for or recognition of adverse consequences from psychotropic medications occurred after these falls. On [DATE], Resident #101 fell while ambulating and sustained impacted acetabulum and pelvic fractures, was hospitalized , and died as a result of the fall per the medical examiner.The Immediate Jeopardy began on [DATE] when Resident #101, who was prescribed lorazepam daily beginning [DATE] and had falls on 5/12, 5/20, and 5/28 with no major injury after no falls since February admission. No monitoring for or recognition of adverse consequences from psychotropic medications occurred after these falls. On [DATE], Resident #101 fell while ambulating and sustained impacted acetabulum and pelvic fractures, was hospitalized , and died as a result of the fall per the medical examiner. Nursing Home Administrator (NHA) A was notified of the Immediate Jeopardy on [DATE] at 2:24 PM. The surveyor confirmed by interview and record review that the Immediate Jeopardy was removed on [DATE], but noncompliance remains at actual harm due to not all staff had received education and sustained compliance had not been verified by the State Agency. Review of an admission Record revealed Resident #101 was a female with pertinent diagnoses which included severe late onset Alzheimer's dementia with agitation, recurrent falls, insomnia, and depression. Review of Minimum Data Set (MDS) dated [DATE] revealed, a Brief Mental Status Score (BIMS): 11 which indicated moderate cognitive impairment. Review of Care Plan for Resident #101, started on [DATE], revealed Resident #101 was at risk for falls due to impaired balance, did not ask for assistance, but prefers to remain independent. Resident #101 was on psychoactive medications which increase her risk. Interventions included Monitor medication side effects for potential gait disturbances or other safety issues and Visual checks per facility policy. Note: Requested policy for visual checks and was informed the facility does not have a policy for visual checks. Review of Resident Care Summary dated [DATE], revealed, .Independent: Bed Mobility, Chair to Bed/Chair transfers, and Walk 10 feet. Review of electronic correspondence received from Director of Nursing (DON) B on [DATE] revealed, fall dated [DATE] occurred at 5:10 AM. Review of Event Summary Report dated [DATE], revealed, CENA alerted by roommate that resident had fallen. Resident was lying on her back parallel to the bed. She had just come out of the bathroom at the time of fall per roommate. C/O (complaint of) increased pain to the L (left) hip.Unable to properly assess the L hip d/t (due to) pain. Placed pillows under her to make her more comfortable and called (Initial) the On-call Provider to have her transported to the ER for an eval. No indication that Resident #101's medications were reviewed at the time of fall to determine if they contributed to the fall despite an increase in behaviors after starting Lorazepam. In an interview on [DATE] at 11:00 AM, Registered Nurse (RN) M reported when she went into the room, Resident #101 was on the floor on her R (Right) side. Resident #101 was in a lot of pain. RN M reported she wanted to do her own thing and was angry at staff when staff checked on her because she felt she could do it herself. In an interview on [DATE] at 3:25 PM, CNA II reported Resident #101 had gotten up, went to the bathroom and the roommate had turned on the call light to alert us. CNA II reported she went into the room and found Resident #101 on the floor between her and her roommate's bed, and she was in a lot of pain. CNA II reported Resident #101 was independent, she liked to do a lot of things herself, and she didn't like staff to assist her, but was not aggressive or combative.Review of ED Triage Notes dated [DATE] revealed, .Closed displaced combined transverse-posterior fracture of left acetabulum; ground level fall. (complex fracture of the left hip socket's bony structure, characterized by a break that runs across the socket and extends to its posterior (back) wall, is not open to the outside (closed) and has bone fragments that have moved out of alignment).Review of CT of the Pelvis without Intravenous Contrast dated [DATE] at 7:45 AM, revealed, .Impression: 1. Complex and displaced left acetabular fracture with extension into the left iliac wing resulting in a posttraumatic protrusion appearance of the femoral head.2. Mild to moderately angulated and minimally displaced fracture of the left inferior pubic ramus.Review of Geriatric Trauma Consult dated [DATE] at 8:29 AM, revealed, .She is

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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 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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on record review and interview, the facility failed to implement care plan interventions and the facility policy to prevent falls in 1 of 7 residents (Resident #102) reviewed for fall prevention, resulting in the potential for falls and injury. Findings includeResident #102:Review of an admission Record revealed Resident #102 was a male with pertinent diagnoses which included dementia, confusion, incontinence, reduced mobility, fall risk, and end stage Alzheimer's disease. Review of current Care Plan for Resident #102, revised on 9/5/2025, revealed the focus, .(Resident #102) does not want to experience a fall resulting in major injury. with the intervention .Bed in low position.Accompany resident (ex. 1:1, stand by assist, dayroom monitoring, 15 min checks, line of sight).Visual checks per facility policy. Review of Resident Care Summary dated 9/8/25, revealed, .Safety: Bed by all for increased floor space.Fall mattress next to open side of bed for increased protection from injury.Review of Event Summary Report dated 9/5/25, revealed, . Safety: Bed by wall for increased floor space (fall mattress) 9/4/25 at 10:00 PM.Bed Mobility: Supervision/Touching (9/4/25 4:00 PM). Summary of Events: CNA (Certified Nursing Assistant) walked by room to see resident getting out of bed and sliding to the floor in a sitting position. Resident said he was trying to leave.Resident was gotten up in wheelchair and placed by nurses' station. Full thickness mattress placed by resident bed for additional protection from injury should another fall of a similar nature occur. Referred to Quality Assurance for further review .Investigation: This resident was extremely confused at the time of admission. The fall occurred several hours after admission. The new environment was likely a contributory factor. The resident seemed unaware that he could not walk and thought he could leave. When he attempted to stand, he slid to the floor. The low bed prevented injury. Staff appropriately got the resident out of bed and kept him under observation near the nurse's station.IDT (Interdisciplinary Team) Recommendations: Resident reviewed with Interdisciplinary team r/t (related to) his recent fall. Risks, current status and interventions reviewed. Resident is at risk for falls R/T confusion, weakness and lack of safety awareness. Risks, current status and interventions reviewed and remain appropriate at this time. Recommend to continue with current plan of care and implement the following changes to plan of care: One side of bed was placed next to the wall, and a full thickness mattress was placed on the other side of the bed-to be used whenever the resident is in bed. Resident's care plan and care summary have been updated appropriately. During an observation on 09/24/25 at 2:10 PM, Resident #102 was observed in bed, fall mattress was placed on its side at the side of his bed, not next to the bed lying flat on the floor. During an observation and interview on 09/24/25 at 2:11 PM, Licensed Practical Nurse (LPN) O was observed placing the fall mattress on the floor next to Resident #102's bed. She placed a wedge on his right side and tucked it under him; enabler bar was up on the right side. LPN O reported she was in the room diagonal, across the hallway giving medication to another resident, and she was coming to see Resident #102 in a second. LPN O reported the CNA should have laid down the mattress when she left the room. In an interview on 09/24/25 at 2:17 PM, CNA EE reported she had to take his roommate out in his wheelchair, and she had forgot to lay the fall mattress back down on the floor next to Resident #102's bed. CNA EE reported she thought LPN O was going to go right in Resident #102's room but she should have laid it down. In an interview on 09/25/25 at 1:27 PM, Clinical Nurse Supervisor (CNS) G reported Resident #102 had been a resident at the facility a couple of weeks. CNS G reported the staff were keeping a closer eye on him as he was a fall risk, have him in the open area so more eyes can be on him. CNS G reported the fall mattress was in place for Resident #102 in case he would roll out of bed. Resident #102 can be redirectable approximately 80% of the time but he does attempt to get up out of his chair as well. In an interview on 09/24/25 at 10:25 AM, Director of Nursing (DON) B reported the facility was using fall mattresses and fall mats for residents who had falls or were fall risks. Review of policy, Falls: Risk Screening, Prevention, and Post Fall Follow Up dated 7/21/24, revealed, .To outline the process to identify fall risk, interventions to prevent falls and patient or resident injuries, and to outline the required process for post fall follow-up for rehab and nursing centers .A patient fall is a sudden, unintentional descent, with or without injury to the patient, that results in the patient coming to rest on the floor, on or against some other surface (e.g., a counter), on another person, or on an object (e.g., a trash can). When a patient rolls off a low bed onto a mat or is found on a surface where you would not expect to find a patient, this is considered a fall. If a patient who is attempting to stand or sit and falls back onto a bed, chair, or commode, it is only considered a fall if the patient is injured .Care planning and evaluation will be completed by a licensed nurse who will initiate and update the plan of care and

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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. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to prevent the risk of urinary tract infection and ensure urinary catheter tubing and drainage bag were not resting on the floor in 2 of 2 residents (Resident #102, #105) reviewed for urinary catheter use, resulting in the potential of a urinary tract infection. Findings include: .A CAUTI (Catheter associated urinary tract infection), or a UTI associated with a catheter, is common if you have an indwelling catheter inside your urethra.Symptoms are similar to a general UTI and include bloody or cloudy urine, gritty particles or mucus in your urine, urine with a strong odor, pain in your lower back, chills and fever. (https://www.healthline.com/health/sediment-in-urine)Resident #103: Review of an admission Record revealed Resident #103 was a male with pertinent diagnoses which included stroke and gross hematuria (blood in urine). During an observation on 09/24/25 at 2:32 PM, Resident #103 was observed lying in his bed, bed was low to the ground, and his catheter bag was on the floor without a barrier under it. Licensed Practical Nurse (LPN) V entered the room and confirmed the catheter bag was on the floor. LPN V obtained a towel and placed it under the catheter bag she had placed on the fall mattress next to Resident #103's bed. In an interview on 09/25/25 at 12:48 PM, Clinical Nurse Supervisor (CNS) F reported Resident #103 had a foley and was diagnosed gross hematuria. CNS F reported the foley catheter was last changed in August 25. Resident #105: Review of an admission Record revealed Resident #105 was a female with pertinent diagnoses which included dementia, insomnia, diabetes,Review of current Care Plan for Resident #105, revised on 10/23/24, revealed the focus, .(Resident #105) has an indwelling catheter and is at risk for health care complications. with the intervention .Secure foley.Keep catheter tubing free of kinks. Keep drainage bag below level of bladder. During an observation on 09/24/25 at 11:31 AM, Resident #105 was observed self-ambulating in her wheelchair, she had the catheter bag in a privacy bag, but the tubing was dragging on the floor from when it came down the front of the chair into the privacy bag under her chair. There was approximately 12 inches of catheter tubing running along the floor as she ambulated around the building. During an observation on 09/24/25 at 11:36 AM, staff had stopped to assist Resident #105 with her blankets, and after Resident #105 headed in the other direction the catheter tubing was still dragging along on the ground under the wheelchair. The urine in the tubing appeared to be dark yellow in color with an orange tinge to it as well as cloudy in appearance. During an observation on 09/25/25 at 09:14 AM, Resident #105 was observed in the back 200 hallways, self-propelling down the hallway. The catheter bag was in the privacy bag, which was dragging on the ground, the tubing was draped down the front of her wheelchair and tucked in the bag and the tubing was dragging on the floor underneath the chair into the catheter bag. In an interview on 09/25/25 at 09:19 AM, LPN R reported Resident #105 had had recurrent urinary tract infections. Review of Comprehensive Visit dated 9/9/25 at 6:23 PM, revealed, .Note based on chart review and conversation with staff. Resident was seen wheeling herself around the building .Staff reported that she has been confused recently, more than her baseline. Orders for UA (Urinalysis) to rule out UTI (urinary tract infection) .Review of Urinalysis (UA) Do Culture if Indicated results note dated 9/9/25 at 7:40 PM, revealed, Resident #105 had yellow .turbid, cloudy .trace of blood .protein .Large leukocyte esterase .white blood cells . bacteria- many .In an interview on 09/25/25 at 1:02 PM, CNS F reported Resident #105 had a UTI earlier this month, the catheter was changed on 9/9/25 and she was prescribed an antibiotic. CNS F reported the catheter tubing should not be dragging on the floor as it contaminated the tubing, and then the bag. In an interview on 9/29/25 at 3:27 PM, Infection Preventionist (IFP) E reported the catheter tubing should not be dragging on the ground, because the floor was dirty and the catheter tubing was connected to the catheter bag and can lead to contamination.Review of policy, .Urinary Catheter Care and Management Policy - Rehab and Nursing Centers dated 4/21/24, .Indwelling Collection Devices: A closed sterile urinary drainage system .Indwelling Urinary Catheter - A catheter placed in the bladder via the urethra, with the intent to remain in place after insertion, to provide continuous urinary drainage to an external collection device . Maintain catheter tubing and drainage bag off the floor .